HHELMS
Humanitarian and Health Evaluation, Learning and Monitoring in Somalia

Evaluation of the Gaashaan Protection Project

Evaluation Report

March 2026

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Oxford Policy Management Limited
Registered in England: 3122495

Ground Floor
40-41 Park End Street
Oxford, OX1 1JD
United Kingdom

Tel: +44 (0) 1865 207 300
Fax: +44 (0) 1865 207 301
Email: admin@opml.co.uk
Website: www.opml.co.uk
Twitter: @OPMglobal
Facebook: @OPMglobal
YouTube: @OPMglobal

Preface and acknowledgements

This evaluation is being carried out by the Humanitarian and Health Evaluation, Learning and Monitoring in Somalia (HHELMS) Consortium, led by Oxford Policy Management, including Consilient Research, New Access International, WorldPop, Laasfort Consultancy Group, and Social Development Direct.

Thanks are due to Gaashaan and the UK Foreign, Commonwealth and Development Office (FCDO) staff for access to information and for comments on an earlier version of this report, as well as to all key informants and participants in focus group discussions.

The report has been prepared by Michelle Spearing, Team Leader; Stephen Jones, Evaluation Adviser; Maureen Murphy, Protection Specialist; Manar Zaki (Consilient), Data Collection Manager; Berglind Bernardsdottir (Consilient), Field Research Manager; Madelyn Haden, Monitoring, Evaluation, and Learning Systems Specialist; and Ashika Sharma, Research Lead. The Project Manager is Mike Wake. Field data collection was undertaken by Consilient research teams.

For further information contact a5507@opml.co.uk. The IATI reference number for the project is GB-GOV-1-300978

Executive summary

Overview of the evaluation

The Gaashaan Protection Project was implemented from November 2023 until its early closure in March 2026. The project sought to deliver sustainable humanitarian response and prevention activities to address protection and gender-based violence (GBV) risks, including through empowering communities, building local organisations' capacity, and promoting gender equality and the protection of civilians.

The Gaashaan evaluation was designed to support learning from experience, to increase the evidence base (for Somalia and globally) around what works to improve protection from GBV and child protection risks, to evaluate the results achieved, and to support adaptive management during implementation through periodic reflections.

The evaluation was designed to have three rounds (initial, interim, and final), to allow progress to be assessed, with an increasing focus on measuring and explaining the results achieved. Primary data collection was undertaken and a draft report prepared for the initial round (which included an initial assessment of the situation in the communities Gaashaan was targeting against the outcome and impact indicators, as well as an assessment of progress on implementation to date) before the decision was taken by the UK Foreign, Commonwealth and Development Office (FCDO) to close the project early. This draft initial report has been edited and supplemented with additional secondary data in order to provide an overall assessment of the project, with a focus on learning to inform a transition to new support arrangements.

The Gaashaan Protection Project

Gaashaan was designed to be implemented over five years, to 2028. It was delivered by a consortium of international and national non-government organisations (NGOs): Save the Children (the project lead); International Rescue Committee; CARE International; Save Somali Women and Children (SSWC); Somali Women and Development Centre (SWDC); Somali Women's Studies Centre (SWSC); and Gargaar Relief and Development Organisation (GREDO). The project also aimed to leverage actions being implemented under the FCDO's Challenging Harmful Attitudes and Norms for Gender Equality and Empowerment in Somalia programme (CHANGES II) in Galkayo South, Baidoa, Holwadag, and Kismayo.

At commencement, Gaashaan aimed to directly benefit 43,756 individuals, including men, women, boys, and girls, with 5% being people with disabilities. Additionally, around 117,200 indirect beneficiaries were to be reached through advocacy and awareness efforts (based on populations in target areas).

The project's expected overall impact was that women, girls, and boys would be better protected against GBV and child abuse, and would receive a high-quality response where needed. The project sought to deliver sustainable humanitarian response and prevention activities to address protection and GBV risks, including through empowering communities

and building local organisations' capacities to reduce sexual violence and GBV and other child protection risks, and to promote gender equality and the protection of civilians.

Gaashaan had four intended outcomes:

1. Provision of quality specialised GBV and child protection services, targeting vulnerable communities affected by humanitarian crises, specifically women, girls, and boys.
2. Enhance the capacities of community members and key stakeholders to prevent, mitigate, and respond to protection risks.
3. Strengthen protection monitoring systems to efficiently trigger responses, and inform and adapt programming for better protection outcomes.
4. Strengthen the capacities of women's rights organisations and grassroots local civil society organisations that are promoting gender equality and the protection of women and girls in humanitarian crises.

During its inception phase (November 2023 to March 2024) phase, Gaashaan responded to displacement, loss of lives, livelihoods, and infrastructure, and increased risk of disease outbreaks caused by flooding and excessive rainfall in late 2023 (compounded by conflict) by prioritising 10 districts and pivoting to emergency response. From April 2024, planned multi-year interventions commenced, with Year 1 activities focused mainly on Outcomes 1 and 2. When early closure was announced in 2025 the project team developed a comprehensive close-out plan, which has been implemented.

Methodology

During inception, the evaluation team reviewed the original theory of change (ToC) and worked with the Gaashaan team to clarify and amend the ToC and to more fully articulate the key causal pathways and the mechanisms by which results were to be achieved. Outcome and impact indicators were also amended to enable more feasible and useful measurement. This subsequently informed development of the evaluation framework.

The research methodology for the evaluation was based on undertaking three rounds of primary data collection. The first (and in the event only) round took place during February/March 2025. This included collecting data through focus group discussions (FGDs) and key informant interviews (KIIs) in a sample of the communities in which Gaashaan was working. This was intended to provide a basis for progress and to provide evidence about contextual factors and issues affecting GBV, child protection, and the implementation of project activities. National-level KIIs were also undertaken, along with a review of project data and documentation; a review of the project's monitoring and evaluation system; and evidence from third-party monitoring (TPM) undertaken by the Humanitarian and Health Evaluation, Learning and Monitoring in Somalia (HHELMS) Consortium.

Findings: relevance

The ToC only partially provided a valid and appropriate framework for the implementation of Gaashaan. The main causal pathways were identified but there was no overall narrative or comprehensive articulation of assumptions, nor were the context or relations between key stakeholders adequately represented.

Gaashaan had systematic processes to identify the needs of those at risk – and survivors – of GBV and child abuse, based on an understanding of GBV and child abuse risks at local levels. This included needs identified through consultation during project design, as well as through structured assessments at local level and regular monitoring in coordination with the wider protection sector. FGD data suggest that community members consider that Gaashaan appropriately identified needs and responded to them, though gaps in service provision remain to be filled.

Gaashaan mapped service provision and community-level support for survivors and those at risk, and worked in coordination with other protection actors to maintain an understanding of capacity gaps over time, though there was variation in how this assessment was carried out at the local level. The project engaged with coordination and monitoring mechanisms that helped it to stay informed of gaps as they emerged, and took these into account when designing and implementing activities. There was evidence of active response to capacity gaps but insufficient data were available to assess the appropriateness and effectiveness of these responses.

Gaashaan had a presence, through staff or partners, in communities where it was implemented, and had, to a good extent, identified the relevant local structures, and gaps and opportunities, relating to responding to GBV and child abuse risks at community level, although this was more challenging in remote and insecure locations.

The project design allowed for advocacy and awareness-raising engagement at the community, sector stakeholder, and national levels. Gaashaan engaged stakeholders at each level and planned to support women's rights organisations in their advocacy efforts but substantive national-level advocacy activities did not place prior to project closure.

The project design recognised the context of recurrent natural disasters and shifting patterns of conflict in Somalia, particularly related to climate change, insecurity, and seasonal inaccessibility. It allowed for the repurposing of funds in contexts of acute crisis to address urgent needs, as seen in the response to El Niño during the inception phase. The project also allowed for regular reflection and adaptation at quarterly intervals. The project successfully used design flexibility to respond to unexpected shocks but there may be scope for developing a crisis modifier mechanism for future interventions.

Findings: coherence

In addition to Gaashaan, several other international organisations, international NGOs, and civil society organisations, were addressing GBV and child protection in Somalia during the period in which the project was being implemented, often through collaborative networks and referral systems. Many related services are provided through government facilities and national and district governments are engaged in the planning, delivery, and monitoring of services. The unexpected and immediate ending of United States Agency for International Development (USAID) programmes has created a major challenge for funding and coordination in the sector.

Humanitarian coordination in Somalia is well established and generally ensures coherence. It includes a Protection Cluster, which consists of international organisations, local and international NGOs, and government. Within this coordination, monitoring and joint needs

assessment on protection issues take place through the GBV Area of Responsibility (AoR) and Child Protection AoR.

Gaashaan was designed explicitly to complement the wider protection sector and humanitarian programming, as it sought to build capacities across a range of services and community mechanisms. Gaashaan was strongly integrated into the coordination mechanisms and, as such, was well placed to fill gaps and to complement the activities of other actors. However, the sudden and unexpected cessation of USAID funding undermined coordination and reduced available protection services. While it is too early to determine the full impact of cuts, it presents additional challenges to the maintenance of coherence as the footprint of wider humanitarian programming changes.

Findings: effectiveness

Outcome 1: Data collected from FGDs in sampled locations suggest moderate to good availability of services in most locations, with significantly lower availability in a handful of remote locations. Where services do exist, all communities noted barriers to accessibility (such as distance or cost), as well as limited acceptability (i.e. whether services are seen as acceptable to use).

Across most communities, respondents noted improvements in service availability, and many attributed these improvements to the Gaashaan project. National stakeholders emphasised the results of capacity building to address GBV case management. Informants also noted that Gaashaan had reduced barriers to reporting GBV. There was also evidence of positive changes in child protection in their communities over the past year, often linked to Gaashaan-supported activities, related to increased awareness, better access to services, and shifts in community behaviour. The closure of referral systems and projects previously funded by USAID increased demand for Gaashaan to provide services, while forcing an end to planned coordination.

Outcome 2: The presence of community mechanisms (as perceived by participants in community FGDs) to prevent, mitigate, and respond to GBV and child abuse vary across locations, with remote locations scoring particularly low. Protection structures exist in most locations, and some received capacity-building support from Gaashaan, but these mechanisms could be further strengthened in most cases.

Gaashaan focused on capacity building and awareness raising in communities and worked with existing community structures to ensure timely support to survivors, though physical safety constraints (e.g. shelters, improved lighting, latrines) were not addressed in general. The fact that some other programmes provide monetary incentives to community groups while Gaashaan did not was a potential source of tension, while some informants believe the project did not do enough to support the economic empowerment of vulnerable women.

Outcome 3: Protection monitoring arrangements within the context of GBV and child protection in Somalia involve a multifaceted approach, combining formal and informal systems, with a growing emphasis on data utilisation and integration with early warning systems. These arrangements aim to trigger effective responses and ensure better protection outcomes for women and children. At the local government level, there are varying degrees of formalised reporting structures. Current efforts to strengthen the capacity

of local actors to collect and use monitoring data for GBV and child protection interventions are reported to be limited.

Outcome 4: The baseline capacity of women's and girls' groups, civil society actors, and platforms to advocate for the protection of women and children, particularly regarding GBV and child protection, varies across Somalia. While some groups exhibit strong capabilities and influence, others face significant limitations in funding, technical skills, and access to national platforms. Gaashaan intended to enhance this capacity and collective action for social change and policy reforms that promote gender equality and civilian protection, but at the time of its closure it had not reached the stage of carrying out a structured baseline assessment of capacity.

Findings: efficiency

Sufficient data were collected by the project to enable in principle the assessment of the cost efficiency of the delivery of outputs (e.g. cost per number of people and communities supported). Assessing cost effectiveness would have required measurement of outcomes and impact and the allocation of costs to results at these levels.

Gaashaan's monitoring, evaluation, accountability, and learning (MEAL) framework was comprehensive and detailed and its monitoring system included tools that should have both supported accountability and enabled adaptive implementation based on emerging lessons and needs. These included quality benchmark monitoring, work breakdown structure, data quality assessments, and an action tracker. The monitoring, evaluation, and learning (MEL) systems review conducted for the evaluation found that these tools were only partially used to guide project implementation.

Findings: impact

The safeguarding provisions put in place by Gaashaan appear to have been strong and appropriate, encouraging both mitigating measures to reduce risks and effective responses where risks arise.

Before project closure, there was early positive evidence of impact in terms of improved protection and reduced risks. Risks of violence against women and girls (VAWG) were reported to have been reduced over the past year, with this decline largely attributed by community members to increased awareness activities, improved community mobilisation, and the presence of programmes like Gaashaan. Similarly, most community leaders considered that child protection risks have decreased over the past year, although in a few locations risks have remained constant or become worse.

Findings: sustainability

Gaashaan's strategy for sustainability was based on using its five-year time frame, and independence from other programmes, to focus on building institutional as well as community capacities. This was intended to be achieved through working with and through government-led services, and existing community mechanisms enhanced the sustainability of the approach. However, current funding crises within Somalia, together with shifting aid

priorities globally, increased the challenges for sustainable capacity building as other forms of support were reduced. The early termination of the project has limited even further the prospects for sustainability. However, the project team developed a sustainability plan as part of the project close-out arrangements.

Conclusions

Project achievements

There is evidence that Gaashaan made some progress towards achieving results towards Outcomes 1 and 2 in the areas where it was working, and there is evidence of progress towards the expected impact. Most communities reported perceptions of reduced risks of VAWG, and improved child protection, over the period of implementation, and attributed this to increased awareness, community mobilisation, and the presence of projects and programmes, including Gaashaan. There is widespread recognition among communities that service availability and access have improved over the past year, with many directly attributing these positive changes to the Gaashaan project. Gaashaan is considered by community members to have made contributions to strengthening community mechanisms to address GBV and improve child protection – though achievement varies across locations. The project also actively addressed supply-side barriers. A strong belief exists among stakeholders that communities took ownership of the project's initiatives, viewing them as inherently theirs rather than external interventions.

What worked well?

The evaluation found that the following aspects of Gaashaan’s operations appeared, in general, to have worked well:

1. The identification of those at risk and the tailoring of responses to meet their needs.
2. The mapping of service provision and community-level support for survivors and those at risk.
3. Ensuring effective safeguarding procedures and practices.
4. The establishment of a local presence in communities and developing effective collaboration with both formal structures (e.g. health system) and community structures (including with internally displaced persons (IDPs)), though this was more challenging in remote areas.
5. Gaashaan's design incorporated provisions for the complex and changing Somali context, including its ability to respond to acute crises.
6. Referral systems are generally well established and routinely updated, ensuring survivors can access a full range of services, which has been particularly crucial in the wake of USAID funding cuts.
7. Working in a coherent and complementary way with other initiatives and through humanitarian coordination mechanisms.
8. Providing capacity building and awareness raising in communities.
9. Gaashaan undertook significant capacity-building activities with specialist service providers, particularly those in health clinics. Training for health staff on clinical

management of rape, and for GBV focal points and community health workers on case identification, confidentiality, and safe referrals, led to improved technical capacity and better care for survivors.

What needed improvement?

The evaluation identified the following areas where improvement was needed (with recommendations related to each of these set out in the following section):

1. The evaluation found that while the ToC was valid, it lacked a fully articulated narrative and specific assumptions related to key causal pathways.
2. While Gaashaan mapped service provision and engaged with mechanisms to stay informed of gaps, the evaluation noted that not all sites were equally strong in reporting on capacity needs identification. A more systematic approach to identifying and documenting these gaps across all locations would have allowed Gaashaan to tailor its capacity-building and response activities to the needs of different communities and service providers. Further, it would have been useful to standardise approaches to capacity mapping to enhance coherence across organisations and across locations.
3. The evaluation highlighted instances where local government requests or practices, such as mandatory reporting of GBV cases, did not align with international best practices regarding confidentiality and survivor-centred approaches.
4. The evaluation noted that while Gaashaan targeted hard-to-reach areas, there are still significant gaps in scaling up outreach to pastoralist or nomadic communities who are constantly on the move and lack a permanent protection presence.
5. The widespread funding cuts, particularly from USAID, have severely impacted the availability of protection services across Somalia, leading to a dramatic reduction in service providers and raising concerns about unmet needs and the sustainability of remaining services.
6. While the project's MEAL framework was deemed appropriate for guiding project implementation, MEAL tools were only partially being used to guide project implementation.
7. Integration of government and community structures remains weak.
8. Given the predictability of recurring crises in Somalia and the impact of funding cuts on service provision, future programmes should include a crisis modifier mechanism with a contingent annual budget to ensure immediate support during emergencies and to maintain service continuity.
9. While coordination is generally strong, differing approaches/tools utilised by various NGOs can cause confusion in the community. Future programming should involve advocacy for greater harmonisation among operational agencies and actively work to improve clarity on who offers which services and ensure proactive communication.

Lessons

The following lessons emerge from the project's experience up to its closure:

1. Flexibility to respond to emergencies is crucial in order to address the vulnerabilities faced by women and children.
2. Leveraging existing local presence can support access and operations in hard-to-reach and high-risk areas.
3. A community-centred approach fosters ownership.
4. Robust monitoring and evaluation systems are of vital importance to protection systems.
5. Strong coordination with government and the protection cluster is key.

Recommendations

FCDO should consider the following recommendations in future protection programming:

1. Expand and refine the ToC for the intervention.
2. Systematise the identification of capacity gaps.
3. Strengthen engagement with local governments.
4. Enhance interventions for hard-to-reach populations.
5. Address sustainability in light of funding cuts.
6. Enhance data utilisation for adaptive management.
7. Enhance the integration of community and formal systems.
8. Plan for recurrent crises.

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List of abbreviations

AoR	Area of Responsibility
BEM	British Embassy Mogadishu
CAAFAG	Children associated with armed forces and armed groups
CPIMS+	Child Protection Information Management System Plus
FCDO	UK Foreign, Commonwealth and Development Office
FGD	Focus group discussion
FGM/C	Female genital mutilation/cutting
FGS	Federal Government of Somalia
FMS	Federal Member State
FS-EWEA	Food security early warning early action
GBV	Gender-based violence
GBVIMS	Gender-based Violence Information Management System
GREDO	Gargaar Relief and Development Organisation
HARBS	Humanitarian Assistance and Resilience Building in Somalia
HHELMS	Humanitarian and Health Evaluation, Learning and Monitoring in Somalia
IDPs	Internally displaced persons
IRC	International Rescue Committee
KII	Key informant interview
MEAL	Monitoring, evaluation, accountability, and learning
MEL	Monitoring, evaluation, and learning
MHPSS	Mental health and psychosocial support
NGOs	Non-government organisations
PEP	Post-exposure prophylaxis
SEAH	Sexual exploitation, abuse, and harassment
SSWC	Somali Women and Children Care
SWDC	Somali Women and Development Centre
SWSC	Somali Women's Studies Centre

ToC	Theory of change
ToRs	Terms of reference
UASC	Unaccompanied and separated children
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAWG	Violence against women and girls

1 Introduction

1.1 The Gaashaan Protection Project

The Gaashaan Protection Project is a standalone, flexible protection programme for Somalia. Gaashaan (meaning 'shield' in Somali) seeks to deliver sustainable humanitarian response and prevention activities to address child protection and GBV risks, including through empowering communities and building local organisations' capacities, and it also seeks to promote gender equality and the protection of civilians. Funded by FCDO, Gaashaan is delivered by a consortium of international and national NGOs. Save the Children serves as the lead partner, and contributions also come from the following: the International Rescue Committee (IRC); CARE International; SSWC; SWDC; SWSC; and GREDO. Each member of the consortium has a presence within targeted regions in Somalia and implements diverse multi-sectoral initiatives which Gaashaan leverages and complements. The project further builds upon interventions under the CHANGES II project, which took place in Galkayo South, Baidoa, Holwadag, and Kismayo.[1]

Gaashaan was designed as a five-year intervention that was expected to run from 2023 to 2028 and has been implemented since November 2023. Gaashaan is being terminated early and will now end on 31 March 2026. This reflects a strategic decision by FCDO, which seeks to redirect resources towards integrated multi-sectoral programmes that aim to create a more holistic approach, rather than funding standalone protection projects. This is taking place in the context of a significant reduction in aid across the humanitarian sector both globally and in Somalia.

Further details about the implementation of the project are included in Chapter 3.

1.2 Purpose, objectives, and scope of the evaluation

A three-phase evaluation process was designed to run alongside the implementation of the project, allowing the evaluation team to assess progress towards its intended results and to identify lessons at three points, initially during year one of implementation and subsequently at mid-point and on project completion. The evaluation terms of reference (ToRs) stated that the evaluation would have four **purposes**:

1. Learning: To process and reflect on the information generated from monitoring and evaluations (and from any other evidence-generating activities) and use it to continuously improve the project's ability to achieve results; in effect, to maximise the project's effectiveness and efficiency, and the sustainability of its impact.
2. To increase the evidence base around 'what works' to better protect women, girls, boys, and men from GBV and the various child protection risks among communities impacted by humanitarian crises in Somalia.
3. Accountability: While the focus is primarily on learning, assessment of whether the project is contributing to outcomes will also support accountability to the UK public and to the Somali people.

