©JHNP/2014/Ohanesian

Final Progress Report

June 2016

USAID
FROM THE AMERICAN PEOPLE

Together with Somali Health Authorities

World Health Organization unicef UNFPA

THE USAID SUPPORT TO

THE SOMALI JOINT HEALTH AND NUTRITION PROGRAMME

2012-2016

Reporting Agency:	UNICEF
Country:	Somalia
Title:	Joint Health and Nutrition Programme
Donor:	USAID
Report type:	Final Report

PROJECT SUMMARY

Programme/Project Name	**Somali Joint Health and Nutrition Programme (JHNP) 2012-2016**
Location	Somaliland/North West Zone (**NWZ**), Puntland/North East Zone (**NEZ**) and Central South Zone (**CSZ**) of Somalia
Participating UN Organizations	United Nations Children Fund (**UNICEF**) World Health Organization (**WHO**) United Nations Population Fund (**UNFPA**)
Implementing Authorities	Ministry of Health, Federal Government of Somalia (**FGS**); Ministry of Health, Puntland (**NEZ**); Ministry of Health, Somaliland (**NWZ**)
Currently Engaged Donors in addition to the United States Agency for International Development (**USAID**)	The Government of the United Kingdom of Great Britain and Northern Ireland/Department for International Development (**DFID**); The Government of Sweden/Swedish International Development Cooperation Agency (**Sida**); The Government of **Finland**; The Government of Switzerland/Swiss Agency for Development and Cooperation (**SDC**)
Grant Agreement Number	XI 120002
UNICEF Ref (PBA Number)	SC120611 (2013); SC141030 (2014)
UNFPA Projects and Fund code	SOM2R21A, SOM2R22A, SOM2R23A, (UCJ11)
WHO Ref (Award Number)	59890
Report Type	Final Report
Report Number	Third and final report
Report Due Date	15 June 2016
Period Covered by Report	27 September 2012 - 26 March 2016
Contribution from USAID - Amount in USD	USAID Tranche 1: = US$ 1,149,963 (October 2012) USAID Tranche 2: = US$ 1,390,298 (March 2014) USAID Tranche 3: = US$ 715, 134 (January 2015) **TOTAL = US$ 3,255,395** **(Total Contribution from all JHNP Donors: US$ 114,134,821)**
Funds (USAID) Disbursed to UNICEF: UNFPA: WHO: Administrative Agent (AA) fee:	**US$ 3,255,395** US$ 1,258,008 US$ 556,742 US$ 1,440,645 Nil
Expenditure of USAID Grant	• ~Fund utilization rate of total funds received by May 2016: 100% • Official expenditures to be communicated by UNICEF HQ

Expected Programme Duration	5 Years: February 2012 - December 2016	Budget Forecast over 5 years	~US$ 236 million
Programme Objectives	**Impact:** Improved health and nutrition status of Somali people contributing to reduction in maternal and child mortality. **Outcome:** Increased use of reproductive, maternal, newborn and child health (RMNCH) and nutrition services that are available, accessible, affordable, of acceptable quality and adaptable. Results are set out in the Programme Document[1] and logical framework (revised in 2015) to align programming with in-country Health Sector Strategic Plans.		
Geographical Focus	All three Somali zones. Focus of service delivery is initially in the following nine regions: ▪ Lower Juba, Galgaduud and Banadir - CSZ ▪ Nugaal, Mudug and Bari - NEZ ▪ Togdheer, Awdal and Sanaag – NWZ		
Agency Contacts	▪ Anirban Chatterjee (Chief of Health) UNICEF, achatterjee@unicef.org ▪ Humayun Rizwan (PHC Medical Officer) WHO, rizwanh@who.int ▪ Achu Lordfred (Maternal Health Advisor) UNFPA, lordfred@unfpa.org		
Ministry of Health (MoH) Contacts	▪ Abdullahi Hashi Ali (Director General, FGS) drhashi4@hotmail.com ▪ Abdirizak Hirsi (Director General, NEZ), abdirizak30@yahoo.com ▪ Suleiman Jama Diiriye (Director General, NWZ), solomon.dierie@gmail.com		
Joint Coordination Unit (JCU) - JHNP	▪ Raza Zaidi (Senior Programme Manager, JHNP), razaidi@unicef.org ▪ Esther Waters-Crane (Program & Planning Specialist), ewaterscrane@unicef.org		
Administrative Agent (UNICEF)	▪ Sarah Elamin Ng'inja (Planning, M&E Manager), snginja@unicef.org		

[1] JHNP Programme Document Control:
Initial Proposal: Developed with input from donors, authorities and United Nations partners; shared with stakeholders in January/February 2012;
Strategic concept and design document: Formally submitted to donors in February/March 2012;
Programme document: Finalised in August 2013 after the development of the three Health Sector Strategic Plans; Programme document approved by the Steering Committee on 4 October 2013.

I. EXECUTIVE SUMMARY

While the Somali health sector and the Joint Health and Nutrition Programme (JHNP, 2012-2016) have made considerable gains since 2012, undergoing a real transformation, the road ahead remains extremely fragile and uncertain. Mitigation of risks and the legitimacy of the authorities is critical for the success of the sector in 2016 and beyond, especially now that the Essential Package of Health Services (EPHS) is accessible to more than 5.6 million people in all nine targeted regions, creating huge demand for health services. There has also been significant implementation of the Somali Health Policy and the Health Sector Strategic Plans (HSSPs) which has created momentum for continuous development and growth.

