



World Health
Organization

WHO contribution in Somalia 2020-2025

Evaluation report

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

Contents

Contents.....	iii
Acknowledgements.....	iv
Acronyms and abbreviations	v
Executive summary	vi
1 Introduction	1
2 Evaluation design and methodology.....	9
3 Findings	15
4 Conclusions	72
5 Recommendations	75
6 References.....	85

List of tables

Table 1 WHO budget categorization.....	4
Table 2 Planned, financed and utilized costs of WCO	5
Table 3 Expected uses of the evaluation by the stakeholders.....	8
Table 4 Achieved sample size of primary data collection.....	10
Table 5 Evaluation criteria and questions.....	12
Table 6 Evaluation limitations and impact on the evaluation findings.....	13
Table 7 Evidence map - internal and external coherence	30
Table 8 Summary of contribution analysis of WHO's strategic priorities in Somalia	40
Table 9 Immunization coverage by antigen (2024)	42
Table 10 Disease burden.....	43
Table 11 Funding for the 2022–2023 biennium	58
Table 12 Funding mobilization by strategic priority	59
Table 13 WCO risk and mitigation measures for future funding.....	65

List of figures

Figure 1. Trend of financing from 2018–2019 to 2024–2025, by segment	5
Figure 2. The reconstructed theory of change	17
Figure 4. Immunization coverage by year.....	42
Figure 5. OPV vaccination status by age group.....	44
Figure 6. Perceptions of the effectiveness of WHO's work in reaching the most vulnerable	56

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Acronyms and abbreviations

BCG	bacille Calmette–Guérin	OECD	Organisation for Economic Co-operation and Development
CHW	community health worker	OPV	oral polio vaccine
DAC	[OECD] Development Assistance Committee	PHC	primary health care
DTP	diphtheria–tetanus–pertussis vaccine	RMNCA	reproductive, maternal, neonatal, child and adolescent health
EPI	Expanded Programme on Immunization	SDGs	Sustainable Development Goals
EQ	evaluation question	SP	strategic priority
GPEI	Global Polio Eradication Initiative	ToC	theory of change
GPW	General Programme of Work	UHC	universal health coverage
HMIS	health management information system	UN	United Nations
IDP	internally displaced persons	UNCT	United Nations country team
IDSR	integrated disease surveillance and response	UNDP	United Nations Development Programme
IHR	International Health Regulations	UNFPA	United Nations Population Fund
IPV	inactivated polio vaccine	UNICEF	United Nations Children’s Fund
KI	key informant	UNSDCF	United Nations Sustainable Development Cooperation Framework
KII	key informant interview	WASH	water, sanitation and hygiene
KPI	key performance indicators	WCO	WHO country office
M&E	monitoring and evaluation	PHC	primary health care
NGO	non-governmental organization	PPP	public–private partnership
NTP	National Transformation Plan	RMNCA	reproductive, maternal, neonatal, child and adolescent health

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.

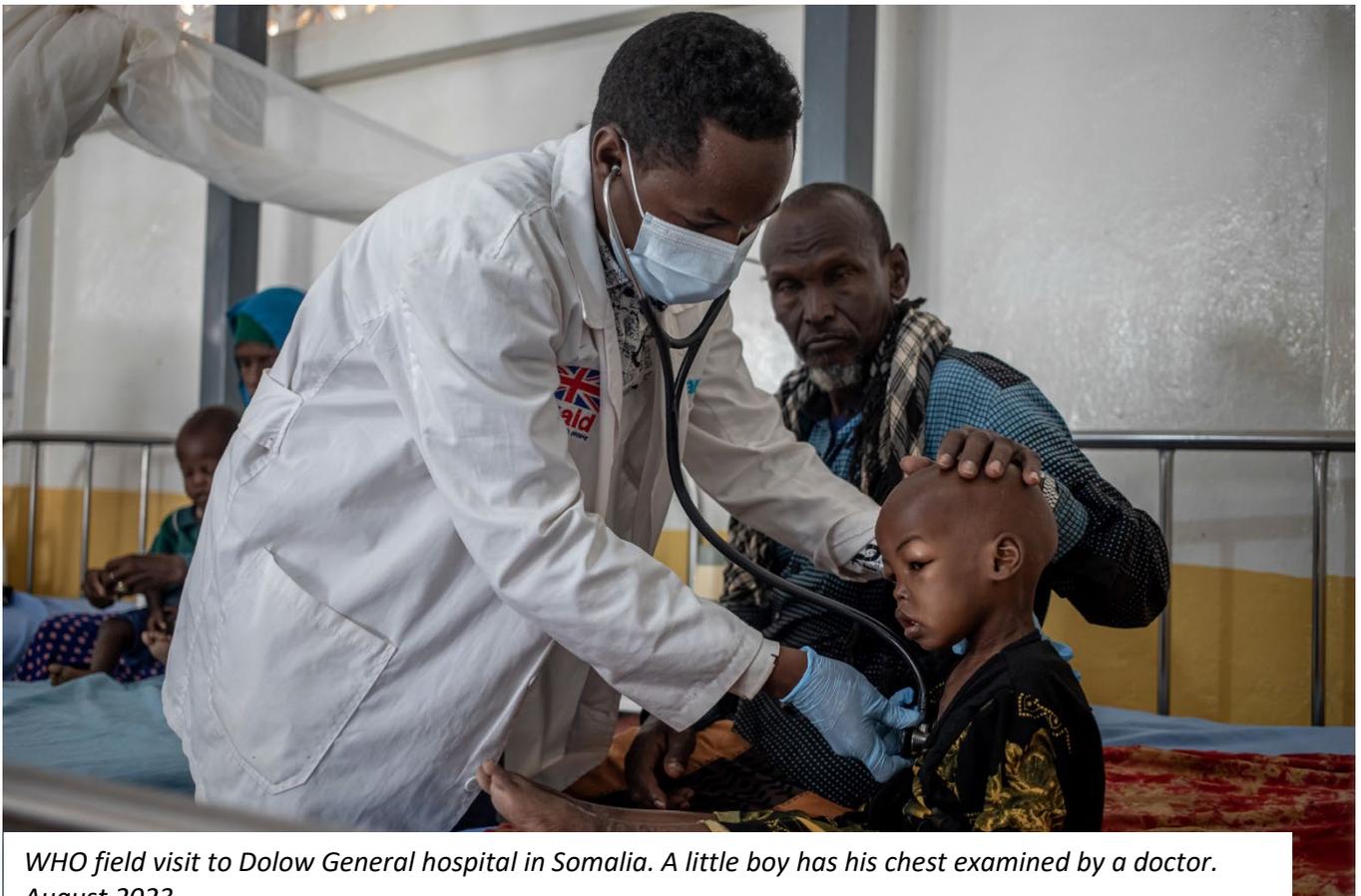
1.6 Conclusions

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
© WHO / Ismail Taxta*

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

1 Introduction

1. This independent evaluation of the contribution of the World Health Organization (WHO) in Somalia for the period 2020–2025 assesses country-level results in relation to national priorities, in alignment with the WHO global and regional agendas and the United Nations Sustainable Development Cooperation Framework (UNSDCF) [\(10\)](#). Alignment is ensured with the Thirteenth General Programme of Work of WHO (GPW 13) for 2019–2025 [\(11\)](#) and the Fourteenth General Programme of Work of WHO (GPW 14) for 2025–2028, [\(12\)](#) which together define WHO’s strategic priorities across the evaluation period and beyond.
2. The evaluation forms part of WHO’s organization-wide biennial evaluation workplan for 2024–2025, underscoring the Organization’s commitment to evidence-based decision-making, transparency and accountability. It was jointly commissioned by the WHO Evaluation Office, the WHO Regional Office for the Eastern Mediterranean and the WHO Somalia Country Office. The terms of reference are presented in Annex 1. The inception phase, completed in June 2025, comprised an initial desk review, five key informant interviews to better frame the evaluation expectations and approach, the formulation of a theory of change (ToC) by the evaluation team, the design of the methodology and a validation workshop. The primary data collection was conducted in July 2025 (see below).
3. The evaluation was conducted in accordance with the principles and standards set out in the revised WHO Evaluation Policy (2025) [\(13\)](#). The report comprises: (a) an introduction section, which includes an overview of the Somalia context and WHO’s portfolio of work (evaluation object); the purpose, objectives and scope of the evaluation; the evaluation stakeholders; and potential uses of the evaluation; (b) the evaluation criteria and questions; (c) the evaluation methodology; (d) the evaluation findings; (g) conclusions; and (h) lessons learned and recommendations.

1.1 Background and context

4. The Federal Republic of Somalia is classified as both a least developed country and a fragile state. It remains in a protracted phase of post-conflict and post-disaster recovery and continues to experience chronic insecurity and frequent climate-related shocks, including floods and droughts. Since 2022, Somalia has maintained a grade 3 emergency classification – the highest level of humanitarian emergency recognized by WHO [\(3\)](#). Since 2007, it has been included in the World Bank list of fragile and conflict-affected countries [\(1\)](#), and security conditions remain precarious, with Mogadishu categorized at level 5 (the highest residual risk level) under the United Nations (UN) security level system [\(2\)](#).
5. Decades of large-scale humanitarian assistance have created a parallel system of service delivery that, while essential for survival, has also entrenched systemic challenges and distortions.

Systematic aid diversion is a deeply embedded problem in the aid environment, serious enough to trigger high-level reforms by the UN humanitarian country team, as acknowledged in recent country team strategies and donor communications aimed at addressing post-delivery aid diversion. These dynamics influence the effectiveness and integrity of programme delivery, community perceptions and the feasibility of scaling up interventions through formal systems.

6. As of 2023, the population was estimated at 18.7 million, with over 54% living below the national poverty line [\(14\)](#). The country has an exceptionally young demographic profile, with over 75% of the population under the age of 30 and a median age of just 15.5 years [\(15\)](#).
7. The country is grappling with a compounding crisis driven by concurrent armed conflict and recurrent climate shocks, which together exacerbate the burden of disease. Flooding events, for instance, have been linked to outbreaks of communicable diseases such as acute watery diarrhoea and cholera [\(6\)](#), which compound an already high burden of both communicable and noncommunicable diseases.
8. Somalia's health system remains severely constrained by a combination of structural weaknesses. These include fragmented governance and institutional systems, critical shortages of health personnel, chronic underfunding and the erosion of service delivery capacity, which has been exacerbated by recent humanitarian funding cuts resulting in the closure of health facilities [\(7\)](#). Compounding these issues is a deficit in reliable health data, which impedes evidence-based planning and response. During the implementation period, the COVID-19 pandemic disrupted Somalia's fragile health system, compounding pre-existing vulnerabilities, such as limited workforce capacity, weak supply chains and inadequate surveillance mechanisms. The pandemic strained service delivery across essential programmes, diverted scarce resources and underscored critical gaps in emergency preparedness, infection prevention and health infrastructure resilience [\(16\)](#), [\(17\)](#).
9. Somalia has a universal health coverage (UHC) service coverage index score of 27 out of 100 [\(18\)](#) and much of the population lacks access to health services. Somalia records some of the highest maternal and child mortality rates globally, with stark health inequities disproportionately affecting vulnerable groups such as women, children, internally displaced persons (IDPs) and rural populations [\(19\)](#). Disadvantaged groups – including the lowest income quintiles, rural and nomadic communities, IDPs, women and persons with disabilities – face persistent barriers to care. These disparities significantly undermine progress towards achieving health equity and the WHO goal of one billion more people with better health and well-being under GPW 13 [\(10\)](#).
10. Gender inequality remains a critical concern. Somalia, with a score of 0.776 on the United Nations Development Programme (UNDP) Gender Inequality Index (where 1.0 denotes complete inequality) ranks fourth from last globally – near the bottom of the scale [\(20\)](#). The country has not ratified the Convention on the Elimination of All Forms of Discrimination Against Women, limiting the legal framework available to address gender-based disparities in health, education and participation [\(21\)](#).

1.2 Object of the evaluation

- 11.** The object of the evaluation is WHO’s contribution at country level in Somalia. The Country Cooperation Strategy (CCS) for WHO and Somalia 2021–2025 [\(8\)](#) reflects the World Health Organization’s vision and strategic framework to guide the Organization’s work in Somalia, with the overarching aim of promoting health, keeping the country safe and serving the vulnerable. It responds to the national health and development agenda and identifies a set of agreed joint priorities for WHO’s collaboration with Somalia. Over the past decade, the partnership between the WHO and the Federal Government of Somalia has been progressively institutionalized through the development and implementation of two Country Cooperation Strategies (CCS 2017–2019 [\(22\)](#) and 2021–2025). These strategies have been aligned with the broader United Nations system-wide frameworks for Somalia and designed to enhance coherence and complementarity in humanitarian and development efforts. The formulation of the current CCS was guided by the United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021–2025 and pertinent national, regional and global WHO policy frameworks. Furthermore, extensive consultations were conducted with key representatives from federal and state ministries of health and strategic partners to ensure alignment between the CCS 2021–2025 and GPW 13, the National Development Plan 2020–2024 and UNSDCF 2021–2025.
- 12.** The current CCS for 2021–2025 articulates WHO’s strategic vision and operational framework for supporting Somalia’s health sector. It is anchored in WHO’s overarching mission to promote health, and serve vulnerable populations, while aligning with Somalia’s national health and development agendas. Importantly, the CCS largely operationalizes the WHO GPW 13 for 2019–2023 (extending to 2025 and overlapping with the WHO Fourteenth General Programme of Work for 2025 –2028) within the Somali context, ensuring that global priorities are translated into country-specific actions. It emphasizes an integrated and coordinated approach, leveraging the collective strengths and resources of WHO at the country, regional and headquarters levels to support national health goals and demonstrate measurable impact.
- 13.** WHO’s CCS for Somalia 2021–2025 focuses on four strategic priorities (SPs): (1) advancing UHC through strengthened primary health care; (2) enhancing health security by improving emergency preparedness and response; (3) promoting healthier populations through multisectoral approaches; and (4) strengthening health governance and partnerships. WHO employs a multifaceted operational approach tailored to each priority, encompassing direct implementation, policy advocacy and the provision of technical support. Additionally, progress indicators have been defined for each priority to monitor advancement towards stated objectives.
- 14.** The evaluation reviewed the comprehensive portfolio of WHO’s work in Somalia framed by the four CCS (2021–2025) strategic priorities, ensuring that the work undertaken aligns with WHO’s mandate and Somalia’s evolving health needs. Annex 2 includes a mapping of programmes and interventions within Somalia.

15. The financial framework provides additional insight into the breadth of WHO’s portfolio of work in Somalia. The budget is categorized into four distinct segments, described in Table 1 below.

Table 1. WHO budget categorization

Base programme budget: The core budget is designed to support WHO’s strategic and normative work. It reflects WHO’s core functions under the CCS and the Organization’s global priorities (such as the GPW13 triple billion targets). The base programme budget is allocated across the four strategic priorities and primarily supports technical assistance, capacity-building, policy reform and essential health services. This budget is stable yet limited, typically accounting for less than 30% of total funding in fragile settings like Somalia.

Outbreak and crisis response (budget): WHO’s humanitarian and emergency response budget is mobilized to address sudden-onset crises, epidemics and protracted emergencies. It is highly responsive and surge-oriented, accounting for over half of WHO’s funding for Somalia. It supports emergency health interventions, coordination and response to outbreaks of diseases such as cholera and measles, often operating on short timelines.

Polio eradication budget: Supports the Global Polio Eradication Initiative (GPEI), a vertical programme highly integrated into WHO country work. It is funded by GPEI partners (e.g. the Bill and Melinda Gates Foundation, Africa Centres for Disease Control and Prevention, Rotary International, United Nations Children’s Fund (UNICEF) and Gavi) with the aim of **eradicating polio** in Somalia. The budget includes activities such as immunization campaigns, surveillance and health worker training. It also incorporates broader health system strengthening initiatives.

Special programmes: **Consist of donor-driven**, earmarked funds for targeted health initiatives, which are typically time-bound.

16. Table 2 shows the planned, financed and utilized funding of the WCO in Somalia from 2020 to 2025. Over the three biennia, the awarded budgets consistently covered approximately 73% to 77% of the planned costs. The planned budget reached its peak in 2022–2023, reflecting a 65% increase compared with 2020–2021, before declining in 2024–2025.

Table 2. Planned, financed and utilized costs of WCO

Biennium	2020–2021	2022-2023	2024-2025 ²
Planned costs	121 476 236	200 219 965	140 296 747
Total award budget	90 130 106	145 765 468	107 330 308
Expenditure (budget utilization)	83 616 438	143 943 759	77 261 117
Award budget as percentage of planned costs	74.2%	72.8%	76.5%
Utilization (% of award budget)	92.8%	98.8%	72%

Source: Table developed by the evaluation team on the basis of information in WHO biennial reports and financial documents.

17. A financial analysis of the WCO in Somalia for the 2024–2025 biennium (23) noted that the operational plans for 2024–2025 were developed with limited reference to the CCS, resulting in some misalignment. It also noted that the COVID-19 response diverted attention away from the CCS. From the 2018–2019 biennium to the 2024–2025 biennium, financing of WCO Somalia has been predominantly driven by the emergency segment, underscoring the country’s continued dependence on emergency funding to address urgent health needs and respond to ongoing crises (22). Figure 1 shows the trend of financing from 2018–2019 to 2024–2025, by segment.

Figure 1. Trend of financing from 2018–2019 to 2024–2025, by segment³



Source: WHO Regional Office for the Eastern Mediterranean. Administrative and Assurance Review: WHO Country Office Somalia.

² Note: The figures for the 2024–2025 biennium reflect data extracted as at 15 June 2025. They therefore represent only part of the biennium (approximately 75%, or 18 months), unlike the figures for the 2020–2021 and 2022–2023 biennia, which are complete (24 months, or 100%).

³ The 2024–2025 figures reflect information as of December 2024.

1.3 Purpose, objectives and scope of the evaluation

1.3.1 Purpose and objectives

18. This evaluation was initiated to assess WHO's contributions to Somalia's health sector from 2020 to 2025 and serves both learning and accountability purposes. It focused on evaluating the relevance, coherence, coordination, effectiveness, efficiency and sustainability of WHO's interventions. This assessment was framed within the CCS 2021–2025 and Somalia's national health priorities. It also took account of the dynamic needs of Somalia's population amid prolonged crises, the ramifications of the COVID-19 pandemic and the effects of climate-related challenges. While the CCS results framework served as the principal reference, the evaluation extended its scope to encompass activities undertaken in response to emergent needs, particularly the COVID-19 pandemic and other critical outbreaks, as well as the humanitarian response to health sector needs related to floods, droughts and population movements during the period.
19. The objective was to assess the contributions of the interventions of WHO (headquarters and regional and country offices) to the outcomes and impacts identified in the CCS 2021–2025 focused on addressing Somalia's health priorities. The evaluation also examined the contributions of WHO's work under the CCS to the Somalia Health Sector Strategic Plan III 2022–2026, the UNSDCF for Somalia and the Somalia National Development Plan 2020–2024.
20. The evaluation assessed the gender and human rights dimension of WHO interventions in the context of Somalia in consonance with the UN System-wide Action Plan on Gender Equality and the Empowerment of Women (UN–SWAP 2.0) [\(24\)](#), and the United Nations Evaluation Group (UNEG) guidance [\(25\)](#).
21. This evaluation provides evidence-based recommendations to:
 - Enhance WHO's future programming
 - Inform the development of the next CCS and operational plans
 - Improve resource mobilization and allocation
 - Improve organizational effectiveness in responding to Somalia's evolving health challenges and opportunities
 - Strengthen coherence and complementarity of the CCS with the 2026–2030 UNSDCF and the Humanitarian Response Plan.
22. Given the impending completion of the current CCS period, this evaluation contributes valuable insights into WHO's role and effectiveness in achieving agreed goals, identifying actions required to improve progress during the remaining period of the current CCS cycle, and priorities to be considered in the next CCS cycle.
23. The specific objectives, as defined in the terms of reference and updated during the inception phase of the evaluation, were to:
 - Assess the contribution of the WHO, through its CCS and its response to emerging needs and opportunities, to progress towards the triple billion targets of the

GPW13 and GPW14 at the global level and the health-related Sustainable Development Goals (SDGs) in Somalia.

- Evaluate the extent to which original CCS objectives and targets have been achieved, including relevant indicators in the CCS results framework, and to what extent the dimensions of gender and human rights have been integrated.
- Identify key success factors and emerging good practices, as well as challenges, gaps, risks and areas for improvement.
- Draw lessons and formulate recommendations to inform both the remaining period of the current CCS and the design and implementation of the new WHO CCS to improve WHO's strategic positioning to better support Somalia in accordance with its global health mandate.

1.3.2 Scope

24. The evaluation scope was as follows:

- **Geographic:** The evaluation covered WHO's interventions across all regions of Somalia, encompassing urban, rural and hard-to-reach areas, including regions affected by conflict, displacement and climate-related crises. Given Somalia's complex security landscape, the evaluation prioritized data collection in selected locations, specifically Mogadishu, Jubaland and Puntland, based on logistical considerations and criteria such as the availability of multiple interventions and the presence of marginalized populations, including IDPs. For other areas where security constraints limited in-person fieldwork, remote data collection methods were employed.
- **Temporal:** The evaluation assessed WHO's contributions from the start of 2020 to July 2025, covering the implementation period of the current CCS (2021–2025).
- **Thematic:** The evaluation focused on WHO's overall portfolio of work in Somalia from 2020 to 2025, including the four strategic priorities of WHO's CCS (2021–2025) and the response to the COVID-19 pandemic in 2020. It assessed WHO's contribution to the health system and its humanitarian efforts. The evaluation encompassed all WHO-supported programmes in the areas of UHC, health security, healthier populations, health governance, polio eradication and outbreak and crisis response.

1.4 Evaluation stakeholders

25. The primary intended users of this evaluation include WHO internal stakeholders (staff at the WCO Somalia, the WHO Regional Office for the Eastern Mediterranean and WHO headquarters) and key external stakeholders, particularly the Government of Somalia, the UN country team (UNCT) and donor agencies. As the ultimate users of WHO services, affected populations are also considered evaluation users. To ensure maximum utility and alignment with stakeholders' needs, each primary user group was engaged in targeted feedback opportunities, including

participation in key informant interviews, workshops, briefings and validation sessions, as part of an iterative approach to co-creating recommendations. This approach also involved periodic consultations with WCO Somalia and the Evaluation Reference Group to ensure alignment with regional priorities and adapt findings for broader WHO application. Table 3 summarizes how the evaluation is intended to be used by various stakeholders. The full stakeholder analysis and engagement plan are included in Annex 3.