[1] See https://somaliwomensc.org/projects/changes-ii-project/

4. Strengthening the global evidence base on what works to address and prevent GBV in emergencies.

The evaluation inception report defined **six objectives** for the evaluation:[2]

1. To undertake a baseline assessment of the quality and availability of GBV and child protection services, and of the capacity of community-based protection structures and advocacy organisations.
2. To test the validity of the key assumptions of Gaashaan's ToC during the implementation period.
3. To evaluate effectiveness: the extent to which intended outcomes have been achieved.
4. To assess the extent to which the project is on course to achieve impact (at midline) and has achieved impact (by endline).
5. To determine the cost effectiveness of the intervention approaches used.
6. To review and advise on the development of the implementing partners' monitoring systems.

This report was originally drafted as the initial evaluation report, providing in part a baseline assessment (during early implementation) against which future progress would be assessed. As a result of the early closure of the project, no further rounds of evaluation will take place and this report has been adapted to provide an evaluation assessment of implementation to date, and to focus on lessons and recommendations that can guide future interventions in support of protection and to address GBV.

The **scope** of the evaluation covers all activities undertaken by the project during its period of implementation after the completion of the inception phase (from April 2024). The evaluation has not assessed the humanitarian interventions undertaken during the inception phase (see Section 3.4).

1.3 Stakeholder engagement

The primary **stakeholders** of the evaluation are FCDO and the Gaashaan consortium implementation team, and the secondary stakeholders include the wider humanitarian sector in Somalia, as well as donors and the Somali authorities (see Table 1). Primary stakeholders reviewed an earlier version of this report and the comments received have been addressed in the process of finalising the report. The evaluation report will be used by FCDO to support government and other stakeholders in the design of future interventions, including through presentation at a planned Gaashaan learning event.

[2] As agreed in the inception report, the list of objectives set out in the ToRs was consolidated and simplified.

Table 1: Primary and secondary evaluation stakeholders

Primary stakeholders
Staff of Gaashaan consortium: Save the Children, IRC, CARE, GREDO, SWSC, SWDC, and SSWC
Staff of British Embassy Mogadishu (BEM)
Secondary stakeholders
Staff from United Nations agencies and NGOs from the Protection Cluster and its AoRs
The various international donors funding protection
Staff of relevant federal ministries that oversee women's, girl's, children's, and gender priorities
Regional Cluster Coordinators – United Nations and others
District-level relevant authorities
Staff of Gaashaan consortium based in sub-national coordination offices
Ministry of Health staff at health facilities delivering Gaashaan's interventions
The management staff of one-stop centres and safe shelters
Organisations included in referral pathways
Community leaders – categories include religious leaders, camp leaders, women leaders, etc.
Community members in Gaashaan project locations
Staff of the Ministry of Family and Human Rights Development

In addition, in order to contribute to strengthening the global evidence base, an evaluation summary report will be produced for researchers, international development organisations, and non-government and civil society organisations engaged with GBV and child protection.

1.4 Overview of the evaluation

1.4.1 Approach to the evaluation

The initial evaluation assessed the project's design and early implementation, and provided a quasi-baseline against which to assess changes during the lifetime of Gaashaan.[3] It drew on work done during the evaluation inception period, which included a review of Gaashaan's ToC, a literature review, work to interrogate and revise outcome and impact indicators in the Gaashaan results framework, and a review of Gaashaan's own MEL system.

Primary data were collected from a sample of communities (project locations) and from national staff and other stakeholders. Secondary data from Gaashaan's own reporting system were also used. Community-level data collection took place in February–March 2025 and was followed by interviews with national-level key informants in March–April 2025. Data analysis was completed in May 2025. A draft of the evaluation report was submitted in July 2025 and was revised based on comments received including from FCDO's EQUALS evaluation review.

[3] Recognising that at the time of the initial evaluation, the project was one year into implementation and had therefore already effected some changes.

Further revision has taken place following announcement of the early closure of Gaashaan. This has included the incorporation of updated evidence from Gaashaan's reporting system, as well as data from the 2025 TPM report undertaken since the evaluation's primary data collection.

Further details on the methodology are provided in Chapter 4 and in Annex E.

1.5 Structure of the report

The remainder of this evaluation report is structured as follows. Chapter 2 describes the context for GBV and child protection in Somalia. Chapter 3 provides more details about the Gaashaan Protection Project, including its ToC, results framework, and implementation progress. Chapter 44 explains the methodology of the evaluation. The findings of the evaluation are presented in the following chapters against each high-level evaluation criterion. Chapters 55 through 10, respectively, present the findings on relevance, coherence, effectiveness, efficiency, impact, and sustainability. The conclusions of the evaluation are in Chapter 11 and the lessons and recommendations in Chapter 12.

Additional information is presented in the annexes. Annex A contains the ToRs for the evaluation. Annex B presents and discusses Gaashaan's ToC. Annex C lists Gaashaan's impact and outcome statements and indicators. Annex D sets out the evaluation framework as intended forr the initial evaluation. Annex E provides details on the methodology for the location-based data collection, which provides the baseline for subsequent impact and outcome comparisons. Annex F then presents the baseline assessment against impact and outcome indicators derived from community-level data collection in a sample of Gaashaan's operating locations. Annex G contains the interview guides for the KIIs and FGDs for the location-based data collection, and questionnaires for national-level KIIs.

2 The context: GBV and child protection in Somalia

2.1 GBV in Somalia

GBV affecting women and girls in Somalia remains underreported but widespread. The main GBV concerns in Somalia identified by the project are as follows: rape and sexual assault; domestic violence/intimate partner violence; psychological and emotional abuse; and female genital mutilation/cutting (FGM/C).[4] According to the latest Demographic and Health Survey, in 2020, 15% of ever married women aged 15–49 had experienced physical, sexual, or emotional intimate partner violence in their life time. Child, early, and forced marriage are also common, with 34% of women married by the age of 18 and 16% married by the age of 15.[5] Almost all women (99%) throughout the country experience FGM/C.[6]

Gender inequality, societal power imbalances, and a weakly functioning justice system that leads to a culture of impunity all contribute to an inadequate protection environment that leaves women and girls highly exposed to GBV. Somalia is considered one of most unequal countries in the world in terms of gender equality (ranking 0.7776 in an index in which 1 is being totally unequal).[7] Customs, traditions, and religious beliefs reinforce traditional gender roles that put women and girls at risk of experiencing GBV.[8] Women and girls' risk of experiencing GBV is further increased by other intersecting inequalities which further reduce their power and safety (e.g. education, poverty, family structure, minority clan status, employment status, disability, age).[9]

Somalia has also faced decades of armed conflict, including the insurgency led by Al-Shabaab (the Sunni Islamist militant and political movement based in Somalia). This extended conflict, and the consequent widespread displacement of populations, affects women and girls' risk of GBV. For example, internal monitoring systems such as the Somalia Protection Monitoring System have documented that IDPs are particularly at risk of experiencing GBV, such as sexual violence. Regions that host the highest number of IDPs (Bay, Bakool, and Banadir) also report higher rates of sexual violence against children and women. Research has also documented how women and girls who are displaced are also more likely to experience intimate partner violence.[10]

A weak rule of law and a culture of impunity affect the ability of women and girls to access support services after experiencing violence. Many cases of GBV are not reported and

[4] Typology of harms provided by Gaashaan.
[5] Somalia Demographic and Health Survey, 2020.
[6] *Ibid*.
[7] https://www.undp.org/somalia/our-focus/genderequality#:~:text=Gender%20equality%20and%20women's%20empowerment%20are%20among%20the%20major%20challenges,of%201%20denotes%20complete%20inequality).
[8] Save the Children (2024) 'Report on Gender and GBV Analysis in Somalia/Somaliland'.
[9] *Ibid*.; UNFPA (2022) 'Overview of Gender-based Violence Situation in Somalia'; Dahie, H. A., Dakane, M. M., and Hassan, B. S. (2023) 'Prevalence, patterns, and determinants of gender-based violence among women and girls in IDP camps, Mogadishu-Somalia', *Journal of Migration and Health* 8, p. 100193; Wirtz, A. L., Perrin, N. A., Desgroppes, A., Phipps, V., Abdi, A. A., Ross, B. *et al.* (2018) 'Lifetime prevalence, correlates and health consequences of gender-based violence victimisation and perpetration among men and women in Somalia', *BMJ Global Health* 3(4), p. e000773. https://doi.org/10.1136/bmjgh-2018-000773
[10] Wirtz, A. L. *et al.* (2018) 'Lifetime prevalence, correlates and health consequences of gender-based violence victimisation and perpetration among men and women in Somalia', *BMJ global health* 3(4), p. e000773. https://doi.org/10.1136/bmjgh-2018-000773

remain unaddressed as women and girls do not seek help when they experience violence due to fear of stigma or being ostracised by families or communities, as well as fearing that they will experience divorce, forced marriage, or barriers to getting married. The predominance of the clan system (*xeer)* in the adjudication of cases of GBV perpetuates patriarchal systems and disadvantages female survivors. This occurs in a situation in which male relatives often receive compensation from the perpetrator in cases of sexual violence and in which cases of intimate partner violence focus on mediation and maintenance of the family unit rather than justice for the survivor. Additionally, some GBV survivors are not aware of services and formal structures for recourse. While a failure to seek help in relation to GBV cases is common among all women and girls, there is an even higher prevalence of non-reporting for women with disabilities, who face additional discrimination and barriers to accessing services. Since women and girls with disabilities are frequently excluded from social and cultural participation, they often lack necessary social and legal interpersonal support. A lack of financial resources, the absence of transport, and stigma/discrimination are additional barriers that GBV survivors with disabilities face in accessing services. Service providers also often have a limited understanding of disability and of how to provide inclusive services.[11]

The Somali Government at national and federal levels plays a role in GBV service provision, coordination, and advocacy and awareness raising. Government ministries (e.g. the Ministry of Family and Human Rights Development and the Ministry of Health) are mandated to address GBV and child protection. The government also plays a role in service provision, particularly through health facilities, and security and justice, though challenges exist due to weaknesses in the state and federal system. The Ministry of Family and Human Rights Development has dedicated staff, including case workers and a gender focal person, who are involved in case management once a case is identified. Government representatives also attend sector coordination meetings, and participate in project activities like trainings, official openings, action plan development, service assessments, and validations. Where they are available, police gender desks are also key to reporting GBV cases. Government ministries are also involved in organising activities for international days such as the International Day of the Child, International Women's Day, and 16 Days of Activism Against GBV.

Since Gaashaan started implementation there have been major changes in the aid landscape. In January 2025, USAID issued a stop work order for the vast majority of its programming, only allowing a limited number of 'lifesaving' interventions to continue. Gender-focused work was explicitly excluded from these waivers.[12] Historically, the US Government has been one of the largest humanitarian donors for GBV programming, and nearly US$ 400 million in GBV programming has been terminated globally since the stop work order came into place.[13] After these funding award terminations came into force, only two awards that focused on GBV in emergencies remained, decimating a sector globally where one-quarter of the funding had come from the US prior to January 2025.[14] These cuts,

[11] Somalia Protection Cluster updates.
[12] Women's Refugee Commission (2025) 'Unfunded and Unsafe: How US Aid cuts are threatening gender-based violence prevention and response in humanitarian crises', https://www.womensrefugeecommission.org/wp-content/uploads/2025/06/How-US-Aid-Cuts-Are-Threatening-GBV-Prevention-and-Response.pdf
[13] *Ibid.*
[14] *Ibid.*

together with a broader roll-back of support for women's rights, have particularly affected support for local women's rights organisations in Somalia.[15]

2.2 Child protection risks in Somalia

The main child protection concerns identified by the Gaashaan project are as follows: child separation; child recruitment by armed groups; child labour; physical and sexual violence; early marriage; and neglect and lack of access to basic services. Heightened child protection risks during humanitarian crises in south-central Somalia include sexual violence and GBV, recruitment and use of children in armed conflicts, unaccompanied and separated children (UASC) due to displacement and family separation, and mental health and psychosocial distress of children and caregivers[16] resulting from the effects of conflict or climate shocks. Additionally, displacement can reduce children's access to basic services such as education. The Somalia Protection Monitoring System recorded an increase in protection risks, including family separations and child recruitment, affecting children, for the period January to June 2023.[17]

For decades, Somalia has grappled with the issue of grave violations of the rights of children, including the recruitment of children into armed groups. The 2024 UN Secretary-General's report on children and armed conflict[18] recorded that Somalia had some of the highest number of verified violations against children (2,568) in the world at that time. 768 children (726 boys and 42 girls) were recruited into armed groups, the vast majority into Al-Shabaab (643). Conflict-related sexual violence was verified as being perpetrated against 267 children (265 girls, two boys). 887 children (731 boys and 156 girls) were abducted during this period: the vast majority by Al-Shabaab (850). Attacks on schools (36 in 2024) were also common, directly affecting the safety and wellbeing of children.

While Al-Shabaab accounts for by far the largest share of child recruitment into armed groups, state forces, regional forces, clan militias, and even external armed groups are also implicated in child recruitment. Children's roles vary from combat duties to support roles. Girls often face forced marriages and sexual violence, with related health challenges and stigmatisation. 85% of verified recruitment cases involve boys, but girls are disproportionately subjected to sexual violence and GBV, constituting 98% of such cases. While monitoring mechanisms exist, gaps persist in addressing children associated with armed forces and armed groups (CAAFAG), including limited community outreach, weak implementation of legal frameworks, weak coordination mechanisms, and limited inclusion of local stakeholders. The ongoing military offensive in Al-Shabaab-controlled areas in Galmudug State, and beyond, is a key driver of displacement and increased GBV and child protection risks for affected populations, including CAAFAG.

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[15] UN Women (2025) 'At a breaking point: The impact of foreign aid cuts on women's organizations in humanitarian crises worldwide'.
16 'Somalia Child Protection Area of Responsibility (CP AoR) Mid-Year Bulletin, January–June 2023'. https://reliefweb.int/report/somalia/somalia-child-protection-area-responsibility-response-monitoring-dashboard-january-july-2023-31-july-2023
17 Based on the latest publicly available data online.
18 https://digitallibrary.un.org/record/4084012?ln=en&v=pdf

3 The Gaashaan Protection Project

3.1 Gaashaan project objectives

The overarching impact envisaged by the Gaashaan project is better protection of women, girls, and boys from GBV and child abuse, coupled with the assurance of a high-quality response when intervention is required. The project seeks to deliver sustainable humanitarian response and prevention activities to address protection and GBV risks, including through empowering communities and building local organisations' capacities to reduce GBV and other child protection risks. This is to be complemented by efforts to advance gender equality and safeguard civilians.

The Gaashaan project has four intended outcomes:

1. Provide quality specialised GBV and child protection services, targeting vulnerable communities affected by humanitarian crises – specifically women, girls, and boys.
2. Enhance the capacities of community members and key stakeholders to prevent, mitigate, and respond to protection risks.
3. Strengthen protection monitoring systems to efficiently trigger response, and inform and adapt programming for better protection outcomes.
4. Strengthen the capacities of women's rights organisations and grassroot local civil society organisations promoting gender equality and the protection of women and girls in humanitarian crises.

At the start of implementation, Gaashaan aimed to directly benefit 43,756 individuals, including men, women, boys, and girls, with 5% being people with disabilities. Additionally, around 117,200 indirect beneficiaries are expected to be reached through advocacy and awareness efforts (based on populations in target areas). Gaashaan prioritises areas facing high humanitarian needs, compounded by conflict and climate-related shocks. The focus includes addressing risks of GBV and abuse, exacerbated by the impact of a five-season drought and potential flooding due to El Niño.

During the evaluation inception phase, the evaluation team collaborated with Gaashaan to revise project indicators, ensuring they meaningfully reflect change while remaining measurable amid conflict-affected conditions. This process prioritised feasibility and adhered to ethical standards in conducting GBV and child protection research, emphasising principles such as participant safety, confidentiality, and applying a 'do no harm' approach. The full set of indicators and planned activities is set out in Annex C.

3.2 Gaashaan's Theory of Change

During inception, the evaluation team reviewed the original ToC (see Figure 1 in Annex B). The review noted that there was no fully articulated narrative to support the ToC and that key assumptions related to each causal pathway had not been specified. The evaluation team worked with Gaashaan to develop a more complete articulation of the key causal pathways and the mechanisms by which results are to be achieved. A set of key assumptions relating to each outcome is set out in Annex B.3.3.

A summary of the assessment of the ToC is provided in Section 5.1.

3.3 Gaashaan's geographical focus

3.3.1 Basis for selecting target districts

Somalia can be characterised as experiencing complex, protracted crises, with conflict and high security risks, and ongoing humanitarian needs, exacerbated by regular cycles of drought, flooding, and food insecurity. The Somalia National Bureau of Statistics estimates that there are 2,967,500 IDPs across the country. The target districts for Gaashaan have been prioritised as they experience consistently high levels of humanitarian needs and face the compounding effects of conflict and climate-related shocks and stressors, making populations vulnerable to GBV and abuse. These districts were among the priority locations in the 2023 Somalia Humanitarian Response Plan due to the magnitude and severity of humanitarian needs.

3.3.2 Gaashaan's geographical focus

Gaashaan's interventions are tailored and layered within three categories of implementation for the different locations, as follows:

Category 1 locations comprise five remote and hard-to-reach districts (Wajid, Elbarde, Hudur, Dinsoor, and Mataban), with implementation focusing initially on towns/cities in these areas. Implementation focuses on response activities (Outcome 1), with fewer prevention activities (Outcome 2) due to the sensitivity of GBV and prevention topics in these areas and associated risks for project staff and beneficiaries.

Category 2 locations: implementation occurs both within and outside towns/cities (specifically in IDP camps located outside of towns). All activities across the four outcomes should be implemented in Category 2 locations.

Category 3 locations comprise political centres or capitals. In these locations, the project engages and coordinates with the relevant line ministries that are involved in project implementation and joint monitoring. All activities across the four outcomes will be implemented over time in Category 3 locations.

Table 2 summarises how many rural, urban, and IDP/returnee sites are covered by Gaashaan in districts where it operates.

Table 2: Coverage of Gaashaan across districts

District	Number of communities/sites			
	Rural	Urban	IDP/returnees	TOTAL
Category 1 – remote and hard to reach				
Wajid			4	4
Hudur			3	3
Elbarde			3	3

Dinsoor			4	4
Mataban			4	4
Categories 2 and 3				
Adaado	1	1		2
Dhusa Mareb	1			1
South Galkayo	3	3	1	7
Daynile		3	1	4
Howlwadaag		3	1	4
Kismayo	3	2	1	6
Dhoobley		1	2	3
Afmadhow		1		1
Dollow			3	3
Beled Hawo			2	2
Baidoa			5	5
Beledweyn			6	6
Jowhar			5	5

The project seeks to target **hard-to-reach areas in south-central Somalia** which lack/have low provision for protection and GBV services, **across 18 districts in nine regions across Somalia**: Bakool (Hudur, Wajid, and Elbarde districts); Banadir (Daynile and Howlwadaag districts); Bay (Baidoa and Dinsoor districts); Galgaduud (Adaado and Dhusa Mareeb districts); Gedo (Beled Hawo and Dolow districts); Hiraan (Beledweyn and Mataban districts); Lower Juba (Kismayo, Afmadhow, and Dhoobley districts); Middle Shabelle (Jowhar district); Mudug (South Galkayo district).

The target districts have consistently **high levels of humanitarian needs** and face the compounding effects of conflict and climate-related shocks and stressors, making populations vulnerable to GBV and abuse. These districts are among the priority locations in the 2023 Somalia Humanitarian Response Plan due to the magnitude and severity of humanitarian needs. The Somalia National Bureau of Statistics also estimates that there are 2,967,500 IDPs across the country, 2 million of whom reside within **Banadir, Hirshabelle, Galmudug, Jubaland, and Southwest states.**

Minority groups (including Eyle, Tumaal, Gaboye, Jareer, Arabs, and Bantu clans) in humanitarian priority areas face additional protection risks and barriers to prevention and response due to social norms around clan-based identity and hierarchical power dynamics, resulting in systematic exclusion from protection systems due to their limited power within the dominant clan system within Somalia.

Throughout implementation, the security environment in some of the project locations has remained volatile, characterised by persistent threats from Al-Shabaab, escalating clan conflicts, increasing diplomatic tensions, economic challenges, social unrest, and other significant security concerns.

3.4 Humanitarian pivot during the inception phase

The project's **inception period** lasted from October 2023 to March 2024. The effects of **El Niño** during the October to December short rainy season in 2023 resulted in **excess rainfall and flooding** along the main rivers, the Juba and Shabelle. This resulted in population displacement, loss of lives, livelihoods, and infrastructure, and increased risk of disease outbreaks. Due to the projected worsening of the humanitarian situation in these hotspot areas, with the effects of floods compounded by conflict, **Gaashaan adapted plans during inception and the first year of implementation to prioritise 10 districts**: Howlwadaag, Daynile, Beledweyn, Jowhar, Baidoa, Kismayo, Afmadhow, Dhusa Mareeb, Dollow, and South Galkayo. During this first six-month phase, Gaashaan reached about 5,000 women and children directly impacted by severe flooding in 10 of the 18 most flood-affected project districts, providing them with general emergency supplies to reduce their vulnerability.