Fully aligned to the principles of the 'New Deal', the 'Somali Compact' and the 'Somali Health Policy', the JHNP continued scaling up delivery of the EPHS and more specifically reproductive, maternal, newborn and child health (RMNCH) and nutrition services throughout the duration of the programme.

The United States Agency for International Development (USAID) is one of the JHNP donor agencies providing support to the programme through a parallel financing modality.

USAID has provided support to the programme in three tranches. As a result of this funding, the programme has achieved the following results, further expanded on within this report:

Governance and Leadership

- Reproductive health technical advisors were recruited and in situ in all three zones between 2012-2015, contributing to revision of the Reproductive Health (RH) Strategy and development of three zonal plans; functional RH working groups and task forces; and strengthening of RH strategic and implementation functions of the three Ministries of Health (MoH).
- All three authorities were supported with the development of a zero tolerance female genital mutilation/cutting (FGM/C) legislative framework through the development of anti-FGM/C policies and religious decrees (*fatwas*). The Federal Government of Somalia (FGS) drafted a zero tolerance FGM/C bill and a series of consultative sessions were held with stakeholders to facilitate its finalization. Regional and national dialogues with prominent religious leaders to facilitate issuance of an anti-FGM/C *fatwa* were held.

Health Workforce

- Partial support to a midwifery school from 2012-2013 in Mogadishu and training of 40 midwives during the same period.
- Training of 40 clinical staff for a diploma on Comprehensive Emergency and Obstetric Care (CEmOC) during 2015-2016, based on a standardised curriculum developed in 2014.
- A total of 61 community health workers (CHW) in all three zones trained in 2015 on a standardised curriculum developed with USAID support in 2014.

Service Delivery

- Community dialogues and engagement on FGM/C led to 81 new communities/villages declaring total abandonment of all forms of FGM/C in 2014 and a further 25 communities in 2015.
- A total of 16,400 people in the catchment of the Maternal and Child Health (MCH) centres have access to improved water sources.
- Sustainable WASH services provided in five MCH centres benefiting 1,500 users of health facilities and CHWs.
- Fifteen communities in the catchment of the MCHs triggered to attain open defecation free status.
- Five project communities, in the EPHS catchment area, empowered to plan and effectively manage the operation and maintenance of WASH facilities in a sustainable manner.

II. PURPOSE

With the support of international partners, Somalia is starting to experience gains in the area of governance, security and early development. The health status of Somali people is also seeing progress, as evidenced by declining maternal and child mortality estimates. However, Somalia still continues to rate among the worst countries in the world for maternal and infant mortality.

With a population of approximately 13 million in 2016, Somalia has one of the highest total fertility rates (6.7) in the world, while life expectancy is only around 55 years.[2] Access to birth spacing services is limited and 98 per cent of women experience FGM/C. The Social Institutions and Gender Index for 2014[3] places the country on the sixth lowest position in the world, with 'very high' discriminatory family codes, 'very high' levels of restricted physical integrity, and a 'very high' level of restricted resources and assets.

Giving birth remains one of the greatest risks to a woman's life. When women become pregnant, their chance of survival drops considerably due to limited antenatal care (ANC), restricted medical supplies, extraordinarily poor healthcare availability and lack of infrastructure.[4] A woman's life time risk of dying due to pregnancy related causes is approximately 1 in 18, which compared to other developing countries, is very high.[5]

In light of these challenges, USAID support targeted activities critical for the health status of women, girls and children, with particular risks relating to sexual and gender related health issues.

Purpose of grant

'Increased use of RMNCH and nutrition services which will be more available, accessible, affordable, adaptable, and of acceptable quality.'

Expected results of the USAID investment include:

- Effective technical assistance available in all three zones contributing to the revision of RH strategy and development of three zonal plans; functional RH working groups and task forces; and strengthening of RH strategic and implementation functions of the MoH.
- Contribution to the development and approval of FGM/C abandonment policies and legislations in all three zones with scaling-up of community-based FGM/C abandonment interventions through advocacy and community mobilization in 106 communities (81 communities during 2012-2014, and a further 25 in 2015).
- Partial support to a midwifery school in Mogadishu and training of 40 midwives.
- Training of 40 clinical staff (diploma training on CEmOC) on a standardised curriculum in NWZ and CSZ and training of 30 clinical staff from all three zones on anesthesia.
- Sixty CHWs in all three zones trained on a standardised curriculum developed with USAID support.
- A total of 12,000 people in the catchment of the MCHs have access to improved water sources.
- Sustainable WASH services provided in five MCH centres to benefit 1,500 users of health facilities and CHWs.
- Fifteen communities in the catchment of the MCHs attaining open defecation free status.
- Five project communities, in the EPHS catchment area, empowered to plan and effectively manage the operation and maintenance of WASH facilities in a sustainable manner.

2 UNICEF, The State of The World's Children in 2014-in numbers, 2014
3 2014 Social Institutions and Gender Index, OECD Development Centre
4 UNICEF (2011) State of the World's Children.
5 Trends in Maternal Mortality 1990-2013, WHO, UNICEF, UNFPA and the World Bank estimates, 2014.