Table 3. Expected uses of the evaluation by the stakeholders

Stakeholders	Expected uses of the evaluation
WCO – WHO Representative and technical teams	Will utilize the evaluation findings to refine strategies, improve programme implementation and align efforts with national health priorities. The insights will support targeted capacity-building efforts and better resource allocation, ensuring WHO’s operations are responsive to Somalia’s unique health challenges.
WHO Regional Office for the Eastern Mediterranean	The evaluation will assist the Regional Office in providing tailored guidance and assistance to the WHO country offices in the region. The findings will inform regional strategies and highlight best practices that can be scaled up across other countries facing similar health system challenges. The Regional Office’s role in harmonizing regional interventions with global frameworks will be strengthened through this feedback loop.
WHO headquarters	Will use the evaluation outcomes to ensure that the Organization’s global policies and technical support frameworks are effectively translated into country-level outcomes. The evaluation will guide the refinement of global health initiatives, ensuring alignment with Somalia’s evolving health context, while fostering accountability and WHO learning.
Ministry of Health	The Ministry of Health will leverage the evaluation to enhance collaboration with WHO and ensure that WHO support aligns with national health policies and strategies. By integrating the evaluation findings into its work, the Ministry can strengthen its leadership role in the health sector and address identified gaps in policy implementation, service delivery and capacity-building initiatives.
Line ministries involved in the One Health approach and finance	Line ministries, such as those responsible for agriculture, environment, finance, livestock and forestry, will benefit from the evaluation by identifying opportunities for improved collaboration in the One Health framework. The Ministry of Finance, in particular, can use the findings to devise sustainable health financing mechanisms and ensure alignment between donor contributions and national health budgets.
Office of the Prime Minister	The Office of the Prime Minister will use the evaluation to enhance intersectoral coordination, particularly in health governance and the broader One Health

	approach. It will ensure alignment with national development priorities, facilitating a multisectoral response to health challenges that incorporates the contributions of various government agencies.
Health partners	National and international health partners, including NGOs and civil society organizations, may use evaluation findings to assess alignment between their efforts and WHO’s priorities and to identify partnership opportunities. The insights will help reduce duplication of efforts, enhance outcomes and identify systematic challenges affecting health actors in the country.
Donors	WHO activities are supported by a range of donors. This evaluation will serve as an accountability tool, providing transparent evidence of WHO’s contributions and their alignment with donor priorities. Donors have an interest in knowing whether their funds have been spent efficiently and effectively and whether they have contributed to donors’ own strategies and programmes.
UNCT	UNCT will use the evaluation to ensure that WCO activities are effective and aligned with UN programmes and the UNSDCF collective goals. The findings will provide a basis for stronger interagency cooperation, integrated programming and shared advocacy for health as a critical pillar in Somalia’s development goals.
People served/affected populations	As the end users of services, the people served are the drivers of demand and have a primary interest in recommendations to improve service delivery. As evaluation resources are limited, the service end users will not be included directly in evaluation activities. However, their voices will be reflected through desk reviews and group discussions held with health staff and community health workers.

Source: Evaluation terms of reference (affected populations included by the evaluation team).

2 Evaluation design and methodology

26. The methodology is summarized here; Annex 4 provides a more detailed explanation.

2.1 Approach and methods

27. The evaluation employed a mixed method, non-experimental, theory-based methodology to

systematically assess how and why WHO’s interventions in Somalia did or did not contribute to expected health outcomes. The evaluation used a reconstructed theory of change (see Annex 5) to verify whether WHO’s interventions have achieved their intended results and analyse the mechanisms and enabling conditions that contributed to success or failure. The evaluation team’s assessment of the validity of the ToC is included in Annex 6.

28. Data collection involved extensive desk reviews of programme documents and published case studies, secondary quantitative data analysis of available WHO programme monitoring data, in-depth interviews (IDIs), key informant interviews (KIIs), focus group discussions (FGDs) and a perception survey conducted among WHO staff and implementing partners. Primary data was collected through both remote (online) and in-person methods. The evaluation team visited Somalia between 6 and 13 July 2025, completing data collection in Mogadishu. The national consultant continued collecting data in Puntland and Jubaland until 17 July 2025.
29. Purposive sampling was used to select stakeholders for all primary data collection activities (KIIs, FGDs and perception surveys), based on stakeholder roles and levels of engagement with WHO’s programmatic portfolio in Somalia. A stakeholder analysis guided this selection process to optimize the richness of insights gained from a limited number of interviews, while ensuring a balanced representation across key stakeholder categories. Representatives of organizations of persons with disabilities were included in data collection. A log of all interviewees was maintained and periodically reviewed to assess the balance of representation, including internal versus external actors, policy-level versus implementation-level stakeholders, sectoral diversity and the mix of governmental and nongovernmental participants. Despite WHO encouragement of stakeholder participation, the perception survey response rate was low, with only 47 respondents (further detail on these respondents is provided in Annex 4).
30. A summary of data collection methods is shown in Table 4 below.

Table 4. Achieved sample size of primary data collection⁴

Method	
KII/IDI	Number conducted
WHO staff (country, regional, HQ)	24
Federal Ministry of Health and Human Services officials	12
Federal member state health authorities (15) and public health officers (8)	23
UN agencies and international partners (UNICEF, UNFPA, etc.)	6
International/national NGO partners/ private sector / academia	8
Development partners and donors	4
Community representatives (organizations of persons with disabilities)	1
Total	78
Focus group discussions	
Frontline health workers	6 (39 participants, 10 male; 29

⁴ A total of 66 KIIs were planned, but 78 were conducted; 8 FGDs were planned and 7 were conducted.

State public health officers	female) 1 (8 participants, 7 males 1 female)
Workshop	
State health directors	9 participants, 7 male 2 female
Perception survey	
WHO staff and partner staff	47

- 31.** Data analysis was conducted through a rigorous, systematic process involving the organization, classification, tabulation and synthesis of collected information. The quantitative data from the perception survey was analysed using a descriptive statistical approach. Responses to each closed-ended question were compiled and grouped by response category. Frequencies and corresponding percentages were calculated to determine how respondents rated each item. The data were then organized into tables for each evaluation criterion (e.g. relevance, effectiveness, sustainability) to provide a clear visual summary. For the qualitative data, the evaluation team primarily employed thematic analysis to identify recurrent patterns, key themes and areas of interest across the dataset. The analysis was iterative and grounded in a three-pronged analytical framework: “noticing, collecting and thinking” (26).
- 32.** The evaluation matrix served as guiding tool to ensure that data analysis remained focused, structured and aligned with the evaluation questions and intended outcomes. Through this approach, the evaluation team ensured that data was transformed into coherent, credible and actionable findings

2.2 Evaluation criteria and questions

- 33.** The evaluation was guided by the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) evaluation criteria (27), including relevance, coherence and coordination, effectiveness, efficiency, and sustainability and connectedness. In addition, the evaluation integrated a cross-cutting analysis, consistent with the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) criteria (9), ensuring that gender equality, human rights and equity (including disability inclusion) dimensions were adequately examined.
- 34.** The evaluation questions (EQs) and subquestions were organized into a comprehensive evaluation matrix, which outlines corresponding indicators, data sources and analytical methods, providing a clear framework for data collection and analysis (see Annex 6).

35. The evaluation criteria and questions are detailed in Table 5 below.

Table 5. Evaluation criteria and questions

Relevance
EQ1.1 To what extent have WHO’s vision, strategies and interventions aligned with Somalia’s national and local health priorities, needs and policies?
EQ1.2 To what extent has WHO in Somalia adapted to changes in population priorities and emerging health needs, particularly for vulnerable groups (IDPs, refugees) in response to evolving humanitarian crises?
Coherence and Coordination
EQ2.1 To what extent are WHO’s interventions and priorities in Somalia consistent internally across WHO’s three levels and externally with other development partners?
EQ2.2 To what extent has WHO in Somalia contributed to UN system-wide and health sector coordination for both development and humanitarian action?
Effectiveness
EQ3.1 To what extent have the planned outputs and outcomes (in the areas of UHC, health security, healthier populations, governance, polio eradication, outbreak and crisis response) been achieved?
EQ3.2 What factors contributed to or hindered the success of WHO interventions across priority areas and specific planned results? What are the key challenges, lessons learned and areas for improvement?
EQ3.3 To what extent have WHO-supported programmes integrated cross-cutting issues of health equity, gender equality, human rights and disability inclusion?
Efficiency
EQ4.1 To what extent are WHO’s internal M&E systems, resource management and external donor-facing communication mechanisms supporting WHO’s performance in Somalia?
EQ4.2 What resource mobilization measures should WHO Somalia adopt to secure flexible funding for the next strategic phase in a fragile context?
Sustainability/Connectedness
EQ5 To what extent has WHO contributed to building national capacity for long-term health outcomes, and how likely are WHO-supported initiatives to be sustained within the Somali health system?

2.3 Limitations of the evaluation

36. Mitigation measures were applied during the evaluation to address evaluability and pragmatic factors that could have affected evaluation implementation (Table 6). As a result, there were no serious risks to the evaluation that affected the reliability of the findings.

Table 6. Evaluation limitations, mitigation measures and impact on the evaluation findings

Risk	Description	Mitigation measures and impact on the evaluation
Security concerns	Security risks may arise during data collection, especially in conflict-affected areas.	The evaluation team conducted a thorough risk assessment prior to conducting fieldwork. In-person interviews were limited to safe locations; remote data collection methods were utilized in cases where in-person interactions were not possible. The evaluation team received security briefings while in country and adhered to WHO’s security protocols.
Unclear/expanded scope	Certain thematic elements may require further delineation, particularly in distinguishing between WHO’s comprehensive portfolio and the CCS for 2021–2025. Additionally, some stakeholders within WHO may anticipate a more in-depth evaluation of the COVID-19 response from 2020 onward.	Initial consultations with WHO Regional Office and country office stakeholders confirmed that the COVID-19 response would be reviewed as an aspect of WHO’s emergency response in Somalia only in 2020, with the aim of maintaining focus and analytical depth related to the CCS’s defined implementation period. The evaluation team established clear boundaries for the evaluation in collaboration with WHO stakeholders during the data collection phase.
Low response rate	There may be limited response to the perception survey.	The evaluation team worked with WCO Somalia and the Evaluation Reference Group to communicate the importance and objectives of the perception survey. Only 47 responses were collected, a moderate number for this type of exercise, but still useful as a perception survey in order to triangulate with data from other sources. The evaluation team has analysed the responses and, when relevant, has included them in the evaluation report as a triangulating factor. A summary description of the survey results is included in Annex 11.
Staff turnover	Turnover among WHO and stakeholder may affect access to some key informants.	In some cases alternative stakeholders were proposed to replace staff who had moved from specific positions.
Tight deadlines	The evaluation timeline concludes in September. Such a short timeline may make it challenging to collect and analyse the relevant and necessary information.	The evaluation team has ensured that conclusions and recommendations are based on solid evidence and that gaps are highlighted in order to propose remedial action.

<p>M&E</p>	<p>At the WCO level, the absence of an integrated M&E tool limits the ability to systematically track progress against logframe indicators. The existing scorecard system is largely communicative rather than analytical, lacking robust M&E evidence to justify the ratings. Similarly, the KPI “traffic light” system – intended to illustrate progress towards corporate outcomes – does not provide objective assessments.</p> <p>At the output level, evaluating progress towards WHO’s programmatic outputs in Somalia remains challenging due to the complexity of multiple reporting frameworks and the reliance on online platforms that aggregate data at the global or regional level. While denominator data has been introduced under GPW 14, outputs and outcomes remain aggregated globally, with limited granularity to reflect Somalia’s specific trajectory</p>	<p>The team sought access to available national and UN data on select indicators which can be used to track progress made by the programme in 2020–2025. Qualitative data supplemented the limited quantitative data available for CCS outcome indicators. Additionally, broader changes in the health landscape were examined.</p> <p>The team reported on select output achievements related to specific donor reports reviewed.</p>
<p>Gender, equity and human rights</p>	<p>Capturing disaggregated data is crucial to analyse the extent to which the response addressed the needs of women, persons with disabilities, marginalized populations and other vulnerable groups. However, disaggregation is not systematic in Somalia, and a plurality of information systems further complicates the assessment.</p>	<p>The evaluation team has cross-checked available data from different sources in order to cover potential gaps. When it was not possible to reach a clear understanding of the breakdown of information on the beneficiaries targeted, this is mentioned in the evaluation report.</p>
<p>Financial data</p>	<p>Insufficient data may be a challenge to the efficiency analysis. Unit cost analysis may not be feasible due to data limitations, and it may not be possible to conduct cost-effectiveness analysis, as comparable data on outputs and outcomes are insufficiently available across interventions.</p>	<p>The analysis focused on periods in which financial data was available and robust.</p>

2.4 Ethical considerations

37. The evaluation has been conducted in accordance with the revised WHO Evaluation Policy (13) and adhered to the principles outlined in the WHO Evaluation Practice Handbook (28). Furthermore, it complies with the UNEG Norms and Standards for Evaluation (25), the UNEG Ethical Guidelines for Evaluation (2020) (29), the UNEG Code of Conduct for Evaluation in the United Nations System (30) and the UNEG Standards for Evaluation in the UN System (31).
38. Accordingly, the evaluation team has upheld the highest ethical standards throughout the evaluation process. This includes evaluator obligations of independence, impartiality, credibility and accountability, ensuring informed consent, voluntary participation, anonymity, confidentiality, data protection and adherence to the “do no harm” principle. The evaluation

team confirms that no team member had any conflict of interest.

39. The evaluation team recognizes the right of all individuals to provide information confidentially and by informed consent. Participants were clearly informed about the scope and limitations of confidentiality prior to engaging in data collection activities. The team committed to safeguarding the dignity, rights and well-being of all participants, particularly during field consultations, and ensured that ethical standards were applied consistently across all stages of the evaluation. Strict confidentiality was maintained regarding all information collected. Keystone Global Analytics, the evaluation team’s field partner, is well-versed in local dynamics and the political environment. Collaboration with a national partner who possessed a strong understanding of the sociocultural context and local languages ensured that the evaluation respected local sensitivities and cultural boundaries. The evaluation design and field implementation processes were explicitly structured to respect cultural norms, align with established social structures and observe relevant cultural protocols. Tailored communication strategies were applied to address potential language barriers. Specifically, the perception survey was administered in both English and Somali, while focus group discussions were conducted in Somali.

2.5 Data quality and management

40. All evidence was verified and corroborated through systematic triangulation (source, method, investigator and geographic triangulation) and analysis of findings from diverse stakeholders to ensure quality and impartiality and reduce the risk of bias.
41. The WHO Evaluation Office bears ultimate responsibility for quality assurance for this evaluation and has ensured the quality of data (validity, consistency and accuracy) and evaluation team contributions throughout. The KonTerra Group’s quality assurance expert conducted an internal review of all deliverables before submission of the evaluation report. Details of KonTerra’s quality assurance procedures are provided in Annex 4.

3 Findings

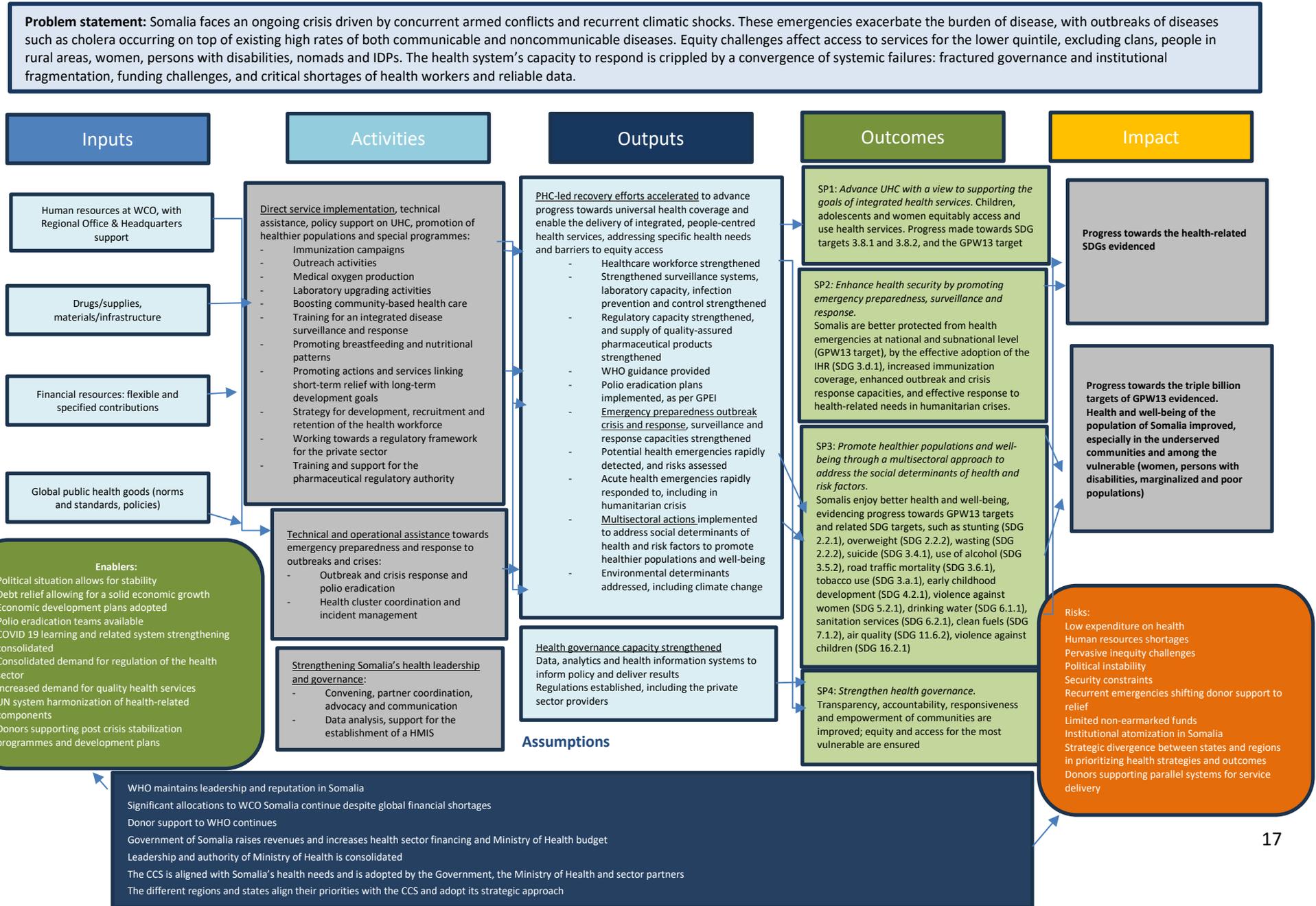
During the inception phase, the evaluation team reconstructed a tentative ToC in order to facilitate analysis of WHO CCS through a theory-based approach. The ToC was validated through the Evaluation Reference Group. The ToC outlines how WHO’s support is intended to contribute to health outcomes in Somalia, linking inputs and activities to outputs, outcomes and impact. It reflects the Organization’s strategic focus on universal health coverage, emergency preparedness, healthier populations and health governance, while incorporating cross-cutting principles of equity, gender and human rights. The reconstructed ToC is summarized in Figure 2 and the narrative is presented in Annex 5.

In Box 1 below, the evaluation team offers an assessment of the appropriateness of the ToC as an addition to the EQs listed in Table 5 to provide insight into the relevance of the CCS since the ToC is the foundation of the work being done in the country.



Somali Health worker administers polio vaccine to a young child during a door-to-door immunization campaign, protecting vulnerable communities. August 2025. © WHO / Abdirahman Caaylawe

Figure 2. The reconstructed theory of change



Box 1: The Theory of change: an initial assessment

The ToC is relevant, conceptually rigorous and logically sound and it aligns with global and national frameworks. However, its plausibility is constrained by Somalia's volatile political and financing environment and by misalignments between some outcome ambitions and WHO's actual operational focus in Somalia. Developing contingency strategies for risks and calibrating ambitions to operational realities would improve the ToC's overall robustness and practical credibility.

The ToC is conceptually well aligned with Somalia's pressing health needs and national priorities. It explicitly acknowledges the country's high burden of communicable diseases alongside rising noncommunicable conditions and the exceptionally high rates of maternal, neonatal and child mortality. By embedding maternal and reproductive health within the revised Essential Package of Health Services 2020, the ToC presents a coherent and relevant vision for a primary health care-led recovery and progress towards universal health coverage.

The ToC places strong emphasis on equity, prioritizing maternal, newborn and child health in its design. The ToC explicitly recognizes that women, IDPs, nomadic populations and other marginalized groups face disproportionate barriers in accessing health care. From a strategic design perspective, this reflects an appropriate prioritization of maternal, newborn and child health as a pathway to reducing health inequities and advancing SDG3: good health and well-being.

However, in practice, WHO's programmatic engagement in Somalia has not adequately prioritized maternal health. Field implementation has focused more heavily on polio eradication, communicable disease control, emergency response and governance functions. While these are relevant and pressing needs, the gap between the ToC's stated emphasis on maternal, newborn and child health and the limited operational investment in this area represents an important shortcoming. Given Somalia's persistently high maternal mortality ratio and neonatal death rates, the lack of consistent WHO programmatic attention to this area undermines the ToC's overall relevance and risks missing one of the most critical drivers of health inequities in the country. Interviews with clinical care experts highlighted a pattern of suboptimal antenatal care utilization in Somalia, which they perceived as contributing to a higher incidence of intrapartum complications, including birth asphyxia, and subsequent increases in neurodevelopmental disabilities such as cerebral palsy. While population-level epidemiological data on cerebral palsy in Somalia remain scarce, stakeholder testimonies are consistent with findings from comparable low-resource settings, where weak maternal health service coverage correlates with higher burdens of birth asphyxia and neurodevelopmental impairment ([32](#)).

In other areas, the ToC remains highly relevant. It responds to systemic barriers, such as fragmented governance, weak health information systems and critical workforce shortages. Its multisectoral framing – linking health with water, sanitation, nutrition and climate resilience – reflects a comprehensive understanding of Somalia's health determinants. The articulation of

assumptions, enablers and risks adds contextual realism, although mitigation strategies for risks such as political instability and donor dependency remain underdeveloped.