3.5 Year 1 implementation activities

From April 2024 (Year 1 of implementation), previously planned multi-year interventions commenced. These have included the following (noting that no activities in relation to Outcome 4 had been undertaken during Year 1 and only one activity for Outcome 3 had been undertaken):

Outcome 1:[19]

- Dissemination of information on referral pathways at community level and national GBV AoR and Child Protection AoR to ensure that all relevant stakeholders had access to updated documentation.
- A toll-free hotline (number 9997) introduced by GREDO, in partnership with Save the Children International, providing support six days a week and allowing survivors to disclose their experiences without fear of exposure or retribution, addressing a critical need in the community.
- Doctors, nurses, and midwives trained on clinical management of rape.
- Training of community health workers on GBV core concepts and basic principles, and psychological first aid.
- Rooms established and made operational in supported health centres in some locations, with ongoing rehabilitation and construction in other locations.
- Case management service providers trained on standardised GBV support, UASC care, CAAFAG, and family tracing and reunification.
- Distribution of dignity kits to vulnerable women and girls.

[19] Gaashaan has reported (see the Gaashaan Year 2 Quarter 2 Narrative Report) that it has developed updated, comprehensive referral pathways, enabling streamlined access to medical, legal, psychosocial, and reunification support for over 200 GBV and child protection survivors, including children. The report states that the consortium members continue to use the referral pathway established and developed in Year 1 of the project, which were reported as active and functional in all project target districts. The referral pathways enhance access to child protection and GBV services, including by strengthening integrated responses with other services in each district, such as nutrition and health.

- Foster care families in IDP camps trained, and alternative care families supported.

Outcome 2:

- Engagement of community members, including Child Welfare Committees, in identifying child protection and UASC cases and reporting them to the consortium's members.

Outcome 3:

- Training of service providers on the GBV Information Management System (GBVIMS) and Child Protection Information Management System Plus (CPIMS+).

3.6 Project close-out

FCDO decided in mid-2025 that the project should close with effect from 31 March 2026. This reflected a strategic decision to reduce funding and redirect resources towards integrated multi-sectoral programmes, rather than funding standalone protection projects. Gaashaan's Year 3 Quarter 1 report noted that:

> '*This decision, while understood within the larger context of funding reallocations, poses significant challenges for the communities and partners who have been integral to Gaashaan's protection efforts. The implications of this early closure are profound, particularly for the vulnerable populations, including women, girls, and marginalised groups, who rely on the program for essential support.*'

The project team responded to the closure by developing a comprehensive close-out workplan to guide the final phase of the programme's implementation, with a view to ensuring that all critical activities are completed efficiently and with minimal disruption to services. This includes a sustainability plan:

> '*This plan focuses on strengthening the capacities of local partners and community structures, empowering them to maintain essential protection services even after the program has ended. fostering resilience within these communities, so they can continue to care for and protect those most at risk.*'

The Year 3 Quarter 1 report also noted that:

> '*A comprehensive handover process is being implemented to facilitate the transfer of knowledge, facilities, and resources to relevant government institutions and local organisations. This transition aims to ensure that the thrust gained through the Gaashaan Program continues, supporting the ongoing safety, dignity, and empowerment of women, girls, and other vulnerable groups who have benefited from the program.*'

4 Evaluation methodology

4.1 Evaluation questions

During the inception phase, evaluation questions were developed that draw on the evaluation objectives set out in the ToRs (see Annex A.2.3) and discussions with BEM, the Gaashaan project team, and evaluation Steering Committee members. The evaluation framework for the initial evaluation (showing the sources of evidence used to answer each evaluation question) is provided in Annex D.

4.2 Location studies

As described in the introduction, this evaluation was intended to be the first of three rounds across which progress towards the achievement of the project's intended outcomes and impact could be assessed. It was also intended to provide opportunities for reflection and to identify lessons. A key source of evidence to assess progress was intended to be provided by **location studies** involving the collection of data from focus groups and key informants in a sample of the communities where Gaashaan is working. The details of the location study methodology are set out in Annex E, including the ethics and safeguarding approach applied and the instrument pre-testing process.

To enable comparison across project sites and over time, responses from FGDs were analysed descriptively and scored numerically using a Likert-type rubric, where 1 indicated the most negative experience and 4 the most positive. Discussions covered the following domains: *safety in the home; safety in the community; availability of formal services for women and girls; quality of services; acceptability of service use; community support for women and girls; safety of boys; safety of girls; availability of child protection services; and community support for child protection*. To generate comparable numeric indicators across locations, we converted these frequencies into average scores.[20]

The location studies were intended to provide a basis of assessment against which subsequent progress could be measured – though noting that this should not be considered a 'baseline' in that implementation of at least some project components was already well under way. Since the planned future rounds of data collection will not now take place, the location studies have been used to provide information on the progress and context of implementation during the first full (and only) year of the project.

Challenges to, and limitations of, the evidence obtained from the location studies are discussed in Annex E.5.

[20] Using the following formula: score (location, indicator) = $\frac{(f_1 \times 1) + (f_2 \times 2) + (f_3 \times 3) + (f_4 \times 4)}{(f_1 + f_2 + f_3 + f_4)}$
Where, f_1 = the number of participants who selected the option scored as 1; f_2 = the number of participants who selected the option scored as 2; f_3 = the number of participants who selected the option scored as 3; f_4 = the number of participants who selected the option scored as 4.

4.3 National-level KIIs

KIIs were carried out with project stakeholders and representatives from the Protection Cluster to both contextualise the findings and provide additional detail about project implementation. It was also intended to interview key informants from the government but despite many efforts this did not prove possible.

Table 3: National-level key informants interviewed

Name	Position
Muna Hussein	GBV AoR Coordinator
Amin Mohamed	Child Protection AoR Coordinator
Yusuf Mayow	CHANGES – Programme Manager – Programme Operations
Mumin Mukhtar	CARE – Programme Manager
Abdijabar Rashid Maalim	IRC – Senior Prevention Officer
Abdi Ali Abdi	Save the Children International – Gaashaan Project Coordinator – Programme Operations
Shukria Dini	SSWC – Executive Director – SWCS
Ibrahim Ahmed Ali	SWDC – Gaashaan Project Coordinator
Abdiweli Shariff Ali	Programme Coordinator, Gargaar Relief and Development Organization (GREDO)

4.4 Secondary data

The evaluation reviewed and drew on a wide range of project documentation and monitoring system outputs, informed by the monitoring systems review that was undertaken during the inception phase.

Table 4: List of main documents reviewed

Document name
Save the Children International Safeguarding Policy Framework
Gaashaan Emergency Response Plan
Gaashaan MEAL Plan 2023
Gaashaan ToC
Gaashaan Logframe
Gaashaan Programme Narrative
Introductory Presentations
Gaashaan Main Workplan
Gaashaan Annual Review
Gaashaan Inception Report November 2023–March 2024
Gaashaan quarterly reports up to Year 2 Quarter 3
Gaashaan Annual Review Year 2 (2024/25)
Gaashaan TPM Report January 2026

Table 4 lists all documents reviewed. The most significant sources include the following:

Quarterly progress reports that provide summaries of implementation status and reflections on progress against planned activities.

Case management and hotline logs, offering insights into patterns of service use, types of incidents reported, and referral processes.

Training attendance records and pre-/post-test results, which informed initial assessments of capacity-building efforts and knowledge transfer among stakeholders.

Minutes of strategic reflection workshops, documenting internal learning, shifts in project design or the implementation strategy, and challenges encountered.

The internal indicator tracking dashboard, which offers early insights into the project's performance metrics aligned with the revised results framework.

Project design documents, including the ToC and logframe, which were assessed to evaluate internal coherence, responsiveness to community needs, and alignment with international best practices.

Institutional coordination plans and partner implementation guidance, which were reviewed to assess coherence across partners and complementarity with other sectoral interventions.

Service provision data and referral pathway documentation, used to inform initial assessments of coverage and accessibility under the effectiveness criterion.

Financial and procurement documents, which informed early reflections on the potential for cost effectiveness under complex operational conditions.

TPM report – an independent verification of activities undertaken since inception and the services supported by the project (conducted May–August 2025).

4.5 Data analysis

Data from the location study KIIs and FGDs were transcribed and tabulated in Excel (in Somali) and then translated into English for summary against the evaluation questions. Data from national KIIs and the review of documentation were also tabulated against the evaluation questions. Triangulation and synthesis of evidence from different sources was undertaken to generate the evaluation findings. These findings are set out in the following chapters.

5 Findings: relevance

5.1 To what extent does the ToC provide an appropriate and valid framework for the implementation of Gaashaan?

The ToC only partially provides a valid and appropriate framework for the implementation of Gaashaan. The main causal pathways are identified but there is no overall narrative or comprehensive articulation of assumptions, nor are the context or relations between key stakeholders adequately represented.

There was no fully articulated narrative to support the ToC in the project proposal or in the inception report, and key assumptions related to each causal pathway were not specified. During the inception phase, the evaluation team reviewed the results framework and details on proposed project activities to clarify the ToC underpinning Gaashaan, and carried out an online workshop with Gaashaan staff to identify assumptions around the causal pathways between outputs and outcomes, and to identify any factors that may not have been articulated. Further insights were gained through meetings with Gaashaan staff and engagement with experts on the evaluation Steering Committee, including consideration of how Gaashaan intersects with other programming in its locations. Consideration of global literature, lessons from Somalia, and expert observations further highlighted what kinds of changes may lead to the desired outcomes, and what factors may influence this. A summary of evidence from literature that is relevant to the Gaashaan ToC was prepared.

The analysis of Gaashaan's ToC and its underlying assumptions is presented in Annex B. This includes the evaluation team's efforts to articulate causal pathways and the rationale for the combination of components. Noted weaknesses in the ToC include poor articulation of the following:

- The rationale for high levels of flexibility in Gaashaan due to both a shifting context and an approach which seeks to complement the wider sector.
- The need for cross-sectoral advocacy and adaptation in humanitarian responses in the face of current funding cuts.
- The specific ability and intention of Gaashaan to respond to mobile populations in Somalia, including articulating how internal coordination and external engagement with the GBV and Child Protection AoRs are expected to support this.
    - The rationale for and benefits of the uniquely long-term nature of Gaashaan as a protection capacity-building project that it is assumed will help build capacities over time and in response to the context.

5.2 To what extent, and how, does the project respond to the identified needs of survivors, groups at risk of GBV and child abuse, and their communities, in different locations?

Gaashaan has systematic processes to identify the needs of those at risk of – and survivors of – GBV and child abuse, based on an understanding of GBV and child abuse risks at local levels. This includes needs identified through consultation during project design, as well as through structured assessments at the local level and through regular monitoring in coordination with the wider protection sector. FGD data

suggest that community members consider that Gaashaan appropriately identifies needs and responds to them, though there remain gaps in service provision.

The Gaashaan project design specifies GBV and child abuse risks that are common across Somalia, as well as some specific risks in different types of location, such as remote areas, areas with IDP populations, and areas where armed groups are present. Gaashaan has conducted mapping of GBV and child protection services in project areas to assess and respond to the specific needs of survivors and at-risk groups, including by documenting the availability and accessibility of essential services in each district.

Gaashaan also participates in ongoing needs assessment, in coordination with the GBV and Child Protection AoRs, and supports the GBV and child protection risk monitoring systems that the AoRs currently use prior to conducting community-based activities. National-level key informants from Gaashaan and representatives of the Protection Cluster noted that joint assessments between Gaashaan and other organisations occur in some locations and/or are planned to be undertaken in future. These include analyses of gender and conflict sensitivity issues, cultural barriers, and the risk of retaliation or discrimination against participants. One informant noted that Gaashaan contributed significantly to the last risk monitoring exercise by the AoR, through providing both human resources and logistical support. This safety audit exercise looked at the GBV and child protection risks in IDP camps in the different districts in the country, mapping over 1,300 sites. The results have been used widely across the protection sector.[21]

The location studies found that Gaashaan identifies needs locally. National key informants, and staff and partners, confirmed the use of assessments and vulnerability criteria[22] to help inform the design of the project, including assessing GBV and child protection risks, identifying the beneficiaries based on vulnerability to those risks, and mapping service provision to ensure that the project responds appropriately.

FGD data suggest that community members generally perceive Gaashaan as addressing identified needs in protection, noting that the project addresses gaps in healthcare and psychosocial service provision, and weaknesses in the quality of services. They also acknowledged the importance of Gaashaan's approach of working at the community level to address barriers to reporting through awareness raising. Community members identified remaining concerns that were largely in line with Gaashaan's intended future focus. FGD respondents who were aware of Gaashaan noted that staff have held consultations with various local groups to understand their needs.

Gaashaan's quarterly reports highlight examples of activities being tailored to meet contextualised needs. For example, following community consultations, dignity kits and female hygiene kits that were distributed were tailored to local needs and preferences (such as including culturally appropriate clothing and solar lighting) and were targeted to those who were most vulnerable. Quarterly reports also detail how community outreach teams and committees have worked to help communities recognise and identify GBV/child protection concerns, address harmful traditional practices through community engagement, and

[21] Gaashaan's collaboration with the wider protection sector is explored further in the sections on coherence and effectiveness.
[22] Including those from minority clans, IDPs, and people with disabilities.

establish confidential reporting mechanisms that protect survivors' privacy and safety.[23] These actions reflect a design that is responsive to community-level needs and opportunities, including through directly engaging local actors, tackling context-specific protection risks, and creating safe channels for reporting and accessing support.

5.3 To what extent, and how, does the project identify service capacity gaps, and does the design allow for appropriate responses?

Gaashaan has mapped service provision and community-level support for survivors and those at risk and works in coordination with other protection actors to maintain an understanding of capacity gaps over time, though there is variation in how this assessment is carried out at the local level. The project engages with coordination and monitoring mechanisms that help it to stay informed of gaps as they emerge, and takes these into account when designing and implementing activities. There is evidence of active response to capacity gaps but insufficient data are available to assess the appropriateness and effectiveness of these responses.

The initial mapping exercise carried out by the project generated detailed, district-level data on the presence and number of GBV and child protection service providers, enabling a precise understanding of geographic disparities. The mapping included data collection at community level and updates to referral pathways, with partners submitting additional data in mapping templates, validation by the Ministry of Family and Human Rights Development, and the establishment of oversight mechanisms. The exercise informed Gaashaan's design as it provided a guide for strengthening referral pathways, improving stakeholder coordination, and enhancing information sharing.

Some variation was reported in the local process for identifying capacity development needs. In some locations, Gaashaan staff described using a combination of structured assessments, ongoing consultations, community feedback, and coordination with other stakeholders to identify protection needs and capacity gaps. The structured assessments are collaborative and include input from government ministries and community structures, as well as inter-agency meetings and annual training needs reviews. In other locations, such as Wajid, assessments are more informal or are based on direct observations and community feedback.

After having undertaken regular mapping, Gaashaan staff bring together all those who are working in those specific areas to understand the service that they are providing, the hours they are working, and the person who is specifically present there providing the service. Gaashaan staff also assess the capacity of case managers to understand where the gaps are, to ensure that capacity development plans are appropriately targeted. Gaashaan staff attend monthly meetings with the national protection cluster to provide and receive updates on protection provision and gaps. They collaborate on quarterly child protection and GBV service mapping and referral pathway mapping led by the cluster at district level and in IDP camps, and they disseminate this information.

[23] Gaashaan Year 2 Quarter 3 Narrative Report 2025.

Service availability data at the district level highlight significant differences between urban and rural areas. While political centres such as Kismayo, Beled Hawo, and Dhoobley have multiple providers across GBV and child protection services, remote districts and those newly liberated from insurgent control have limited or no provision, revealing clear capacity gaps that require targeted resource allocation.

Across most districts staff described well-established referral systems that enable survivors to access the full range of services even when one organisation cannot meet all needs. In some regions, coordination goes beyond referrals to include structured inter-agency engagement, such as monthly meetings, joint planning sessions, and information sharing. These coordination processes are used to track service availability, assess gaps, and harmonise efforts, particularly in areas with more active civil society and donor engagement.

In some states, it was noted that local governments sometimes request information or processes that are not in line with international best practice for GBV or child protection case management. For example, one stakeholder noted the issue of mandatory reporting: it is expected that GBV cases, especially rape cases, will first be reported to the government before support can be provided, contravening the principle of confidentiality and posing risks for survivors, partners, and case workers. In other cases, it was mentioned that some government authorities discourage reporting, to prevent the region being portrayed as experiencing a lot of violations. This suggests a wider gap in establishing support for formal GBV reporting and referral systems.

The Gaashaan Year 2 Quarter 3 Narrative Report states that 127 health workers have been trained in different areas, including psychological first aid and safe referral recognition, and five clinical management of rape rooms have been established and made functional in supported health centres. In Dinsor, the closure of two health facilities prompted Gaashaan to take immediate short-term measures, engage Protection Cluster AoRs, and develop a response plan. Additionally, 735 inclusive and accessible booklets were developed and disseminated, targeting women, children, persons with disabilities, and marginalised groups.

5.4 To what extent does the project design identify and respond to gaps and opportunities at the community level?

Gaashaan has a presence, through staff or partners, in the communities in which it is implemented and has, to a good extent, identified the relevant local structures, and gaps and opportunities, relating to responding to GBV and child abuse risks at community level, although this has been more challenging in remote and insecure locations.

One of the strengths of the Gaashaan approach, as identified by staff, is its community-centredness. The Gaashaan Year 2 Quarter 1 Narrative Report (April–June 2024) describes how Gaashaan conducted consultations with affected populations, engaging marginalised groups, such as women-headed households and persons with disabilities. Robust feedback and complaints mechanisms were found to be in place, including community feedback sessions and dedicated hotlines, to ensure affected populations could report confidentially and receive prompt responses. This reflects a strong commitment to accountability and inclusivity, ensuring that diverse community voices inform programming and that mechanisms are in place to address concerns swiftly and effectively.

In many areas, staff noted during KIIs that they hold deep consultations with IDP leaders, women's groups, youth, elders, and other local actors to understand capacity needs and gaps in protection, as well as community strengths. This understanding has been harnessed to form committees that have become part of the protection response. During KIIs, community leaders in many locations reported active communication between community members and Gaashaan staff, particularly for flagging child protection concerns. In national KIIs the project's engagement at the community levels was seen as a key project strength, particularly efforts to establish different community structures. Stakeholders also stated that the information that is shared through the GBV and child protection sub-clusters helps them understand issues that occur in communities.

Gaashaan does not provide routine monetary incentives to community members as the project wishes to emphasise the voluntary nature of the work. However, other programmes in this area do provide incentives to programme volunteers – creating a disparity. To overcome any tensions around this, Gaashaan has sought to foster greater understanding of the voluntary nature of community roles.

5.5 To what extent does the project design reflect the policy and institutional context, including opportunities for, and challenges to, influencing at different levels?

The project design allows for advocacy and awareness-raising engagement at the community, sector stakeholder, and national levels. Gaashaan has engaged stakeholders at each level and plans to support women's rights organisations in their advocacy efforts but substantive national-level advocacy activities have not yet taken place.

There are, broadly, three different levels at which Gaashaan can influence to support protection: the community level; the sector stakeholder level (like the GBV AoR and the other clusters); and the national level, including the Ministry of Family and Human Rights Development, and the Ministry of Justice and Constitutional Affairs.

In national-level KIIs with staff, partners, and representatives of the Protection Cluster, the structure of Gaashaan in regard to advocating for change at multiple levels was noted as a unique facet of the project and was highly appreciated. These stakeholders noted that Gaashaan's approach connects advocacy at different levels, from the grassroots upwards, which empowers community structures. This then informs engagement at the local and federal member state levels up to the national level. Gaashaan also recognises the importance of humanitarian agencies as influential actors connected to both communities and government institutions. It was noted that Gaashaan has engaged all relevant stakeholders from the outset.

The design noted the project's intention of influencing at the national level around the stalled Sexual Offences Bill and the implementation of an FGM ban, as well as through the humanitarian institutional architecture. Project staff felt that arguments are resonating with government stakeholders, which is an important step towards changing legislation.

To date, Gaashaan has provided training to human rights and child rights coalitions on gender and GBV, on advocacy, on child rights, and on strategic communications. During

implementation, the initial plan to hold a national forum on the social and economic costs of GBV and child protection issues, and to facilitate a high-level discussion on the approval of GBV and child protection laws, shifted towards supporting engagement with women's rights organisations. This work has helped build up an understanding of issues and the institutional ecosystem for effecting change. Staff noted that there is a newly appointed Minister of Family and Human Rights Development, and that this has provided an opportunity for Gaashaan to build new relationships at a national level to ensure support for the project and child protection and GBV service provision.

5.6 To what extent does the project design reflect the complexity and changeability of the Somali context, including provision for periods of acute crisis?

The design recognises the context of recurrent natural disasters and shifting patterns of conflict in Somalia, particularly related to climate change, insecurity, and seasonal inaccessibility. It allows for the repurposing of funds in contexts of acute crisis to address urgent needs, as seen in the response to El Niño during the inception phase. The project also allows for regular reflection and adaptation at quarterly intervals. The project has successfully used design flexibility to respond to unexpected shocks so far, but there may be scope for developing a crisis modifier mechanism for future interventions.

Many national key informant stakeholders noted how Gaashaan was able to respond to the impact of the El Niño climate event. The Consortium Management Unit has an emergency fund that enables the project to facilitate a rapid response to crises.