The JHNP represents an important opportunity to support more sustainable health systems strengthening programming as prioritised by Somali Health Authorities (HAs). It represents a new commitment between the Somali HAs, UN agencies, donors and key stakeholders to transition from humanitarian and emergency responses to a country-owned and country-led development approach to improve health outcomes for women and children across all the three zones. The JHNP is designed within the six health systems strengthening building blocks.

The six key areas of the JHNP based on the building blocks are:

1. Governance and Leadership: Improved governance and leadership at all levels of the health sector.
2. Health Workforce: Skilled and motivated health workforce distributed equally and equipped to deliver quality RMNCH and nutrition services through a continuum of care.
3. EPHS/RMNCH and Nutrition Services: are available, accessible, affordable, of acceptable quality and adaptable, within the EPHS framework.
4. Health Financing: Steady progress made to an equitable and efficient health financing system.
5. Essential Medicines and Commodities: Improved access, availability, quality and rational use of essential medicines, vaccines, commodities, medical equipment and physical structures.
6. Health Information: Improved access, availability, acceptability, quality and use of health information that covers disease surveillance, policy research, as well as the health management information system.

The USAID support to the JHNP specifically contributes to the following building blocks:

- Building Block 1: **Governance and Leadership**;
- Building Block 2: **Human Resources for Health**; and
- Building Block 3: **Better Service Delivery** focusing on RMNCH, WASH and FGM/C abandonment.

Programme priorities for USAID were identified by the Zonal Working Groups and Technical Coordination Group (TCG) from the JHNP programme document and the log frame. In consultation with the Somali HAs and UN agencies, JHNP prioritised activities that are vital to deliver programme outputs; are feasible; ensure continuity; and are expected to present good value for money. Given the developing status of the health sector, the programme activities supported by USAID are fundamental to ensure the strength of longer term activities in the JHNP, which are expected to be funded by other donor governments in the future.

Specific Objectives of the USAID support are:

I. Increase the capacity of the zonal MoHs to coordinate and manage RH strategies and interventions.

II. Improve awareness at community level along with advocacy and Behaviour Change Communication (BCC) interventions for the abandonment of FGM/C and to develop linkages with health facilities for complicated cases as defined in the EPHS.

III. Improve access to, and availability of, life-saving and other reproductive and emergency obstetric care services for Somali women in targeted regions through strengthening the capacity of clinical officers in the referral centres as defined in the EPHS.

IV. Improve community (in EPHS catchment area) access and ownership of improved water and sanitation facilities, including community-led total sanitation and behaviour change.

III. RESOURCES (USAID) FOR JHNP

Budget category	Amount in US$
GRANT SUPPORT 1 (2012)	
Training of female community health workers	428,736
Curriculum development for diploma training on CEmOC	88,859
Support to midwifery school in Mogadishu and training of 40 midwives	213,782
Capacity development of zonal ministries of health on reproductive health	122,400
TOTAL COST OF ACTIVITIES UNDER PROPOSAL 1:	853,777
Cross Sectoral Cost	150,666
Global Indirect Cost	145,520
GRAND TOTAL OF PROPOSAL 1:	**1,149,963**
GRANT SUPPORT 2 (2014)	
Capacity development of zonal ministries of health on reproductive health	105,570
Policy and legislation on FGM/C abandonment	120,000
Training of clinical staff on EmOC and anesthesia	623,771
Community empowerment on FGM/C abandonment	200,229
TOTAL COST OF ACTIVITIES UNDER PROPOSAL 2:	1,049,570
Cross Sectoral Cost	185,218
Global Indirect Cost	155,510
GRAND TOTAL OF PROPOSAL 2:	**1,390,298**
GRANT SUPPORT 3 (2014-15)	
Establishment of sustainable water supply system based on two strategic boreholes rehabilitation and extension to health facilities, communities and schools in the catchment	45,000
Rehabilitation/Extension of three mini-water systems with solar powered pumps	10,000
Construction/Rehabilitation of sanitation facilities (with hand washing station) at five Outpatient Therapeutic Centres (OTPs)/Maternal Child Health Centres including connection to water supply system	150,000
Construction/Rehabilitation of sanitation facilities (with hand washing station) at five Schools in in the catchment of MCHs including connection to water supply system	150,000
Support Community Led Total Sanitation (CLTS) approach to achieve Open Defecation Free status in 15 villages	35,000
Procurement of Hygiene kits (Water purification tablets each containing 7,000 tabs, 400 collapsible jerry cans, 2 drums of chlorine powder, 400 plastic buckets and 2,000 bars of soap which is enough for 400 households)	35,000
Community mobilization, dissemination of key hygiene promotion messages and distribution of hygiene kits to promote safe hygiene and household water treatment	60,000
Capacity development of communities/MCH to manage and maintain their water systems and to improve hygiene practices	30,786
Transportation and storage costs	17,206
TOTAL COST OF ACTIVITIES UNDER PROPOSAL 3:	575,792
Cross Sectoral Cost	86,369
Global Indirect Cost	52,973
GRAND TOTAL OF PROPOSAL 3:	715,134
GRAND TOTAL OF USAID FUNDS TO THE JHNP	**3,255,395**

IV. END OF PROGRAMME RESULTS AND PROGRESS

Summary of progress against milestones (Tranches 1- 3) is provided in the table below:

Expected Results		Progress against results
Leadership and Governance		
1.1	Capacity development of three zonal MoHs on reproductive health	**Activity completed**
Health workforce		
2.1	Curriculum development for diploma training on CEmOC	**Activity completed**
2.2	Training of 60 female community health workers	**Activity completed**
2.3	Support to midwifery school in Mogadishu and training of 40 midwives	**Activity completed**
2.4	Policy and legislation on FGM/C abandonment	**Activity completed** - Policy approved for NEZ and Zero Tolerance Bill drafted in CSZ and NEZ.
2.5	Training of clinical staff on CEmOC and anesthesia	**Training on CEmOC completed** **Anesthesia training not completed**
Service Delivery		
3.1.1 3.1.2	81 communities in JHNP regions announce abandonment of FGM/C in 2014; 25 more communities in JHNP regions announce abandonment of FGM/C in 2015;	**Activity completed** - With additional funding from UNICEF, 142 communities in total declared total abandonment
3.2	Sustainable WASH services provided in 5 MCH centres to benefit 1,500 users of health facilities and CHWs;	**Activity ongoing**
3.3	5 project communities empowered to plan and effectively manage the operation and maintenance of WASH facilities in a sustainable manner;	**Activity completed**
3.4	12,000 people in the catchment of the MCHs have access to improved water sources;	**Activity ongoing –** expected completion June 2016
3.5	15 communities in the catchment of the MCHs attaining open defecation free status	**Activity ongoing**

The programme has successfully reached all but three milestones agreed with USAID. These are under way and due to be completed by the end of June 2016. Details are provided below:

1. <u>Leadership and Governance:</u>

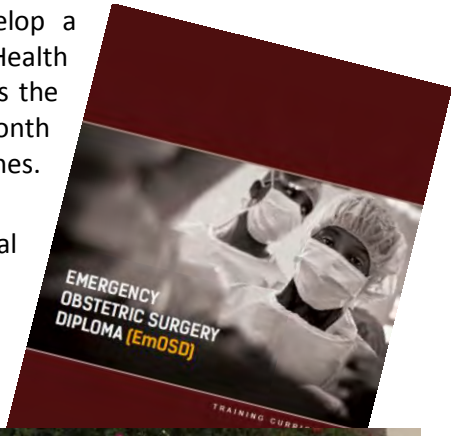
Capacity development of three zonal MoHs on reproductive health

Three advisors were placed in the Ministries of Health to support all three zones on RH strategic issues, establishment of RH units and activation of RH working groups and task forces at the zonal level. Long term technical assistance was critical for the revision of the RH strategy and the development of three plans through an extensive consultative process. The strategy and the three plans were finalised in February 2014, reviewed by the Health Sector Committee (HSC) and endorsed by the Health Advisory Board (HAB) in late 2014. The capacity of the RH teams within the MoH has now been sufficiently bolstered and funds from USAID and other donors exhausted. The long term technical advisor positions were dissolved in July 2015.

2. Health Workforce:

Diploma on CEmOC for clinical staff

One of the key activities for human resource development was to train 60 clinical officers/ doctors in Emergency Obstetric Surgery diploma, to improve their practical skills to perform caesarean sections and other procedures. WHO provided technical support to develop a standardised curriculum in 2014 which was endorsed by the Health Authorities. In 2015, technical expertise was hired by WHO to assess the proposed training institutes for their capacities to hold the nine-month diploma course and to identify and train the trainers in all three zones. After the assessment, three institutes were selected:



- CSZ: Somalia University attached with Banadir National Referral Hospital as a teaching hospital
- NEZ: East Africa University with Garowe General Hospital as a teaching hospital
- NWZ.: Institute of Health Sciences with Hargeisa Group Hospital as a teaching hospital

A training of trainers was conducted in Hargeisa in May-June 2015. A total of 12 trainers participated from all three zones. In addition, three plans were produced for the next level training. The letters of agreement (LOA) with the training institutes were signed and training commenced at the beginning of 2016. The training comprised of three months classroom and six months supervised clinical training in the identified hospitals.

Picture 1 Master trainers trained for the diploma course, 2015

The training of anesthesiologists was added to the 2014 grant, based on the assumption that it could be done at a low additional cost, using the WHO curriculum developed for Sudan, and conducted by the University of Sudan in combination with the CEmOC training. A review of the proposal submitted by the University of Sudan revealed high costs for the anesthesiologists training and the CEmOC training costs were also higher than originally foreseen. USAID funds were used, in combination with pooled JHNP funds to cover the CEmOC training in line with the milestones, which were met. JHNP pooled funds were used to support the training in Somaliland, while USAID funds were used to support the trainings for practitioners from Central South and Puntland. However, the anesthesiologist training could not be accommodated within the budget. The adaptation of the Sudanese anesthesiologist's curriculum will be carried out by WHO using its own funds in 2016 with a view to the successor of the JHNP taking this activity forward beyond 2016.

Community Health Workers training

In 2014 the curriculum for CHWs was developed, endorsed and printed, followed by a Training of Trainers (ToT) conducted in Puntland (NEZ) for trainers from NEZ and CSZ. The trainers subsequently trained 20 CHWs each through the University of Somalia. Following this, in early 2015, 20 CHWs were trained in NEZ and a further 20 CHWs in CSZ. In Somaliland (NWZ), the CHW curriculum of the Somaliland MoH was used and with the support of the Tropical Health and Education Trust (THET) a training of nine months was conducted to train 21 CHWs. The training included six months basic literacy training. Training of all 61 targeted CHWs has been completed.