The ToC demonstrates a moderate degree of analytical rigour: The ToC is rigorous in structure and alignment with global and national strategies, but the absence of deeper operational evidence on maternal health and risk mitigation reduces its overall rigour. The problem statement is grounded in data on Somalia’s disease burden, highlighting the dual challenge of communicable and noncommunicable diseases and extremely high maternal and child mortality. Rigour is enhanced by explicitly embedding human rights, equity and gender as cross-cutting principles. References to global frameworks (SDGs, GPW13, UHC service package) further strengthen its evidence base. The ToC is also clearly articulated through a logical results chain: inputs → activities → outputs → outcomes → impact. Indicators are defined for each strategic priority, providing a foundation for monitoring and evaluation (M&E). However, the programmatic implementation is not systematically monitored in relation to the CCS strategic priority indicators. A log frame linking activities and outputs to outcome indicators is lacking, which limits the ability to assess WHO’s specific contributions. Moreover, several outcome indicators are influenced by multiple external factors and, even when measured, may not accurately capture the extent of WHO’s contribution.

Rigour is weakened by two key issues. First, there is limited grounding in contextual analysis of implementation realities. While systemic risks (fragmented governance, insecurity, donor dependency) are acknowledged, the ToC does not rigorously test how these constraints may disrupt causal pathways. Additionally, there is weak evidence on maternal health pathways. Despite recognizing maternal mortality as a central issue, the ToC does not provide a detailed causal chain for how interventions will reduce maternal and neonatal deaths, limiting analytical robustness in this priority area.

The ToC is generally sound in its logic, with clear and reasonable pathways from interventions to outcomes: Outputs related to primary health care (PHC) recovery, emergency preparedness, multisectoral action and governance are logically linked to outcomes related to UHC, health security and healthier populations. These connections are conceptually strong and supported by global health evidence. The ToC appropriately addresses systemic weaknesses (workforce, financing, health information, regulation), ensuring that service delivery outcomes are linked to structural reform. The inclusion of measurable indicators (e.g. the UHC service coverage index, maternal mortality ratio, vaccination coverage) increases the soundness of the framework. Yet, soundness is compromised by an over-reliance on assumptions. The ToC assumes stability in donor support, government commitment and political conditions. Without stronger contingency planning, the logical chain risks collapse under real-world fragility. Additionally, the ToC should illustrate feedback or adaptive learning loops, which are essential in fragile contexts where strategies must evolve.

The ToC demonstrates strong alignment with results-based management principles. The results chain is clearly articulated from inputs to activities to outputs to outcomes to impact, with measurable indicators at both output and outcome levels. Outputs are framed in terms of capacity-strengthening and system improvements (e.g. “healthcare workforce strengthened”;

surveillance systems, laboratory capacity, and infection prevention and control strengthened”), while outcomes are expressed in change-oriented language that captures intended shifts in behaviour, access and well-being (e.g. “Somalis enjoy better health and well-being through a multisectoral approach to addressing the social determinants of health and risk factors”).

The ToC is only partially plausible due to gaps in operational focus and lack of explicit mitigation measures. Overall, the focus on strengthening PHC, workforce, governance and data systems is highly plausible, as these are recognized global levers for sustainable health system recovery. Similarly, emergency preparedness and multisectoral action (e.g. water, sanitation and hygiene; climate resilience) are feasible and highly relevant, given Somalia’s recurring crises. Partner coordination and WHO’s normative authority provide a realistic basis for influencing national policies and strategies. However, the ambition of reducing maternal and neonatal mortality through WHO’s current portfolio is not plausible, given that maternal health is not a major operational focus in Somalia, despite its prominence in the ToC. Assumptions about political stability, donor alignment and federal–state cooperation are optimistic, but without explicit mitigation measures, achieving outcomes is less plausible. Furthermore, the scale of systemic challenges (severe human resource shortages, fragmented institutions, insecurity) may overwhelm the scope of WHO’s interventions, reducing the likelihood of achieving transformative outcomes.

The ToC embeds equity, gender and human rights principles across several outputs and outcomes. For instance, in the outputs, there is explicit mention of people-centred health services, equity barriers across the life course and multisectoral actions to address social determinants, which reflects attention to affected and vulnerable populations. Additionally, outcomes are framed around equitable access for children, adolescents, women and marginalized groups, signalling recognition of population disparities. However, there are gaps in operational sensitivity. While the ToC language acknowledges vulnerable groups (women, IDPs, nomadic groups, people with disabilities), evidence from the field does not always match up with the ToC aspirations.

3.1 Relevance⁵

2.5.1 Alignment of WHO’s vision, strategies and interventions with Somalia’s national and local health priorities, needs and policies (EQ1.1)

Key Finding 1: During the evaluation period (2020–2025), WHO’s strategies and interventions were formally and substantively aligned with Somalia’s national and local health priorities, needs and

⁵According to the OECD, the DAC criterion of relevance address the “extent to which the intervention objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change” (27).

policies. This alignment is evidenced by WHO's central role in providing normative guidance, technical support and thought leadership in the health sector. The breadth of alignment underscores WHO's role as a normative anchor in Somalia's health policy ecosystem and its contributions in providing frameworks and standards that connect global health objectives with Somali national strategies.

Key Finding 2: However, given Somalia's protracted crisis conditions, WHO's programmatic portfolio was heavily pulled towards emergency response and health security. This shift can be interpreted both as evidence of adequate capacity to adapt to Somalia's fragile context and as a constraint in fully operationalizing other priorities, such as maternal health and accountability to communities. Additionally, external alignment at the national level did not always translate into relevance at the state or district levels, and several stakeholders identified insufficient subnational consultation and intervention customization as shortcomings.

42. WHO's work was strategically aligned with national policies and frameworks. The CCS for Somalia (2021–2025) was explicitly designed to align with national health and development priorities. Document reviews show that its formulation process drew upon the Somalia National Development Plan (2020–2024), particularly the social development pillar, which prioritized improving equitable access to health services through enhanced prevention, surveillance and financial protection (33). According to the CCS document, its development was also guided by a review of other key sectoral strategies including the Somali Roadmap towards Universal Health Coverage 2019–2023 (34), which guides Somalia's efforts to expand service coverage and enhance protection against financial hardship; the Health Sector Strategic Plan 2017–2021 (35), which sets system-level priorities for the health workforce, service quality and financing; and the Essential Package of Health Services (36), which defines Somalia's core set of essential services and system functions.
43. WHO has provided normative guidance, technical standards and thought leadership, ensuring that global evidence and frameworks such as the International Health Regulations (IHR) (2005) (37) and SDG3 are adapted to Somalia's national context. WHO's strategies reflect both corporate priorities (under GPW 13) and reinforce Somalia's national policy agenda, enhancing rationality across humanitarian, development and health system objectives. Evidence from the key informant interviews and focus group discussions suggests that WHO's normative role is applicable and necessary, provided it is paired with light-touch delivery support and governance strengthening. WHO's contribution is anchored in standards, regulatory strengthening, development of a health management information system (HMIS) and partner coordination, functions that are feasible even amid health system collapse and that create the enabling environment for service recovery (e.g. HMIS support and regulatory capacity).
44. There is evidence of operationalization beyond paper norms such as in the establishment of the interim National Medicines Regulatory Authority in 2023 (38), the implementation of integrated disease surveillance, the technical assistance related to human resources for health and health financing, and the maintenance of essential services during shocks. These signal movement from normative products to institutional practice. Moreover, WHO has made substantial

contributions in knowledge generation and operational research in Somalia. Key examples include collaborative work with UNICEF on mortality estimation and data triangulation, a study on mental health evidence and priority-setting (39), a case study on essential ingredients of sustainable community-based mental health services in Somalia (40) and operational research on critical care, notably, a survival analysis of critically ill COVID-19 patients in Mogadishu (41). These outputs are central to WHO's unique contribution to national strategies, even if they are not easily captured by outcome indicators.

45. Results are observable at the system and institutional levels (frameworks established, systems running), but the measurement of the cascade from technical guidance to provider behaviour and population outcomes is weak. The strategic priority indicators rely on high-level national metrics (e.g. UHC index, vaccination coverage, under-5 mortality), which are appropriate for assessing sector performance but do not isolate uptake, fidelity or quality effects attributable to WHO's normative work, thereby limiting contribution analysis in a volatile context.
46. Intervention strategies were aligned with Somalia's health sector needs and priorities, as articulated in national and sectoral frameworks and policies. WHO's support to critical health systems enablers – including the Essential Package of Health Services (EPHS), health information systems and regulatory frameworks for pharmaceuticals and infection prevention and control – was well aligned with the EPHS 2020 emphasis on functionality and quality of care. Similarly, investments in integrated disease surveillance, laboratory strengthening⁶ and incident management directly advanced IHR core capacities, further demonstrating congruence between WHO's implementation strategies and Somalia's policy priorities.
47. This alignment was positively recognized by a range of stakeholders. Positive feedback on the relevance of WHO's strategy was received from a broad range of interviewed stakeholders including WHO, other UN agencies, government counterparts and NGOs. Findings were similarly positive among perception survey respondents, most of whom (43 out of 47) affirmed that WHO strategies are aligned with national and local priorities. This alignment underscored WHO's role in providing strategic guidance and normative support in fragile and conflict-affected settings, consistent with its global mandate.
48. During the evaluation period covered, WHO's support targeted many of the areas where capacity-building was most needed in Somalia: surveillance, laboratories, case management, oxygen therapy, infection prevention and control and risk communication, which mirrored both the country's fragile context priorities and the IHR core capacities. The implementation strategies adopted emphasized health system strengthening and service delivery intensification in ways broadly appropriate to the national context. More recently, there has been an intentional shift from ad hoc outbreak response to building integrated disease surveillance and response and community-based surveillance that is now being implemented in hundreds of facilities and districts, with the dissemination of national guidelines and training materials and the establishment of a multi-stakeholder technical working group. This trajectory, which is in alignment with the Government's current priorities, is explicitly described in publications of the

⁶ The WHO Regional Office for the Eastern Mediterranean promoted the development of a national laboratory policy and the engagement of Somalia with the Global Laboratory Leadership Programme.

Regional Office (42). Somalia health information system assessments were confirmed in the stakeholder interviews.

49. However, findings from this evaluation indicate that, beyond the Organization’s normative function, WHO’s engagement in maternal health-specific interventions has been limited, despite a clear need. The CCS is aligned in its technical focus with the Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy 2020–2024 (43) and 2023–2027 (44), which place maternal and neonatal survival at the centre of national priorities. WHO country office communications highlight its role in providing technical strategic and operational support to the national RMNCAH programme, with the overarching goal of reducing persistently high maternal and child mortality (45). WHO has engaged in RMNCAH through service provision and outreach teams for emergency response, although informants highlight the need for a more integrated response to the challenges, requiring specific programmatic approaches from WHO. WHO, UN and government stakeholders frequently identified the United Nations Population Fund (UNFPA) as a key agency for reproductive and maternal health. However, they emphasized the need for strengthened coordination and integration with UNFPA to ensure coherent and effective strategic support for the RMNCAH strategy.
50. Several stakeholders, particularly at the federal and state levels, reported that WHO’s operational modalities had, at times, resulted in the creation of parallel structures. For instance, the fact that WHO programme officers at different levels were accountable primarily to WHO rather than to government institutions was viewed as undermining national ownership and health system integration. These parallel structures were also reflected in focus group discussions, where health workers described WHO’s operational presence as essential but not necessarily integrated into sustainable government systems. This reflects a broader challenge in aid coordination in fragile contexts, where humanitarian imperatives can inadvertently weaken local governance structures if not carefully aligned (46), (47).
51. External alignment at national level does not always translate into relevance at state or district level, where needs and delivery constraints differ substantially. Several stakeholders pointed to insufficient subnational consultation and customization of interventions. Despite the strong technical leadership, partners and stakeholders reported fragmentation and duplication. Some partner activities remain donor-driven or tailored to donor priorities rather than subnational needs.

“There has been no consultation related to the strategy that WHO follows at the country level... there is no space where we can make inputs and recommendations to the upcoming five years.”

Representative of an organization of persons with disabilities

“Some priorities [are] donor-driven... what’s needed in Kismayo may not be the priority in Bossaso... customization is missing.” Government stakeholder

52. Donor preferences, vertical programme funding (e.g. Global Polio Eradication Initiative) and short-term emergency funding incentivize parallel service delivery and outreach campaigns that are not always integrated into government systems. This limits WHO’s ability to align partners around a long-term, government-owned health system strengthening agenda.
53. Systemic barriers limiting the ability of affected populations to provide feedback on health services undermines alignment with national and global commitments on community engagement and equity. This gap was highlighted by key informants and health workers who participated in focus groups, who noted limited participation of service users in WHO-supported planning and implementation. It is further evidenced in a 2024 multi-sector needs assessment, which indicated that affected populations faced systemic barriers to providing feedback and complaints regarding humanitarian and health services (48). Barriers affecting access and participation are well characterized in Somalia and include exclusion of marginalized clans, gender and disability inclusion challenges, difficult access to hard-to-reach areas, restrictive security management, political interference and counter-terrorism legislation (4).
54. While many stakeholders acknowledged WHO’s focus on recurrent and emergency responses as evidence of WHO’s responsiveness and adaptability to Somalia’s volatile context, they also raised questions about the balance between emergency response and longer-term system strengthening. Respondents emphasized that WHO’s operational focus during the evaluation period (2020–2025) was heavily weighted towards recurrent humanitarian and emergency responses, notably disease outbreaks, droughts and conflict-related health crises. This is coherent with the context, but also driven by donor funding priorities, which favour emergency response. A substantial proportion of mobilized resources were therefore directed towards emergency health interventions, with fewer resources for longer-term system strengthening. This imbalance is well documented in evaluations of WHO’s role in fragile states, where immediate life-saving interventions often overshadow health system-building efforts (49), (50).
55. The relevance of WHO’s actions was reduced by plausibility gaps in the ToC (Box 1 above). While the Organization’s pathways for governance strengthening, emergency preparedness and polio eradication are realistic, the ambition of reducing maternal and neonatal mortality through WHO’s current portfolio is not plausible, given that maternal health is not a major operational focus in Somalia despite its prominence in the ToC. Furthermore, the absence of explicit mitigation measures to protect against political instability, donor misalignment and gaps in federal–state cooperation reduce the likelihood of achieving transformative outcomes.

3.1.2 Extent to which WHO in Somalia adapted to changes in population priorities and emerging health needs, particularly for vulnerable groups (EQ1.2)

Key Finding 3: WHO in Somalia has shown considerable adaptation to changing population priorities and emerging health needs – especially for vulnerable groups – in response to evolving humanitarian crises, notably COVID-19, droughts, floods and recurrent outbreaks. This has involved operational

flexibility, targeted outreach, alignment with national strategies and strong coordination with partners.

Key Finding 4: However, adaptations have remained primarily operational rather than programmatic, with limited recalibration of strategic frameworks such as the CCS to reflect the protracted emergency dimension of Somalia’s health landscape. Gaps persist in systematically addressing the needs of minorities, marginalized groups, persons with disabilities and populations in hard-to-reach areas, where structural barriers to access remain insufficiently tackled.

56. WHO in Somalia displayed operational flexibility and responsiveness during the evaluation period. In stakeholders’ interviews, there was strong convergence on WHO’s strength in adapting its operations to shocks. WHO has been leading the Health Cluster and has embedded itself within the broader Humanitarian Response Plans. It has been actively engaged in identifying emerging health needs related to the recurrent humanitarian crisis in the country, aligning its activities with Humanitarian Needs and Response Plan priorities, such as outbreak detection, rapid response and sustaining essential service delivery. Stakeholders interviewed provided examples as illustrations of WHO’s capacity for timely and context-relevant operational adaptation including:
- **WHO’s contributions during the COVID-19 pandemic:** The pandemic response included the establishment of in-country polymerase chain reaction testing and expansion of laboratory capacity across federal member states of Somalia. This was reported as a successful instance of WHO’s flexibility in taking advantage of available funding to enable further reach.
 - **WHO’s cholera outbreak response in 2022** was found to have reflected WHO’s responsiveness and ability to adapt programming to emerging needs in the country. The response was structured around a five-pillar framework –coordination, surveillance, outbreak control, nutrition and integration of essential health services– supported at headquarters level but providing sufficient flexibility to enable the Organization to remain responsive to the rapidly evolving epidemiological situation on the ground. Flexibility was demonstrated through timely reallocation of resources, deployment of mobile response teams and strengthened cross-sectoral coordination.
57. Programming specifically prioritized IDPs and refugees through vaccination campaigns and other emergency response activities pivotal in protecting vulnerable populations. WHO has made strides in prioritizing IDPs and refugees through mobile outreach, targeted vaccination and outbreak-specific interventions. For instance, between January and February 2023, oral cholera vaccine was administered to 905 229 people living in IDP camps (90% of the target) across 10 drought-affected districts in Somalia (51). As one WHO stakeholder observed: “We always make sure that those vulnerable communities are getting the services... during cholera... there is a dedicated plan only to respond and to vaccinate and to reach those IDPs.” Leadership in polio eradication, measles and cholera vaccination campaigns and response to diphtheria and

whooping cough outbreaks was pivotal in protecting vulnerable populations.

“In the recent cholera vaccination, I worked in the IDP health facilities. The community was reached extensively with these vaccination services whether it was cholera, measles, polio...” Focus group participant, Garowe

- 58.** Attention to broader equity challenges remains insufficiently addressed. Despite the aforementioned efforts, broader equity challenges remain insufficiently addressed. The CCS explicitly references gender, equity and human rights, especially the rights of people with disability as key for strong, sustainable and inclusive health service delivery, yet commitment is largely rhetorical without demonstrated integration of these cross-cutting elements into implemented strategies. Key informants highlighted systemic barriers, such as language, clan affiliation, gender norms and discrimination against persons with disabilities. Focus groups confirmed that nomadic groups, marginalized minorities and women often face unique barriers, such as interrupted vaccination schedules or the requirement for men’s authorization to seek care. Furthermore, the UHC roadmap, a core aspect of WHO activities, reportedly does not provide specific measures to address discrimination ([52](#)). This gap was recognized by the WHO stakeholders interviewed as a deficiency in their work. These gaps are symptomatic of larger issues within the humanitarian response in the country, as evidenced by the recommendation of the 2025 Inter-Agency Humanitarian Evaluation of the Response to the Humanitarian Crisis in Somalia ([4](#)) to establish of a gender working group to systematically address gender-related barriers in Somalia’s health system – a recommendation yet to be implemented.
- 59.** Programmatic frameworks have not kept pace with operational adaptation. The CCS was neither reformulated nor subject to a mid-term review during the period 2020–2025, despite the significant shocks experienced and the expectation of a mid-term review specified in the CCS document.⁷ The lack of strategic recalibration limited opportunities to embed emergency response within a nexus approach, which could have facilitated a clearer pathway towards national ownership and long-term resilience. This challenge is further exacerbated by the absence of a systematic context monitoring mechanism and an insufficient organizational culture of learning and reflection, both of which hinder timely adaptation of programmes in response to the evolving context. Although strategic priority 2 of the CCS recognizes emergency preparedness and response as a core function, as noted above in relation to EQ1.1, WHO’s emergency role has frequently mirrored parallel service delivery rather than contributing to systemic health system strengthening.

⁷ “In 2023, a CCS mid-term evaluation will take place to assess progress towards the health outcomes, using the Country Results Framework indicators as a baseline, together with qualitative impact analysis through examples of successes in the country. The mid-term evaluation will be used to adjust priorities and outcomes based on the changing need in the country, as well as to effectively achieve the desired health outcomes. The final evaluation will be carried out in 2025.” Country Cooperation Strategy for WHO and Somalia 2021–2025, p. 36 ([8](#)).



3.2 Coherence and coordination⁸

3.2.1 Internal and external consistency of WHO's interventions and priorities (EQ2.1)

Key Finding 5: WHO's interventions in Somalia show moderate technical and operational coherence with external partners (especially for vertical, emergency and immunization programmes), although internal consistency across WHO's three levels is uneven. Vertical programmes (notably immunization, polio and other disease-specific initiatives) are highly coherent across country, regional and global levels.

Key Finding 6: In contrast, emergency response, UHC and health system strengthening programming reveal misalignments driven by funding flows, communication gaps, regional boundary issues (between the Eastern Mediterranean and Africa regions) and an under-articulated strategic response (e.g. lack of CCS mid-term review). Externally, WHO is widely recognized as the technical lead and coordination convenor, but fragmentation, parallel systems and donor-driven priorities limit full harmonization with partner agendas. Additionally, analysis of the internal coherence of WHO's programmes reflects a mixed picture of strategic alignment, with examples of functional integration, but also persistent fragmentation and structural barriers.

- 60.** Flagship vertical programmes (polio, routine immunization) demonstrate high internal alignment in objectives, planning and funding mechanisms across the three levels (headquarters, Regional Office and WCO). Vertical, well-resourced global initiatives provide standardized governance, predictable funding channels and technical guidance, which promote strong internal coherence. Key Informants reported that polio planning follows a clear top-down risk assessment and budgeting approach that is coordinated across levels. Nevertheless, there was some divergence among the stakeholders regarding the extent to which different vertical programmes were aligned.

“Polio is the only vertical program where the three levels are aligned...” WHO stakeholder

- 61.** Emergency response and health system strengthening showed inconsistent internal alignment. Informants flagged unclear funding flows, uneven technical follow-up from the Regional Office

⁸ According to the OECD, the DAC criterion of coherence addresses “the compatibility of the intervention with other interventions in a country, sector or institution” (27). In other words, how well does the intervention fit? The OECD describes coordination as a critical mechanism for achieving policy coherence, particularly in complex governance environments such as those involving sustainable development or humanitarian–development–peace nexus approaches.

and limited WHO headquarters engagement with Somalia realities.