The project's design allows for monitoring of the context and reflection on how best to respond. The 'Gaashaan Year 2 Quarter 2 Narrative Report (July–September 2024), for example, states that many areas face operational challenges due to ongoing conflicts, with clan fighting affecting domestic stability and displacement disproportionately impacting vulnerable groups, and with the dire situation intensified by flooding.

Local partners conduct quarterly monitoring, which presents an opportunity to change activities that are poorly targeted or ineffective, or no longer fully relevant due to the changing context. The Ministry of Family and Human Rights Development also conducts its own monitoring and gives Gaashaan recommendations through the Consortium Management Unit. This can support Gaashaan to re-programme: for example, if it is found to not be the right time for a particular activity due to immediate risks, like flooding. Several staff highlighted existing mechanisms within communities – especially protection committees and local leaders – as key assets that could help absorb the shock of external disruptions. These networks are seen as both information sources and first responders, especially in areas where the Gaashaan team can no longer operate directly.

Gaashaan operates in underserved and high-risk areas where GBV and child protection services are often limited. Hard-to-reach areas (particularly those with security concerns) were mentioned by national and local staff in KIIs as key challenges in the complex operating environment. Partner presence, acceptance, and access in remote areas is central to the project design as it allows Gaashaan to reach those locations despite restricted travel

and access for Gaashaan staff. This expands the potential for geographical and demographic reach to marginalised groups and underserved areas. This approach is seen as an important contribution to the sector. The presence of staff and partners on the ground is also seen as a way to mitigate the impacts of both insecurity and seasonal challenges to access during the rainy season (during which, roads and air strips can be unusable in some months). Even if coordination and joint activities are reduced during these periods, some support is still in place.

In the context of contracting donor funding (particularly following the closure of USAID) and a reduction in services, hope was expressed by some stakeholders that Gaashaan may step in to help fill some of these gaps. Gaashaan's quarterly reporting for Year 3 notes a variety of adaptations as staff attempt to respond to the constrained funding situation. Staff noted that they always seek to fill gaps where possible with consortium resources. Flexibility in regard to maintaining relevance in the changing context is seen as a key success criterion for many Gaashaan partners. Some Gaashaan staff noted that FCDO's flexibility allowed them to undertake rapid emergency response on top of other activities. However, other staff suggested that the project does not have sufficient flexibility, with only minimal budgetary flexibility during the first year. The need for greater use of budgets for emergency response was also noted. One staff member suggested the need for a more effective crisis modifier mechanism for immediate support, potentially with an anticipatory annual budget, given the predictability of recurring crises.[24]

[24] A crisis modifier mechanism provides pre-arranged flexibility in funding to allow for rapid responses to unforeseen crises within development projects.

6 Findings: coherence

6.1 What, if any, other interventions and organisations are providing related GBV and child protection services or addressing norms around GBV and child protection?

In addition to Gaashaan, several other international organisations, international NGOs, and civil society organisations are addressing GBV and child protection in Somalia, often through collaborative networks and referral systems. Many services are provided through government facilities and national and district governments are engaged in the planning, delivery, and monitoring of services. The unexpected and immediate ending of USAID programmes has created a major challenge for funding and coordination in the sector.

All local authority respondents strongly emphasised that the protection of women, girls, and children is a core administrative responsibility, independent of external projects. They framed protection work (such as combating violence against women, addressing FGM, and child protection) as an inherent part of mandated duties. Local authorities stressed their pre-existing commitment to safeguarding vulnerable groups, even before Gaashaan's arrival. They reported that their work includes conducting community awareness campaigns, educating the public on the dangers of harmful practices such as FGM, and addressing cases of early marriage through community engagement and issuing warnings when risks are identified. However, while there was a shared emphasis among respondents on protection responsibilities, the depth of familiarity with specific protection initiatives varied. In some areas, authorities had general knowledge of broader protection efforts but lacked detailed awareness of specific projects or focal organisations operating in their regions. Some local authorities described direct engagement with Gaashaan activities, including participation in training sessions, collaboration on protection initiatives, and the appointment of focal points to liaise with implementing partners. The project had not yet engaged with other local authorities but this was planned to take place during further implementation.

A range of international NGOs like the Danish Refugee Council, SOS Children's Villages, International Medical Corps, IRC, and Trocaire provide specific protection services and are part of collaborative networks and referral systems for protection services, as well as delivering trainings on child protection and women's protection to both communities and to service providers. These collaborative networks also include government ministries like the Ministry of Family and Human Rights Development. National and local NGOs, such as the Somali Women and Child Care Association, are active in providing GBV prevention and response services and engage in coordination efforts, and are often the institutions that identify and report GBV cases to the referral system. In one KII with a community leader, it was noted that the variety of approaches and tools utilised by NGOs (not necessarily as part of Gaashaan) is confusing for the community. This suggests that there is still scope for improvement in ensuring coherence among operational agencies. In remote locations, staff noted that, although basic services exist, Gaashaan is the only actor with consistent protection and comprehensive case management expertise.

The changing funding landscape in Somalia has had a significant impact on the protection sector and on the implementation of the Gaashaan project. Reduced funding allocations

have led to resource constraints among key protection partners, resulting in limited field coverage, high staff turnover, and disruptions in service delivery and referral pathways. Multiple informants at both the local and national levels described the termination of USAID programming in particular as a threat to the coherence and potential impact of the protection sector across Somalia. The stop work order issued by USAID in January 2025 affected most of the humanitarian organisations in Somalia. Funding cuts in 2025, particularly cuts in funding from USAID, have led to a dramatic reduction in service provision for both GBV and child protection. The GBV protection sub-cluster estimates that 70% of GBV service providers have ceased operations – not only as a result of the USAID freeze but also due to the follow-on effects of the US and other countries, and the United Nations, reducing contributions to humanitarian aid. One informant estimated that 25 health facilities have already closed in Jubaland alone. The GBV AoR was also reported to be revising the GBV Minimum Essential Services Package, with some services being removed in response to cuts. The full, long-term impacts of the USAID cuts were not fully known at the time of data collection, as it was not clear which programmes would re-start after what was initially called a '90-day pause', and which would be fully shut down. Subsequent analysis of GBV funding globally shows that almost all GBV programming has been eliminated and 83% of USAID contracts globally have been terminated.[25]

Funding pressures have weakened coordination structures and decreased the availability of complementary services for GBV and child protection at the community level. These conditions are likely to have a direct impact on the Gaashaan project, with previously existing referral pathway actors and aid providers reducing their programming or completely ceasing to operate in Somalia. Given the extensive nature of cuts, affecting 70% of service providers, all Gaashaan implementation areas are likely to be affected by a reduction in referral pathway service providers. In addition, while the outcomes are not yet known, the global 'humanitarian reset' may see the GBV AoR (and Child Protection AoR) folded into the wider Protection Cluster – reducing the dedicated space available to coordinate with other stakeholders to address these issues.[26] Similarly considerable reductions were seen in the availability of child protection services as a result of the USAID terminations and general reductions in humanitarian aid. National key informants noted that protection has been heavily affected as a sector, particularly as protection programming is not always prioritised as a lifesaving intervention. These cuts, while widespread, affected certain geographic areas more than others initially. Somaliland and Puntland were mentioned by respondents as particularly losing service coverage overall, though the tenuous security situation was also noted as contributing to service withdrawals in certain areas, not just funding cuts. Staff informants particularly noted that the sudden nature of the pull-out of these funds meant that proper handovers and sustainability plans could not be implemented – compounding the challenges inherent to the funding withdrawal.

[25] Schreiber, M. (2025) 'Rubio announces that 83% of USAID contracts will be canceled', *NPR*, 10 March. https://www.npr.org/sections/goats-and-soda/2025/03/10/g-s1-52964/rubio-announces-that-83-of-usaid-contracts-will-be-canceled

[26] COFEM (2025) 'COFEM's Open Letter to Mr. Tom Fletcher, the United Nations Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator'. https://cofemsocialchange.org/cofems-open-letter-to-mr-tom-fletcher-the-united-nations-under-secretary-general-for-humanitarian-affairs-and-emergency-relief-coordinator/

6.2 What arrangements are in place for ensuring coherence with these other interventions and organisations?

Humanitarian coordination in Somalia is well established and generally ensures coherence. It includes a Protection Cluster, which consists of international organisations, local and international NGOs, and government. Within this coordination, monitoring and joint needs assessments on protection issues take place through the GBV AoR and Child Protection AoR.

Coordination among protection actors in Somalia is generally strong, both at the national level and in most districts. Gaashaan actively engages with all relevant stakeholders. Gaashaan staff referred to the GBV AoR and Child Protection AoR representatives as being 'go-to' individuals for coordinating and sharing on service mapping and strengthening referral pathways. They engage on a monthly basis with local authorities, community-based structures, and humanitarian clusters to ensure coordination, accountability, and integration within the broader protection framework. Furthermore, the Ministry of Family and Human Rights Development has liaison officers who are paid by the Gaashaan project to actively engage in project monitoring and provide feedback from communities, supporting a coherent approach to delivery. They invite government representatives to participate in project activities where possible, such as trainings, official openings, meetings to develop action plans, service assessments, and validations. Staff noted that this coordination enables them to direct issues to service providers that can respond if they themselves cannot, given the fact that the scale of need is beyond Gaashaan's ability to address alone. This helps to ensure that protection programming is integrated with broader humanitarian efforts and that community needs are addressed holistically through multi-sectoral collaboration.

Coordination of GBV response is primarily led by the GBV AoR, co-led by the United Nations Population Fund (UNFPA) and IRC at the federal level. The Child Protection sub-cluster is co-led by the UN Children's Fund (UNICEF) and Save the Children. The Somalia Protection Cluster is led by the United Nations High Commissioner for Refugees (UNHCR) and coordinated by the Danish Refugee Council. The Child Protection AoR, GBV AoR, and Protection Cluster operate at both national and regional levels.[27] Coordination mechanisms include monthly meetings at district and state levels for the GBV and child protection sub-clusters, quarterly project planning meetings, and engagement with government ministries. Gaashaan often presents its work at these meetings. It also informs advocacy through presentation and policy briefs at national roundtables, and it participates at donor learning events. These platforms are used to track service availability, assess gaps, and harmonise efforts.

According to Gaashaan's mapping, referral systems are generally well established and routinely updated to ensure survivors can access a full range of services. Staff noted that they constantly update the referral mechanism, or pathways. This has been particularly important in the wake of USAID cuts.

National key informants reported strong integration of Gaashaan into the GBV and child protection cluster systems, including proactive efforts to ensure project activities are

[27] During the period of this evaluation, reorganisation of the cluster systems was occurring globally, with GBV and child protection sub-clusters expected to merge into the Protection Cluster.

implemented in line with technical guidance from these national coordinating bodies. This can be seen in the multiple references respondents made to the development and roll-out of key guidance documents and updates to GBV and child protection standard operating procedures and coordination with the Protection Cluster. Staff described strong collaborative relationships with other local and international NGOs, community-based organisations, and government ministries, typically in the form of joint case management, referrals, training, and capacity building. Gaashaan is engaging actively with all the stakeholders relevant to its work, which gives monthly opportunities at coordination meetings to present online or in person – and also at emergency meetings if needed.

Informants noted gaps in knowledge of the other protection actors, as well as other clusters. Gaashaan is seen as a particularly important partner for supporting service mapping and the development and dissemination of referral pathways. One national stakeholder referred to Gaashaan as their 'go-to' organisation for coordinating and sharing on mapping and said they saw the project as a core support on strengthening the referral pathways.

Most local administrations who were interviewed reported having engaged with Gaashaan to some extent. Engagement typically includes participation in training sessions, exchanging reports, implementing activities based on Gaashaan's directives, and forwarding community needs and complaints to the project team. Some administrations also described direct meetings with senior Gaashaan staff to discuss project implementation and share ideas on how to improve activities. This close involvement supports coherence. However, not all districts engage proactively or enthusiastically with Gaashaan. In some remote districts staff reported that Gaashaan is largely operating alone in the protection space due to barriers to local authority involvement, which limits opportunities for collaboration and learning and places an additional burden on Gaashaan teams to meet community needs singlehandedly. In these locations Gaashaan will need to undertake additional work to understand the context-specific barriers preventing local authority engagement in some areas, and potential strategies to address these, particularly relating to low overall capacities.

The Child Protection AoR Referral Pathway report for Jowhar, Middle Shabelle (updated in March 2024) outlines a coordinated network of service providers who ensure children are safely and promptly linked to quality support. Services include creative and social activities, life skills education for adolescents, case management, psychosocial support/mental health counselling, legal aid, health and nutrition, mobility aid, nutrition and primary healthcare, and alternative care. The pathway lists key focal points, with contact details for each service, enabling timely referrals. Multiple organisations contribute to service delivery, including local and international NGOs. Hotlines operate with varying hours, with several agencies providing 24/7 access, ensuring continuous availability of emergency support.

Likewise, the Child Protection Referral Pathways report for Baidoa, Dinsor, Elbarde, Hudur, and Wajid outlines multi-agency mechanisms that link children to appropriate and timely support services. Across these districts, the pathways include case management, family tracing and reunification, counselling and mental health support, life skills education for adolescents, and recreational/creative/social activities. Additional services cover nutrition, primary healthcare, legal aid, education enrolment, non-food item support, and multi-purpose cash assistance. These tools are designed to strengthen coordination between agencies, ensuring clarity on roles, avoiding duplication, and enhancing access to protection services in both IDP and host community contexts.

Staff reflections on coordination challenges reveal a layered picture. While some respondents reported smooth coordination, others described practical gaps, policy misalignment, and logistical constraints that limit how effectively organisations are able to work together. Staff highlighted opportunities to improve effectiveness – particularly by obtaining greater clarity on who offers which services, and ensuring proactive communication between actors. Several respondents described coordination breakdowns due to unequal technical capacity across organisations. Differences in case management standards, referral procedures, and confidentiality protocols were cited as challenges that make collaboration difficult. Another commonly cited barrier is misaligned organisational policies, particularly around data privacy and reporting, as well as logistical constraints when coordination meetings are held far away from operational sites.

The TPM findings underscore a correlation between the level of access to services and the strength of government coordination. Coordination levels are relatively higher in areas where the government's institutional capacity is greater, and therefore they have more value-add to programming. Access and coordination levels are correspondingly lower where the government has less capacity to participate in project programming.

The limited number of protection actors who are likely to remain after the USAID cuts will make it harder for Gaashaan to coordinate as intended in its design and in line with its modus operandi to date. At the time of primary data collection for the evaluation, Gaashaan partners had been trying to advocate at cluster levels to cover gaps caused by USAID cuts. While Gaashaan's design allows it to be somewhat flexible, it cannot scale up to meet all unmet needs.

6.3 To what extent is Gaashaan coherent with wider humanitarian programming?[28]

Gaashaan is designed explicitly to complement the wider protection sector and humanitarian programming, as it seeks to build capacities across a range of services and community mechanisms. Gaashaan has been strongly integrated into the coordination mechanisms and, as such, is well placed to fill gaps and to complement the activities of other actors. However, the sudden and unexpected cessation of USAID funding has undermined coordination and has reduced available protection services. While it is too early to determine the full impact of cuts, they present additional challenges to the maintenance of coherence as the footprint of wider humanitarian programming changes.

Gaashaan's quarterly narrative reports note how the project coordinates with complementary interventions to meet the different needs of targeted communities, including with other Humanitarian Assistance and Resilience Building in Somalia (HARBS) programmes, like Danwadag and BRCiS on early warning, disaster preparedness, and response, and engagement with the GBV and Child Protection AoRs to discuss and identify critical gaps in the GBVIMS. The project is now focused on implementing tailored capacity-building interventions to strengthen the system's functionality and user experience. This

[28] To improve clarity, this question has been reformulated from that set out in the evaluation framework ('In what ways does/should Gaashaan intersect with wider humanitarian programming?').

demonstrates a coherent approach, involving working closely with established coordination mechanisms, aligning capacity-building efforts with identified system gaps, and ensuring that improvements directly enhance the effectiveness and usability of GBVIMS across stakeholders.

Within the consortium, it was reported that there is internal coherence within the activities being delivered by different partners. The consortium has three international partners and four national partners, and they operate and work in different districts and locations, depending on the presence of consortium partners and the accessibility of communities. The national partners coordinate work, making sure that children and women who move from one area to another are referred. All partners attend regular meetings to engage in coordination. Partners also share learning to build collective capacity. If an organisation is not strong in a certain area, then the partners can offer support and guidance. The consortium coordinates and supports national partners and international partners in their work, and in sharing learning and achievements during the quarterly meetings. The consortium respondents noted that while the activities across the consortium are generally the same, there are some differences in the roles of international versus national NGOs. The international NGOs mostly provide the technical support or contribute in terms of facilitating training of trainers and giving guidance, since they have strong technical teams. The Save the Children technical team provides trainings and other support on child protection across the consortium, while IRC provides trainings for anything to do with GBV, such as the Women Rise training of trainers curriculum for project staff. Save the Children has facilitated a training on caring for survivors for the consortium across all areas. National partners focus on community-level engagement activities (around 90% of their effort), with some advocacy work with the district- and state-level governments, since they have high visibility and acceptance in the community. Learning events within the consortium were mentioned by respondents as being important mechanisms for sharing on both contextual challenges and technical response.

Across all locations, Gaashaan plays a distinct role within the protection sector. It fills service gaps, responds to unmet community needs, and works in locations that are often underserved or ignored by other organisations, like locations with weak power systems, limited humanitarian access, and high vulnerability due to conflict and displacement.

Respondents pointed to funding issues, particularly in the wake of USAID freezes, as a major constraint affecting coherence – especially when staff turnover or reduced presence hampers regular inter-agency interaction. Fears (which proved to be well-founded) were also expressed about potential upcoming cuts to the UK aid budget, which it was believed would negatively affect the limited services that remain after the USAID terminations. It was noted that while the expectations on Gaashaan were high, it was not possible for the project to fill all the gaps introduced by the USAID withdrawal, nor to meet all protection needs and gaps caused by conflict.

7 Findings: effectiveness

7.1 To what extent are quality GBV and child protection services accessible, available, and acceptable for different at-risk groups and in different contexts, at baseline? (Outcome 1)

Data collected from FGDs in sampled locations suggest moderate to good availability of services in most locations, with significantly lower availability in a handful of remote locations. Where services do exist, all communities noted barriers to accessibility (such as distance or cost), as well as limited acceptability (i.e. whether services are seen as acceptable to use).

Full details of the findings from the location studies in relation to the availability, quality, and acceptability of services are set out in Annex section F.2). The results are summarised quantitatively in Table 5, where the 'scores' in the first column are on a scale from 1 (most negative) to 4 (most positive), and the numbers in each of the other columns show the number of locations (out of the 18 total) where the Likert-scale rating (averaged across all of the focus groups at that location) fell within each defined interval, with the mean score across all 18 locations in the bottom row. These scores were originally intended to provide a reference point against which subsequent progress would be assessed in further rounds of the evaluation.

Table 5: Outcome 1: distribution of scores by community and mean

Score	Availability of, and ease of access to, GBV services for women and girls	Quality of GBV services for women and girls	Acceptability of GBV services for women and girls	Availability of child protection services
3.50 – 4.00	2	1	1	0
3.00 – 3.49	0	2	7	2
2.50 – 2.99	10	8	6	9
2.01 – 2.49	4	5	3	4
1.51 – 2.00	1	0	1	2
1.01 – 1.50	1	1	0	1
1.00	0	1	0	0
Mean across all locations	2.55	2.36	2.67	2.50

Across all areas, key informants at both district and local authority levels described their efforts to bridge gaps through community mobilisation and local initiatives. However, they also acknowledged that without broader investment, and systemic support, existing services remain inadequate to meet the protection and welfare needs of vulnerable children. Informants noted that ongoing weaknesses in service provision are primarily in areas of service provision that are less directly under the control of Gaashaan: for example, issues of

privacy and confidentiality when cases are reported to the police and/or the legal system are seen as still a challenge.

Delayed reporting of cases impacts the ability of survivors to receive timely care. Barriers to reporting are a key factor determining service uptake and are affected by multiple factors. There is stigma associated with being a survivor of abuse. There is also fear that a survivor will be seen as having lied to get financial support and that reporting may be harmful to clan and community dynamics. When perpetrators belong to very powerful clans and the survivor is from a minority, or hails from a less powerful clan group, there are power dynamics which determine responses. Police are pressured to drop cases linked to clan elders, who are very influential, or those linked to governments or key line ministries. There are also financial constraints on reporting, as well as safety, security, and access constraints.

7.2 Early indications of progress towards Outcome 1

Across most communities, respondents noted improvements in service availability, and many attributed these improvements to the Gaashaan project. National stakeholders emphasised the results of capacity building to address GBV case management. Informants also noted that Gaashaan has reduced barriers to reporting GBV. There was also evidence of positive changes in child protection in their communities over the past year (often linked to Gaashaan-supported activities), related to increased awareness, better access to services, and shifts in community behaviour. The closure of referral systems and projects previously funded by USAID has increased demand for Gaashaan to provide services, while forcing an end to planned coordination.

Informants were able to identify some changes which they attributed to Gaashaan. Informants felt that Outcome 1 has been one of the strongest areas of progress for Gaashaan. TPM confirmed that staff across all facilities had received training in GBV and child protection within the last year. Staff highlighted the value of these trainings in improving their clinical skills and their ability to provide survivor-centred care. Respondents also noted the need for refresher courses to ensure knowledge retention.