Picture 2 Graduation Ceremony of CHWs in Somaliland, 2016

NEZ: Training of CHWs' Trainers

Midwifery training in Mogadishu

Along with other JHNP donors, USAID support to midwifery schools was used to establish/ strengthen nine midwifery schools in the three zones. USAID support was specifically used to strengthen the midwifery school in Mogadishu and funds were fully drawn down in 2014. The school is now receiving ongoing support from the JHNP pooled fund and 44 post-basic midwives and 22 basic midwives are currently undergoing training.

Midwifery students – Theoretical Exam

Midwifery students – Practical Exam

Mogadishu Midwifery School, Banadir

Policy and legislation on FGM/C abandonment

All three authorities are working towards zero tolerance FGM/C legislative framework through development of anti-FGM/C policies and religious degrees (*fatwas*). The FGS drafted a zero tolerance FGM/C bill and a series of consultation sessions with stakeholders have been held to facilitate its finalization. Regional and national dialogues with prominent religious leaders to facilitate issuance of an anti-FGM/C *fatwa* were organised. The *fatwa* promoting abandonment of all forms of FGM/C will be key in supporting endorsement of the anti FGM/C bills. Advocacy for endorsement of the pending new policy advocating for abandonment of all forms of FGM/C in NWZ was organised with key stakeholders. In NEZ, advocacy and lobbying sessions to win over parliamentarians for the endorsement of the anti FGM/C bill were held with key stakeholders including Parliamentary Committees, religious and traditional leaders, members of women and youth groups and cabinet ministers. Despite the existence of the Policy and *fatwa* outlawing all forms of FGM/C in Puntland, some religious leaders are not in favour of a law advocating for abandonment of all forms of FGM/C. The focus in future will be to win the support of the parliamentarians and other key stakeholders to facilitate endorsement of the draft legislation outlawing all forms of FGM/C.

3. Service Delivery:

Abandonment of FGM through community empowerment

To instigate positive changes at societal and community levels, efforts by UNICEF continued in all three zones to increase knowledge on the benefits of abandoning FGM/C through community-led dialogues, advocacy, out-reach campaigns and education, policy dialogues and referral for services. Advocacy was scaled up at different levels, involving religious leaders, community leaders, women groups and in and out of school youth networks. Community members were trained to champion FGM/C abandonment at all levels. USAID funds were used to focus on Central South Somalia.

The 'Community and National Champions on FGM/C abandonment' approach was supported in Central South Somalia. The approach engaged community members to influence families and communities to abandon FGM/C of all forms by reaching out to over 100,000 people. Educating community members through a peer-to-peer approach and by respected people, such as religious leaders and health professionals, on the benefits of abandoning FGM/C also proved to be effective. These community dialogues and engagement led to 52 communities in Central South Somalia declaring total abandonment of all forms of FGM/C.

Picture 3 FGM/C targeted discussions, CSZ, 2015

The public declarations ceremonies were attended by government representatives, media houses - both print and electronic, community members including women, men, religious leaders, village committees, female circumcisers and girls who had been saved from FGM. Drama, poems and songs advocating for abandonment of all forms of FGM/C were presented to educate the community.

Schools represent one of the key entry points for activities to effect changes in adverse gender norms. A total of 70 Child Rights Clubs (CRC) in primary schools are functional in the three zones with 1,500 members actively involved in dialogues on abandonment of FGM/C and early and forced marriage. This approach enables young people to feel more comfortable discussing sensitive issues, such as FGM/C and harmful gender norms. Through the youth forums, USAID funds contributed to further sensitizing an additional 300 young people on FGM/C abandonment in NWZ, NEZ and CSZ.

Traditional birth attendants (TBA) within the targeted communities were empowered with the support of religious leaders. Consequently, over 50 female circumcisers have abandoned FGM/C and are actively advocating FGM/C abandonment. One of the TBAs narrating said,

> *"I have been doing this practice for the last 25 years, it was a source of income for my family support but fortunately the religious leaders told us that we, the circumcisers will be liable for this evil practices. Since then, I decided to stop it and never again even if for the life of me. Moreover, I will voluntarily allot time to advocate against it. Thanks for the religious leaders who share with us the negative repercussions of the FGM harmful treatments in Islam".*

However, there is a divide among religious scholars over the legitimacy of female circumcision in Islam. Some clerics oppose the adoption of the zero tolerance towards FGM/C, while others push for total eradication of the practice. This has created a stumbling block, preventing the Ministry of Religion from taking a clear stance towards FGM/C total abandonment and has also resulted in the silence of popular religious scholars. Islamic scholars who have a clear position against all forms of FGM/C have been identified to lead the advocacy campaigns. The recently established religious leaders' network is expected to support the move towards reaching consensus on total abandonment by religious leaders.