“The programme that should be the biggest is the Emergency Response Programme. ... there’s low alignment when something as simple as how much funding is flowing down from [the] top [of the organization] to the country...nobody can answer that question.” -WHO stakeholder

62. Analysis of the internal coherence of WCO’s programmes in Somalia reflects a mixed picture of strategic alignment, with examples of functional integration, but also persistent fragmentation and structural barriers. WHO stakeholders cited notable examples of situations in which internal coherence has been strengthened through deliberate integration. The polio and immunization teams are particularly well-integrated: they engage in joint planning, share resources and leverage polio staff and infrastructure for broader immunization and surveillance functions, thereby minimizing duplication of human resources and field operations. Similarly, during crises such as the COVID-19 pandemic and recurrent droughts, WHO’s technical teams demonstrated close collaboration, pooling expertise and resources to mount coordinated responses. Despite these positive examples, internal fragmentation remains a significant challenge. Vertical programmes, including those on polio, immunization, nutrition and emergencies, often operate in silos, with parallel workplans, distinct reporting lines and donor-driven funding streams. Maternal health and nutrition are particularly under-integrated, lacking dedicated staff and systematic inclusion in joint planning processes. As one internal observation noted:

“We have a very strong immunization team, but maternal health and nutrition are not as well integrated. There is no dedicated staff for maternal health, and nutrition is often left out of joint planning.” WHO stakeholder

63. Several systemic barriers reinforce fragmentation. WHO’s internal organizational structure, with distinct technical units and compartmentalized reporting lines, limits cross-programme collaboration. Donor earmarking of funds, especially for polio and immunization, further constrains integration by locking resources into vertical priorities. High staff turnover exacerbates these challenges, preventing sustained efforts to build integrated teams.

64. There is strong external consistency with other development partners in terms of technical leadership and coordination. WHO is widely documented and acknowledged by stakeholders, including through KIIs, as the technical convener and trusted coordinator in humanitarian and health sector forums (53), (54), (55). Key Informants emphasized WHO’s centrality across coordination platforms (health sector coordination committee, technical working groups, donor forums) and its role in joint advocacy during COVID-19, and this finding has been triangulated through different sources and documents. As highlighted by one government stakeholder, *“Coordination... was the heart of everything... joint advocacy by the ministries of health and WHO, together with the donors, was impactful.”* Interviews with key informants from WHO, the United Nations and the Government and document reviews (donor reports) confirmed that WHO’s normative role and convening power produce strong external consistency where

partners follow a government-led platform and vertical programmes provide clear deliverables. Perception survey respondents were similarly positive. When asked about the extent to which WHO’s interventions and priorities in Somalia are consistent with those of their organization, 29 out of 47 rated them as “very consistent” or “perfectly consistent”, with an additional 11 rating them as “moderately consistent”.

65. However, external consistency is limited by persistent fragmentation, donor-driven priorities and limited subnational customization. Table 7 presents an assessment of WHO’s internal and external coherence in Somalia across key programmatic domains. It examines the degree of alignment and coordination at three levels: internal alignment between WHO headquarters, the Regional Office and the Country Office; programmatic coherence within the Country Office; and external alignment with partners. The analysis also reflects the strength of the evidence underpinning each judgement. The table highlights both areas of strong coherence (such as immunization and polio) and shows domains where alignment and integration remain weak or fragmented, based on a comparison of vertical programmes, emergency response, health system strengthening, and the UHC strategy and the CCS and an analysis of subnational customization.

Table 7. Evidence map – internal and external coherence

Domain	Internal alignment (WHO headquarters–Regional Office–WCO)	Internal programmatic coherence	External alignment (WCO–partners)	Strength of evidence
Vertical programmes (polio, immunization)	High –structured, funded, coherent across levels	High – adequate operational capacity	High – partners align on campaigns and surveillance	Strong (multiple interviews, programme documents)
Emergency response (e.g. COVID-19 pandemic, cholera outbreaks)	Mixed – operationally coherent but strategic oversight and funding alignment weak	Mixed – fragmentation due to donor-driven funding streams; also, WHO capacity sometimes limited by donor funding; WHO pushed beyond its role	High operational coordination, but parallel modalities present	Moderate to Strong (FGDs, multiple interviews)
CSS, health system strengthening, UHC strategy	Low – weak Regional Office–headquarters follow-up	Moderate – adequate integration of base programmes, but challenges in maternal	Moderate – partners support health system strengthening committees, but fragmentation persists	Moderate (document review and stakeholder interviews)

		health and nutrition; systemic gaps in alignment overall		
Subnational customization	Low – limited programmatic guidance from Regional Office/headquarters to address inclusion	Moderate – progress towards better state and district adaptation	Low – partners have limited integrated strategies for marginalized groups	Moderate (report of Office of the United Nations High Commissioner for Human Rights and focus group evidence)

Key: **Green**: high/strong; **Yellow**: mixed/moderate; **Orange**: low/weak.

66. Several factors contribute to these gaps in external and internal alignment. Based on document reviews and stakeholder interviews, these factors include:

- **Funding fragmentation:** The influx of COVID-19 pandemic and polio eradication resources created a well-resourced WCO able to operate at scale, but also created imbalanced incentives. Vertical programmes had clear funding pipelines, while health system strengthening and cross-cutting functions lacked similarly flexible financing. Stakeholders noted that large shares of funding are retained upstream. There is also weak downstream transparency.
- **Communication and follow-up gaps:** The recommendations of Regional Office missions are not consistently followed up by the WCO. Additionally, Somalia is not always adequately supported in Regional Office biennial planning. The result is weak feedback loops and missed opportunities to translate regional technical advice into country practice.
- **Geographical/regional complexity:** Somalia is located within the Eastern Mediterranean Region, but the context aligns significantly with the African Region. Exclusion from some African regional meetings (border health) and confusion about which regional mechanisms apply have produced practical coordination gaps. Somalia’s regional categorization (Eastern Mediterranean versus Africa) has created policy and operational blind spots.

“We get very little steer from the regional office on big strategic issues ...”-WHO stakeholder

- **Operational imperative outweighed strategic recalibration:** The scale and frequency of shocks forced operational responses (campaigns, mobile teams, surge staff). Without a formal mid-term review of the CCS, these operational adaptations did not coalesce into a revised programmatic strategy, so operations outweighed

strategic alignment.

- **National context and donor fragmentation.** A heavily donor-dependent system with multiple implementing partners perpetuates parallel mechanisms. WHO's convening role helps, but it cannot fully substitute for pooled financing or strong subnational governance.

67. Nonetheless, WHO Somalia has demonstrated strong collaboration with neighbouring countries to strengthen nutrition support, enabling both regional alignment and cross-border synergies. A notable example is the joint implementation of the Partnership for Nutrition Project funded by European Civil Protection and Humanitarian Aid Operations (ECHO), which brought together regions (Africa and Eastern Mediterranean) and agencies (WHO, UNICEF and UNFPA) to improve the coverage and quality of nutrition services in Ethiopia and South Sudan as well as Somalia (56). This initiative fostered harmonization of approaches, joint capacity-building and coordinated cross-border interventions.

3.2.2 WHO Somalia's contribution to UN system-wide and health sector coordination for both development and humanitarian action (EQ2.2)

Key Finding 7: WHO in Somalia has contributed significantly and substantively to both UN system-wide and health sector coordination during 2020–2025. Its leadership is visible in UN coordination structures, its technical expertise underpins sector-wide policy and strategy development, and its field presence ensures cluster coordination across all states. WHO has been central to outbreak response and health system strengthening, earning a strong reputation among stakeholders and donors for technical authority and reliability. Its added value lies in its technical expertise, rapid outbreak response and normative leadership in health system strengthening.

Key Finding 8: However, coordination challenges persist, particularly around duplication, parallel systems, limited government leadership at subnational levels and insufficient community accountability. The transition towards area-based coordination is expected to address field-level challenges.

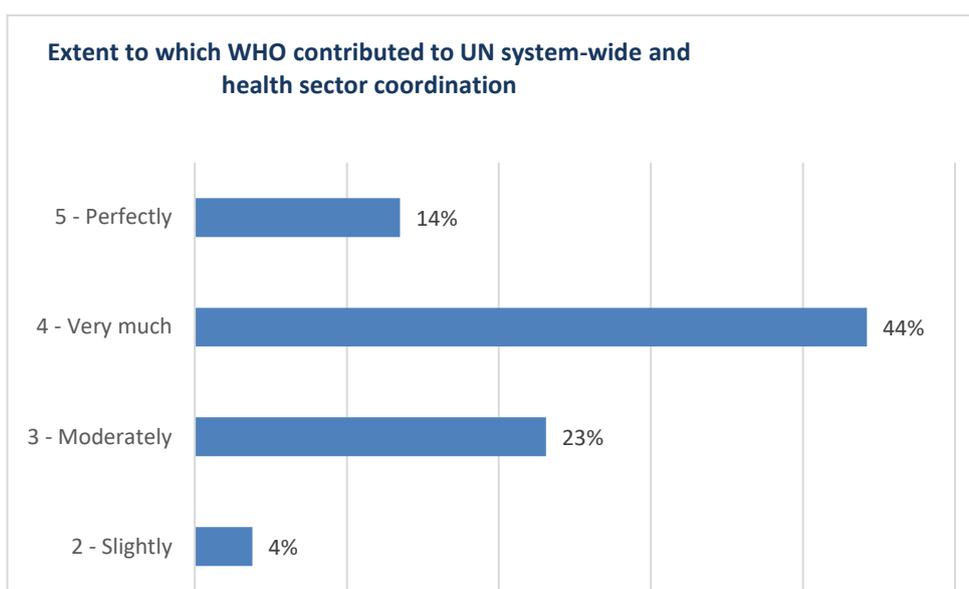
68. WHO is widely acknowledged as a central actor in the UN system in Somalia. WHO's alignment with the UNSDCF 2021–2025 further ensures system-wide coherence with national development priorities. WHO is a standing member of the UN country team, the humanitarian country team and the Development Partners Group. These engagements situate WHO at the centre of the UN's collective efforts in Somalia. Interview data confirm that WHO participates in and sometimes leads multiple UN coordination mechanisms, including the social and human development working group (57), the Global Action Plan for Healthy Lives and Well-being (58), disability initiatives and joint funds such as the Somalia Multi-Partner Fund (59).
69. WHO has actively supported the development and functioning of health sector coordination

structures at national and subnational levels. This is supported by extensive evidence triangulated across multiple data sources, including key informant interviews, health worker focus groups, a workshop with state-level stakeholders and document reviews. WHO’s contributions include leading the Health Cluster, supporting government health authorities in establishing thematic technical working groups (for example, on health information management, RMNCAH, surveillance) and supporting the Ministry of Health in leading coordination platforms. WHO also provides public health support and cluster coordination at state level, reflecting its wide geographic deployment. In emergencies, WHO leads outbreak response coordination, provides technical guidance and mobilizes partners for life-saving interventions, as seen during the COVID-19 pandemic and recurrent cholera outbreaks.

- 70. WHO is widely acknowledged by stakeholders as the first point of contact for the Federal Ministry of Health and partners during both routine planning and emergency response. Key informants reported that regular coordination platforms, including monthly disease programme reviews, Health Cluster meetings and a donor forum, enabled systematic dialogue and joint planning. At the state level, WHO’s embedded staff supported ministries in establishing field-based coordination platforms and were reported to have improved responsiveness to local needs. In practice, this strengthened the vertical linkages between federal and subnational coordination mechanisms, although their functionality remained uneven.
- 71. Stakeholders were positive in their judgement of WHO’s contributions to UN system-wide and health sector coordination. Key informants emphasized that WHO’s role is valued not only for its presence but for its thought leadership and technical credibility. For example, WHO’s coordination in the COVID-19 response was singled out as demonstrating agility and capacity to mobilize partners in response to urgent needs. Respondents in the perception survey also rated WHO’s contribution to UN system-wide and health sector coordination highly (39 respondents out of 45 reported moderate to very high contributions), as shown in Figure 3.

Figure 3. Stakeholders’ perceptions of WHO’s contribution to UN system-wide and health sector coordination

Source: Perception survey



72. WHO and government stakeholders in the KIIs ascribed several positive results to WHO's convening power. First, key informants indicated that joint planning and resource mobilization efforts, such as pandemic fund and ECHO grant proposals, have been made possible through inter-agency collaboration facilitated by WHO. Second, service delivery was perceived to have improved through reductions in duplication, for example by harmonizing human resources planning and integrating training activities across partners. Third, WHO's leadership during emergencies, including the COVID-19 pandemic and drought response, was reported to have enabled rapid deployment of resources, joint operations centres and integrated surveillance systems. These mechanisms were perceived to have not only strengthened the immediacy of responses but also generated durable assets, such as public health laboratories and nutrition stabilization centres that were subsequently integrated into routine health services. Also, WHO in collaboration with the Ministry of Health, developed a case study on COVID-19 as part of a broader series of 15 case studies conducted across the Region in 2021–2022 (60). These studies showcased how global, regional and national data and evidence were applied to support timely and effective responses to the COVID-19 pandemic. Additionally, immunization coverage, particularly among zero-dose children, was also reported to have improved as a result of coordinated outreach and joint microplanning.
73. Stakeholders interviewed also reported that WHO's convening role has been instrumental in advancing strategic health information governance. For instance, a WHO mission to Somalia in June 2022 identified opportunities to strengthen national capacity for evidence-informed policy-making and to enhance health information systems, supporting the implementation of Somalia's health information strategy. WHO facilitated the technical working group that developed the health information strategy for the period 2023–2027, which is now being implemented under the leadership of the Government. These contributions reflect WHO's normative role in promoting evidence-based policymaking and system strengthening.
74. Despite these achievements, coordination mechanisms faced persistent challenges. At the federal level, political tensions and donor-driven priorities occasionally disrupted national coordination platforms, leading to fragmented responses and parallel systems. Donor funding modalities, often project-based and short-term, reinforced silos and limited opportunities for system-wide approaches, undermining the broader vision of the Essential Package of Health Services. Sustainability also remained a critical limitation: while coordination improved service delivery in the short term, limited government financial commitment and high staff turnover hindered the institutionalization of gains. Moreover, fragmentation persisted across clusters and technical working groups, with some partners operating in parallel to government-led structures, which diluted efficiency and accountability.
75. Furthermore, despite strong strategic alignment with UN partners, implementation gaps persist. Collaboration with UNICEF, UNFPA, the World Food Programme (WFP) and the Food and Agriculture Organization of the United Nations (FAO) is systematic. This includes joint programming such as the ECHO-funded Partnership for Nutrition Project involving WHO, UNFPA and UNICEF (56). However, evidence from interviews with WHO, UN and government stakeholders, complemented by document reviews, indicates that effective field-level integration of RMNCAH remains limited, suggesting an implementation gap.

76. Additionally, WHO has worked with the Federal Ministry of Health to strengthen government ownership, but the Ministry’s variable capacity and influence at the state and district levels continues to complicate coordination (33). While WHO supports federal and state health authorities, some government stakeholders interviewed were of the opinion that WHO’s facilitation of state-level participation in international forums occasionally undermines the authority of the Federal Ministry of Health, illustrating tensions in federal–state relations.
77. The transition towards area-based coordination is expected to address field-level challenges. The transition towards area-based coordination is ongoing. As noted in the Inter-agency humanitarian evaluation report (4), “area-based coordination was expanded, with Area Humanitarian Coordination Groups led by UN OCHA or NGO partners active in various districts and regions”, a finding further corroborated by key informant interviews at state level. Area-based coordination is expected to address coordination issues by integrating access, equity and participation at district level. WHO’s ability to adapt to this evolving coordination architecture will be key to sustaining its leadership role.

3.3 Effectiveness⁹

3.3.1 Extent to which planned outcomes and outputs have been achieved (EQ3.1)

Key Finding 9: WHO has been most effective in immunization, surveillance and emergency response, with evidence of outputs contributing to outcomes. WHO made a plausible and measurable contribution to immunization coverage and child survival outcomes. Coverage of the third dose of the pentavalent (Penta-3) vaccine increased to 70% in 2024 (coverage of 83% in 2024 according to the District Health Information System 1 [DHIS2] data, but subsequently revised downward to 70% (WHO/UNICEF estimates of national immunization coverage [WUENIC] data)), supported by WHO’s outputs in cold chain strengthening, Expanded Programme on Immunization (EPI) system support and vaccination campaigns. These improvements contributed to a modest decline in under-5 child mortality (from 117 to 114 per 1000 live births), illustrating WHO’s effectiveness where outputs are closely linked to service delivery.

Key Findings 10: WHO was effective in building Somalia’s health security capacities, particularly through support for integrated disease surveillance and response, laboratory systems and rapid response teams. This led to improved outbreak detection and timely response, with the percentage of events receiving a rapid response rising from 51.7% to 68.3%. Low cholera case fatality rates (0.06%) further highlight strengthened epidemic preparedness and case management capacity.

⁹ The DAC criterion of effectiveness is defined as “the extent to which the interventions achieved, or were expected to achieve, their objectives, and results, including any differential results across groups (27)” Effectiveness focuses more closely on outputs and attributable results than impact.

However, recurrent epidemics demonstrate the fragility, inequity and insufficiency of prevention and control measures and limit broader health security gains.

Key Findings 11: Effectiveness in maternal and newborn health was constrained by limited programmatic prioritization and weak data systems. Maternal mortality and skilled birth indicators remain outdated, and availability of essential medicines stagnated at 28%, weakening the attribution chain. WHO's contribution here is visible mainly through normative support and general system strengthening, rather than measurable service-level improvements.

Key Finding 12: In the domain of health governance, WHO has effectively used its convening power to support coordination frameworks, policy development (such as the Essential Package of Health Services 2020 and RMNCAH strategies) and integration of health into social protection. However, progress is measured largely through binary or ordinal indicators (e.g. "Yes/No"; "Partially"), which limit the ability to assess the quality, functionality and downstream impact of governance reforms.

Key Finding 13: There is a systematic misalignment between WHO Somalia's output indicators and the strategic priority (SP) outcome indicators. Outcome indicators are often high-level (e.g. maternal mortality, sanitation coverage, essential medicines availability) and influenced by multiple external factors. WHO's country-level output indicators reflect its largely normative, system-enabling and governance-focused role. This disconnect makes it difficult to attribute outcome-level changes to WHO's contributions. By contrast, in areas where outputs and outcomes are tightly aligned – such as immunization and health security – evidence of WHO's contribution is stronger and more credible. Without intermediate, functionality-based indicators, WHO's normative and operational achievements risk being undervalued and under-documented.

WHO's contributions - overview of progress across the four strategic priorities

78. Annex 8 presents a table which integrates the CCS outcomes indicator framework and the WCO Somalia output indicators. Planned outcomes (and their indicators) are a joint responsibility of WHO, the Government of Somalia and other partners, while planned outputs are primarily the responsibility of WHO. The table in Annex 8 provides a structured overview of progress against WHO's four strategic priorities (SP1–SP4) in Somalia during the 2020–2025 evaluation period. It presents outcome and impact indicators alongside baselines, 2023 achievements and 2025 targets, while mapping these to corresponding WHO outputs and key performance indicators (KPIs). Each strategic priority –advancing universal health coverage (SP1), strengthening health security (SP2), promoting healthier populations (SP3), and reinforcing health governance (SP4) – is accompanied by narrative notes on progress and data quality considerations. This format highlights both areas of measurable advancement, such as immunization coverage and outbreak detection, and domains where progress is hindered by data gaps, methodological inconsistencies and/or reliance on binary indicators. The table thus serves as an analytical tool for assessing WHO's contributions, identifying causal linkages between outputs and outcomes and flagging attribution gaps that affect the robustness of performance assessment.



Qansaxleey Maternal and Child Health Centre, outpatient consultations in Dolow, Somalia. A doctor provides information to a mother carrying her child. © WHO / Ismail Taxta

SP1 - Advancing universal health coverage

79. WHO's contribution to UHC outcomes in Somalia is most visible in immunization coverage and child survival. The plausibility of contributions is strongest where WHO's outputs are closest to

service delivery and routine systems. The expansion of the essential service package and quality improvements in primary health care created a direct pathway towards higher immunization uptake. This is reflected in the rise of Penta-3 coverage to 83% in 2024 (District Health Information System 1 [DHIS2] data), subsequently revised downward to 70% (WHO/UNICEF estimates of national immunization coverage [WUENIC] data) (61), a result plausibly linked to WHO's outputs in strengthening EPI systems, reducing missed opportunities for vaccination and improving cold chain management. These changes, in turn, underpin incremental progress in child mortality outcomes, with the under-5 mortality rate declining from 117 to 114 per 1000 live births.

80. However, the causal link becomes weaker in the area of maternal and newborn health. Here, outcome indicators such as maternal mortality and skilled birth attendance remain outdated or missing, while WHO's outputs are reported only as "status", without quantified measures. The absence of recent data and reliance on partial progress reports break the attribution chain, making it difficult to substantiate WHO's role beyond a general supportive influence. Similarly, the stagnation in essential medicines availability (28%) illustrates a disconnect between normative guidance and tangible outcomes.

SP2 - Health security

81. In the domain of health security, the contribution pathway is more robust. WHO support in strengthening integrated disease surveillance and response (IDSR), IHR core capacities, laboratory systems,¹⁰ incident management and rapid response teams aligns directly with observed improvements in epidemic detection and response. The percentage increase timely detection of and response to events, which rose from 51.7% to 68.3%, is a credible reflection of these investments. Similarly, the slight gains in IHR core capacity scores provide further evidence of WHO's central role.
82. Yet, the causal pathway is not without gaps. The absence of reliable data on IDSR coverage prevents a full assessment of system functionality, while deterioration in nutrition outcomes (with acute malnutrition prevalence reported at 14.3%) is largely driven by exogenous shocks, such as drought and food insecurity (62). In such cases, WHO's outputs, although relevant, cannot realistically shift outcomes on their own, underlining the limits of attribution in highly volatile humanitarian settings.

SP3 - Healthier populations

83. WHO's efforts in community health promotion and nutrition policy support show modest contributions to population health outcomes. Incremental improvements in exclusive breastfeeding (from 33% to 34%) and reductions in stunting (down to 26% in 2023) suggest that

¹⁰The institutional commitment to consolidate stronger laboratory systems is evident in the participation of various line ministries in the Global Laboratory Leadership Programme) workshop held in Muscat in July 2024: Ministry of Labour and Social Affairs, Ministry of Environment and Climate Change, Ministry of Agriculture and Livestock, and Ministry of Health and Human Services.

WHO's guidance on infant and young child feeding and community health worker interventions are contributing factors, although the scale of impact is limited.