Across most communities, respondents noted improvements in service availability and access over the past year, with many directly attributing these changes to the Gaashaan project. These changes include increased access to healthcare and psychosocial support, expanded awareness-raising campaigns, and strengthened coordination with local authorities, such as police and justice systems. Eight out of 13 community leaders explicitly identified Gaashaan as a primary driver of recent service improvements. These leaders described enhanced availability of health services, dignity kits, hygiene items, and psychosocial support, often noting Gaashaan's role in facilitating referrals, delivering direct assistance, or conducting community sensitisation. Leaders emphasised that awareness campaigns are slowly helping survivors feel more empowered to come forward. Respondents from Mataban, Marergur, Wajid, Afmadow, Dollow, Diinsoor, Kismayo, and Dhoobley all referenced Gaashaan's role in expanding access and improving quality of care. An additional three community leaders acknowledged improvements seen through a broader lens, citing multiple actors – including Gaashaan, Danish Refugee Council, UNHCR, Save the Children, and local government agencies – as contributing to change. The remaining two

leaders, from Cadado and Hudur, either reported no significant service-related improvements or did not associate changes with Gaashaan.

These data suggest uneven coverage of Gaashaan's support to improve services. The TPM revealed variations in the frequency and nature of support provided by the programme across facilities, which may have been partially driven by the absence of regularly updated stock-tracking systems at half of the facilities. TPM confirmed that Gaashaan's support was concentrated in accessible and semi-accessible districts where roads, proximity to larger population centres, existing health infrastructure, and greater partner presence facilitate implementation.

Further variation in support may be partly attributable to funding changes across the wider sector and the related drop in the availability of health facilities through which specialist services can be provided. The TPM confirmed that Gaashaan has supported the establishment and refurbishment of rooms for the clinical management of rape within eight health centres, and provided support to four existing safe houses. While the programme's annual report states that nine rooms for the clinical management of rape and six safe houses were supported, only the number of facilities noted above were confirmed as operational and open at the time of the TPM as several were shut down in 2025 due to funding cuts. This highlights the impact of cuts across the wider sector on the availability of services; some facilities are no longer operational at all.

Multiple national stakeholders reported that the project engages in considerable capacity-building activities with multiple stakeholders, including building the capacity of specialist service providers on case management and information management – particularly those based at health clinics. This includes training health staff on the clinical management of rape, and training GBV focal points and community health workers on the identification of GBV and child protection cases, confidentiality, safe referrals, and do no harm principles. They noted how these trainings address common weaknesses seen with protection service providers, such as not respecting confidentiality, failing to make referrals, and failing to identify risks of violence. Consistent mentoring and supportive supervision were cited as key strategies for supporting service provision. Overall, key informants believed that these trainings improve the technical capacity of services providers and that survivors are now receiving better care. One informant noted that after training medical doctors, nurses, and midwives on clinical management of rape, they have seen a positive outcome as doctors in rural areas are doing proper clinical management of rape – their understanding and their knowledge is seen to have increased after the training, including doing proper follow-up and reporting on survivors' progress, maintaining confidentiality, and providing psychosocial and medical support. Psychological first aid skills taught during the training have improved, as has how first-line responders listen, reassure, and support, reducing the risk of re-traumatisation. Occasionally, in severe cases, advocacy is also required, which is identified during monthly case review meetings. Engagement with service providers is ongoing.

Service provider key informants noted that capacity building had been valuable to date but also that ongoing or additional support would be welcome. There is strong evidence of improvements being brought about through training, captured in Gaashaan's post-training participant feedback and review, as well as field monitoring reports across all the districts where Gaashaan is implemented. Training has increased case identification, as focal points – particularly in health facilities – are now better able to identify signs of GBV and child

protection risk, including less visible forms like emotional abuse or neglect. Staff also noted that training has improved referral accuracy and timeliness. Refresher trainings are also conducted. Case management training has strengthened the quality of documentation across one-stop centres and community structures, and focal persons are now more consistent in regard to recording disclosures and obtaining informed consent. Monitoring reports within Gaashaan suggest that survivors themselves report feeling safer and more supported when they interact with trained focal points. Respondents spoke about how these trainings have extended the coverage of trained personnel to additional districts, although some districts only have one person, which means provision is sporadic.

The Child Protection Referral Pathways Report for Baidoa, Dinsor, Elbarde, Hudur, and Wajid outline service types, focal contacts, and operational hotlines, several with 24/7 availability. The pathways improve the accessibility and timeliness of quality child protection services for at-risk groups, including children in IDP camps and host communities. The pathways also include referral guidelines that stress the need for informed consent, prioritisation of the best interests of the child, and ensuring non-discrimination and inclusion. At the time of the evaluation, Gaashaan had not yet specifically targeted children associated with armed groups.

A 24/7 hotline has been introduced to improve access to services, which Gaashaan staff reported is improving access to care for survivors, with usage reported quarterly. One staff member noted that in the last quarter there were 34 cases and in the previous quarter 50, indicating that communities are aware of the hotline and how to access it. However, while hotlines are widely promoted within Gaashaan as a feedback mechanism, gaps remain in their functionality, visibility, and usability. Only half of facilities visited for the TPM had hotline numbers clearly displayed, and two hotlines (out of eight) were either not answered or directed callers to a voicemail box where they could leave a message.

Supply-side barriers – such as a lack of physical rooms and medical supplies – have been to some extent addressed by Gaashaan. For example, in some health facilities, clinical management of rape spaces have been constructed, to allow health providers to privately counsel survivors of rape. Multiple key informants mentioned providing post-exposure prophylaxis (PEP) kits and other needed supplies to clinically manage cases of rape and GBV. These interventions were noted as being particularly needed, given the USAID terminations, which have affected UNFPA medical supply chains. At the time of the TPM it was noted that many of the existing facilities lacked basic equipment and medical supplies needed to provide services, including sterile gloves, infection prevention materials, and PEP kits. While bulk procurement of sterile gloves and infection prevention materials are not in Gaashaan's remit, the distribution of PEP kits to refurbished facilities is, and one out of the eight health facilities (Adaado General Hospital) reported not having received PEP kits from the Gaashaan consortium.

Informants spoke about the use of community awareness-raising activities to build awareness of existing GBV and child protection services and to shift perceptions of these. Safe spaces are seen to be an effective hub for referral support and information sharing. Some respondents noted that an increases in case self-referrals – rather than just referrals from other services – may be an indication that attitudes are changing about support services. However, it was also noted that attitudinal change takes a long time to materialise and it may take some time to fully see the difference in reporting after awareness is raised.

Taboos against reporting are strong. Leaders in Marergur and Afmadow pointed out that raising community awareness – through projects like Gaashaan – has led to a perceived decrease in forced marriage and child recruitment.

The TPM suggests there are some significant gaps in referral pathways. Although referral maps and service point contacts have been developed and are reported to be updated quarterly, the TPM suggests that they are not always physically accessible to frontline service providers, and referral maps that are available were often reported to be out of date.

The USAID terminations and subsequent shutdown of many referral systems has affected frontline service providers. Referrals they would typically make are no longer possible, and material supplies that would normally be available are suddenly not. As described by one informant, in many districts there might now be two or three protection service providers per district, where there were previously more than 20. However, at the time of data collection the exact number of service providers ceasing operations was in flux as the USAID 'freeze' had not yet been fully communicated as being a 'termination' to the grantees who would be affected. Further, key material support, such as PEP kits, will go out of date and will not be able to be restocked if further funding is not found to replace terminated grants.

Local authorities interviewed described collaboration with organisations working under the Gaashaan project. They conveyed a strong view that services should be driven by government, with Gaashaan adding value in capacity building and coordination. District authorities confirmed awareness of Gaashaan's presence through community outreach efforts, particularly activities to raise awareness about protection risks, promote reporting of child separations and personal violence, and connect individuals with service providers. Gaashaan was recognised for maintaining high standards in community engagement and strengthening local protection responses, with authorities welcoming planned assessments and expanded activities. Some improvements were observed in IDP sites supported by the Gaashaan project: for example, in Mataban, the local authority described improvements compared to the past, largely attributing progress to the establishment by the Gaashaan project of an office that assesses and reports incidents.

Most FGD and community leader respondents reported some level of positive change in child protection in their communities over the past year, often linked to Gaashaan-supported activities. Improvements were commonly described in terms of increased awareness, better access to services, and shifts in community behaviour. A few leaders reported no significant changes. Cadado and Jowhar leaders reported no difference in services, and the Diinsoor leader described ongoing support but no major improvements. The Dollow leader noted a decline in services due to reduced aid, regional insecurity, and logistical barriers, such as road closures.

Staff respondents confirmed that Gaashaan has trained both formal service providers and informal community actors. These include clinical health workers, case managers, community health workers, police, committee members, and local NGO staff. The trainings cover a range of topics, with a strong focus on referral pathways, case management, clinical management of rape, and child safeguarding.

Staff described training on clinical management of rape and case management protocols as central components of capacity building. This training was considered as equipping staff to

provide timely, sensitive, and confidential support to GBV survivors. In Jowhar, Dinsoor, and Beled Hawo, respondents explained how committees and community members are included in trainings to ensure localised response capacity. In Howlwadaag, the respondent reported being directly involved in delivering and facilitating trainings, suggesting a high level of community engagement.

7.3 To what extent are communities empowered to prevent, mitigate, and respond to GBV and child abuse, and to what extent are community-based protection structures effective in this regard? (Outcome 2)

The presence of community mechanisms (as perceived by participants in community FGDs) to prevent, mitigate, and respond to GBV and child abuse vary across locations, with remote locations scoring particularly low. Protection structures exist in most locations, and some have received capacity-building support from Gaashaan, but these mechanisms could be further strengthened in most cases.

Full details of community-level findings are presented in Annex section F.3. These findings are summarised in Table 6, which shows the number of communities whose average rating for community-level support falls within each interval (on a scale where 4 is most positive and 1 most negative), along with (in the bottom row) the average rating across all locations.

Table 6: Outcome 2: distribution of scores by community and mean

Score	Community support for women and girls experiencing violence	Community support available to protect children
3.50 – 4.00	1	2
3.00 – 3.49	5	5
2.50 – 2.99	5	4
2.01 – 2.49	5	5
1.51 – 2.00	1	0
1.01 – 1.50	1	2
1.00	0	0
Mean	2.40	2.37

Stakeholders from different organisations/locations described different strategies/forms of organisation for these community structures. Some spoke of combined committees in certain communities, which are the result of a desire not to have separate GBV committees and child protection committees, to avoid confusion about who can help with what. These combined committees advance efforts on both GBV and child protection and are often integrated into existing community committees. Others spoke of separate communities for child protection, usually Child Welfare Committees, and of GBV being handled through GBV focal points within the community or GBV focal point committees. Many communities also have a committee and a focal point for persons with disabilities, who raise concerns relating to people with disabilities and link with other protection actors who support people with

disabilities. There are obvious overlaps between the issues addressed by these different groups and collaboration is crucial.

Several national respondents spoke about the importance of Gaashaan's approach of supporting community-based structures, and how this aspect is quite unique in humanitarian programming in Somalia. Field staff emphasised how Gaashaan has made deliberate efforts to work alongside existing structures, rather than introducing entirely new systems, ensuring that interventions are grounded in the local context. However, where needed, Gaashaan has also helped establish these structures, involving men, women, and youth, and it provides training and support to them. These groups engage in monitoring and have action plans. However, while such groups are present at the current stage of the project, they have varying levels of capacity and presence within communities.

Gaashaan works with a range of structures, such as Child Welfare Committees, GBV structures, watch groups, and youth and woman-led structures, so project staff are in a position to identify priority protection concerns and implement localised action plans. In regard to determining who participates in these communities, stakeholders described a targeted process that aims to ensure diversity within these groups. Criteria are used to select people who are working on the issues of gender and child protection, and people who already working on other community issues. This grassroots empowerment seeks to help prevent GBV and child protection abuses, especially when it comes to family separations and child recruitment. This is an added value for Gaashaan as these structures were not previously supported by any other programme.

7.4 Early progress towards Outcome 2

Gaashaan has focused on capacity building and awareness raising in communities and has worked with existing community structures to ensure timely support to survivors, though physical safety constraints (e.g. shelters, improved lighting, latrines) have not yet been addressed, in general. The fact that some other programmes provide monetary incentives to community groups while Gaashaan does not is a potential source of tension, while some informants believe the project is not doing enough to support the economic empowerment of vulnerable women.

A key strategy for Gaashaan so far has been capacity building and awareness raising. Staff described conducting regular training sessions and awareness campaigns to ensure that community members, leaders, and structures are informed and sensitised on, and prepared to respond to, GBV and child protection risks. These trainings often include information on referral pathways, such as hotlines and government services, equipping local actors to engage with formal support systems.

In terms of response systems, Gaashaan works with existing structures to ensure timely support to survivors. Mechanisms such as regular reporting from community focal points, case documentation, and digital registration systems for children are used to streamline case management and follow-up. Staff noted that local mechanisms, such as trusted individuals or group leaders, share incidents with project teams, who can then quickly intervene. While awareness raising has been extensive up to now, some physical safety features, such as improved lighting and gender-segregated latrines, were noted as areas where Gaashaan's engagement has so far been limited. In certain locations, formal referral

mechanisms exist between community committees and Gaashaan staff to ensure survivors receive timely assistance.

Respondents noted changes in the knowledge of committee members after participating in training and working with the project. They are now able to identify not only cases of violence, but also potential risk factors the project can address, such as a lack of light in an IDP camp or women having to go outside of the camp for water at certain times.

Gaashaan has strengthened and facilitated the establishment of community committees like community Child Welfare Committees, child protection committees, GBV structures, watch groups, and other women-led structures. These structures have been supported to develop their own community-led action plans and have received regular mentorship and refresher sessions. Community-based groups have participated in community awareness raising aimed at changing inequitable attitudes and beliefs. Informants noted that there is now much greater awareness within communities. Some noted a gradual community-led change in behaviours and attitudes in the community, with reduced social stigma. Once the committees are established, training is provided and then localised workplans are developed. The primary roles of these groups are to monitor protection risks, refer cases that are identified, and raise awareness within the communities.

TPM confirmed that while Gaashaan's community-based engagement efforts have contributed to increased awareness of available services, its implementation demonstrates significant variability in engagement efforts, visibility, and community recognition across sites.

Many national stakeholders noted that coordination between communities and government/clusters makes a very positive contribution to protection. Some noted that district authorities, such as those in Kismayo and Dolow, now rely on Gaashaan's community structures to identify and escalate protection concerns and understand how to reach communities. However, it was also noted that the community protection structures being established/strengthened by the project are not yet fully integrated into formal government structures, particularly in rural areas. It was noted that more still needs to be done to enhance those linkages through Gaashaan, and by other actors, as it requires time and sustained effort to change the minds and perceptions of formal institutions so that they really work closely with community structures. Staff noted that they are raising awareness among government institutions and local authorities on the importance of collaborating and working closely with community structures.

7.5 What protection monitoring arrangements exist, and to what extent do they contribute to an effective GBV and child protection response? (Outcome 3)

Protection monitoring arrangements within the context of GBV and child protection in Somalia involve a multifaceted approach, combining formal and informal systems, with a growing emphasis on data utilisation and integration with early warning systems. These arrangements aim to trigger effective responses and ensure better protection outcomes for women and children. At the local government level, there are varying degrees of formalised reporting structures. Current efforts to strengthen the

capacity of local actors to collect and use monitoring data for GBV and child protection interventions are reported to be limited.

A key component of formal monitoring is the utilisation of specialised information management systems like the GBVIMS and CPIMS+, which have been rolled out and are in use by organisations within the Gaashaan consortium. These systems are not only tools for internal monitoring, they also facilitate safe data sharing with the government. Beyond these specialised information management systems, organisations also rely on their routine monitoring and evaluation systems, which are considered robust as regards tracking data, particularly through quarterly reports. These data are crucial for decision-making and are used to support early warning and coordination, and to improve the provision of services, ultimately contributing to better outcomes for women and children.

Gaashaan has larger plans to integrate protection monitoring into existing early warning systems across the country. A consultant has recently been hired to assess how this integration will work. This initiative is expected to come online in Year 3 of the project. The expectation is that greater preparedness, facilitated by these integrated systems, can reduce GBV and child protection risks: for example, by enabling proactive measures before an anticipated flood. Existing early warning community structures and systems, often established through other projects like those relating to food security, livelihoods, and water, sanitation, and hygiene initiatives, are being mapped to link with GBV and child protection efforts.

At the local government level, there are varying degrees of formalised reporting structures. In Baidoa, a decentralised reporting structure is in place, with focal points embedded within 10 settlements, who monitor incidents and violations and report back to the central administration. This system aims to ensure timely identification and referral of cases, although challenges related to capacity and resources exist. In Galkacyo South, there is ongoing information sharing between local government bodies and organisations to identify and respond to incidents. Baidoa also has a more institutionalised structure, with the Ministry of Family and Human Rights Development operating specific departments focused on gender and child protection, maintaining systems for tracking and responding to incidents. Howlwadaag has a community-based early reporting system in which designated individuals in each neighbourhood immediately inform local authorities about incidents, leading to collaborative action with security forces and district officials. However, in some locations there is a lack of clear awareness relating to, and formal tools for, tracking and reporting GBV or child protection incidents, even at the hospital level.

Local administrations primarily provide security support to organisations, conducting security assessments and arranging escorts. There is little evidence of structured capacity-building efforts to date that focus on improving data collection or monitoring systems. Local administrations suggested that support could include strengthening coordination with NGOs through regular monthly meetings. Howlwadaag, however, already demonstrates more active and structured efforts as the Ministry of Justice and Constitutional Affairs has formed a local committee to gather information from youth and girls, and is implementing regular awareness campaigns.

It was noted that local authorities that have already been supported have started to see the benefits of community collaboration because they receive real-time data and reliable

information, and opportunities for collective action and timely response, which enhances protection for all.

As noted earlier, the Gaashaan conducted several monitoring exercises that highlighted progress in community protection, such as increased awareness, improved safeguarding practices, strengthened capacity of community protection structures, establishment of private case spaces, and enhanced referral mechanisms. Challenges identified included volunteer burnout and infrastructure gaps, with agreed actions to tackle these involving the provision of tools, structured incentives, additional training, and partnerships. On accountability, 669 pieces of community feedback were collected via the feedback reporting mechanism, comprising 31% information requests, 20% setting out support needs, 12% suggestions, and 37% expressing appreciation. The Talk to Loop platform was deployed, focal points were trained, and feedback was systematically routed.

7.6 What is the capacity of women's and girls' groups, civil society actors, and platforms to advocate for reform and the implementation of policies that promote the protection of women and children? (Outcome 4)

The baseline capacity of women's and girls' groups, civil society actors, and platforms to advocate for the protection of women and children, particularly regarding GBV and child protection, varies across Somalia. While some groups exhibit strong capabilities and influence, others face significant limitations in regard to funding, technical skills, and access to national platforms. Gaashaan intends to enhance this capacity and collective action for social change and policy reforms that promote gender equality and civilian protection, but has not yet reached the stage of carrying out a structured baseline assessment of capacity.

At the national level, stakeholders hold mixed views on the advocacy capacity of women's and girls' groups and civil society actors. Some perceive these groups as strong, highlighting influential individual women with high-level government connections and organisations with robust grassroots networks and cultural knowledge. These groups are often effective in forming coalitions with national or international organisations, which increases their visibility and political leverage, enabling them to influence policy discussions and demand government accountability. They are seen as having a positive influence on women's and girls' rights organisations as regards engaging with policymakers such as government ministries and members of parliament. In this regard, Gaashaan's advocacy works indirectly by empowering local women's rights organisations. Authorities in Howlwadaag reported extensive multi-level engagement with both governmental and non-governmental actors, noting strong involvement from the Ministry of Family and Human Rights Development, national and regional women's leadership structures, and various human rights organisations advocating for women's rights. They observed an improvement in the situation for women, with increased institutional support and available advocacy platforms.

Conversely, other national stakeholders view these groups as inconsistent or weak, often lacking a clear vision beyond externally funded programmes, and facing restrictive financial challenges. Organisations differ significantly in size, experience, donor linkages, and experience of advocacy for policy change. While some are well-organised, with strong local

legitimacy and involvement in case referral and awareness campaigns, others lack adequate funding, legal registration, and technical skills in documenting and policy advocacy. They also often lack access to national-level platforms or decision-making spaces. These groups require more structured capacity building, particularly in regard to policy engagement strategies that utilise evidence-based data. Some grassroots organisations possess large constituencies and a deep understanding of the local context and issues, and provide everyday protection, but they often have zero funding and remain invisible to donors, national policymakers, and local authorities. These grassroots groups are effective at the local level but face challenges in advocating for national-level change, such as passing gender equality or child rights bills in parliament. Many bills and laws in Somalia remain stalled in parliament, and while women's rights organisations are increasingly focusing on these, budget constraints often hinder their advocacy efforts at this higher level.