Sustainable WASH services provided in 5 MCHs to benefit 1,500 users of health facilities and CHWs

Activity 1 *Construct/rehabilitate sanitation facilities (with hand washing stations) at 5 OTPs/MCH centres including connection to a water supply system*

The following five MCHs were provided with WASH services:

Zone	Region	MCH/Community	WASH services provided
Somaliland	Awdal	Sheed Dheer MCH	*Sanitation facility and water supply connection*
		Old Baki MCH	*Water supply connection*[6]
Puntland	Nugaal	Dhiganle MCH	*Sanitation facility and water supply connection*
		Hasbahale MCH	*Sanitation facility and water supply connection*
Central South Somalia	Galgaduud	Guriel MCH	*Sanitation facility and water supply connection*

Besides construction of sanitation facilities, Old Baki, Sheed Dheer, Dhiganle and Hasbahale MCHs have been connected to, or provided with, water supply. Four additional health facilities in Galgaduud will also be connected to a water supply system, with the re-programmed funding from Old Baki. Funds were fully drawn down and construction of sanitation facilities is now at final stages.

Activity 2 *Procurement of hygiene kits (containing water purification collapsible jerry cans, chlorine powder, plastic buckets and bars of soap)*

USAID funds enabled UNICEF to procure emergency supplies, including soap and water purification chemicals and pre-position them in Somaliland and Puntland to meet the needs of 2,400 emergency affected households for a period of three months. These supplies form part of the hygiene kits distributed to over 14,000 drought-affected families in Somaliland and Puntland.

12,000 people in the catchment of the MCHs have access to improved water sources

Activity 1 *Establishment of sustainable water supply system based on two strategic boreholes rehabilitation and extension to health facilities, communities and schools in the catchment*

Two sustainable water supply systems were established in Garowe and Eyl districts, Nugaal region.

In Hasbahale village, Eyl district, the existing water supply system, fed from a borehole, was upgraded to a mini water supply scheme to meet the needs of approximately 7,000 people. This was achieved through the construction of a $20m^3$ reinforced concrete storage tank and three new water kiosks with four sprouts to minimise waiting time at the water kiosk. The water supply system was

[6] In August 2015, World Vision constructed a set of new latrines at the Old Baki MCH facility using external funding. To avoid duplication, UNICEF re-programmed the funds set aside to four other MCHs in Dhuusamarreeb in Galgaduud where the construction of sanitation facilities is expected to be completed in June 2016.

extended to the Hasbahale School with 870 children (391 girls; 479 boys) and the Hasbahale MCH, regularly attended by 200 users.

In Balley village, Garowe district, an existing borehole was rehabilitated and upgraded into a mini water supply system to meet the needs of 1,000 people in the community. The system was extended to serve the Balley Primary School with a total enrollment of 112 pupils (50 girls; 62 boys). The system is equipped with a ground masonry tank and two public kiosks with four taps to minimise the waiting time at the water kiosks. Four air-valves to de-aerate the pipeline with a 720m pipeline were also installed. For the water to reach the school, the system was equipped with a booster pump and a booster pump housing.

Activity 2 *Rehabilitation/extension of three mini-water systems equipped with solar powered pumps*

In Old Baki village, Baki district, Awdal region, the construction of a shallow well and the other components of the mini water supply system to benefit 1,784 people, are at an advanced stage of completion. The installation of the reinforced concrete rings for lining of the shallow well has been completed, as well as the construction of a 25m^3 elevated water tank. The room for the caretaker, the well, the water kiosks for the school and community, the laying of the piped network and the installation of the solar powered submersible pump and solar panels will be completed by the end of June 2016. UNICEF is providing technical support to the partner to address initial project constraints enabling the project to be completed.

Picture 4 Six-tap water kiosk, Old Baki village

Picture 5 Caretaker hut, Old Baki village

In Sheed Dheer village, Baki district Awdal region, the rehabilitation lining for the 18m deep shallow well has been completed, benefiting 1,116 people. The caretaker room, lockable community water kiosk and the 25m^3 elevated tank have been completed. The piped network, solar powered submersible pump and panels installation and the construction of the water kiosks at the school is expected to be completed by June 2016.

In Dhiganle village, Eyl district, Nugaal region, the USAID contribution to the JHNP was used to construct a sub-surface dam measuring 120m in length, 6m in depth and 1m in width at the dry river bed. The rationale for the sub-surface dam technology is to ensure retention of water in the sand upstream of the sub-surface dam. Through construction of the sub-surface dam, the water retained in the sand started recharging the defunct shallow well located upstream of the dam. The shallow well is being rehabilitated, in parallel with the construction of three new water kiosks, a 20m^3 elevated reinforced concrete tank and the installation of solar panels to power the submersible pump. The trench for the 1.2 km conduit pipeline has been excavated, awaiting installation and testing of the pipes in June 2016. This intervention will provide 917 households, or 5,502 people, access to safe water. The Dhiganle School and MCH will also be connected to the water supply system to meet the needs of 500 school going children (225 girls; 275 boys) as well as 100 health facility users.

15 communities in the catchment of the MCHs attaining open defecation free status

Activity 1 *Supporting Community Led Total Sanitation (CLTS) approach to achieve Open Defecation Free status in 15 villages.*

As part of the UNICEF CLTS scaling up strategy, a total of 118 facilitators were trained across the country for direct implementation of CLTS. These training events took place in Doolow between 1-4 March 2015; in Garowe between 28 March – 1 April 2015; and in Hargeisa between 19-23 April 2015. CLTS activities in eight villages in Awdal and Galgaduud regions were implemented by NGO partners, while in Nugaal, the MoH led implementation of CLTS in seven villages.