- 84.** The contribution story weakens substantially when looking at water, sanitation and hygiene (WASH) and road safety. Sanitation coverage fell from 42% to 33%, and road traffic mortality improved (20 per 100 000), there are no linked WHO output KPIs to trace a causal pathway. In such cases, WHO's normative role remains important at the policy level, but the absence of measurable outputs means attribution to these outcome shifts cannot be claimed. Furthermore, large data gaps in safe drinking water indicators sever the output–outcome chain.

SP4 - Health governance

- 85.** WHO's convening role in governance and technical assistance is reflected in its sustained contributions to health sector coordination mechanisms, technical working groups and platforms for surveillance and emergency response – largely convened by the Ministry of Health, with substantive WHO support. This role is further underscored in the humanitarian domain, where WHO leads the Health Cluster, and in donor engagement forums such as the Somali Health Partners Group.
- 86.** Nevertheless, the outcomes are presented as binary or ordinal (“Yes/No” or “Partially”), without indicators of quality or functionality. This reduces the ability to link governance reforms to downstream outcomes in a robust way. While WHO's contribution here in shaping the institutional architecture is clear, the lack of measurable indicators weakens the attribution story and confines the attribution claim to a supportive, enabling contribution.
- 87.** Overall, the alignment between outcome and output indicators in Annex 8 is mixed, which directly affects the strength of the contribution analysis. In areas such as immunization, outbreak detection and emergency response, outcome indicators are well linked to specific WHO outputs (e.g. vaccination campaigns, IDSR strengthening, rapid response team deployment), allowing for a credible causal pathway and stronger contribution claims.
- 88.** By contrast, in maternal health, essential medicines, WASH and governance, the outcome indicators are either outdated, lack disaggregation or are tracked through broad binary “Yes/No” outputs that fail to capture functionality or quality. This misalignment limits the ability to attribute progress to WHO's work and reduces the evaluative robustness of the contribution story. In some cases (e.g. malnutrition, sanitation, maternal mortality), the absence of directly corresponding output indicators or reliance on exogenous factors means that WHO's role can only be inferred as supportive rather than demonstrated. As a result, the strength of the contribution analysis varies significantly across the four strategic priorities, being strongest where output and outcome indicators are tightly aligned and weakest where data gaps, methodological inconsistencies, or non-specific outputs undermine attribution.
- 89.** Table 8 summarizes the contribution analysis on WHO's four CCS strategic priorities in Somalia, based on the available data on outcome and output indicators detailed in Annex 8. For each priority, the causal pathways illustrate how WHO's outputs plausibly contributed to

intermediate and outcome-level changes, while the breakpoints highlight gaps that weaken attribution or limit sustained impact. The fourth column suggests practical next steps to strengthen contribution claims going forward.

Table 8. Summary of contribution analysis of WHO’s strategic priorities in Somalia

Strategic priority	Causal pathways	Breakpoints	Practical next steps to strengthen contribution claim
SP1 - Advancing universal health coverage	WHO guidance and support for UHC package → adoption at primary care level → improved service readiness (notably immunization) → higher coverage and reduced child mortality.	Outdated maternal health baselines; lack of quantified output data; poor availability of essential medicines.	Tighten the results chain; quantify outputs (e.g. % facilities implementing UHC package with supervision); refresh baselines (maternal health, workforce); triangulate evidence with service readiness and microplans.
SP2 - Health security	WHO’s technical assistance in IDSR, lab strengthening, rapid response team deployment and emergency operations → earlier outbreak detection and containment → measurable rise in timely response.	Limited IDSR coverage data; weak outcome metrics for nutrition; high contextual confounding from humanitarian crises.	Stabilize surveillance methods; expand IDSR coverage; systematically document rapid response team/emergency operations centre activation; triangulate outbreak response records with surveillance indicators.
SP3 - Healthier populations	WHO technical support to nutrition and health promotion → strengthened community health worker interventions and adoption of infant and young child feeding practices → incremental improvements in nutrition outcomes.	Missing WASH data: absence of output KPIs linked to WASH and road safety; reliance on multi-agency interventions where WHO’s role is diffuse.	Update nutrition and WASH baselines; develop clear WHO-attributable KPIs (e.g. community health worker coverage for infant and young child feeding counselling); apply contribution-tracing to link community interventions with outcome shifts.
SP4 - Health governance	WHO’s policy dialogue, convening power and governance support → creation of coordination structures and integration of health in wider policies → indirect reinforcement of UHC and health security outcomes.	Binary reporting of outputs; absence of quality/functionality measures; difficulty linking governance structures directly to population-level outcomes.	Replace binary “Yes/No” indicators with functionality measures (e.g. frequency and outputs of coordination meetings); link governance support to measurable downstream service delivery improvements.

Further assessment of WHO’s contribution to broader changes in the health landscape

90. WHO’s contribution to broader changes in Somalia’s health landscape was examined to provide further insights on specific programmatic elements. The Organization’s sustained role in health system strengthening, primary responsibility for polio immunization and extensive presence in emergency response activities have created the operational foundations that support progress in immunization and disease control.

91. WHO’s technical and operational support has been effective in enabling initial vaccine uptake across Somalia. Outputs such as nationwide immunization campaigns, strengthening of cold chain systems, training of health workers and intensified surveillance contributed to relatively strong coverage for early-dose vaccines, as shown in administrative (DHIS2) data, including OPV1 (94%), DTP1 (93%) and BCG (83%). These outputs demonstrate WHO’s capacity to mobilize communities and extend access to immunization services. However, systemic gaps in follow-up mechanisms and defaulter tracking remain evident in the sharp declines between the first and third dose of DTP and between the first and second dose of measles vaccine (81% versus 45%) and in persistently low IPV-2 coverage (28%). While WHO’s contribution to expanding initial access is clear, sustaining full immunization schedules requires stronger government engagement, targeted outreach, strengthening of routine immunization and better use of data systems.



WHO field visit to Dolow General hospital in Somalia, August 2023. © WHO / Ismail Taxta

92. Table 9 visually reinforces the disparities between high initial vaccine uptake and low completion rates. The data trend shows a strong start with BCG, OPV1 and DTP1, but the sharp decline for IPV-2 and measles-2 highlights systemic challenges in sustaining immunization schedules. The steep drop from measles-1 to measles-2 signals a significant risk of measles outbreaks due to inadequate herd immunity, while the weakness in IPV-2 coverage jeopardizes progress towards polio eradication.

Table 9. Immunization coverage by antigen (2024)

Month	BCG	DTP1	DTP3	Measles1	Measles2	OPV0	OPV1	OPV3	IPV-1	IPV-2
Jan	80%	93%	81%	83%	13%	44%	93%	82%	80%	20%
Feb	78%	89%	79%	78%	12%	42%	90%	79%	77%	18%
March	82%	91%	82%	81%	13%	45%	92%	83%	77%	22%
April	76%	88%	79%	77%	17%	44%	89%	80%	72%	24%
May	81%	88%	77%	82%	17%	44%	89%	80%	70%	30%
June	83%	94%	81%	78%	14%	44%	95%	81%	75%	27%
July	82%	92%	81%	77%	14%	42%	93%	83%	78%	28%
Aug	84%	91%	83%	82%	17%	46%	94%	86%	80%	34%
Sept	84%	96%	85%	83%	17%	45%	95%	87%	83%	31%
Oct	84%	93%	86%	82%	17%	46%	93%	87%	83%	30%
Nov	88%	99%	89%	87%	17%	48%	98%	89%	81%	34%
Dec	90%	101%	91%	87%	24%	48%	102%	92%	87%	40%
Total	83%	93%	83%	81%	16%	45%	94%	84%	79%	28%

Source: Ministry of Health/WHO dashboard.

93. There is limited year-on-year improvement in overall immunization performance. As shown in Figure 4, while certain antigens show relative stability or minor increases in coverage (e.g., DTP3), others have stagnated or declined (e.g., OPV0 and IPV1), reflecting uneven programmatic focus and possibly fluctuating service delivery capacity. The persistence of low coverage for measles-2 and IPV-2 across multiple years indicates that these are not temporary anomalies but systemic weaknesses requiring targeted solutions.

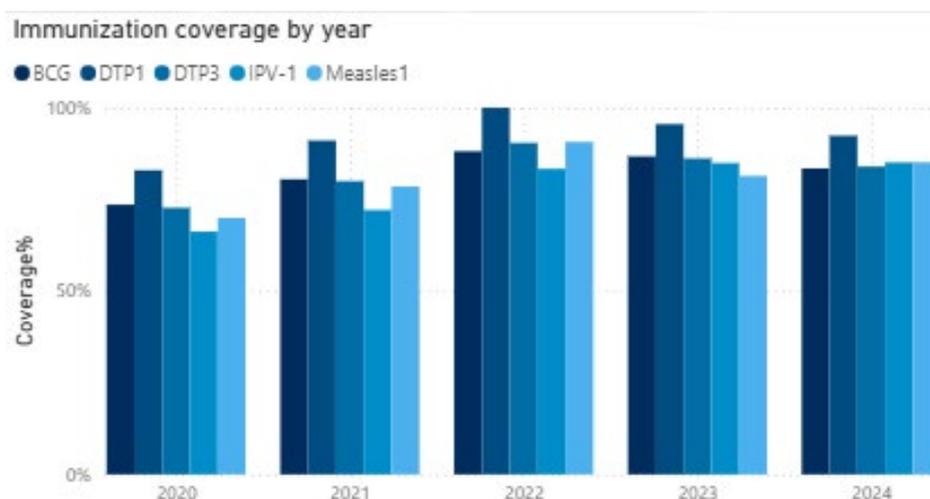


Figure 3. Immunization coverage by year

Source: Ministry of Health/WHO dashboard.

94. WHO’s outputs in surveillance and campaign delivery have contributed to stronger coverage in some regions such as Nugal, Mudug and Karkar, although data irregularities (coverage over 100%) point to denominator weaknesses. However, WHO-supported service delivery in chronically underperforming areas like South Mudug, Middle Juba and Sool has faced persistent access barriers linked to insecurity, remoteness and logistical challenges. These inequities highlight the importance of WHO’s ongoing efforts to expand mobile and community-based immunization, which are especially relevant for nomadic and displaced populations.
95. At the district level, the disparities are even more pronounced, with the pattern illustrating

inequitable access where children in fragile districts may be systematically left behind. Districts such as Galkayo North (Mudug) reported implausibly high coverage in 2024 (e.g. BCG at 240%, DTP3 at 366%, measles1 at 323%, IPV-1 at 399%), which reinforces concerns around denominator accuracy and quality of the administrative data. In contrast, the performance in districts such as Mahaday (Middle Shabelle), Taleeh (Sool) and Rabdure (Bakool) is critically poor, with Mahaday recording coverage below 20% across all major vaccines and Taleeh at nearly zero for essential antigens.

96. Somalia’s public health landscape between 2020 and 2025 reflects both advances in surveillance and persistent challenges in disease prevention and control. This assessment is substantiated through triangulated evidence from stakeholder interviews, focus group discussions with health workers and document reviews. Despite WHO efforts in emergency responses and preparedness activities, the burden of disease outbreaks and of endemic malaria remain high in Somalia, as reflected in Ministry of Health/WHO dashboard analysis (see Table 10). The disease burden is concentrated in high-risk geographical areas (Banadir, Bay, Gedo, Shabelle regions) and among vulnerable populations (children under 5, nomadic populations and IDPs). While the available data on **polio, measles, malaria and cholera** indicate high surveillance activity, data inconsistencies (such as reporting coverage over 100%) also highlight challenges with denominator accuracy and mask true inequities.

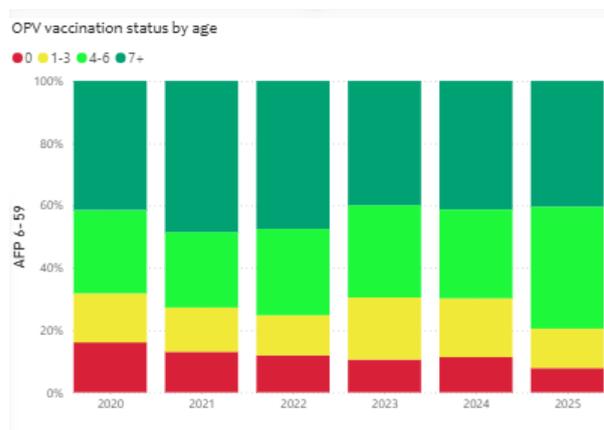
Table 10. Disease burden

Disease	Description
Polio	While circulation of circulating vaccine-derived poliovirus (cVDPV) is limited to a few hotspots (Bay, Gedo), persistent under-immunization and vulnerabilities in nomadic and IDP populations mean there is an ongoing risk of resurgence.
Measles	With >7000 confirmed cases and recurring seasonal peaks, measles remains a major epidemic threat, driven by low second-dose coverage and high numbers of zero-dose children.
Malaria	Despite strong testing, endemic transmission persists in southern and riverine districts, with under-5 children accounting for 77% of the burden of disease, indicating limited impact of control strategies on child morbidity.
Cholera	Large-scale outbreaks continue annually, with children disproportionately affected, although very low case fatality rates (0.06%) highlight strong case management.

97. Detection of poliovirus in Somalia meets WHO-recommended surveillance benchmarks, indicating that the country’s surveillance system has sufficient sensitivity to identify poliovirus circulation. The dashboard data analysis indicates that, between January 2020 and May 2025, Somalia reported **2208 acute flaccid paralysis (AFP) cases**, with 31 confirmed as vaccine-derived poliovirus (VDPV). Of these, 11 were immunodeficiency-related (iVDPV), 2 circulating (cVDPV) and 18 ambiguous (aVDPV). Males (56.5%) were slightly more affected than females (43.5%). Urban children accounted for the majority of cases (39.2%), but children in **nomadic (19.6%) and IDP (11.1%)** populations were also disproportionately vulnerable due to limited access to routine immunization.
98. Despite some improvement in OPV uptake, many AFP cases involved children who received only 1–3 doses, underscoring **persistent under-immunization** and continuing risk of poliovirus

outbreaks. Most cVDPV cases were clustered in **Bay and Gedo**, confirming them as high-risk zones. Surveillance gaps in other regions may obscure the true extent of transmission. The highest AFP burden was among children under 5, particularly those age 3–4 years (29.1%), followed by infants under 1 year of age (21.3%). This age profile mirrors known poliovirus susceptibility, reinforcing the need for early and complete vaccination. Figure 5 shows OPV vaccination status by age group and reveals that younger children had significantly fewer OPV doses compared with older cohorts. The trend highlights delays in vaccine initiation and dropouts in the early years of life.

Figure 4. OPV vaccination status by age group



Source: Ministry of Health/WHO dashboard.

99. Although acute cholera outbreaks continue to occur in Somalia, the low case fatality rate and the decline in the frequency and scale of outbreaks since 2023 suggest improvements in outbreak detection and response capacity and the positive effects of strengthened WASH interventions. The Ministry of Health/WHO dashboard analysis indicates that, between January 2020 and June 2025, Somalia reported 66 608 suspected cholera cases, with 5996 confirmed positives and only 37 deaths, yielding a case fatality rate of 0.06%, well below the WHO emergency threshold. Over 56% of suspected cases were in under-5 children, highlighting the high paediatric burden. The sex distribution was nearly equal (51% male, 49% female). The highest case numbers occurred in Nugal, Hiran and Marodijeh, although outbreaks were widespread across the central and northern regions. Seasonal peaks coincided with the rainy season (April–June), underscoring the link between rainfall, flooding, water contamination and outbreaks. The epidemic thresholds exceeded WHO’s epidemic alert levels for several weeks in 2023, indicating acute outbreaks. However, subsequent declines reflect improved outbreak response and effective WASH interventions.

100. The surveillance data underscore systemic gaps:

- **Insufficient data quality assurance:** Implausibly high coverage figures indicate inadequate validation exercises, especially in districts consistently reporting rates above 100%. Current estimates are built on weak population denominator estimates, without sufficient refinement of catchment area mapping.
- **Inequitable coverage:** Chronically underperforming districts indicate that gaps in coverage require enhanced support, including mobile outreach, community-based

immunization and tailored microplanning informed by geospatial data. Measles-2 and IPV-2 coverage rates currently represent the weakest points in Somalia’s immunization system, with already disadvantaged areas particularly affected.

101. The case review below provides details about the strengthening of health systems and the health workforce through community health workers in Somalia

CASE REVIEW

Strengthening health systems and workforce through community health workers in Somalia

Background

The country faced severe strain during the COVID-19 pandemic and the devastating 2022 drought. These crises disrupted the delivery of essential health services, further limiting access to care—particularly in remote, underserved and marginalized communities.

WHO's strategic intervention

To mitigate the collapse of service delivery and address critical human resource shortages, **WHO Somalia implemented a large-scale deployment of community health workers (CHWs)** as part of its emergency health response.



COVID-19 response (2020–2021)

- **3227 CHWs** deployed across 51 high-risk districts.
- CHWs conducted active case detection, contact tracing and risk communication.
- **Over 2.1 million households visited**; CHWs identified **32.7% of suspected COVID-19 cases**.
- CHWs traced **13 279 close contacts** – seven times the number detected through facility-based surveillance.

Drought response (2022)

- **2194 CHWs** deployed in 29 drought-affected districts.
- Delivered **basic health services to 2.3 million households**.
- Screened **385 260 children for malnutrition** and treated **34 171 cases of acute diarrhoea**.
- Educated **523 000 pregnant and lactating women** on infant and young child feeding practices.
- Referred **13 818 children with hypoxemia** to primary care facilities.

Effectiveness in health system strengthening

The CHW initiative demonstrated measurable effects across key pillars of health system strengthening:

Surveillance and early detection:

- CHWs effectively extended the reach of the national **Early Warning, Alert and Response Network (EWARN)** into hard-to-reach areas.
- Generated **21 000 alerts during COVID-19** and **12 736 alerts during the drought**, with high rates of timely verification and response.

Service delivery and equity:

- Expanded coverage of essential health services to marginalized and displaced populations, addressing entrenched geographic and socioeconomic inequities.
- Maintained continuity of critical services – including maternal and child health, nutrition and epidemic control services – during periods of system disruption.

Workforce expansion and gender equity:

- CHWs filled critical workforce gaps, functioning as the backbone of community-level service delivery.
- Over half of the deployed CHWs were women, contributing to both **gender balance in the health workforce** and the provision of culturally sensitive services to women and children.
- CHWs also provided psychosocial support and referral pathways for survivors of **gender-based violence**, which increased during the pandemic.



Community trust and engagement:

- By recruiting CHWs from within the communities they served, WHO fostered trust, improved health-seeking behaviour and strengthened accountability.
- CHWs served as a vital interface between communities and formal health systems, ensuring local ownership and sustained uptake of services.

Lessons learned

CHWs are a cost-effective strategy:

- Evidence from Somalia demonstrates that CHWs contribute to improved epidemic preparedness, equitable access and progress towards UHC.
- CHWs generate health, social and economic returns, making them a cost-effective strategy for fragile settings (63).

Cultural familiarity and presence in hard-to-reach areas enhance access:

- CHWs' familiarity with cultural norms and community dynamics enabled tailored, context-specific interventions.
- Their presence allowed for rapid response in insecure or remote areas inaccessible to traditional health services.

Conclusion

The deployment of CHWs by WHO Somalia represents a **transformative approach to health system strengthening in fragile and crisis-affected contexts**. By bridging workforce gaps, expanding equity in service delivery and strengthening epidemic surveillance, CHWs mitigated the immediate impacts of COVID-19 and drought while laying the groundwork for a more resilient, equitable and responsive health system. Sustained investment in CHWs and their integration into Somalia's health system architecture is essential for advancing UHC and building long-term system resilience. A main concern expressed in the stakeholder interviews is the limited financial commitment of the Government to this cadre of health workers, as the majority of primary health workers are funded by NGOs.

3.3.1.1 Programmatic assessment challenges

- 102.** Evaluating progress towards WHO's programmatic outputs in Somalia remains challenging due to the complexity of multiple reporting frameworks and the reliance on online platforms that aggregate data at the global or regional level. These platforms, primarily linked to WHO's GPW13, do not sufficiently disaggregate country-level performance, making it difficult to directly link field-level programme implementation to corporate outcomes. Key informants consistently highlighted the absence of Somalia-specific baseline values and targets for GPW13 output indicators. While denominator data have been introduced under GPW14, outputs and outcomes remain aggregated globally, with limited granularity to reflect Somalia's specific trajectory. A further limitation is the lack of disaggregated data, which constrains meaningful equity analysis and obscures differential impacts on vulnerable populations (nomadic groups, IDPs and rural communities).
- 103.** At the WCO level, the absence of an integrated M&E tool limits systematic tracking of progress against logframe indicators. The existing scorecard system is largely communicative rather than analytical and lacks robust M&E evidence to justify the ratings. Similarly, the KPI "traffic light"

system, which is intended to illustrate progress towards corporate outcomes, may provide misleading, subjective assessments. For instance, the scorecard for output 1.1.3 (“Improved access to quality essential health services irrespective of gender, age or disability status”) assigns a maximum score of 4 for reducing inequities. This approach is at odds with the documented inequities in service access and outcomes in Somalia (64), (65) and highlights a disconnect between reported scores and contextual realities.

- 104.** The donor-specific monitoring frameworks developed by WCO Somalia have met accountability requirements but are largely insufficient to rigorously measure outputs. For example, in the ECHO-funded nutrition initiative (56), 511 552 individuals were reported to have been reached, including 473 101 directly benefiting from essential supplies provided to health facilities. However, these figures were estimated using population-based projections, rather than direct beneficiary monitoring. Furthermore, crude mortality rate was used as an outcome indicator. While crude mortality is a key humanitarian metric, it is a non-specific measure influenced by multiple determinants, which limits its usefulness as a sole indicator of health programme effectiveness (66).
- 105.** The ECHO reporting also highlighted significant underachievement against original targets.¹¹ While the first interim report suggested 3.2 million direct beneficiaries, the updated report for 2023 confirmed only 473 101 direct beneficiaries against a planned target of 5 million. This represents an under-delivery relative to planned outputs, described as the most robust estimate available.
- 106.** Achievement of output targets related to UHC also remains debatable. WHO projected that an additional 1 million Somalis (above a 2018 baseline) would be benefiting from UHC by 2025. However, Somalia’s population grew by more than 3 million in the same period (67), meaning that projected UHC gains were outpaced by demographic growth. The UHC service coverage index value (27) did not improve between 2019 and 2023 (68). Some independent studies reflect an index value of 33.5 for 2025) although, Somalia’s score remains among the lowest globally (69). The improvement of the UHC service coverage index reflects progress in some dimensions, notably related to maternal, newborn and child health (e.g., antenatal care, immunization and skilled deliveries). However, methodological differences between the 2019 and 2025 may account for part of the reported improvement.
- 107.** Despite these gaps in output achievement, the evaluation acknowledges several important strengths identified through desk reviews and primary data collection:
- The number of individuals reached despite operational challenges
 - Efforts to address inequities in hard-to-reach areas through outreach and catch-up campaigns
 - The commitment of WHO staff and implementing partners in a fragile context
 - Good practice in the deployment of state-level public health officers to coordinate health emergencies, strengthening subnational response.