At the community level, local actors play a crucial role in raising awareness, reporting cases, and collaborating with NGOs, but their direct involvement in shaping broader government policy remains limited or indirect. Community leaders have varying levels of awareness regarding local efforts to influence policies related to VAWG and child risks. While few reported direct involvement in formal policymaking, many described community-based initiatives aimed at shaping responses, improving services, or changing harmful social norms. Women's groups, youth organisations, religious leaders, and NGOs are instrumental in driving awareness and advocacy efforts, challenging harmful practices, promoting behaviour change, and connecting survivors to support systems. These groups intervene at the community level through awareness raising, training, and facilitating access to services. In some areas, community committees and traditional leaders actively report cases to Gaashaan and partners, leading to emergency support, medical care, or legal follow-up, especially for sexual violence cases. While these are mostly case-based responses, they indirectly contribute to programming priorities and service delivery by ensuring incidents are documented and acted upon. However, in some locations, there is a noted lack of local structures or community-led organisations capable of sustained policy influence, with policy matters often handled by external actors without direct community involvement.

The presence and roles of women's rights organisations at the local level were confirmed in most locations. These groups primarily focus on awareness raising, case reporting, and community mobilisation to address VAWG. They often collaborate directly with NGOs, including Gaashaan partners, or serve as referral agents. Women's rights organisations strive to influence the community by promoting peaceful resolution, improving service access, and ensuring the voices of vulnerable women are heard. They actively intervene in cases of FGM, abuse, or neglect, sometimes facilitating emergency medical referrals with NGO support. Some women's groups identify vulnerable families, disseminate training content, and act as key actors in grassroots protection. However, there are significant gaps in coverage, with limited or no presence of such groups in some rural settings and most organisational activity concentrated in camps, towns, or areas with active NGO partners.

Community leaders widely agree on the need for more efforts to influence programmes and policies addressing violence against women and children. They highlight the necessity for expanded awareness campaigns, especially in rural and underserved areas, and call for greater investment in trained staff, locally based organisations, community-led structures, health centres, safe spaces, and hotlines. Better communication channels and local offices or representatives are also stressed. Gaashaan is frequently recognised as a trusted actor

for strengthening these connections. Despite some acknowledged limitations in local capacity, community leaders believe external support and community-driven action can significantly enhance outcomes.

District and local authorities are actively engaged in advocacy initiatives and community dialogues to reduce GBV and child protection risks, though the level of organisation varies. Examples include initiatives organised by district administrations in collaboration with partners, focusing on awareness and improving survivor support services. Authorities also reported close collaboration with the State Ministry of Family and Human Rights Development, including participating in GBV and child protection discussions and trainings facilitated by the ministry. Some locations have longstanding and institutionalised collaborations involving social affairs committees, district authorities, and relevant ministries, forming structured channels for addressing survivor needs. Advocacy efforts often focus on strengthening legal responses, increasing community awareness, and supporting survivors, including formal engagements with judicial authorities. Community dialogues are inclusive, involving elders, women, and local administrators, and promote survivors' rights and access to legal support. Women's associations and youth groups play a central role in leading community-based interventions, with authorities providing financial, security, legal, and administrative support.

Local authorities expressed a willingness to support Gaashaan's efforts through providing logistical assistance, mobilising resources, and facilitating community access. They view this cooperation as part of their broader responsibility to support initiatives benefiting the local population, particularly in addressing violence. Some want to see an expansion of Gaashaan's activities, including building dedicated facilities to strengthen local protection capacity. Gaashaan involves the government as the duty bearer once a case is identified and escalated. This engagement, involving various institutions like local NGOs, the police gender desk, and the Ministry of Gender, has reduced risks for local NGOs, who are sometimes perceived as exaggerating GBV cases. By involving the government, they build allies at the government level to address these cases, and as Somali state institutions strengthen, key ministers are increasingly demanding to be involved from the beginning. This engagement increases pressure on the government to act and also exposes the government to the realities faced by women's rights organisations, something which is seen as aiding Gaashaan's response.

Staff across nearly all locations confirmed that Gaashaan's ongoing efforts include advocacy activities related to GBV and child protection, primarily focusing on awareness raising, promoting vulnerable populations' rights, and building community capacity. Community outreach and training sessions are central methods in this area, particularly targeting women, girls, and marginalised groups. Legal and institutional advocacy has also played a role in the project's early stages, with engagement of legal professionals to advocate for survivors' rights. Collaboration with ministries and civil society organisations for joint advocacy efforts has also occurred, especially during humanitarian crises. Advocacy is framed as a routine part of Gaashaan's programming, occurring regularly, often multiple times a month, and tied to broader awareness campaigns or global events. Advocacy includes both general advocacy (e.g. promoting the inclusion of marginalised tribes) and issue-specific advocacy (e.g. the prevention of child recruitment, support for GBV survivors).

8 Findings: efficiency

8.1 To what extent are sufficient data available and being collected to enable the cost effectiveness of interventions to be assessed?

Sufficient data are collected by the project to enable, in principle, the assessment of the cost efficiency of the delivery of outputs (e.g. cost per number of people and communities supported). Assessing cost effectiveness would have required measurement of outcomes and impact, and the allocation of costs to results at these levels.

Staff reported collecting data regularly (weekly, monthly, or quarterly) on the number of individuals assisted, services provided, satisfaction with support, and community needs. This provides adequate data for Gaashaan to assess its cost efficiency at the output level, as set out in its Value for Money Framework, which measures costs against the number of women and girls supported, the number of communities supported, and the number of women's rights organisations supported.

8.2 To what extent is the project's MEAL framework, including intended data collection, appropriate for guiding project implementation?

Gaashaan's MEAL framework is comprehensive and detailed, and its monitoring system includes tools that should both support accountability and enable adaptive implementation based on emerging lessons and needs. These include quality benchmark monitoring, work breakdown structure, data quality assessments, and an action tracker. The MEL systems review conducted for the evaluation found that these tools are only partially being used to guide project implementation.

Across all Gaashaan project locations, staff described monitoring as an essential and ongoing part of service delivery. Monitoring and evaluation are not treated as standalone events but are built into the project cycle. Staff emphasised the importance of tracking service implementation regularly to understand what is working, what challenges arise, and where improvements are needed. The use of internal mechanisms, such as scheduled reviews and structured documentation, suggests a strong institutional commitment to quality assurance. The Gaashaan programme review at the end of Year 1 noted that most monitoring visits identified significant progress and adherence to quality standards, while also reporting that there were gaps in how beneficiaries engaged with and understood the project across several indicators.

Community engagement is a key tool for monitoring, particularly in ensuring services remain responsive. Staff described built-in feedback loops where input from participants is gathered and used to inform decisions about service design and delivery. These processes contribute to continuous adaptation and responsiveness. Feedback is gathered through regular engagement with community organisations, direct interactions during capacity-building sessions, and observations made in the field.

In several sites, more structured supervision mechanisms are in place, with designated staff overseeing continuous oversight. These systems focus on collecting both qualitative and quantitative data through direct engagement with service users and providers. The information gathered is used to identify ongoing issues, which are then addressed through formal reporting and follow-up procedures. While most sites described active monitoring, a few locations are still in the planning or early implementation stages.

Several respondents stressed that tracking change requires not only evidence that activities have been delivered but also direct insights from those receiving services – particularly regarding satisfaction, challenges, and ongoing needs. For example, staff in Beledweyn and Jowhar highlighted the need for follow-up evaluations and dialogue with community members to determine whether services were delivered as planned and what issues may have emerged. Several staff, including those in Afmadow, Beled Hawo, and Howlwadaag, identified feedback from both service providers and community members as essential to understanding outcomes as it helps to assess the usefulness of capacity-building activities, the relevance of services, and the strength of local partnerships. A few respondents took a more community-facing perspective. For example, the staff in Wajid and Diinsoor noted the value of community dialogue and personal feedback for understanding change and maintaining engagement.

Data collection typically includes interviews with survivors, committee members, and members of community structures. This includes gathering feedback on satisfaction, unmet needs, and community perceptions of change. Respondents in some locations also mentioned preparing individual case studies and using digital monitoring tools to assess whether objectives have been met. These efforts are supported by feedback from hotlines and community-based observation.

While several respondents reported no major difficulties in obtaining the necessary data, others identified specific operational challenges. These include limited access to hard-to-reach or conflict-affected areas, the unreliability of transportation, and technological limitations. In Baidoa and Dinsoor, staff noted the challenge of reaching remote locations due to insecurity or the lack of regular flights. In Afmadow, outdated or low-capacity data collection devices were cited as limiting factors.

The MEL systems review (see Section 4.2 of the inception report) conducted as part of the evaluation inception phase concluded that there was a need to flesh out data collection methodologies, to address assumptions within each indicator, and to include more contextual data in indicator descriptions. The review also found some discrepancies in reporting.

9 Findings: impact[29]

9.1 To what extent does the project design incorporate appropriate safeguarding and measures to ensure no harm is done?

The safeguarding provisions put in place by Gaashaan appear to be strong and appropriate, encouraging both mitigating measures to reduce risks and effective responses where risks arise.

Safeguarding analysis was described by key informants as taking place from the project design stage onwards. Safeguarding issues are identified in every activity. As a mitigation measure, Gaashaan staff have been trained on, and are aware of, appropriate boundaries, and know how to respond if harm occurs. Complaints mechanisms, suggestions boxes, the provision of safeguarding staff, trainings, and codes of conduct were mentioned as means to ensure safeguarding. Others emphasised the importance of building trust with communities by maintaining open lines of communication, listening to concerns, and conducting regular field visits. Partners, such as GREDO, have zero tolerance of sexual exploitation, abuse, and harassment (SEAH) and have safeguarding policies in place and provide staff trainings on SEAH on a yearly basis, as well as providing trainings for new staff. They also undertake reference checks with the police and previous employers. It remains to be seen whether these policies are effective in the context.

Partners described feedback reporting mechanisms for cases in which communities have concerns about the services that Gaashaan provides and they stated that these allow for reporting of any safeguarding issues. There are anonymous and confidential feedback channels for community members to report concerns. One of the most common mechanisms cited was the use of community-based reporting tools, such as suggestion boxes and hotline numbers, which allow beneficiaries to report abuse or misconduct confidentially and to trigger referrals/responses where needed. These tools were described by staff as accessible and responsive, and as playing a key role in the early identification of harm. However, it was noted that many of these mechanisms require users to be literate, and that this would be a barrier for some community members seeking to complain about the project or to report SEAH directly through formal mechanisms, although concerns may be flagged via community leaders. Community respondents noted that the same barriers exist for reporting safeguarding concerns as exist for reporting GBV cases, in terms of cultural norms relating to GBV as well as low expectations of response. Ongoing work will be needed to create awareness of expected safeguarding standards and different mechanisms for flagging and responding to concerns. In sensitive or high-risk cases, Gaashaan staff explained that quick and confidential responses are key and that Gaashaan has mechanisms in place for this. One respondent detailed the response process for incidents such as abductions, including securing the survivor's safety, protecting her identity, and providing psychosocial and medical support.

[29] It was too early, at the initial evaluation stage, to assess impact, and it will now not be possible to make any impact assessment given the early closure of the project. In line with the evaluation framework, the key focus has been on assessing measures to reduce unintended negative consequences.

The TPM also revealed room for further improvement in safeguarding practices at facility level. While all staff reported having received safeguarding training at least once, and both health facility and safe house staff appeared fairly well versed in safeguarding principles, one facility (Adaado General Hospital) did not have a formal safeguarding policy, and there were varying levels of awareness of complaint reporting mechanisms. This suggests that greater efforts are needed to standardise protection and safeguarding training frequencies and to ensure universal cohesion of safeguarding policies.

9.2 Baseline and early indications of impact

There is early positive evidence of impact in terms of improved protection and reduced risks. Risks of VAWG were reported to have been reduced over the past year, with this decline largely attributed by community members to increased awareness activities, improved community mobilisation, and the presence of programmes like Gaashaan. Similarly, most community leaders considered that child protection risks have decreased over the past year, although in a few locations risks have remained constant or become worse.

Although the initial evaluation is not designed to capture impact, and impact indicators have not specifically been measured, given that the project is in the second year of implementation some changes have already been observed. Several informants noted early achievements that point towards higher-level impacts, particularly in line with the qualitative aspects of the impact indicators (see Annex C). Several barriers to achieving impact were also identified in some locations.

Scores against the impact indicators are shown in Table 7 (Impact Indicator 1) and Table 8 (Impact Indicator 2). The table shows the number of communities (out of the total of 18) whose average rating across all FGDs falls within each score interval (where 4 is most positive and 1 the most negative), and the mean across all communities. Further details are provided in Annex F.1.

Table 7: Impact Indicator 1 – distribution of scores by community and mean

Score	Most women and girls generally feel safe in their homes	Most women and girls generally feel safe in the community
3.50 – 4.00	2	2
3.00 – 3.49	4	1
2.50 – 2.99	9	8
2.01 – 2.49	2	6
1.51 – 2.00	1	1
Mean	2.75	2.71

Table 8: Impact Indicator 2 – distribution of scores by community and mean

Score	Most girls in the community are safe when participating in activities in public spaces	Most boys in the community are safe when participating in activities in public spaces
3.50 – 4.00	2	1
3.00 – 3.49	7	5
2.50 – 2.99	8	6
2.01 – 2.49	1	6
1.51 – 2.00	0	0
Mean	2.98	2.73

The majority of community leaders reported that the risk of VAWG had reduced over the past year, largely attributing this decline to increased awareness activities, improved community mobilisation, and the presence of programmes like Gaashaan that focus on the prevention of, and response to, violence. In Mataban, Dhoobley, Daynile, Marergur, Afmadow, and Kismayo, leaders believed there had been a reduced incidence of violence. They noted that awareness-raising campaigns, trainings, and capacity-building sessions conducted by the Gaashaan project have increased awareness of risks, encouraged reporting, and reduced stigma around seeking services. Leaders highlighted that initiatives such as disseminating hotline numbers, organising women's and girls' groups, and engaging local leaders were instrumental in fostering safer environments. In Beledweyn and Diinsoor, reductions in risks of VAWG were also noted but these were attributed more broadly to general increases in community-level awareness, NGO collaboration, and ongoing peace and stability efforts. Where there had been no perceived reduction in violence, or an increase, this was attributed to a lack of consistent programming to date or to external factors such as conflict. In Cadado and Hudur, leaders observed that risks remain volatile or have worsened, either because of ongoing conflict, overpopulation, or a lack of consistent programming. In Hudur, leaders noted that growing urban migration has led to an increase in violence despite past improvements.

Most community leaders agreed that child protection risks have decreased over the past year, although in a few locations risks remain constant or have worsened. Many leaders attributed the decrease in risks to awareness-raising activities by the Gaashaan project. Respondents from Mataban, Wajid, Diinsoor, Afmadow, Dhoobley, and Dollow clearly linked the positive changes to the work of Gaashaan and highlighted the importance of community mobilisation sessions, direct awareness campaigns at mosques, schools, and water points, the distribution of posters, and trainings for both children and adults. In Beledweyn, while improvements in peace and stability were mentioned, the leaders credited a broad range of NGOs – including the Danish Refugee Council, UNHCR, the World Food Programme, Save the Children, and WARDI – for contributing to reduced risks, rather than Gaashaan alone.

In contrast, leaders in Cadado noted that risks still fluctuate, depending on the presence of conflict or events like football tournaments that gather large groups of youth and sometimes lead to increased drug use or violence. Some respondents, such as those in Marergur, stated that community members' reluctance to attend awareness sessions limits how much risk reduction can be achieved. In Hudur, risks were reported to have worsened due to

overpopulation and incidents of serious abuse, despite some programmatic interventions, highlighting that structural problems like poor security and overcrowding can override awareness efforts if they are not properly addressed.

The Gaashaan Year 2 Quarter 1 Narrative Report shared a detailed story from GREDO illustrating an impact outcome: a survivor (Aamina) called the Gaashaan hotline, accessed comprehensive support (including legal assistance, psychosocial care, and safe housing), and successfully escaped an abusive situation. She ultimately became an advocate for the hotline. This represents a tangible example of a transformation in an individual's life, demonstrating the project's capacity to create lasting, positive change for survivors.

10 Findings: sustainability

10.1 To what extent has the project design considered the long-term sustainability of outcomes, including the capacity and preparedness of the organisations that will need to sustain results and the commitment of key stakeholders?

Gaashaan's strategy for sustainability was originally based on using its five-year time frame, and independence from other programmes, to focus on building institutional as well as community capacities. This was intended to be achieved through working with and through government-led services and existing community mechanisms, which was expected to enhance the sustainability of the approach. However, current funding crises within Somalia, together with shifting aid priorities globally, have increased the challenges for sustainable capacity building as other forms of support have been reduced. The early termination of the project has limited even further the prospects for sustainability. However, the project team has developed a sustainability plan as part of the project close-out arrangements.

Gaashaan's design supports the sustainability of services through embedding advanced skills and knowledge within the existing health workforce. This strengthens the capacity of local providers to continue delivering quality GBV response services well beyond the training period. Staff key informants were positive about the potential sustainability of the Gaashaan project and considered that communities were taking ownership of Gaashaan activities and that these were perceived as belonging to the communities and not to the government or international NGOs. Working through community-based structures was seen as a way to ensure the project is culturally accepted and not seen as a 'Western' intervention. Community informants reinforced the view that working through community structures helps to support long-term capacities and shifts in norms that support sustainable improvements in protection.

The project's alignment with long-term protection goals, particularly around GBV and child protection, was cited by staff as supporting sustainability. Ongoing connections to the wider protection sector and government systems enable a longer-term impact.

Community respondents across nearly all Gaashaan locations agreed that the project design incorporates key elements that support sustainable results, including strengthening community structures, skills building, enhancing service provision, and supporting institutional linkages. A number of staff and national stakeholders referenced continuous training and capacity building – both for staff and community members – as a key mechanism through which Gaashaan is working to sustain impact. Informants spoke about changing behaviours and attitudes, and about a range of measure to promote sustainability, including strengthening existing structures and establishing new structures, strengthening the existing referral pathway systems through engagement with the government, as well as engagement with communities so they have a sense of ownership. Several informants stated that the structures put in place will eventually be able to function independently of Gaashaan's financial and technical support in the future. They also spoke about Gaashaan making capital and human resources investments in government systems and facilities, rather than NGO-owned facilities, to build sustainability into these initiatives. For example,

Gaashaan has constructed rooms in government health facilities for the clinical management of rape, and has trained staff so that these remain after the project ends. Some respondents emphasised that long-term benefits are more likely when community needs are consistently identified and addressed, and when capacity-building efforts strengthen both service providers and local systems. Respondents felt that Gaashaan is mainly already doing this well, through its feedback loops, responsive service delivery, and ongoing awareness work. Respondents noted that the project's ability to respond as needs evolve is crucial to sustaining its benefits as it allows it to remain relevant. Some respondents highlighted safe spaces, trained committees, and multi-sectoral collaboration as critical for sustainability. These were seen as features that will outlast the project's direct implementation phase.

Several respondents also highlighted the importance of scaling up coverage and continuing to respond to unmet needs to ensure sustainability. Staff in multiple areas noted that Gaashaan has filled critical gaps in protection, and that if the project were discontinued some gaps would re-emerge. A few respondents noted that careful planning and design adaptations are still required to ensure sustainability. However, the TPM suggested that budget constraints have already led to programmatic adjustments, including the de-scoping of some planned activities, with these trade-offs impacting the scale and uniformity of service delivery.

As reported in Section 3.6, the Gaashaan project team has developed a sustainability plan as part of the project close-out process. The evaluation has not been able to assess the prospects for the success of the sustainability plan.

11 Conclusions

11.1 Project achievements

The evaluation has found evidence that Gaashaan has already achieved some results at the impact and outcome level, even though full implementation of activities under Outcomes 1 and 2 has only been underway for less than a year (following the emergency phase). Most (though not all) communities reported perceptions of reduced risks of VAWG and improved child protection over the period of implementation, and attributed this to increased awareness, community mobilisation, and the presence of projects, including Gaashaan.

There was a widespread recognition among communities that service availability and access have improved over the past year, with many directly attributing these positive changes to the Gaashaan project. Gaashaan is also considered by community members to have made contributions to strengthening community mechanisms to address GBV and improve child protection, though achievement varies across locations.

The project actively has addressed supply-side barriers by constructing spaces for the clinical management of rape in government health facilities and by providing essential medical supplies like PEP kits, which are particularly needed given the termination of funding from other sources. These interventions ensure that necessary resources are available for critical services. However, coverage of these improvements is not universal across Gaashaan target areas.

A strong belief exists among stakeholders that communities have taken ownership of the project's initiatives, viewing them as inherently theirs rather than external interventions. This is fostered by Gaashaan working through community-based structures, which enhances cultural acceptance and ensures that the project is not perceived as a ‘Western’ imposition. The project's alignment with long-term protection goals, particularly in the areas of GBV and child protection, further contributes to its chances of sustained impact, supported by ongoing connections to broader protection sectors and government systems. The project team has identified further support to these community-led aspects as crucial in the last months of project implementation in order to have a lasting impact.

The project design was intended to support advocacy for change at community, stakeholder (e.g. GBV AoR and other clusters), and national levels (Ministry of Family and Human Rights Development, Ministry of Justice). This approach was intended to connect grassroots empowerment with engagement at local and federal member state levels. However project closure has occurred before significant activities could be supported at national level.