Pictures 6 and **7** CLTS community facilitators training in Quotay village

While a total of 15 communities were mobilised for CLTS support, only one has achieved self-declared open defecation free (ODF) status and two other communities are under way to achieving the milestone. A number of challenges were encountered leading to under achievement on this component, including targeted communities in Awdal region migrating early in the year due to drought conditions, access difficulties following limitations on movement of UNICEF staff in the aftermath of the attack in Garowe in April 2015, as well as delays in signing new partnership agreements following efforts to align internal partnership review processes and the management of resource transfers to civil society organizations with UNICEF global guidance. UNICEF and the Norwegian Refugee Council (NRC) signed a partnership agreement in March and the CLTS support is ongoing in Galgaduud region. In Awdal and Nugaal regions, UNICEF and partners will continue post triggering follow-up activities to achieve ODF status in these villages.

Activity 2 *Construct/rehabilitate sanitation facilities (with hand washing stations) at five schools in in the catchment of MCH, including connection to water supply system*

Construction of sanitation facilities has been completed in in Sheed Dheer and Old Baki schools in Baki district, Awdal region benefiting a total of 250 school-going children. Construction of sanitation facilities is ongoing in three schools in Dhuusamarreeb district, Galgaduud region, where delays were experienced in signing the partnership agreement with NRC. Once completed the facility will benefit a total of 600 school-going children. Besides construction of sanitation facilities, five schools including Old Baki, Sheed Dheer, Balley, Dhiganle and Hasbahale have been connected to or provided with water supply benefitting 1,732 school children.

Five project communities empowered to plan and effectively manage the operation and maintenance of WASH facilities in a sustainable manner

Five community WASH committees have been established and trained to manage and maintain their water systems and improve hygiene practices. The targeted community committees were Sheed Dheer and Old Baki communities in Baki district, Awdal region, Somaliland; Dhiganle and Hasbahale communities in Eyl district, Nugaal region, Puntland; and Balley community, Garowe district, Nugaal.

V. GENDER AND THE JHNP

Somalia ranked fifth most dangerous country in the world for women[7] and the Social Institutions and Gender Index for 2014[8] places the country on the sixth lowest position in the world. More generally, the participation and role of women in politics and decision-making spheres is extremely limited, perpetuating narrow gender-based roles and inequalities. In the ministries of health, representation of women in top positions is very low. Few amongst them are the Federal Minister of Health, Minister of Health Galmudug and Director of Planning, Somaliland.

Somali life expectancy is very low at 55 years: 53 years for men and 57 years for women[9]. One in 22 women in Somalia have a life time risk of dying during pregnancy. As per UN interagency estimates, 3,400 women died because of pregnancy related complications in 2015, much more than the 896 battle related deaths during 2011-2015.[10] While the maternal mortality ratio is improving (at 732 per 100,000 live births in 2015) albeit at insufficient pace, Somali women still suffer disproportionately compared to men as a result of lack of access to health services, lower education levels about health seeking behaviours and lack of influencing power within the community and the family unit to enable them to negotiate their own and/or their children's health needs[11].

As per the maternal mortality study in Somaliland[12], one third of the deaths among women aged 15-49 years are due to obstetric haemorrhage, the leading cause of maternal-related deaths (12.1 per cent), followed by pregnancy-induced hypertension (9.1 per cent). Obstetric haemorrhage is disproportionately higher among women aged 25-34 years. Maternal death is as twice as high in rural than urban areas (40.6 per cent vs 20.7 per cent). The majority of deaths took place outside the health facilities and affected those who live two or more hours away from the nearest health facility.

The JHNP was designed to focus mainly on the health needs of women and children. In service delivery, the scope of the programme prioritises RMNCH and nutrition services.

In the area of the health workforce, JHNP supported 15 midwifery schools, through which 815 female students have benefited by completing the training or are under training. The programme is ensuring uptake of trained midwives in EPHS facilities to the maximum extent possible and others have the required skills to get decent jobs in the private sector.

Data from the EPHS and CEmOC implementing partners indicates the following gender disaggregation of health staff working in JHNP regions.

Table: Health staff disagregated by gender in EPHS and CEmOC facilities in JHNP regions

	EPHS	
	Male	Female
Doctors	94%	6%
Nurses	41%	59%
Midwives	6%	94%
Technical Support Staff	49%	51%
Non technical Support Staff	54%	46%
Overall MCH/HC/RHC	40%	60%
PHU (CHWs)	72%	28%

	CEmOC	
	Male	Female
Doctors	70%	30%
Nurses	35%	65%
Midwives	2%	98%
Technical Support Staff	69%	31%
Overall CEmOC	35%	65%

7 UNDP Women's Empowerment and Gender Equality Strategy 2011-2015
8 2014 Social Institutions and Gender Index, OECD Development Centre
9 http://www.prb.org/DataFinder/Topic/Rankings.aspx?ind=6
10 http://data.worldbank.org/indicator/VC.BTL.DETH
11 UNDP Gender Brief in Somalia 2011
12 WHO, 2014, Somaliland Women of Reproductive Age Mortality Survey

No national level survey has been carried out in the country since 2006, to have gender disaggregated information on health. Similarly, Health Management Information System (HMIS) data is not fully disaggregated by gender. From HMIS data in 2015, overall female to male ratio for outpatient visits in MCH/HCs was 57.9:42.1 in three zones. However, this ratio does not include those RMNCH visits which are specific for women.