¹¹ Donor-related reports have their own outputs and outcomes, which are not linked directly to those for the strategic priorities of the CCS.

Box 2. Commentary on the disconnect between outcome indicators and WHO's work

A key finding of the evaluation is the **misalignment between strategic priority outcome indicators and the actual scope of WHO's normative and operational work in Somalia**. While the outcome indicators are drawn largely from global frameworks such as the SDGs, UHC index and IHR core capacities, they do not always correspond to the scale or nature of WHO's country-level interventions. For example, in maternal and newborn health, outcome indicators include the maternal mortality ratio and skilled birth attendance rates. However, WHO Somalia's contribution in this area has been largely normative and included issuing guidelines, supporting policy frameworks (e.g. Essential Package of Health Services 2020, RMNCAH strategy) and building governance capacity, rather than direct service delivery. The reliance on high-level mortality indicators, often outdated or unavailable, creates a **disconnect between WHO's actual outputs (guideline adoption, policy dialogue, training) and the outcome measures used to judge effectiveness**. This undermines attribution and obscures WHO's enabling role.

Similarly, in essential medicines and WASH, outcome indicators such as availability of essential medicines and access to sanitation services are reported, but WHO's work is mainly limited to regulatory support, normative guidance and cross-sectoral convening. **With no direct operational role in service provision or infrastructure, WHO cannot plausibly be held accountable for population-level shifts in these domains**. The absence of intermediate or functionality indicators (e.g. proportion of facilities with no stock-outs, quality of water and sanitation protocols adopted) weakens the contribution chain.

By contrast, in **immunization and health security**, where WHO combines normative guidance with significant operational support, including cold chain strengthening, campaign delivery, surveillance and rapid response teams, the outcome indicators (e.g. immunization coverage, timely outbreak detection) are both measurable and closely linked to WHO's outputs. This alignment explains why contribution claims in these areas are stronger and more credible.

Overall, the evaluation finds that the **disconnect stems from a reliance on outcome indicators that are too broad, too distal or too dependent on exogenous factors**, while WHO's country office outputs are often normative, binary or system-enabling in nature. Without intermediate indicators that capture the uptake, functionality and quality of WHO's contributions, the effectiveness of its normative and operational work in Somalia is under-documented and at risk of being undervalued.



WHO's response to the drought crisis in Baidoa, Somalia (November 2022): A doctor at Bay Regional Hospital assesses a young child for malnutrition as WHO supports lifesaving care for children affected by severe drought and food insecurity. © WHO / Ismail Taxta

3.3.2 Factors that contribute to or hinder the success of WHO interventions across priority areas, lessons learned and areas for improvement (EQ3.2)

Key finding 14: WHO's interventions in Somalia (2020–2025) achieved notable successes due to its technical authority, strong national presence and ability to mobilize resources for emergency response. These factors enabled WHO to influence policy, strengthen systems and coordinate partners effectively.

Key finding 15: However, political instability, insecurity, funding dependence and weak government ownership continue to hinder the sustainability and equity of outcomes. Lessons point to the need for stronger government leadership, financing and integration, as well as strategies to transition emergency-driven capacities into sustainable national systems.

Factors contributing to success include:

108. Technical leadership and normative guidance: WHO's technical expertise and policy leadership were consistently identified as central to the success of interventions. As discussed under effectiveness, stakeholders emphasized WHO's role in supporting the Government of Somalia in

developing core policies that underpinned sectoral planning.

“WHO was actually the good hand on technical support to the Somali government... WHO was the leading agency, technically and financially... supporting the Somali health policy and subsequent strategic plans.” -Somali Ministry of Health official

109. Strong national presence and rapid response capacity: WHO had an extensive field footprint, with over 140 international and national staff, 25 public health emergency officers, 200 district officers and more than 2000 trained CHWs by 2023. Stakeholders interviewed and secondary documentation confirm the importance of this footprint in enabling WHO to be the first responder during crises. This capacity allowed WHO to respond effectively to the COVID-19 pandemic, cholera outbreaks and famine-related health emergencies, which in turn enhanced its reputation and influence.

“WHO is the lead in any situation... whenever there is a crisis or emergency, WHO is the first to intervene and to be on the ground through our very huge national presence.” WHO stakeholder

110. Resource mobilization through emergencies: The COVID-19 pandemic, recurrent cholera outbreaks and drought-related famine risk catalysed donor support, enabling WHO to expand staffing, deploy mobile teams and strengthen surveillance and laboratory systems. Emergency-driven resources were used to establish infrastructure, such as laboratories, trauma care and surveillance systems that could serve functions beyond the immediate response.

111. Coordination and partnerships: As discussed under the coherence and coordination criterion, WHO played an effective central convening role in technical working groups and in the Health Sector coordination committee, fostering joint planning and problem-solving between federal and state authorities and partners. Its leadership in immunization was cited as an example of successful multi-stakeholder coordination, where participatory decision-making and strong funding produced results.

112. Laboratory and surveillance strengthening: WHO’s investment in laboratory infrastructure and workforce training improved national diagnostic capacity.

“WHO has deliberately set up laboratories in Somalia... not only for measles and polio, but other diseases... strengthening the capacity of the individuals themselves by deliberate training. This has sustained the programmes in the country.” WHO stakeholder

Factors hindering success and key challenges include:

- 113.** Political instability and governance fragmentation: Chronic political instability and fragmented governance hindered progress. High turnover in ministry leadership required WHO and partners to “start from zero” repeatedly, undermining continuity. Competition between federal and state authorities also distorted resource allocation, with political demands sometimes outweighing epidemiological evidence.
- 114.** Insecurity and access constraints: WHO operations are costly and logistically challenging due to insecurity and poor infrastructure. Large parts of the country remained inaccessible, creating “blind spots” where monitoring and supervision were impossible.

“Most places we can’t go by road... we have to charter planes... It’s extremely expensive at all levels.”-WCO stakeholder

- 115.** Donor dependence and funding gaps: Emergency-driven funding created a massive workforce that risks collapse without clear handover strategies or increased domestic financing. Current funding shortages have already led to the closure of hundreds of clinics, potentially resulting in loss of gains achieved. Resource allocation is uneven across the territory.

“The problem is... how do you sustain these people when the government has no resources?...”—WHO stakeholder

- 116.** Bureaucracy and delays: WHO’s internal procedures and slow funding flows sometimes limited timely response.

“Sometimes the response comes when the emergency is already ended... the bureaucratic system of WHO actually needs to be reviewed.”-Government stakeholder

- 117.** Parallel systems and limited government ownership: As discussed under the coordination, coherence and relevance criteria, although coordination structures exist, duplication and parallel systems remain. WHO’s direct role in service delivery and contracting health workers, while necessary during crises, has sometimes limited institutional ownership by the Federal Ministry of Health.
- 118.** Inadequate M&E: Disparities in health information systems affect adequate programme management, as is discussed further under the section on efficiency below.
- 119.** Several lessons were derived from document reviews and stakeholder interviews:
- **Emergencies can serve as opportunities for system-building:** COVID-19 showed that emergency funding can be used to build capacities in areas such as laboratories, surveillance and trauma care.
 - **Local ownership is essential for sustainability:** Programmes must be handed over

to government leadership, with domestic financing as a precondition for long-term continuity.

- **Coordination is at the heart of effective response:** Joint advocacy and coordination between WHO, the Government and donors during COVID-19 improved alignment and responsiveness.
- **Evidence-driven planning enhances impact:** Situation analysis and data audits should guide prioritization in resource-constrained settings.

120. Areas for improvement identified include:

- **Strengthening sustainability and handover strategies:** There is a need to transition WHO-supported capacities into government-led structures supported by domestic financing.
- **Enhance government ownership and accountability:** Implement a phased transition from UN/WHO-led delivery to government-led planning and oversight, with clear accountability mechanisms at federal and state levels.
- **Expand integration and reduce fragmentation:** Align humanitarian and development streams, which often run as separate programmes with different funding, strategies and actors. This leads to duplication, inefficiencies and gaps. Ensure that emergency health responses (e.g. cholera outbreak control, vaccination campaigns) are connected to and strengthen long-term systems (e.g. primary health care, surveillance, supply chains). This will reduce parallel systems.
- **Target marginalized and hard-to-reach populations:** Strengthen equity-focused approaches, including services for IDPs, nomadic groups, women and people with disabilities.
- **Streamline WHO procedures:** Review bureaucratic processes to enable faster and more flexible funding flows in emergencies.
- **Develop health financing strategies:** Support Somalia to establish domestic resource mobilization mechanisms, including insurance schemes and private sector engagement, to reduce donor dependency.
- **Institutionalize good practices:** Sustain emergency-driven innovations by linking community health and community health workers to the formal service delivery structure, as outlined in the Somalia Essential Package of Health Services (2020) – an area still limited, particularly for WHO-supported CHWs – while also institutionalizing trauma care and strengthening surveillance systems to function beyond crisis cycles.

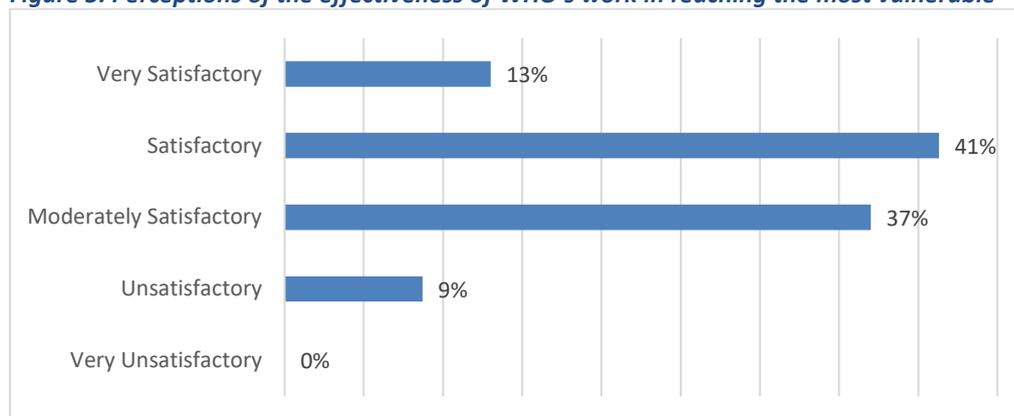
3.3.3 Extent to which cross-cutting issues have been integrated (EQ3.3)

Key finding 16: WHO has been moderately effective in addressing cross-cutting issues normatively in Somalia and has aligned its work with equity, gender, human rights and disability inclusion objectives at the strategic (normative) level. The Organization has also enabled important system-level entry points for these cross-cutting issues.

Key finding 17: WHO has been weak in operational mainstreaming of cross-cutting dimensions in Somalia. Implementation gaps at subnational level, limited accountability to communities, uneven disability inclusion and resource and operational constraints have meant that, in practice, integration remains incomplete.

- 121.** There is demonstrated normative alignment with equity and rights-based goals. This is demonstrated by the explicit framing of the CCS 2021–2025 around promoting health, keeping the country safe and serving the vulnerable and by the links between WHO strategic priorities and national policy instruments that are equity-focused (e.g. Essential Package of Health Services, UHC roadmap, National Development Plan).
- 122.** WHO’s normative inputs and technical guidance contributed to the framework in which equity-oriented goals are enshrined. Specifically, WHO supported the development of the Essential Package of Health Services 2020 and the RMNCAH strategy. The equity-oriented goals of universal access to health care and prioritization of women and children are enshrined in these policies, alongside the inclusion of service packages intended to reach underserved groups.
- 123.** Gender is not systematically mainstreamed in CCS implementation. This was also reflected in lower perceptions of WHO’s alignment with gender equality goals in the perception survey compared with other themes. This is despite the UN Somalia Gender Equality Strategy 2021–2025, which identifies explicit deliverables for mainstreaming gender across UN programmes. As WHO’s country engagement is situated within the UNCT/UNSDCF architecture it would therefore be expected to mainstream gender and inclusion, like other UN partners.
- 124.** The specific needs of vulnerable populations are not being adequately addressed within the CCS framework. The CCS framework also inadequately addresses considered systemic and cross-cutting access barriers. As a result, WHO did not sufficiently develop operational strategies to overcome challenges such as restricted access for minority groups (due, for example, to language barriers), communities in hard-to-reach regions and populations marginalized by clan dynamics or gendered determinants.
- 125.** There were limits to inclusion in practice. Implementing partners interviewed reported the adoption of inclusive service strategies. Despite these efforts, however, stakeholders identified persistent challenges in meeting the needs of vulnerable populations. In focus group discussions, health workers emphasized the difficulty of serving pastoralist and nomadic populations, including IDPs who settle far from health facilities. Gaps were similarly reflected in the perception survey, where over a third of respondents (17 out of 46) considered WHO’s effectiveness in reaching the most vulnerable as “moderately satisfactory” and an additional four respondents rated it as “unsatisfactory”. Figure 6 shows stakeholder perceptions of the effectiveness of WHO’s work in reaching the most vulnerable.

Figure 5. Perceptions of the effectiveness of WHO’s work in reaching the most vulnerable



Source: Perception survey.

- 126.** Independent reviews and sector reporting show limited operationalization of disability-inclusive health services and a nascent disability inclusion practice in the health sector. This is despite the presence of roadmaps and growing statistical evidence on disability (70), (71).
- 127.** Beneficiary participation across programme design and implementation remains a significant gap. This was highlighted in key informant interviews with representatives of organizations of persons with disabilities. Accountability to affected populations remains underdeveloped in Somalia. The individuals interviewed indicated a need for more proactive engagement with disability associations and a need to ensure their meaningful participation in planning. The need for meaningful engagement with organizations representing persons with mental health needs was also mentioned by informants as necessary to further enhance inclusivity in future programming.
- 128.** Weak M&E frameworks and lack of systematic data disaggregation (both on programmatic inclusion and on proportion of the population affected) hinder reliable assessments of the effectiveness of inclusion efforts. Furthermore, the lack of a dedicated gender and inclusion specialist within the WCO hinders the operationalization of gender-responsive and inclusive solutions and limits institutional capacity to embed equity considerations into programme implementation and monitoring. Donor reporting often includes gender-disaggregated data; however, in reports of the European Commission’s Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO, these figures are primarily derived from population estimates rather than actual service usage. An exception is noted for a project funded by the Italian Agency for Development Cooperation on improving essential health services in Somalia (72). In the final report on the project, disaggregated data were provided on access for persons with disabilities, mental health service provision, outreach activities and gender-disaggregated patient statistics. While this reflects best practices, the lack of a consolidated, integrated data system prevents comprehensive evaluation of progress.
- 129.** Mainstreaming of equity, gender equality, human rights and disability inclusion remains particularly challenging in Somalia. Access to regions under the control of non-State actors is constrained. Key informants noted that government restrictions limit humanitarian engagement with non-State actors for the negotiation of access. An access working group has been established to address this problem, but its capacity to yield tangible outcomes remains limited.

The Inter-agency humanitarian evaluation report on Somalia recommends strengthening this group (4). Stakeholders were of the view that WHO should support these efforts and encourage UNICEF to assume system-wide leadership on access coordination.

- 130.** Financial barriers further exacerbate inequities. Approximately 70% of health services in Somalia are delivered by private providers, making care unaffordable for average and poor citizens. Nikoloski et al. (69) describe this as a systemic failure. High costs deter healthcare utilization, with approximately one third of the population foregoing care when needed. This outcome is reflected in a low incidence of catastrophic health expenditure – a sign not of protection, but of non-utilization – and unmet healthcare needs concentrated among the most socioeconomically deprived groups.

3.4 Efficiency¹²

3.4.1 Extent to which WHO’s internal M&E systems, resource management and external donor-facing communication mechanisms supported WHO’s performance (EQ4.1)

Key Finding 18: WHO Somalia’s portfolio has been sustained largely through emergency and vertical funding, but weak, non-integrated M&E and large base strategic priority funding gaps are constraining adaptive management, obscuring value-for-money and skewing delivery away from equity-oriented, system-strengthening priorities.

Key Finding 19: The internal M&E system lacks an integrated, programme-level performance architecture. Data are optimized for global aggregation rather than for operational decision-making. This limits mid-course correction, learning and portfolio reprioritization.

- 131.** As noted in the section on limitations, the efficiency analysis is largely reliant on the 2022–2023 biennium to provide some insight into efficiency. Data was insufficiently available to complete other planned analysis.
- 132.** WHO Somalia’s portfolio has been sustained largely through emergency and vertical funding, but weak, non-integrated M&E and large base strategic priority funding gaps are constraining adaptive management, obscuring value-for-money and skewing delivery away from equity-oriented, system-strengthening priorities. A large proportion of funding for the **2022–2023 biennium was linked to emergency response** (notably in connection with the COVID-19 pandemic, outbreak and crisis response and the Polio Eradication Initiative). This enabled the WCO to sustain a significant operational presence in Somalia. **Non-base strategic priorities** dominate funding, receiving **81%** of total funds, although they comprise only **73%** of the total budget. **Base strategic priorities** are underfunded relative to their budget share, receiving only **19%** of total funding.

¹² The criterion of efficiency is defined as, “The extent to which the intervention delivers, or is likely to deliver, results in an economic and timely way (27).” In other words, efficiency means how well resources are being used.



Galmudug laboratory activities, Somalia. July 2023. © WHO

Table 11. 2022–2023 biennium funding (United States dollars)¹³

Segment 22-23 Biennium	Strategic priority/ category	Budget	Total funding	SP funding as a percentage of total funding
Base	SP 01 - UHC	22 914 700	15,036,606	10%
	SP 02 - Emergencies	27 962 100	7,436,173	5%
	SP 03 - Healthier populations	1 936 000	60,293	0%
	SP 04 - Country support	10 755 200	5,398,665	4%
Base total		63,568,000	27 931 737	19%
Non-base	SP 10 - Polio	46 975 000	42,633,316	29%
	SP 13 - Outbreak and crisis response	126 918 156	76,112,068	52%
	SP 14 - Special programmes	83 000	83,000	0%
Non-base total		173,976,156	118 828 384	81%
Total		237,544,156	146,760,121	100%

Source: WHO budget data

133. Structural underfunding of base priorities has limited WHO’s ability to deliver cross-cutting, foundational functions (primary care/UHC, prevention/health promotion, country support).

¹³ Each strategic priority includes: the planned budget allocation, total actual funding received, strategic priority funding as a percentage of total funding (share of each strategic priority in overall funding), difference between budget and actual funding (financing gap), proportion of the gap relative to the budget (percentage gap).

In 2022–2023, base strategic priorities received just 19% of total funding, although they accounted for 27% of the budget. This suggests a potential misalignment between long-term health system strengthening and short-term programmatic focus. The overall funding gap of 38% underscores the need for more robust resource mobilization strategies, particularly for foundational health initiatives. **The base strategic priority category suffers a disproportionately high funding gap (56%), indicating systemic underinvestment in foundational priorities. SP 02 (emergencies) and SP 03 (healthier populations) are particularly vulnerable, with gaps of 73% and 97%, respectively. Table 12 shows funding mobilization by strategic priority and reflects the fact that non-base priorities (SP10, polio: 90.8%; SP13, outbreak and crisis response: 59.9%) attracted the bulk of resources. This imbalance sustains operational presence but crowds out preventive and systems work, impeding coherent delivery across the results chain.**

Table 12. Funding mobilization by Strategic Priority

SP code	Funding mobilization (%)	Notable insights
SP 01 - UHC	65.6%	Moderate funding success
SP 02 - Emergencies	26.6%	Underfunded
SP 03 - Healthier populations	3.1%	Critically underfunded
SP 04 - Country support	50.2%	Partial funding
SP 10 – Polio	90.8%	Highly efficient
SP 13 - Outbreak and crisis response	59.9%	Moderate efficiency
SP 14 - Special programmes	100%	Fully funded

Source: WHO budget data

- 134.** Funding gaps are greatest in areas focused on equity. SP03 (healthier populations) was 97% underfunded (only 3.1% mobilized). SP01 (UHC) had a 34.4% funding gap, limiting primary care and maternal health improvements, especially in underserved districts.
- 135.** Operational efficiency is further eroded by high security and logistics costs. Operating in Somalia entails disproportionately high costs due to security-related requirements, including armed escorts, even for short movements, and the additional expenses associated with supply-chain risk management. These costs are further aggravated by insecurity, gatekeeping systems linked to clan structures and the need to minimize risks of aid diversion. Stakeholders consistently noted that Somalia’s governance context further exacerbates inefficiencies and increases transaction costs.
- 136.** Internal management and coordination issues (reported in the stakeholders’ interviews) present additional challenges. Inefficiencies persist in coordination across the three levels of WHO (country, regional and headquarters). Weak follow-up of missions and insufficiently integrated operational oversight hinder the office’s ability to maximize the impact of its resources. Additionally, donor relations are decentralized/outsourced to Nairobi and are insufficiently linked to programme implementation, producing reporting and communication gaps.
- 137.** The overarching implication is that programme delivery remains predominantly reactive and

vertically driven, with comparatively strong performance in polio eradication and emergency surge response, but weaker outcomes in routine service provision, equity-oriented priorities such as maternal health and access for marginalized populations, and system-strengthening functions that depend on sustained base funding and robust feedback mechanisms.