11.2 What has worked well?

The evaluation has found that the following aspects of Gaashaan’s operations appear, in general, to be working well:

1. The identification of those at risk and the tailoring of responses to meet their needs.
2. The mapping of service provision and community-level support for survivors and those at risk.

3. Ensuring that effective safeguarding procedures and practices are in place, noting that some long-term weaknesses remain and that the efficacy of these arrangements should be monitored and adapted over time.
4. The establishment of a local presence in communities and developing effective collaboration with both formal structures (e.g. health system) and community structures (including with IDPs), though this has been more challenging in remote areas. Gaashaan's community-centred approach is seen as a key strength, allowing the project to tailor interventions to local contexts and to address critical needs.
5. Gaashaan's design incorporates provisions for the complex and changing Somali context, including its ability to respond to acute crises. The project has an emergency fund that allows for rapid response to emerging needs, such as the El Niño floods. Its partners have an existing presence and existing access in hard-to-reach areas, enabling service delivery despite security concerns and seasonal challenges. Quarterly monitoring and feedback from the Ministry of Family and Human Rights Development allows for reprogramming and adaptation to immediate risks.
6. Gaashaan is considered a 'go-to' organisation for coordinating and sharing on service mapping and strengthening referral pathways. However, many referral pathways have broken down following funding cuts across the wider aid sector. Gaashaan's efforts helped to plug gaps and respond to changes in service availability in the wake of USAID funding cuts but resources were insufficient to cover all gaps.
7. Working in a coherent and complementary way with other initiatives and through humanitarian coordination mechanisms. Gaashaan is strongly integrated into the GBV and child protection cluster systems, with proactive efforts to align project activities with technical guidance from these national coordinating bodies. This is evident in respondents' references to the development of key guidance documents and updates to standard operating procedures.
8. Providing capacity building and awareness raising in communities to monitor protection issues and play a role in the referral system.
9. Gaashaan has undertaken significant capacity-building activities with specialist service providers, particularly those in health clinics. Training for health staff on clinical management of rape, and for GBV focal points and community health workers on case identification, confidentiality, and safe referrals, has led to improved technical capacity and better care for survivors.

11.3 Areas of weakness

The evaluation identified the following areas of weakness, recognition of which can inform and improve future programming:

1. While the current ToC provides a generally appropriate framework, it lacks a fully articulated narrative, and specific assumptions related to key causal pathways. Several informants highlighted the project's successful adaptation to the El Niño crisis as a strength, and the importance of flexibility in the changing Somali context was noted as a key success criterion for partners. However, this adaptive capacity and its underlying rationale are not fully integrated into the ToC. Additionally, the ToC does not sufficiently detail the intention to respond to mobile populations.

2. While Gaashaan has mapped service provision and engages with mechanisms to stay informed of gaps, not all sites are equally strong on identifying capacity needs. In some areas, assessments are more informal or are based on direct observations, rather than structured processes.
3. Some informants noted instances where local government requests or practices, such as mandatory reporting of GBV cases, do not fully align with international best practices and standards regarding confidentiality and survivor-centred approaches.
4. While Gaashaan targets hard-to-reach areas, there are still significant gaps in scaling up outreach to pastoralist or nomadic communities, who are constantly on the move and lack a permanent protection presence.
5. The widespread funding cuts, particularly from USAID, have severely impacted the availability of protection services across Somalia, leading to a dramatic reduction in service providers and raising concerns about unmet needs and the sustainability of remaining services.
6. While the project MEAL framework is appropriate for guiding project implementation, tools are only partially being used to guide project implementation. Improving data collection and monitoring in challenging areas would provide a more complete picture of what is working and where resources are most effectively utilised, enabling better-informed decisions for adaptive management.
7. While Gaashaan has successfully strengthened community-based protection structures, the integration of these structures with formal government systems remains weak and many government entity approaches are not aligned with international best practices. Instances were noted of cases where local government practices, such as mandatory reporting of GBV cases, conflicted with international best practices on confidentiality and survivor-centred care.
8. Although the project allows for adaptation and for pivoting of activities during acute crises, the crisis modifier does not sufficiently anticipate crises.
9. While coordination is generally strong, differing approaches/tools utilised by various NGOs can cause confusion within communities.

12 Lessons and recommendations

12.1 Lessons

1. **Flexibility to respond to emergencies is crucial for addressing the vulnerabilities of women and children:** Gaashaan's ability to pivot quickly to emergency response during the El Niño floods in its first year highlights the importance of having an emergency fund and flexible programming to address newly emerging needs in a volatile context like Somalia, where humanitarian needs can increase vulnerability for women and children.
2. **Leveraging existing local presence can support access and operations in hard-to-reach and high-risk areas.** Gaashaan's success so far in these locations has been partly due to its partners having an existing presence and existing access, which mitigates security and seasonal access issues. However, provision for remote and mobile populations remains weaker than for other communities.
3. **A community-centred approach fosters ownership:** Working through, and strengthening, community-based structures, rather than imposing external systems, has been key to the project's cultural acceptance and to fostering a sense of community ownership over protection issues.
4. **Robust monitoring and evaluation systems are of vital importance to protection systems:** The use of specialised information management systems (GBVIMS, CPIMS+), routine monitoring and evaluation, and community feedback loops are crucial for tracking progress, identifying gaps, informing decision-making, and adapting programming to remain relevant. Plans to integrate protection monitoring into existing early warning systems are seen as a vital step towards proactive risk reduction, allowing for preparedness measures to be taken ahead of anticipated crises.
5. **Strong coordination with government and clusters is key:** Active engagement with government ministries and humanitarian AoRs for GBV and Child Protection is vital for coordination, accountability, information sharing, and adapting to service gaps, especially in the context of funding cuts.

12.2 Recommendations

Recommendations are set out below for FCDO to consider in future protection programming.

1. Strengthen the ToC

The project's ToC, while valid, lacks a fully articulated narrative and specific assumptions for each causal pathway. The ToC for any future protection programming should explicitly detail the rationale for the project's flexibility to respond to changing contexts, particularly in light of funding cuts across the sector. It should also clearly articulate the specific intent to engage with mobile populations, and expand on the function of multi-level advocacy. Given the current funding constraints, the ToC could also incorporate the need for cross-sectoral advocacy in the face of funding cuts (in addition to government-focused policy advocacy). Explicitly incorporating these elements into a future ToC would ensure the project's design

fully reflects its operational realities and strategic contributions, making it more robust and responsive to the complex and dynamic Somali context.

2. **Systematise the identification of capacity gaps**

While Gaashaan maps service provision, the evaluation found that the process for identifying capacity gaps and training needs is not consistently strong across all sites. Future programming should implement a standardised and documented process for identifying these gaps across all locations to ensure that capacity-building efforts are precisely tailored to the specific needs of different communities and service providers. This should be done continuously and systematically. This would also enhance coherence across organisations and locations. Ensuring local staff are consistently and formally engaged in identifying training needs, beyond just implementing predetermined plans, is a potential area for further inquiry and improvement. A more systematic approach to identifying and documenting these gaps across all locations would make it possible to tailor capacity-building and response activities even more precisely to the specific, evolving needs of different communities and service providers, thereby increasing their relevance.

3. **Strengthen engagement with local governments**

Future programming should intensify ongoing advocacy and capacity-building engagement with local and state-level authorities through dialogue, workshops, and technical assistance to promote adherence to international guidelines for GBV and child protection case management.

4. **Enhance interventions for hard-to-reach populations**

To improve effectiveness, future programming should develop specific, flexible strategies for reaching and continuously supporting mobile and underserved groups (principally nomadic pastoralist groups), possibly through mobile units, technology-based solutions adapted for low-literacy contexts, or strengthened partnerships with local community networks that move with these populations.

5. **Address sustainability in light of funding cuts**

The widespread and unexpected cessation of funding from major donors like USAID has severely impacted the protection sector, leading to a dramatic reduction in service providers and raising concerns about sustainability. FCDO staff should actively engage the humanitarian sector and donors to highlight the critical need for sustained funding for protection services in Somalia and strategically plan for the long-term viability of interventions beyond current funding cycles.

6. **Enhance data utilisation for adaptive management**

Future programming should prioritise training and equipping local staff and community focal points in remote areas with robust, user-friendly data collection tools, potentially including offline capabilities. This should take place in collaboration with existing partners who have access that enables them to gather qualitative and quantitative data from hard-to-reach and mobile populations (e.g. pastoralist communities) who are currently underserved. This would involve establishing clearer feedback loops and follow-up mechanisms in these areas to ensure that the data are not just collected but are actively analysed and used to adapt

programming. This includes addressing operational challenges in data collection, ensuring timely analysis, and establishing clearer protocols for how insights from MEAL are translated into programmatic adjustments and decision-making at all levels, from field teams to consortium management.

7. **Enhance the integration of community and formal systems**

Future programming should prioritise and intensify efforts to formalise the links between the community protection committees (e.g. Child Welfare Committees, GBV focal points and committees) and relevant local and national government institutions, such as the Ministry of Family and Human Rights Development and district-level authorities. This could involve the following: developing formal memoranda of understanding or protocols that define the roles, responsibilities, and reporting mechanisms between community structures and government entities; facilitating joint planning and monitoring sessions between community committees and government officials to foster understanding and ownership; and advocating for official recognition and integration of community-based protection volunteers and committees within government protection frameworks, potentially leading to budgetary allocations or sustained support.

8. **Plan for recurrent crises**

Future programming should further develop a crisis modifier mechanism to anticipate and respond swiftly to recurrent crises. This could include a potential anticipatory annual budget to ensure immediate support during emergencies and to maintain service continuity.

Annex A ToRs for the evaluation of the Gaashaan Protection Project

A.1 Introduction

A.1.1 Description of the intervention to be evaluated.

The British Embassy Mogadishu (BEM) is seeking an independent evaluation supplier to provide evaluation support to the Gaashaan[30] project, a component of the HARBS (*Humanitarian and Resilience Building in Somalia)* programme. The project is a four years and five months (October 2023 - March 2028) intervention delivered by a consortium of six partners in South Central Somalia led by Save the Children, and working alongside the International Rescue Committee, CARE International and four national NGOs: Save Somali Women and Children (SSWC), Somali Women and Development Centre (SWDC), Somali Women's Studies Centre (SWSC) and Gargaar Relief and Development Organisation (GREDO).

This project is an important contribution to the humanitarian and resilience building portfolio's goal of delivering effective, principled, and timely humanitarian support to those in greatest need in Somalia. A review of the UK humanitarian portfolio in Somalia in 2022, brought out the unmet protection needs of vulnerable people, particularly women and children, necessitating the creation of an element dedicated to meet these needs, found to be driven and exacerbated by climate extremes and displacement.[31]

The inception phase of the project (October 2023- March 2024) interfaced with the onset of the 2023 El Nino crisis in the Horn of Africa, where Somalia, especially South-Central regions was extensively impacted. BEM, therefore decided to kick-off an emergency protection response in 10 of the 18 most flood affected project districts, for the first 5 months, and later onboard the rest of the multi-year interventions from April 2024.

In addition to delivering protection interventions to the most vulnerable crisis affected people, the project supports the delivery of the UK's International Women and Girls Strategy[32] empowering communities and local organisations to effectively drive down the high rates of sexual and gender-based violence and other harmful practices as well as increase their capacities as actors in humanitarian response in promoting gender equality and protection of civilians.

The project has four intended outcomes, as follows:

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[30] Gaashaan means Shield in Somalia language, aptly named to highlight the overall aim; shield Somali women and children from conflict and climate driven violence.
[31] Gender Equality and Social Inclusion (GESI) Analysis 2022: A review of approaches across FCDO-Somalia's Humanitarian & Resilience Portfolio: This report indicated significant gaps in knowledge and understanding of understanding drivers of vulnerability particularly amongst women, girls and minority communities and recommended dedicated resources to better promote gender equality, inclusion and address protection concerns within the humanitarian response.
[32] The new International Women and Girls Strategy, launched in March 2023, within which the UK re-commits to support education, empowering and ending violence amongst women and girls, including supporting grassroots organisations.

1. Provision of quality specialised Gender-Based Violence (GBV) and Child Protection (CP) services, targeting vulnerable communities affected by humanitarian crises, specifically women, girls, and boys.
1. Enhance the capacities of community members and key stakeholders to prevent, mitigate and respond to protection risks.
2. Strengthen protection monitoring systems to efficiently trigger response, inform and adapt programming for better protection outcomes.
4. Strengthen capacities of Women Rights Organisations (WRO) and grassroot local Civil Society Organizations (CSOs) promoting gender equality and protection of women and girls in humanitarian crises.

The project is expected to work and coordinate closely with the humanitarian cluster system in Somalia, participating in national and sub-regional cluster coordination mechanisms with the intention of informing and improving protection responsiveness of humanitarian actors.

A.1.2 GESI dimensions of the intervention (if applicable)

Gaashaan's activities will target and address the differentiated needs of women, girls, boys, and men. Monitoring and evaluation activities of the Gaashaan Consortium will collect gender, age, and vulnerability disaggregated data to ensure considerations of inclusion and exclusion, in accessing the protection services, including engagement with community structures.

A.1.3 Description of the context

In Somalia, drivers of the complex protection crises/concerns are inter-connected and protracted, and further compounded by weak protective institutions and frameworks. Somalia continues to grapple with prolonged conflict, recurring climate-related hazards in the form of frequent droughts, flash floods and riverine floods that result in massive displacements, disrupting people's livelihoods and increasing vulnerability across the country. According to the 2024 Humanitarian Needs and Response Plan (HNRP), an estimated 6.9 million people, will require humanitarian assistance in 2024. The same report estimates 80% of these being women and children, who bear the larger brunt of the crises impacts and a multitude of protection risks[33]. The analysis highlights GBV, family separation, child abuse, child recruitment into armed groups, being some of the key protection risks. It projects about 3.2 million people needing GBV related services, and 3 million children needing protection from such harms as physical and sexual abuse, recruitment into fighting groups, harmful practices including being separated from their families[34]. The impact of these harms is aggravated by a protection environment characterized by impediments of access to humanitarian workers and services.

Further, critical gaps and inequality in service provision and response remains a challenge; a situation that has been observed in consistent Somalia Humanitarian Situation Updates, including the HRNP 2024 for Somalia. Limited information and awareness about exploitation, violence risks and available protection services, coupled with low awareness of

[33] Somalia- Humanitarian Needs and Response Plan 2024
[34] Ibid.

basic rights and discriminatory and harmful socio-cultural norms remain as underlying factors to unmet protection[35]. The February 2024 Situational update in particular highlight absence of systematic data collection and reporting on protection incidents, along with a shortage of protection actors, as concerns that undermine efforts to address gender-based violence and harms facing children. Also, the reality that local organisations, and rights representative groups are underrepresented in the Somalia humanitarian system has been acknowledged by humanitarian actors and there are varied efforts to factor localisation and enable quick and timely response informed by local knowledge and expertise.[36]

The UK in Somalia is committed to helping contribute to the safety of women, girls, and children through provision of protection services (addressing GBV and child abuse/rights violation) as well as increasing the capacity of communities and local organisations. As guided by the International Women and Girls Strategy, local organisations, particularly WROs, will be at the heart of Gaashaan's interventions to bring in the deep understanding of local challenges, and potential solutions to increased safety for women and girls.

The project is currently being implemented in 18 districts in some of the HNRP 2024 prioritised regions, most affected by humanitarian crises. In these locations communities in IDP camps as well people living in rural community set ups are targeted by the project interventions. In addition, there are service point facilities consisting of one stop shelters, treatment facilities as well as girls and women safe shelters. The Gaashaan project intends to deliver interventions in newly liberated states, regions that are hard to reach due to conflict (or other) including regions that are vulnerable to climate-related impacts.

Table 9: Gaashaan geographical footprint

State	Regions	Districts
Banadir	Banadir	Howlwadaag and Daynile
Hirshabelle	Hiran and Middle Shabelle	Beledweyn & Mataban Jowhar
Southwest	Bay and Bakool	Baidoa and Dinsoor Hudur, Wajid, and Elbarde
Jubaland	Lower Juba and Gedo	Kismayo, Afmadhow & Dhoobley Beled Hawo and Dolow
Galmudug	Galgadud and Mudug	Adaado and DhusaMareb South Galkayo

A.2 Purpose, scope, and objectives

A.2.1 Purpose of the evaluation

The purpose of this work is to provide an independent evaluation for Gaashaan project with a focus on:

[35] SOMALIA Situation Report Last updated: 17 Mar 2024 OCHA
36 Somalia Humanitarian Needs and Response Plan 2024.

Learning: To process and reflect on the information generated from monitoring and evaluations (and from any other evidence generating activities) and use it to continuously improve the programme's ability to achieve results. In effect, maximise the project's effectiveness, efficiency, and sustainability of impact.

To increase the evidence-base around "what works" to better protect women, girls, boys, and men from GBV and the various child protection risks amongst communities impacted by humanitarian crises in Somalia.

- **Accountability –** whilst the focus is primarily on learning, assessment of whether we are contributing to outcomes will also support accountability to the UK public and to the Somali people.

Further, the BEM, is keen to strengthen the global evidence base on what works to address and prevent GBV in emergencies, providing the UK, and by extension other stakeholders with quality evidence to play an active role in the Call to Action on Protecting women and girls from GBV in humanitarian contexts[37].

BEM and the Gaashaan consortium partnership is the primary beneficiary of the evaluation, considering the need to consistently measure achievement, as well as adapt to contextual changes, for the best interest of Gaashaan's overall outcomes. However, evaluation independence is critical, so the potential evaluation partner will need to balance engaging with the consortium and adaptation, with rigour and independence.

In addition, the project will benefit the Somalia Humanitarian System, in particular the Protection Cluster and relevant members of GBV and CP Areas of Responsibility (AoR). Also included as beneficiaries are donors and Somali authorities, keen to use the evidence generated from the evaluation to adopt strategies that work in enhancing protection of women and children most impacted by humanitarian crises in Somalia. The project will be helping to address gaps in humanitarian protection response, which is assessed to be inadequate in the face of current needs. Lastly, and not the least important beneficiaries will be the Somali people as rights holders, particularly women, girls and children, vulnerable and disproportionately impacted by crises, and continue to bear the brunt of unmet protection needs.

A.2.2 Scope of the evaluation

In order to achieve the objectives of this contract the potential supplier will be expected to deliver a set of specific outputs as outlined under the Objectives section below. The supplier should provide a clear sense of the overall vision in delivering the outputs, broadly describing the proposed approaches and methodologies that will be used. For instance, representatively cover Gaashaan's geographical focus, including enabling programme-wide insights on performance as well as learning from the interventions under implementation.

In terms of **programming and timing**, the evaluation work is expected to potentially start in July 2024, with the expectation that, evaluation products will be delivered throughout the programme to inform us whether our causal assumptions are holding. The evaluation planning may involve 6-12 monthly strategic reflection sessions, to review progress in a bid

[37] The Call to Action on Protection from Gender-Based Violence in Emergencies is a global initiative of governments and donors, international organisations (IOs) and non-governmental organisations (NGOs). Its aim is to drive change and foster accountability from the humanitarian system to address GBV from the earliest phases of a crisis.

to maximize the potential for achieving the intended results. Potential suppliers are expected to propose an overall approach to determining all of this in their bids, with details being finalised by the end of inception period (potentially September 2024), once details of data collection schedules have been worked out with the implementing consortium. The end date for Gaashaan will be end of March 2028, and therefore the final round of data collection should be before end of March 2028, with the report expected in by end June 2028.

A.2.3 Objectives of the evaluation

Rigorous evaluation is a major focus of FCDO (Foreign Commonwealth and Development Office), improve performance management and learning, as well as evidence-based decision making. To this end, the OECD DAC criteria for evaluation will be applied in addressing the evaluation questions[38]. The objectives of this evaluation will be:

1. **Baselining**: To understand the existing state-of-play with regards to quality and availability of services; the strength of the community-based protection structures; the quality of the MEL systems and use of evidence; and the capacity of organisations to advocate for social change (the core aspects of the Theory of Change (ToC) which will be necessary for us to understand, if our intervention is resulting in the desired changes). The exact baselining objectives may be finessed after the ToC workshop.
2. **Test the validity key assumptions in the ToC**. This may also include an initial mapping of the existing evidence/knowledge against some of the key assumptions and will then involve testing whether they are playing out as expected in real-time. This is intended to help the BEM understand whether we are on track to achieve programme outcomes and impacts. It should support evidence-informed adaptation and reflection and highlight any unintended consequences. The specific pathways and assumptions to focus on will need to be decided through the detailed ToC review as part of inception.
3. **Effectiveness:** Assess whether we have achieved our outcomes, where indicative outcome-level evaluation questions may include:
    - Are advocacy efforts and capabilities by civil society actors and women and girls' groups enhanced? Has this resulted in improvements to policy which promote gender equality and protection from GBV?
    - Are reporting systems strengthened as a result of programme activities? If not, why not? If so, is this leading to a more evidence-based and therefore more effective protection response?
    - How **effective** are approaches to recovery and reintegration of women, boys and girls into their communities?
4. Generate an assessment of whether we are achieving or likely to achieve our impact. Indicative impact-level questions may include:
    - Are quality services more accessible and available to SGBV survivors as a result of programme activities?