VI. MONITORING AND EVALUATION

Monitoring and evaluation of the JHNP is conducted according to Standard Operating Procedure (SOP) 004 which stipulates collective NGO, Government and UN roles and responsibilities for the collection and review of HMIS data, against a number of indicators, as set out in the JHNP log frame. In addition, the three UN agencies implementing the JHNP also collect reports directly from NGO partners on a monthly basis and quarterly joint monitoring and supervision visits are conducted by the UN and Government. In hard-to-reach areas, third party monitoring is utilised to verify performance of partners against contractual milestones.

On a quarterly basis, the performance of the programme, against its key log frame indicators, is reviewed by the Joint Coordination Unit (JCU) and shared with the technical coordination group (TCG) and all donors, including USAID. Narrative updates are also provided during these briefings.

In 2015, the Government of Sweden commissioned a Mid Term Review of the JHNP. The review involved collection of primary data from numerous field sites, extensive consultations with JHNP stakeholders, as well as analysis of HMIS data. The review concluded that the JHNP was mostly on track to achieve its five-year objectives. The report is available on the JHNP website: www.jhnp.org

VII. RISK MANAGEMENT

The overall risk rating has not changed over the course of the programme. The risk environment is HIGH but remains MEDIUM with the risk mitigation measures adopted (Refer to the JHNP risk register available from the JCU). In addition to risk assessments carried out by the UN agencies, the programme monitors the following risks (impact and probability) on a six-monthly basis: Political; Conflict; Economic; Fiduciary; Corruption; Institutional; Partnership; Behavioural; and Disasters.

All USAID funds are channeled through the UN through parallel financing modalities and the risk of funds not being used as intended has been low. All the three agencies ensure fiduciary safeguards as per their rules and procedures. The JCU also assists the three UN organizations with the development of SOPs which ensure further safeguards.

Programme planning and expenditure reporting processes have helped to have better information of funds requirement and expenditure and also to link activities with the donor disbursement plan. Allocations and revised allocations of all activities are approved by the Steering Committee and expenditure is reported to all partners on a quarterly basis. The final formal expenditure report is shared by UNICEF HQ based on the Financial Information System.

VIII. LESSONS LEARNT AND WAY FORWARD

Working with Partners

EPHS/JHNP is pioneering a Somali-led approach that has enhanced government empowerment in line with the principles of the Somali Compact and New Deal. The governance mechanism at the zonal, technical and strategic level, with participation of all key stakeholders, is a good example of working with partners. This has contributed to greater understanding of the programme, improved coordination and a more inclusive decision-making process, paving the way for increased harmonization of health sector support to the Government. The Somali Health Policy, HSSPs, joint planning process and related coordination support has also led to improved sector-wide coordination, harmonization and alignment.

Programme Management

Key lessons learned during implementation include:

- In a programme led by multiple agencies, strong coherence should be shown by the top leadership, resulting in a positive trickle-down effect on the success of a programme.
- The governance structure of the programme and regular and consistent consultations are key to the success of any programme.
- The focus should be on the following three management areas: i) transparency in the use of resources ii) simple but effective planning mechanism with involvement of stakeholders at different levels and iii) focus on the delivery of results.

Programme Priorities for 2016

While USAID funding to the JHNP has ended, the programme will continue for one final year (2016), during which the following priorities will be taken forward:

- Use the evidence generated in 2015 to develop a future roadmap (HSSPs Phase II) for the health sector in 2016.
- Ensure a prioritization process during the development of new HSSPs along with harmonization with the new National Development Plan.
- Develop an exit strategy or a successor programme while ensuring continuation of services and gains.
- Scale-up community-based integrated essential services, whenever fiscal space is available.
- Prioritise cross-cutting issues including nutrition, WASH and FGM/C in future HSSPs.
- Further strengthen the joint annual planning exercise under the leadership of health authorities and gradually devolve this to the regional level along with strengthening of Regional Health Management Teams (RHMTs).
- Increase advocacy for an early national level survey to generate evidence to review performance and to set realistic milestones for coming years.

Sustainability

USAID's contribution to the JHNP has been used to support critical activities which will continue beyond the lifecycle of this grant.

The Health Sector Strategic Plans II, being drafted in 2016, will define the priorities for the next five years and will build on the successes gained through programmes such as the JHNP, which were aligned to the delivery of the HSSP I. It is clear that the midwifery schools will continue to be one of the flagship programmes of the health authorities and will feature as part of the successor to the JHNP, when it completes in 2016. Likewise, CEmOC and CHW training will continue through the approved universities and training institutes, as a cornerstone of the government's health workforce meeting. FGM/C eradication remains a priority for partners working in Somalia, and community-led abandonment will be sustained by continuing advocacy and community-led dialogue.

EXPRESSION OF THANKS

The Somali Health Authorities (of the Federal Government of Somalia, the Government of Puntland and the Government of Somaliland), the UN agencies (UNICEF, UNFPA and WHO) and the JHNP Joint Coordination Unit wish to thank the Government of the United States for their support to the programme in terms of financial contribution, technical assistance and support to the various JHNP committees and stakeholder groups.

USAID
FROM THE AMERICAN PEOPLE

Together with Somali Health

World Health Organization unicef UNFPA