- 138.** Stakeholders interviewed highlighted the need for greater efficiency through cost-sharing arrangements and improvement of logistical efficiencies, especially in view of transaction costs which are structurally high (e.g. cost of security escorts). Without harmonized joint logistics and procurement, these expenses dilute frontline delivery (“deadweight” costs). Stakeholders proposed measures to compress overhead costs, including cost-sharing arrangements such as joint office space and pooled security services among UN agencies. Stakeholders also discussed the importance of exploring a joint UN logistics platform, joint procurement mechanisms and shared supply chains to reduce duplicative costs. These suggestions align with the “UN80” initiative unveiled in March 2025, which calls for a system-wide push to streamline operations for improved efficiencies within the UN system ([73](#)).
- 139.** As noted in the section on limitations of the evaluation ([section 2.3](#)), cost-effectiveness analysis is constrained by missing or non-integrated output/outcome denominators. The evaluation team notes that data were insufficient to complete several planned efficiency analyses, limiting credible estimates such as cost per facility supported, per outbreak contained or per additional child reached with essential services.
- 140.** The current M&E framework is insufficient for **integrated and adaptive programme monitoring to support WHO performance in Somalia**. While donor-specific reports often contain detailed information on project implementation, the internal WCO M&E system does not provide the granularity required for rigorous evidence-based operational decision-making, nor does it allow systematic tracking of progress towards predefined outputs and outcomes. The system is geared towards aggregating results for supranational and global platforms, which is useful for reporting against global goals but insufficient for assessing performance at the programme level. This negatively affects both external evaluations (which lack the data to assess effectiveness and efficiency in detail) and internal management, which cannot closely monitor programme implementation across the portfolio.
- 141.** Additionally, the data architecture limits equity targeting. In 2022, WHO supported the Federal Ministry of Health in conducting a national health information system assessment ([74](#)) and developing a strategic plan, with the costing currently being finalized to guide resource mobilization. However, fragmented health information systems and non-integrated M&E reduce the visibility of subnational and population group disparities, hampering allocation to areas where marginal returns (and equity gains) would be the highest. This means that equity-related priorities (maternal health, preventive and promotive services, marginalized regions/populations) are disproportionately squeezed, both by funding patterns and by M&E blind spots that make inequities harder to detect and address in real time.
- 142.** Somalia has an established health management information system (HMIS) that operates on the DHIS2 platform and is implemented across all federal member states. The system collects data from the majority of fixed health facilities, both publicly managed and partner supported.

However, private facilities are not yet integrated into government reporting. Somaliland maintains its own DHIS2-based HMIS, which functions independently and does not merge data with the federal system. Importantly, the HMIS is the only health system component that receives substantial donor funding, underscoring both its centrality and the vulnerability of other underfunded system components (74). Furthermore, resistance by certain federal member states to share or harmonize data remains a barrier to a unified national health information system and to broader health system efficiency.

3.4.2 Resource mobilization measures that WHO Somalia should adopt to secure flexible fund in the next strategic phase (EQ4.2)

143. The recommendations made to answer this question integrate views from stakeholder interviews, focus groups and document review findings, and draw on country and global examples of pooled funds, rapid response mechanisms and public–private partnership arrangements that have worked in fragile contexts.

Summary: WHO Somalia should expand the three-pronged resource mobilization strategy: (1) diversify and broaden the donor base (including multilateral pooled funds, private foundations and regional donors across both Africa and the Eastern Mediterranean); (2) reconfigure donor relations and programme management to offer flexible, results-driven and pooled funding vehicles, backed by a robust, integrated M&E and reporting platform; and (3) scale up strategic partnerships (joint UN pooled proposals, selective public–private partnerships and country trust funds) to reduce competition, increase predictability and enable rapid reallocation in crises.

144. Donor dynamics are shifting, and WHO faces capacity contraction if funding shrinks. While emergency funding has historically provided WHO Somalia with scale and visibility, these conditions may change in the current donor landscape. Stakeholders noted the potential to engage new donors. In addition to the issue of positioning donor relations at the regional rather than the country level, the WCO lacks an integrated M&E framework to demonstrate results and make the case for flexible funding.

“We have gotten first-time donors to WHO Somalia, like the World Diabetic Foundation and L’Oreal Foundation. There’s a lot of potential out there.” WHO stakeholder

145. Donors in fragile contexts prefer instruments that combine rapid response with development impact (the humanitarian–development nexus). Pooled funds and trust funds are proven

instruments for achieving this. Such funds include OCHA’s Somalia Humanitarian Fund;¹⁴ UN Somalia Joint Fund;¹⁵ and the World Bank Somalia Multi-Partner Fund.¹⁶ WHO’s Contingency Fund for Emergencies,¹⁷ the Organization’s internal rapid-response mechanism, is an example of a fund that provides flexible financing that enables quick action in outbreaks. At the same time, this mechanism can be integrated with medium- to long-term system strengthening strategies.

146. Some concrete measures that WHO Somalia should adopt in the medium term (actionable, prioritized) to secure flexible funding in order to overcome current funding shortages are described in Box 3 below.

Box 3. Recommendations for WHO Somalia to improve resource mobilization and secure flexible funding

Broaden/differentiate the donor base – Actively pursue funding from non-traditional donors and regionally relevant funders. As an example, Gavi expanded its funding flexibility during COVID-19 by mobilizing ample, pooled resources for vaccine delivery and working with new donors to finance urgent needs. Diversification provides resilience when traditional donors retrench.

- Develop a targeted outreach strategy to philanthropic and state donors in the Persian Gulf/Middle East and Northern Africa, regional development banks and private foundations (e.g. Gates Foundation, regional family foundations, corporate foundations). Key informant interviews show that it is possible to attract funding from first-time donors.
- Leverage Somalia’s geographic position to open joint outreach to donors in both the African and Eastern Mediterranean Regions. This “two-region” approach can increase the pool of potential bilateral and regional donors.

Create or scale up pooled and thematic funding windows (national or UN-hosted) that ensure flexibility. The Somalia Humanitarian Fund and the Somalia Multi-Partner Fund have effectively pooled donor resources and interventions funded by these mechanisms can be designed to support lifesaving and resilience-oriented programming. As an example, in 2023, joint interventions by the Somalia Humanitarian Fund and the UN [Central Emergency Response Fund](#) enabled pre-positioning and rapid response (75). The Health Pooled Fund in South Sudan and similar multi-donor funds demonstrate how pooled modalities can combine predictable financing with country ownership, even in fragile settings (76). WHO has established experience in accessing pooled funds, having submitted proposals to the Somalia Humanitarian Fund and the UN

¹⁴ [Somalia Humanitarian Fund](#) – Country-based pooled mechanism that has allocated tens of millions of dollars to life-saving work; demonstrated pooled financing and rapid allocation capacity in Somalia.

¹⁵ [Somalia Joint Fund](#) – UN pooled fund for joint development and stabilization programmes that WHO can access and co-design for flexible development finance.

¹⁶ [World Bank Somalia Multi-Partner Fund](#) – Example of a larger investment platform that channels development finance in fragile contexts and can support WHO-aligned sectoral investments.

¹⁷ [Contingency Fund for Emergencies](#) – WHO’s internal rapid response fund that provides flexible resources quickly for outbreak and crisis response.

[Peacebuilding Fund](#) i, and is currently preparing a mental health concept note for the Peacebuilding Fund. Through its active role in both the UN country team and the humanitarian country team, WHO is well positioned to secure future pooled fund resources.

- Integrate gender considerations in resource mobilization, pooled fund proposals and donor engagement efforts. This would align with WHO’s global commitments and also respond to the expectations of donors that increasingly emphasize equity and a gender focus as conditions for funding.

Strengthen WHO Somalia’s donor relations architecture and integrate it with programme

management. WCO Somalia donor relations are managed in Nairobi and are not linked well with programme implementation in Somalia. Integrating donor relations with programming will reduce reporting delays and improve trust.

- Relocate or create a country-level donor relations and partnerships unit within the WHO Somalia country office that is part of programme management, with staff responsible for (a) tailored donor engagement, (b) joint proposal development with UN and government partners, and (c) high-quality, timely reporting.
- Assign specific staff for engagement with multilateral donors (such as the World Bank Multi-Partner Fund and the UN Multi-Partner Trust Fund Office), relations with institutional donors (such as ECHO in the European Union and the Foreign, Commonwealth and Development Office in the United Kingdom), and outreach to foundations and other private partners. Assigning dedicated project managers at the WCO level will be key to strengthening accountability for donor-funded projects and demonstrating good stewardship of resources.

Build an integrated programme management and M&E platform to credibly demonstrate

outcomes. Donors place a premium on measurable impact. Gavi and Global Fund examples show that combining programmatic data with pooled financing increases donor confidence.

- Develop a unified programme results framework and dashboard (including core indicators for immunization, maternal and newborn health, surveillance, mental health, and gender/disability inclusion) and produce donor-facing impact briefs and real-time results-tracking dashboards.
- Offer donors the opportunity fund sectoral “impact corridors” (e.g. vaccine delivery corridors) and “packages” (e.g. a maternal and newborn health surge package) tied to measurable outcomes verified through regular data updates.

Pursue joint proposals with UN and government partners to avoid competition and unlock

larger pooled funds. According to some key informants, there is a clear competition for resources among UN agencies. It will be crucial to avoid competing with other UN agencies for funding in similar areas of work. Rather, integrated and joint funding should be established. WHO is currently engaging in multi-agency proposals and projects, and the experience shows that joint projects necessitate strong project and grant management capacity, especially if WHO is the lead

and administrative agency. Stakeholders explicitly highlighted joint fund-raising as a solution. Country multi-partner funds and UN joint fund models in Somalia are existing mechanisms for funding such joint initiatives.

Leverage WHO’s internal rapid response fund and showcase its value to donors as a multiplier.

WHO’s CFE has successfully enabled quick action in disease outbreaks and is an attractive instrument for donors seeking rapid impact. Packaging CFE with longer-term pooled mechanisms can be persuasive to donors focused on both humanitarian and development goals.

- Use the WHO Contingency Fund for Emergencies as a vehicle for rapid action and invite donors to replenish or co-finance a Somalia-specific rapid response window that is linked to health system strengthening deliverables. Donors can thus contribute to Contingency Fund-backed activities for emergency response but with shared reporting on health systems impact).
- Promote a model that enables donors to fund flexible “surge + sustain” packages by providing initial surge financing through contingency or pooled funds, with a planned transition to pooled development funds.

Leverage WHO’s added value:

- Highlight WHO’s added value in specific and unique dimensions of the Organization’s mandate: its normative role, its support for institutional development, its scientific networks for evidence creation.
- Build on WHO assets such as strong field presence and technical capacity and the potential of WHO to contribute to humanitarian–development–peace nexus work.

Engage the private sector and philanthropic organizations via strategic public–private partnerships and programmatic windows. **Somalia has a viable private sector, including a solid diaspora, that can be leveraged.**

- Prepare concise, impact-focused funding pitches and investment cases (e.g. for immunization coverage, digital HMIS roll-out, community health worker networks) tailored to foundation and corporate social responsibility portfolios.
- Consider product-related PPPs (cold chain for vaccines, digital health platforms), with clear sustainability and co-funding plans.

Adopt a “value proposition” narrative that links emergency impact to health system strengthening and progress towards UHC. WHO can position health system strengthening as being aligned with donor interests and priorities by highlighting that stronger systems help prevent humanitarian crises, enable effective emergency response and improve outbreak control within the broader framework of health system development. Donors prefer investments with demonstrable humanitarian and development returns.

- Reframe funding requests: always tie emergency preparedness/outbreak control to health system strengthening and UHC outcomes – for example, by explaining that funding X for cholera prevention will also strengthen laboratory capacity and thus improve

routine surveillance and maternal care).

- Use “low-hanging fruit” prioritization and data to propose high-impact, short-term wins that are attractive to risk-averse donors.

147. Suggested sequencing and quick wins (first 12 months of the next strategic phase)

- **Establish a country donor relations and partnerships unit embedded in programme management.** Hire one multi-partner fund /UN pooled funds specialist and one private sector/foundations specialist. *Timeline: immediate.*
- **Design a concept note for a Somalia health pooled window** to be co-managed by WHO, the UN country team and the Federal Ministry of Health, linking surge and sustainability modalities. Present to existing and prospective donors. *Timeline: 0–6 months.*
- Launch an integrated M&E dashboard, with core indicators for key areas, such as immunization, maternal and child health, surveillance, gender/disability inclusion, and produce quarterly donor briefs that demonstrate the value of flexible funding for structural improvements. *Timeline: 0–6 months.*
- Pilot two joint funding proposals to be presented to the World Bank Somalia Multi-Partner Fund and the UN Somalia Joint Fund for a health system strengthening + surge capacity package in one or two Somali states. *Timeline: 6–12 months.*

148. WCO should follow up on risks and their mitigation to reduce the effects of disruption. Table 13 highlights two key risks and their mitigation measures.

Table 13. WCO risk and mitigation measures for future funding

Risks	Mitigation measures
Donor fatigue and inability of philanthropic organizations to fill gaps.	Prioritize pooled funds and multi-donor instruments, and frame WHO funding requests around measurable, short-term outcomes plus longer-term health system gains.
Perceived competition with UNICEF and UNFPA for the same funds.	Proactively co-design joint UN proposals with clear comparative advantage statements, highlighting WHO’s added value as the normative and technical lead and highlighting how it can complement the work of other agencies in their areas of operational expertise (nutrition and immunization for UNICEF and reproductive health for UNFPA).



Somalia National Immunization Days: A health worker vaccinates a child as the Ministry of Health, with support from WHO and partners, delivers the novel oral polio vaccine (nOPV2) to protect over four million children under five from polio.

3.5 Sustainability and connectedness¹⁸

3.5.1 Extent to which WHO contributed to building national capacity for long-term health outcomes and the likelihood that WHO-supported initiatives will be sustained (EQ5)

Key finding 20: WHO's contribution is assessed as low in terms of financial sustainability. Continued reliance on earmarked, emergency-oriented donor streams has left base strategic priorities underfunded. The closure of district-level facilities following funding contractions illustrates the fragility of gains, and there is limited evidence of the Government stepping in with financing to ensure continuity.

Key Finding 21: WHO's support has made a moderate contribution to institutional sustainability. The Federal Ministry of Health has demonstrated ownership of the CCS. Yet, persistent fragmentation in service delivery models, political frictions among Somali states and lack of a coherent, affordable

¹⁸ The DAC criterion of sustainability is defined as “the extent to which the net benefits of the intervention continue, or are likely to continue” (27). The connectedness criterion refers to the degree to which humanitarian interventions are designed and implemented to ensure continuity and coherence between immediate relief efforts and longer-term recovery, development and resilience-building objectives, thereby minimizing negative impacts on future systems and promoting sustainable outcomes.

national model of care limit the extent to which institutional gains can be consolidated without WHO support.

Key Finding 22: WHO's contribution to technical sustainability is rated moderate to high, depending on the domain. Surveillance systems, early warning mechanisms and laboratory diagnostic capacity have become embedded in government-led structures and are likely to persist even in the absence of direct WHO involvement. By contrast, PHC delivery practices and equity-oriented outreach remain technically fragile and dependent on parallel delivery mechanisms and external financing, and they have high transaction costs. Weaknesses in M&E, such as denominator inaccuracies and absence of integrated logframes, further limit the adaptive use of data for sustained programme improvement.

Financial sustainability: Low

149. The financial basis for WHO's work in Somalia remains fragile. Domestic resource mobilization is limited and WHO continues to depend heavily on earmarked, emergency-oriented donor funding. For instance, as highlighted in the previous section, in 2022–2023, base strategic priorities (SP1–SP4), received just 19% of total funding, compared with 81% for non-base priorities such as polio and outbreak response. As a result, foundational and systems strengthening interventions remain underfunded. The sustainability of these gains is therefore weak; indeed, contractions in donor financing have already led to the closure of district-level facilities, illustrating the high risk of reversal of gains and loss of service continuity when external resources are withdrawn. Key informants and WHO technical reports highlight that donor support has not been systematically replaced by government financing, leaving the system vulnerable to external shocks.

Institutional sustainability: Moderate

150. On the institutional side, gains are more resilient and government ownership of health strategies is apparent. The Government of Somalia has been engaged as a stakeholder, and the Ministry of Health has demonstrated ownership of the CCS to date, as evidenced by alignment of the CCS with Ministry of Health strategies and as confirmed by key informant interviews. WHO has supported the development of national health strategies and the work of technical working groups, fostering government ownership and institutionalization. The National Transformation Plan signals a commitment to integrating health policies into broader national development and resource mobilization efforts. At the state level, opportunities exist for sustainable health system strengthening, as state authorities have generally developed collaborative relationships with WHO. Key Informants reported openness to establishing frameworks for cooperation, including discussions on state-level funding mechanisms. However, sustainability is undermined by persistent fragmentation in service delivery models, with uneven implementation of the Essential Package of Health Services and parallel approaches under humanitarian response plans. Key informants emphasized the need for a participatory national process to define a coherent and affordable model of care for Somalia, including mechanisms to subsidize access for disadvantaged, marginalized and poor

populations. State-level dynamics and political frictions further complicate a unified institutional response. While institutional structures exist and are engaged, their effectiveness in sustaining progress without continued WHO support remains limited.

Technical sustainability: Moderate to high

151. Technical sustainability varies by domain. Improvements in surveillance systems, early warning mechanisms and laboratory diagnostic capacity are likely to endure, as these practices have been embedded into government-led technical working groups and national health information strategies. These gains are cost-light, practice-based and increasingly institutionalized, suggesting that they would persist even in the absence of a continued WHO presence. However, PHC delivery practices and routine service provision remain technically fragile, as they have high transaction costs and are dependent on parallel delivery mechanisms and ongoing external financing. Moreover, gaps in M&E systems, including denominator inaccuracies and a lack of integrated logframes, limit the adaptive use of data for decision-making, weakening technical sustainability at the programmatic level.

152. The evidence suggests that gains in surveillance, outbreak response and laboratory systems are the most likely to be sustained without WHO, given their institutionalization and lower reliance on recurrent funding. By contrast, gains in PHC continuity and equity-oriented outreach to nomadic and displaced populations are at high risk of reversal, as they depend on external financing, and parallel delivery chains and have substantial recurrent costs. Similarly, the coherence of the integrated PHC model is vulnerable to fragmentation without WHO's convening and technical role.

153. Stakeholders consistently emphasized the strategic importance of private sector engagement as a pathway towards sustainability, noting that approximately 70% of health services in Somalia are delivered through private actors. Across a broad spectrum of stakeholders – including WHO, UN agencies, government counterparts, NGOs and private providers – there was consensus that a functional public–private partnership platform is essential to rationalize service provision, ensure affordability and facilitate the gradual integration of private sector delivery into domestic financing streams. WHO has played a catalytic role by supporting the establishment of a PPP working group, although its full operationalization has been hindered by resource constraints. According to key informants from WHO, government and the private sector, WHO's technical assistance is viewed as indispensable in this domain, particularly in:

- Developing regulatory frameworks and guidelines at the federal level;
- Supporting state- and district-level authorities in identifying context-adapted and practical solutions;
- Promoting service delivery models that are both affordable and accessible to vulnerable populations; and
- Clarifying institutional roles and strengthening emergency preparedness through coordinated engagement with private providers.

154. Emergency and outbreak response activities have established a more consistent institutional

pattern, reinforcing capacities at federal and state level, although they are still heavily dependent on external funding. The Somali Disaster Management Agency has emphasized the need for stronger WHO engagement in national emergency responses. However, informants suggested that political sensitivities, including perceptions of the Agency as a federal political tool, may explain WHO’s cautious approach.

- 155.** Health workforce sustainability is at risk due to heavy dependence on donor financing. WHO and partners have invested significantly in district- and community-level health workers, including CHWs and polio eradication teams. Their performance was widely acknowledged by key informants and health workers as essential for service delivery. The discontinuation of external funding is perceived as an imminent threat to the survival of this model. Some cost-recovery mechanisms and community-based support schemes are being piloted, but these remain fragmented.
- 156.** There has been some attention to the humanitarian–development–peace nexus in practice, including leveraging of emergency interventions to strengthen long-term capacities. The evaluation highlights that WHO Somalia’s interventions have achieved operational connectedness by linking emergency response with longer-term health system strengthening efforts, although important gaps remain. For example, community-based surveillance and incident management systems put in place under humanitarian frameworks were positioned to feed into broader HMIS strengthening and PHC recovery. WHO’s COVID-19 laboratory support was positioned as a cross-cutting means of improving diagnostic capacity. Emergency interventions, such as outbreak control and ECHO-funded services in drought-affected areas, have in several cases been integrated into system-building processes, contributing to institutional resilience at federal and state levels. At the state level, there are encouraging signs of frameworks fostering the collaboration of state health authorities with WHO, which could provide a foundation for more sustainable health system strengthening. The case study below offers another example of this connectedness.

**CASE
STUDY**

WHO’s resilient immunization response in Somalia

Theme: Building health system resilience in conflict-affected settings

Background

Somalia’s health system has been severely disrupted by decades of conflict, political instability and recurrent climate shocks. With one of the lowest health coverage indices globally and frequent outbreaks of vaccine-preventable diseases, the country has faced a dual crisis in recent years: the COVID-19 pandemic and the worst drought in its history. These overlapping emergencies disrupted essential services, particularly routine childhood immunization, underscoring the need for connected approaches that integrate emergency response with long-term system strengthening.

WHO’s strategic contribution

WHO Somalia played a pivotal role in restoring and scaling up immunization services through a strategy that **connected short-term humanitarian response with long-term resilience-building**:

a. Catch-up campaigns and service integration

- Launched accelerated campaigns to reach zero-dose and under-immunized children.
- Integrated COVID-19 vaccination with routine immunization against measles and polio, vitamin A supplementation and deworming.
- Reached over 3.6 million children under 5 with integrated services in 2022.

b. Expanding and connecting service delivery channels

- Increased immunization points from 706 (2021) to 849 (2022), extending reach to underserved areas.
- Deployed over 30 000 vaccinators for house-to-house outreach, vaccinating 84 600 zero-dose children.
- Leveraged WHO’s polio workforce and community health workers to deliver services close to households, ensuring continuity between vertical programmes and routine services.

c. Strengthening surveillance and data systems

- Transitioned to case-based measles surveillance and increased testing laboratories from 3 to 11.
- Supported electronic immunization registry pilots to track children and reduce dropouts.
- Carried out enumeration exercises to enhance microplanning and systematically reach hard-to-access populations.

d. Capacity-building and policy reform

- Trained 3227 health workers in surveillance, sample collection and data management.
- Supported the revision of Somalia’s immunization policy, broadening eligibility and introducing new vaccines (pneumococcal, rotavirus, measles–rubella), thereby embedding gains made during emergencies into the national immunization framework.

Effects

Indicator	Result
COVID-19 vaccine coverage (2022)	41.7% fully vaccinated
Zero-dose children vaccinated	84 600
Children reached through integrated campaigns	3.6 million
Measles tests conducted (Jan–Aug 2023)	1879 (up from 142 in 2018)
Immunization service points	20% increase in one year
Immunization coverage (Penta-3)	Increased from 73% (2020) to 90% (2022)

Lessons on connectedness

- **Integration creates synergies:** Linking immunization with nutrition, deworming and other services enhanced both efficiency and equity.
- **Community trust builds continuity:** Engaging local workers strengthened social connectedness, reducing barriers to access in marginalized settings.

- **Digital systems contribute to resilience:** Electronic registries created continuity between campaigns and routine services.
- **Adaptability creates a bridge from crisis to development:** WHO’s ability to pivot during the COVID-19 pandemic and the drought ensured that emergency gains were institutionalized into broader health system functions.

Conclusion

By simultaneously addressing immediate crises (COVID-19 pandemic, drought, outbreaks) and laying the foundations for long-term immunization infrastructure, WHO reversed declines in coverage and strengthened the capacity of Somalia’s health system.

- 157.** However, the short-term nature of donor funding and the fragmentation of PHC models undermine continuity and limit the transition from humanitarian to development programming. Furthermore, the humanitarian–development–peace nexus has been questioned by several key stakeholders, as it is difficult to implement and coordinate in Somalia. Within WHO, emergency response has largely focused on outbreak response, which should ideally be integrated into a long-term capacity-building process. Evidence from ECHO-funded interventions in drought-affected and hard-to-reach areas suggests partial integration with system-strengthening efforts. However, the heavy reliance on short-term donor support remains a structural limitation.
- 158.** The National Transformation Plan offers a potential unifying framework to enhance operational connectedness, but progress will depend on the mobilization of domestic financing and the establishment of a coherent national PHC model. WHO’s technical assistance – particularly in regulation, PPP development and health workforce sustainability – remains central to ensuring that humanitarian responses are progressively embedded within broader development strategies, thereby enhancing both resilience and sustainability.

4 Conclusions



Galmudug laboratory activities, Somalia. July 2023. © WHO

- 159.** Overall, WHO’s contribution in Somalia between 2020 and 2025 has been broadly relevant, adaptive and technically sound, and has led to measurable gains in emergency response, immunization and surveillance under extremely challenging conditions. However, sustainability, equity and systemic health system strengthening remain fragile. To consolidate progress and ensure lasting health outcomes, it is essential to strengthen subnational engagement, establish relevant monitoring and evaluation systems, diversify financing and embed resilience into PHC and service delivery frameworks.
- 160.** Relevance: WHO’s strategies in Somalia during 2020–2025 were relevant and substantively aligned with national health priorities, sector frameworks and community needs. Through the CCS and WHO’s technical and normative guidance, positioned the organization as a policy anchor, connecting global health objectives with Somali strategies. The theory of change was conceptually sound, but its plausibility was weakened by the volatile political and economic situation, donor dependency and a persistent gap between the prioritization of maternal and child health in strategy and operational investment. Systemic barriers limited the ability of affected populations to provide feedback on health services, undermining alignment with national and global commitments on community engagement and equity. The Organization demonstrated responsiveness by adapting to emergencies such as the COVID-19 pandemic and

recurrent droughts, but the absence of mid-term recalibration of the CCS reduced WHO's ability to embed equity, gender and disability inclusion into programmatic responses, leaving services for minorities, persons with disabilities, nomadic populations and other marginalized groups insufficiently addressed.

- 161.** Coherence and Coordination: WHO's work in Somalia was largely coherent, providing visible leadership in health sector and UN coordination, with its technical authority recognized by partners and donors alike. WHO's field presence enabled effective Health Cluster coordination and supported state-level collaboration. Vertical programmes such as polio eradication were highly consistent across WHO levels and with partners, but broader health system strengthening, UHC and emergency response programmes revealed weaker alignment due to fragmented funding flows, limited HQ/RO engagement and gaps in strategic follow-up. However, challenges persist including duplication of efforts, parallel systems and limited subnational leadership. Donor-driven priorities and weak accountability to affected populations compounded these challenges, reducing national ownership and inclusiveness. Embedding area-based coordination while aligning humanitarian and development efforts remains critical for enhancing coherence, fostering equity and ensuring a genuine shift from parallel delivery to sustainable system integration.
- 162.** Effectiveness: WHO's contribution in Somalia has effectively delivered measurable results in core areas such as immunization, outbreak detection and emergency response, where outputs are closely aligned with outcomes and supported by robust evidence. Expanded immunization coverage (Penta-3 at 83% in 2024 according to the District Health Information System 1 [DHIS2] data, but subsequently revised downward to 70% (WHO/UNICEF estimates of national immunization coverage [WUENIC] data)) and improved timeliness of outbreak response (from 51.7% to 68.3%) illustrate tangible progress attributable to WHO's operational support, complemented by evidence of large-scale deployment of community health workers that safeguarded service continuity, extended surveillance and promoted equity in fragile contexts. These achievements highlight WHO's comparative advantage in acute crisis response and its credibility as a technical lead.
- 163.** However, effectiveness is less evident in maternal and newborn health, essential medicines and broader determinants of health, where outcome indicators are outdated, under-reported or too distal to capture WHO's normative and enabling contributions. Stagnation in essential medicines availability (28%) and lack of up-to-date maternal health data reflect weak alignment between outputs and outcomes. Similarly, while WHO has been instrumental in shaping governance frameworks and interministerial coordination, reliance on binary indicators ("Yes/No") limits the ability to assess the quality and functionality of these reforms. Weak M&E systems and reliance on population estimates limit accountability. A further limitation is the lack of disaggregated data, which limits meaningful equity analysis and obscures differential outcomes in vulnerable populations (nomadic groups, IDPs and rural communities). Strengthening national health information systems, ensuring regular updates and setting targets that balance ambition with feasibility will be critical for enhancing accountability and demonstrating WHO's contribution (through the CCS) to health gains and for ensuring that emergency-driven improvements translate into sustainable, equitable health system progress.

- 164.** Efficiency: WHO Somalia has maintained a significant operational presence in a fragile context largely through vertical and emergency funding, which has supported strong delivery in polio eradication and outbreak response activities. However, this reliance has come at the expense of equity-oriented and system-strengthening priorities, as base strategic priorities, including UHC, prevention, and country support, remain structurally underfunded, with funding gaps exceeding 50%. The skewed resource pattern sustains visibility of the Organization’s work but undermines coherence and long-term resilience. Efficiency is further diminished by fragmented and non-integrated M&E systems, which are optimized for reporting progress on global goals rather for informing country-level decision-making. This weakens adaptive management, obscures value-for-money and limits WHO’s ability to demonstrate results to donors or direct resources towards high-inequity areas. High operational costs – driven by the context of insecurity, gatekeeping issues that hinder access and supply chain risks—further dilute the efficiency of frontline delivery.
- 165.** Internal coordination inefficiencies across WHO’s three levels and decentralized donor relations exacerbate these structural challenges. 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 efforts point to a pathway for greater efficiency if institutionalized. Looking ahead, WHO Somalia’s efficiency will depend on its ability to diversify its donor base, secure flexible pooled financing, strengthen integrated M&E and leverage partnerships to reduce transaction costs and better align resources with equity and system-strengthening objectives.
- 166.** Sustainability and connectedness: WHO’s contributions have laid important foundations for Somalia’s health system, including institutionalization of the Essential Package of Health Services, improved immunization infrastructure and strengthened surveillance systems. WHO also supported capacity development of the health workforce and technical working groups, fostering growing national ownership. Nevertheless, sustainability is jeopardized by donor dependency, high operational costs, weak domestic financing and fragmented models of service delivery. Reliance on WHO-managed delivery structures risks entrenching parallel systems unless capacity transfer and government leadership are more systematically embedded. A comprehensive analysis of workforce sustainability, including financing options, is urgently needed at the district level, with support from both state and federal authorities and with technical assistance from WHO. Strengthening connectedness will require a coherent PHC framework, increased domestic resource mobilization, better regulation of and support for public–private partnerships, and intentional strategies to sustain both the health workforce and essential services after donor support ends. Stronger community engagement and accountability mechanisms will also be critical for ensuring that health system gains are institutionalized that they are responsive to population needs.

5 Recommendations

In addition to the recommendations made in section 3.4.2 (EQ4.2) and based on the evidence in this evaluation, the evaluation team shares a series of recommendations to be taken into consideration by WHO for the next strategic phase. The recommendations were developed in consultation with and validated by the Evaluation Reference Group. Country examples are provided to demonstrate how other operations have implemented specific actions.

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<p>Overall, in the planning for the next CCS, WHO Somalia should reinforce its role as the 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 (PPP) system and sustainable financing, ensuring that WHO’s support contributes to durable, equity-focused health system strengthening.</p>				
<p>1. Strengthen strategic planning and adaptation to Somalia’s protracted crisis context</p>				<p>High</p>
<p>1.1 Institutionalize participatory priority-setting: Conduct structured, participatory priority-setting at federal, state, district and community levels. Ensure the active participation of minorities, nomadic groups, persons with disabilities and women’s organizations to align national frameworks with local needs and improve legitimacy.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Sierra Leone institutionalized community engagement after Ebola (taskforces, chiefdom focal points) to embed local voices in planning (77). 	<p>WCO: Somalia programme management unit</p> <p>Regional Office: UHC/health system strengthening</p> <p>Headquarters: health systems governance and</p>	<p>2025–2026 (mid-term)</p>	<p>ToC plausibility gaps; CCS not adapted to crisis; weak equity integration.</p>	

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<p>1.2 Integrate risk and contingency planning: Update the theory of change to include explicit risk/contingency scenarios (political volatility, access, funding shocks), with decision triggers. This will keep WHO’s portfolio adaptable without abandoning longer-term health system strengthening goals.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Nigeria’s polio EOC architecture used scenario-based triggers to surge operations during outbreaks (78). <p>1.3 Operationalize equity and human rights: Co-develop an operational plan with an equity/human rights-based approach in collaboration with OHCHR/UNICEF/UNFPA and Somali civil society organizations. This will enable a move beyond high-level equity commitments to funded, monitorable actions.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Post-Ebola accountability and inclusion mechanisms in Sierra Leone informed wider scale-up of UN accountability to affected populations (79). 	finance			
2. Improve coordination and accountability mechanisms at subnational levels				Medium
<p>2.1 Institutionalize area-based coordination (ABC): Establish district level platforms, chaired by state authorities and facilitated by WHO. This will help to reduce parallel systems and will align partners around district priorities and access constraints.</p> <p>2.1.1 WHO, in its Cluster Lead role, should advocate for a review and revision of the ABC terms of reference. This process should explicitly define ABC roles and responsibilities and their relationship with existing cluster coordination mechanisms to ensure complementarity rather than competition.</p>	<p>WCO: Health Cluster, focal point for accountability to affected populations</p> <p>Regional Office: emergency preparedness and</p>	<p>Launch: 2025 (short-term)</p> <p>Scale-up: 2026–2027 (long-term)</p>	<p>Coordination challenges; limited legitimacy at district level; insufficient accountability to affected populations</p>	

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<ul style="list-style-type: none"> • <i>Country example:</i> Polio emergency operations centres in Nigeria functioned as joint decision hubs, integrating government, UN and partners—an example for district ABC approaches (80). <p>2.2 Embed community accountability mechanisms: Integrate community feedback tools such as mobile phone hotlines, community scorecards, radio forums in all WHO-supported projects. This will increase responsiveness and trust; and improve outreach to marginalized groups.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Sierra Leone’s post-Ebola community feedback loops and emergency focal points improved two-way communication and service uptake (77). <p>2.3 Validate operational plans through the Health Cluster: Require state/district operational plans to be validated through the Health Cluster. This will enable convergence on one operational map and will reduce duplication.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Afghanistan’s Basic Package Of Health Services used standardized, province-level plans across NGOs to align donors and delivery (81). <p>2.4 Strengthen the commitment to accountability to affected populations by adopting and systematically implementing existing guidelines, tools and frameworks, particularly those aligned with the Somalia National Community Engagement and Accountability Strategy and Action Plan (2022–2024) Task Force and the Complaint and Feedback Mechanism (CFM) Framework, across all programmes and interventions in Somalia.</p> <p>2.4.1 Establish an inter-agency working group on accountability to affected populations (co-led with UNICEF). This will systematize beneficiary participation in design, monitoring and course correction.</p>	<p>response</p> <p>Federal Ministry of Health: technical working groups</p>			

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<ul style="list-style-type: none"> Country example: UNICEF’s accountability to affected populations initiative draws on Sierra Leone’s experience and provides a ready blueprint (82). 				
3. Strengthen monitoring, evaluation and equity-disaggregated data systems				High
<p>3.1 Develop an integrated Somalia monitoring framework: Build a national monitoring framework that maps programme outputs and outcomes to the CCS strategic priorities and links to the GPW13/GPW14 and future GPW indicators with equity disaggregation (sex, age, disability, IDP/host/nomadic, state). This will make results demonstrable and comparable and enable equity tracking.</p> <ul style="list-style-type: none"> Country example: Ethiopia’s national DHIS2 digitization and maturity roadmap improved routine use of disaggregated data for decision-making (83). <p>3.2 Decentralize health information systems: Improve the roll-out of health information systems with district-level DHIS2 dashboards and routine data reviews. This will bring analysis and problem-solving closer to the point of care. Strengthen other essential components of the health information system, such as civil registration and vital statistics system, including cause-of-death data.</p> <ul style="list-style-type: none"> Country example: Studies from Ethiopia show DHIS2 adoption boosting facility and district data use in practice (84). Rwanda strengthened its Civil Registration and Vital Statistics system through a multisectoral approach that digitized birth and death registration and linked health facility reporting with the national statistics office (85). 	<p>WCO: programme management unit, health information systems team</p> <p>Regional Office: information management</p> <p>Headquarters: data and analytics</p>	<p>Framework design 2025–2026 (mid-term)</p> <p>Roll-out 2026–2027 (long-term).</p>	<p>Weak M&E systems; reliance on estimates; inequities in service coverage.</p>	

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<p>3.3 Conduct a CCS mid-term review in the next phase that looks critically at an appropriate balance between humanitarian and development initiatives. This will align the organizational ambitions with the operational realities of a long-running crisis.</p> <ul style="list-style-type: none"> Country example: Afghanistan’s Basic Package of Health Services showed how a standardized PHC platform adapted to conflict can anchor strategy and service delivery over time (86). <p>3.4 Publish an annual “State of Health Equity in Somalia” report: Use routine HMIS, survey and partner datasets. Track operational level efforts at country level in collaboration with other partners. This will create an accountability moment; and can inform donor targeting and course correction.</p> <ul style="list-style-type: none"> Country example: Rwanda’s RapidSMS and CHW reporting produced actionable maternal/child health analytics used nationally (87). <p>3.5 Build capacity for equity analytics: Train Ministry of Health (federal/state) M&E officers in equity-sensitive analytics and evaluation methods. This will enable sustainability of the information system and equity lens.</p> <ul style="list-style-type: none"> Country example: Ethiopia’s DHIS2 maturity work explicitly pairs system upgrades with capacity-building (88). 				
4. Improve resilience and sustainability of Somalia health system				Medium
<p>4.1. Co-develop a Somali PHC Roadmap: Integrate the essential package of health services, RMNCAH and outbreak preparedness into a unified primary health care model. This will reduce vertical silos and improve continuity of care.</p>	<p>WCO: health systems and PHC</p> <p>Regional Office:</p>	<p>2025–2027 (long-term)</p>	<p>Service delivery fragmentation; weak human</p>	

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<ul style="list-style-type: none"> Country example: Afghanistan’s Basic Package of Health Services served as a single, nationally endorsed PHC package across provinces, even in an insecure context (81). <p>4.2 Support a human resource for health strategy for equitable deployment, retention incentives and task-shifting (especially for community health workers in remote districts). Service coverage is constrained by workforce distribution and supervision. Strengthen Somalia’s health workforce by mapping existing staff (formal, CHWs, polio teams) to identify inequities, aligning the HRH strategy with the Essential Package of Health Services and National Transformation Plan priorities and introducing retention and incentive mechanisms for remote settings. This should be complemented by expanding task-shifting and CHW integration with standardized supervision and digital tools, while building Ministry of Health and state capacity for workforce planning and human resources information systems.</p> <ul style="list-style-type: none"> Country example: Rwanda’s ~45 000 CHWs, backed by standardized supervision and digital tools, contributed to gains in maternal and child health access and outcomes (89). <p>Strengthen regulatory capacity for mixed health systems (licensing, facility standards, contracting and PPP oversight). Somalia’s large private/NGO footprint needs stewardship to ensure quality, equity and value. Support the Ministry of Health to develop and revise regulatory frameworks at national and state levels, including licensing standards for health workers and facilities and national service quality standards linked to the Essential Package of Health Services. This should be complemented by work to strengthen regulatory institutions and inspection capacity through training</p>	<p>health system strengthening, UHC</p> <p>Headquarters: service delivery and safety</p>		<p>resources for health; partial PHC adoption; sustainability gaps</p>	

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<p>and joint inspections, while institutionalizing PPP oversight via a working group with clear terms of reference, resource plans and model contracting templates for private/NGO engagement in EPHS delivery.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Afghanistan’s contracted-out Basic Package of Health Services shows how government stewardship can set standards and hold multiple providers to account (81). <p>4.3 Enhance WHO–UNFPA coordination: Develop an integrated strategy with UNFPA for RMNCAH, clarifying roles and establishing joint standard operating procedures and shared results frameworks to improve coherence and donor confidence.</p> <ul style="list-style-type: none"> • <i>Country example:</i> In South Sudan, WHO and UNFPA established a joint strategy for maternal and reproductive health, drawing on their respective mandates. WHO provided the normative guidance, policy development support and capacity-building for health workers, while UNFPA led on procurement and distribution of reproductive health commodities, family planning and community outreach services. To avoid duplication and enhance accountability, the two agencies agreed on a set of standard operating procedures and a shared results framework, which enabled joint monitoring and donor reporting. This integration was instrumental in mobilizing pooled donor support for maternal health under the Health Pooled Fund, which financed both system strengthening and service delivery. Evaluations highlighted that this WHO–UNFPA collaboration improved coherence of technical assistance, efficiency in resource 				

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<p>use and donor confidence, while reinforcing each agency’s comparative advantage in RMNCAH (76).</p> <p>4.4 Pilot integrated service delivery “PHC+” sites that combine RMNCAH, nutrition and outbreak readiness, with independent evaluation for scale-up. Such demonstration initiatives would reduce risk and create an evidence-based playbook for scale-up. The Essential Package of Health Services, as the service delivery framework, already describes RMNCAH healthcare interventions, but outbreak preparedness should be better integrated.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Nigeria’s emergency-ready, campaign-enabled PHC sites within the polio programme provide a template for integration under surge conditions (80). 				
5. Strengthen tri-level WHO coherence and resource mobilization				High
<p>5.1 Institutionalize strategic consultations: Hold biannual strategic consultations of WHO headquarters, the Regional Office and the WCO, with action logs (emergencies, health system strengthening, financing). This will reduce transaction costs; and enable follow-through on technical missions.</p> <ul style="list-style-type: none"> • <i>Country example:</i> In Nigeria, polio emergency operations centres demonstrated the value of disciplined, recurring, multi-partner performance reviews (80). <p>5.2 Increase financial transparency: Publish an annual WHO Somalia funds flow statement (headquarters/Regional Office-retained funds versus WCO disbursed funds, by programme). Transparency builds donor and government confidence. Additionally, this supports a “one plan, one budget” approach.</p>	<p>WCO</p> <p>Regional Office: planning</p> <p>Headquarters: planning, resource coordination and performance monitoring</p>	<p>2025–2027 (long-term)</p>	<p>Partial headquarters–Regional Office–WCO coherence; reliance on emergency funds; sustainability and alignment gaps.</p>	

Specific actions	Responsible WHO units/departments	Timeline Short-term 6 months; Mid-term 1 year; Long-term (> 1 year)	Linked conclusions	Priority High/ Medium/ Low
<ul style="list-style-type: none"> • <i>Country example:</i> In Nigeria, donor coordination and transparent reporting under the Global Polio Eradication Initiative helped sustain large, multi-year investments (80). <p>5.3 Leverage pooled and flexible funding: Use pooled/umbrella proposals hinged to the integrated monitoring framework to reduce overhead and competition. This links money to measurable results and will improve predictability.</p> <ul style="list-style-type: none"> • <i>Country example:</i> Nigeria’s polio programme aligned partner funding to a single performance framework via the emergency operations centre (80). <p>5.4 Establish a Somalia-specific EMRO budget line to resource strategic technical follow-up (mission terms of reference, deliverables, after-action reviews). This will close the headquarters–Regional Office–WCO loop so that technical advice is acted on and tracked.</p>				
6. Develop and implement a comprehensive advocacy strategy for resource mobilization				High

<p>6.1. Develop and implement a comprehensive advocacy strategy for resource mobilization that leverages WHO Somalia’s unique institutional assets: its field presence, technical expertise, global scientific networks and normative authority. The strategy should include the following actions:</p> <ol style="list-style-type: none"> 1. 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). 2. Strengthen country-led advocacy: Align WHO advocacy messages with national priorities articulated in the Health Sector Strategic Plan and the Essential Package of Health Services, demonstrating WHO’s catalytic role in supporting government leadership. 3. Institutionalize a resource mobilization function: Establish a small task team within WCO Somalia to coordinate donor engagement, track funding opportunities and ensure coherence across programmatic areas. 4. Leverage regional and global advocacy platforms: Use WHO’s access to intergovernmental forums and scientific networks to elevate Somalia’s case for sustained investment, reinforcing national messages with global legitimacy. <p><i>Country examples:</i></p> <ul style="list-style-type: none"> • In Ethiopia, WHO developed an investment case for health systems strengthening, explicitly highlighting its normative authority and technical expertise, which helped it successfully mobilize funding from the Global Financing Facility and bilateral donors (90). • In South Sudan, WHO’s leadership in the Health Cluster and its field-level presence were packaged into an advocacy strategy that secured multi-year funding commitments from ECHO and the United States Agency for International Development (USAID) for emergency response and health systems recovery (91). 		<p>2025-2026 short- to medium-term</p>		
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