[38] In adopting OECD DAC criteria for this evaluation, the range of questions expected to be fully developed during inception, should help to determine the extent to which the intervention's objectives and design respond to beneficiaries needs in this context (relevance), the achievement/ fulfilment of objectives, (effectiveness), and including whether the interventions deliver results in a timely manner (efficiency). Also, the extent to which the interventions generate higher level results, and if these are likely to be sustained in the longer term.

- To what extent has the project interventions enhanced the protection of women, girls, boys, and men from GBV and child protection risks?

5. **Determine the cost-effectiveness of various approaches**. The details of this will need to be worked through during inception stage. A plan for this is expected as part of the inception report.
6. **Provide quality oversight of the IPs monitoring systems**. The evaluation supplier will be expected to work closely with the implementing partners to understand what data they are able to collect, versus what needs to be additionally collected by the independent evaluation supplier. The evaluation supplier will be expected to support BEM understand the quality of IP data collection approaches/systems and to provide support to get them to required BEM standard should there be any issues.

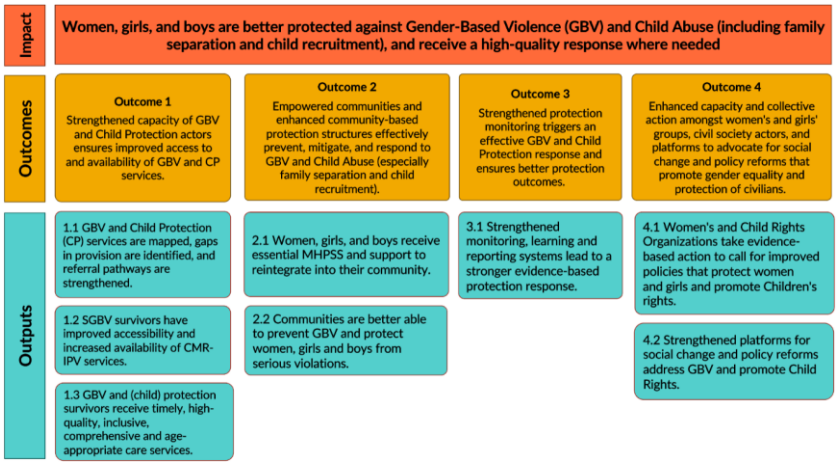
A.3 Methodology

A.3.1 Evaluation methodology

This evaluation will be a theory-based, mixed methods evaluation to assess project progress towards achieving the purpose, (outcomes and impact of the project as presented in the ToC. While addressing the agreed evaluation questions, the methods proposed should be able to test the key causal assumptions and whether activities and outputs are contributing to outcomes and impact, whether the project is in line with local needs and priorities as well as addressing the needs of the population most affected by humanitarian impacts. The evaluation should be phased, so that feedback can inform learning and adaptations as necessary.

Potential suppliers are requested to propose appropriate methodological approaches for delivering the evaluation considering the time, budget, and data sources (*see section 4: on data types and sources*) available for the evaluation. There will be an opportunity to further refine the methodology during inception period (particularly after the Gaashaan project monitoring plan and data collection has been reviewed), to best address the final evaluation questions once agreed. (*See Gaashaan's Theory of Change)*

Table 10: Evaluation methodology



A.3.2 Cross-cutting issues

The evaluation should explore Gender Equality and Social Inclusion dynamics, considering the differentiated needs and vulnerabilities of the different categories and identities in the communities targeted by this project. It should endeavour to bring out how gender inequality and social exclusion manifests within delivery of interventions and how partners appreciate these dynamics and use this knowledge to address them in implementation of activities.

A.3.3 Potential risks and challenges for the evaluation

The evaluation supplier will need to demonstrate that they have a good understanding of the risks of conducting evaluation tasks in complex, conflict affected contexts such as Somalia. In their proposals, potential suppliers will need to identify major risks, articulate risk mitigation strategies, and provide details on robust, regular processes for reviewing and updating risks over the life of the programme.

Potential risks and challenges for this evaluation (but not limited) include:

Conflict risks and access: conflict dynamics in Somalia are complex and ever changing. The Federal Government of Somalia is at war with the designated terrorist group Al-Shabaab who is the major non-state armed actor in the country. Inter and intra-clan conflict dynamics are also evident across the country. Gaashaan project has been set up to deliver interventions in regions newly liberated from Al Shaabab hence lacking sufficient government oversight and is generally hard to access. The supplier should be able to demonstrate the ability to understand and mitigate conflict risks, particularly during data collection.

Quality of data collection: Ensuring quality of data collection is critical for all evaluations in Somalia. This can particularly be a challenge if an evaluation partner is adopting a complex subcontracting approach with limited oversight of enumeration. Ensuring a clear upfront approach to data collection, addressing any enumerator capacity gaps through training, using digital tools (e.g. GPS tracking), and ensuring robust data quality assurance is critical. Potential suppliers are welcome to propose an approach that

incorporates capacity within the implementing consortium, present in all project locations and with internal MEAL expertise.

Significant levels of gender inequality and social inclusion: Gender inequality and social exclusion (particularly along clan lines) is significant in Somalia society. The evaluation supplier needs to have a strong understanding of this, grounded in the Somali context and consider the ways in which this might introduce bias into data collection and analysis. The evaluation supplier should also consider how they would address any risks or issues around Sexual Exploitation, Abuse and Harassment (SEAH) that could arise as a result of the evaluation.

High corruption and wider fiduciary risks: Somalia is a high corruption environment. Although it is not the objective of the evaluation, the evaluation supplier should consider how they would handle any risks or issues if they uncover within the programme any fraud, corruption, loss, or diversion. Also, they should consider the fiduciary risks along their own operation and/or delivery chain.

- **Sensitivity and complexity of evaluating issues of GBV and child protection programming**: by its nature GBV and CP programming in crisis settings is sensitive and will likely involve engaging on issues of complex social norms and interacting with vulnerable people who are survivors of protection violations. Being able to sensitively collect data with the appropriate ethical standards will be key.

A.4 Methods and data collection

A.4.1 Primary and secondary data collection

Primary data Collection: Primary data sources are expected to be from multiple levels of the project's delivery chain, including national and sub-national coordination levels, field implementation locations, including facilities and households where relevant. In particularly, with respect to data collection at field implementation level, the evaluation approach will need to consider a robust sampling approach to locations, and a comprehensive stakeholder mapping to enable answer the research questions proposed. This approach will need to balance robustness and good enough coverage for insight, while also ensuring Value for Money considerations of all the evaluation activities.

Secondary data: The independent evaluation partner should also explore relevant secondary data, for example.

1. **Programme secondary data**: Gaashaan consortium's monitoring activities as well as HARBS results matrix will be important sources of data, considering there has been an initial phase of emergency response, delivering in some of the most flood affected districts targeted by the project. Narrative progress reports, monitoring reports, risk registers etc, will be provided to the evaluation team for review.
2. **Literature Review**: During the **inception** period the evaluation team should conduct a detailed review of the literature, on relevant evaluations and research studies on GBV and Child Protection programming in Somalia. This should be summarised in the inception report and feed into the evaluation design.
3. **Administrative data**: sourced from the humanitarian cluster coordination system in Somalia**,** which will mainly be protection related information about the people impacted by crisis, their needs, and gaps prevailing in meeting these needs.

A.4.2 Data collection respondents

The following list of stakeholders can be anticipated to be included within the primary data collection (quantitative and qualitative) in order to answer evaluation questions:

National level (Mogadishu)

Staff of the Ministry of Women and Human Rights
Staff from lead and member UN agencies and NGOs from the protection cluster and its AoRs.
Staff of Gaashaan Consortium – Save the Children, IRC, CARE, GREDO, SWSC, SWDC and SSWC
Staff of the British Embassy Mogadishu

- International donors funding protection network

Sub national level.

Staff of relevant federal ministries that oversee women's, girl's, children's, and gender priorities.
Regional Cluster Coordinators – UN and others
District level relevant authorities

- Staff of Gaashaan Consortium based in sub-national coordination offices.

Service point Facilities.

Ministry of Health staff at health facilities delivering Gaashaan's interventions
Management staff of one-stop centres and Safe Shelters

- Organisations included in referral pathways.

Community level.

Household level as determined by sampling frames.

- Community leaders -categories could be religious leaders, camp leaders, women leaders, etc.

A.5 Ethics and safeguarding

Reference FCDO (Foreign Commonwealth and Development Office) Ethical Guidance for Research, Evaluation and Monitoring Activities and ask suppliers to consider:

The supplier must adhere to FCDO ethical guidance for research, evaluation and monitoring activities (publishing.service.gov.uk) and be guided by these values; which seek to maximise benefit and minimise harm, respecting people's rights and dignity, act with honesty competence and accountability and deliver work of integrity. Proposals should include these considerations and a statement that the data collectors will comply with the principles expounded by the guidance. The application of ethics will be included in the assessment of bids.

A.6 Workplan and outputs

A.6.1 Requirements (key deliverables and outputs)

The expected core deliverables and outputs for this evaluation are as follows:

Inception period:

Inception report to be shared by 30th September 2024, and should include:

Rapid literature review of GBV and child protection evaluations and research in Somalia.

A review of the Gaashaan monitoring data collection plan – and any recommended changes agreed with partners to support the evaluation.

Outcome of a Theory of Change workshop with Gaashaan partners, which should help flesh out the key causal assumptions that will need further testing through the evaluation.

Full evaluation methodology, which should include data collection (including primary/secondary, and sampling) and analysis plan, against each of the finalised evaluation questions.

- A clear knowledge dissemination strategy, to ensure maximum exposure of the learning within Gaashaan consortium, the targeted wider humanitarian stakeholders, as well as strengthening the evidence base of what works to address protection concerns in Somalia. The strategy should indicate the range of knowledge products; papers, reports, journal entries, blogs, training guidance etc, necessary to disseminate and influence use of evidence generated.

Evaluation implementation period:

The independent evaluation partner will need to define in their initial proposal and refine in inception phase the key phases and rounds of data collection for this evaluation. As stated above, this evaluation is expected to have a number of stages which support learning loops and programme adaption from partners. At minimum we would expect:

Initial (baseline) evaluation report end-August 2024, and reflection workshop with BEM and Gaashaan partners

Mid-point reflection workshop and evaluation report to be around March 2026 and involving BEM and Gaashaan partners.

- Final evaluation report and summary policy briefs provided by end June 2028.

Evaluation dissemination periods

- Evaluation findings dissemination events with key stakeholders in Mogadishu, and Nairobi will be done at key points within the project's life with the final event completed by March-2028.

The inception report, baseline, interim and summative evaluation reports will all be subject to FCDO's independent quality assurance Evaluation Quality Assurance and Learning Services (EQUALS). BEM will facilitate this review processes, while also ensuring that the management and governance structure of the Humanitarian and Health Evaluation Learning and Monitoring in Somalia (HHELMS) programme, within which this evaluation contract will be delivered is adhering to the quality assurance framework, developed to guide research,

evaluation, and analysis outputs of all of HARBS projects[39]. It will be critical for evaluation outputs to achieve adequate scores through this process in order to be classified as robust enough quality to reach FCDO's standards for evaluation.

A.6.2 Contract budget

The contract budget is GBP 400,000 and potential suppliers for this evaluation are expected to provide a costed workplan and in their proposal demonstrate how they have ensured robust value for money for the evaluation work.

Evaluation partners should propose a payments schedule for this work, and as far as possible payments should be linked to evaluation deliverables/outputs (i.e. inception report, interim evaluation report and final evaluation report)

A.6.3 Reporting requirements

The following formal contractual/programme management reporting requirements are expected. In addition, as per the governance arrangements below, more informal progress updates and meetings are expected at a higher frequency particularly during peak periods of data collection and analysis.

Table 11: Reporting Requirements

Report	Discussion
Quarterly progress reports	On a quarterly basis report on progress: **Section 1: Progress update** including updates on activities undertaken, key achievements, details of interactions with / or demand from stakeholders, annex of any presentations made during the quarter. **Section 2: Deliverables update** listing any outputs agreed in the sub-contract at the end of an inception phase, and progress against those outputs. **Section 3: Challenges, issues, risks** (including fiduciary and safeguarding) **and opportunities** – including any mitigation strategies. **Section 4: Forward planning** – list activities over the next 3 months including desk-based, field activities, stakeholder engagement events, or any changes to plans. **Section 5: Financial management** – quarterly financial report using provided template
Annual progress report	As above but covering 12 months delivery and forward look.

[39] HHELMS- Humanitarian Health Evaluation Learning and Monitoring programme has been set up by BEM to provide monitoring, evaluation and learning services for the humanitarian and health portfolio. The detail of the offer has been provided as an annex to this ToR.

A.6.4 Duty of care / security

The supplier must be self-supporting and responsible for their own activities, including making available for their staff transportation, office facilities, logistical or administrative support. They must include all such costs in their bids.

The supplier/s owes a duty of care to all personnel recruited for this work, is responsible for the health, safety, security of life and property and general wellbeing of such and their property and this includes where the supplier personnel carry out the services. The supplier/s warrants that it has and will throughout the duration of the Contract,

Conduct the appropriate risk assessment regarding its delivery of the services.
Provide the personnel with adequate information, instruction, training, and supervision.

- Have appropriate emergency procedures in place to assure their personnel's health, safety, security of life and property and general wellbeing, also including prevention of damage their properties existing or acquired as a result of this contract.

BEM will share available information with the consultants on security status and developments in-country where appropriate. Travel advice is also available online and the potential supplier/s must ensure they (and their personnel) are up to date with the latest security advisory.

A.7 Management

A.7.1 Core evaluation team.

There is a strong preference for a small core evaluation team, who will guide this evaluation over its life ensuring strong control over quality and excellent relationships with stakeholders. It is highly likely that this core team will be complemented by the technical expertise and data collection capabilities of the Gaashaan consortium MEL team, it is necessary that this is explored during inception period.

The evaluation partner should propose a core team (roles, number of days and physical working location). They should also present the core team as an organogram and describe key accountabilities and reporting. The core team should include, but not be limited to:

Team Leader: who will lead the evaluation. They will play a key role in terms of evaluation coherence and quality, as well as wider team management. They will lead relationships with key stakeholders, particularly with BEM, government, and wider stakeholders amongst organisations/partnerships in protection and health sector.

Programme Manager: who will play a critical role in managing timelines, keeping a robust approach to risk management, and oversee and manage any consultant and/or sub-contracting.

- **Protection Evaluation advisor**: who will play a critical role in providing embedded technical advice on gender, social development, and protection. Deep experience and understanding of protection in emergencies highly preferred.

In terms of expertise and skills which should be covered in the core team and wider experts:

Strong track record (at least 10 years) in complex, multi-year evaluation management and quality assurance
Qualitative and quantitative data collection, management, and analysis

Strong contextual understand of protection of people/civilians in humanitarian, fragile and conflict affected contexts.

Strong experience of the Somalia governance and conflict context, and Somali language skills.

Experience and understanding of drivers of gender inequality and social exclusion, especially in humanitarian setting.

- Evaluation and/or research update strategies, including stakeholder engagement and communication.

A.7.2 Governance

The evaluation will be set within the wider management and governance structure of the Humanitarian and Health Evaluation Learning and Monitoring in Somalia (HHELMS) contract being delivered by Oxford Policy Management (OPM) as prime. ***See Annex for the HHELMS Terms of Reference*** and section 38 in the same Annex on the overall contract reporting and governance structure.

In addition to this:

The lead BEM point person on this task is the Social Development Adviser. Evaluation team and BEM point person will meet regularly (likely monthly) to review progress against deliverables.

Engagement with Save the Children – Gaashaan consortium prime - (including other consortium members) at key moments will be at the beginning of the evaluation and regularly thereafter (likely quarterly) to ensure alignment of work with what is practically happening on the ground.

- Engagement with FGS and FMS relevant Ministries: will be done at the beginning of the evaluation and as and when collection of data for the various rounds of evaluation activities will be required.

A.7.3 Conflict of Interest

To ensure the independence of third-party monitoring services and evaluations provided under this contract, it is vital to ensure that MEL services for a specific British Embassy Mogadishu programme are undertaken by a supplier(s) that is not involved in the delivery of the HARBS programme.

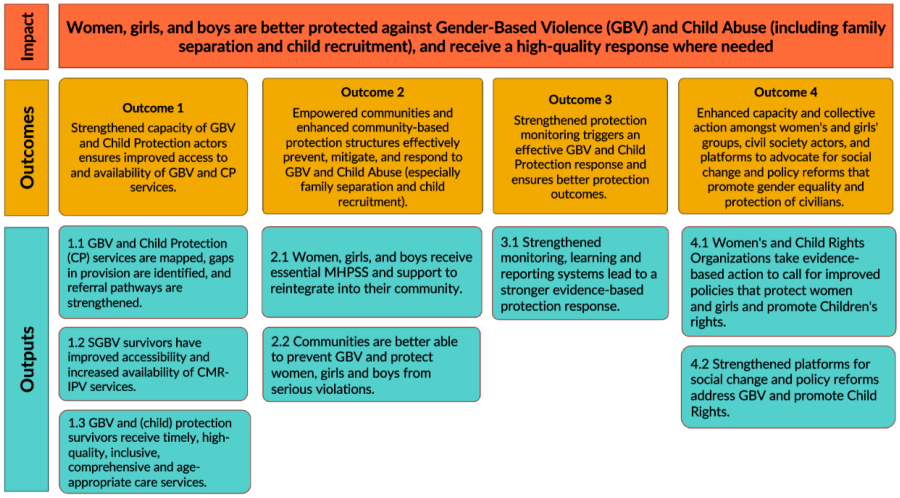
To assist OPM and BEM to assess any potential conflict of interest, suppliers are required to list in their proposal any programmes funded by the British Embassy Mogadishu (that they or their anticipated downstream partners are involved in delivering/evaluating or expect to be involved, between 2023 and 2028.

Annex B Gaashaan's Theory of Change

B.1 Overview and assessment of the ToC

The Gaashaan ToC is summarised in Figure 1, as set out in the Save the Children/CHANGES Consortium Proposal Submission.

Figure 1: Gaashaan ToC



The proposal document states that:

> '*The Theory of Change adopts a comprehensive approach to addressing GBV and Child Abuse by strengthening various elements of the protection ecosystem, from service provision to community empowerment, monitoring, and advocacy for policy change. The ultimate goal is to create a safer and more protective environment for women, girls, and boys.*'

There are a number of assumptions relating to how outputs contribute to the four stated outcomes:

> *'If we bolster the capabilities of GBV and Child Protection actors through activities such as mapping service availability, identifying gaps, and reinforcing referral pathways (Output 1.1), as well as by offering specialised Clinical Management of Rape and Intimate Partner Violence (CMR/IPV) services for survivors of Sexual and Gender-Based Violence (SGBV) (Output 1.2), and ensure that all survivors receive timely, high-quality, inclusive, comprehensive, and age-appropriate care (Output 1.3), then survivors will have the means to safely access the right services when they need them. This, in turn, contributes to the achievement of Outcome 1.*
>
> *If we provide essential MHPSS and support for the reintegration of women and girls (Output 2.1), survivors will not only experience physical healing but will also receive*

> *vital support from their communities. By empowering communities to take a proactive role in preventing GBV and safeguarding their members from violations (Output 2.2), we make a significant contribution to the realisation of Outcome 2.*
>
> *If we enhance monitoring, learning, and reporting systems concerning GBV and child abuse (Output 3.1), responses to instances of GBV and Child Abuse will become grounded in evidence and effectiveness. This reinforces the feedback loop between data collection and responsive action, thereby advancing Outcome 3.*
>
> *If we empower women's and child rights organisations to take evidence-based actions (Output 4.1), and concurrently fortify platforms for social change and policy reforms (Output 4.2), these collective actions will advocate for improved policies safeguarding women, girls, and children. Additionally, they will create a broader societal context that champions gender equality and the protection of civilians, directly contributing to the achievement of Outcome 4.'*

However, there is no fully articulated narrative to support the ToC, in the project proposal or in the inception report, and key assumptions related to each causal pathway are not specified. The MEL systems review undertaken by HHELMS noted the following about the Gaashaan ToC:[40]

> '*there is a good understanding of the external environment and the specific issue it addresses. However, pathways and connections could be made more logical, clear, and complete by engaging in a more detailed discussion on assumptions and risks. Evidence should be cited, justifying connections between outputs, outcomes, and impacts….. Assumptions and Risks could be more detailed. For example, "bolstering" GBV and Child Protection actors and offering CMR/IPV services to survivors does not necessarily mean that survivors will have the "means" to access the right services when needed-- this is an assumption that the "connection" factor exists. Even with services in place, survivors may not receive communication about services, may be out of the service area, or may be otherwise blocked from accessing services (physically, socially, or culturally). Identifying these assumptions, and the risks that emerge from them, is key to improve the ToC.*'

The MEL systems review also noted that there was no indication of community stakeholder engagement in developing the ToC and that 'A plan should be explicitly detailed on how community stakeholders contributed to the development on the ToC, how lessons learned will be adapted into the ToC, and how the community stakeholders can take ownership of the ToC.'

B.2 Reviewing the ToC

During the inception phase, the evaluation team reviewed the results framework and details on proposed project activities to clarify the ToC underpinning Gaashaan, and also carried out an online workshop with Gaashaan staff to identify assumptions around the causal pathways between outputs and outcomes, and to identify any factors that may not have been articulated. Observations on and analysis of the ToC generated during the ToC

[40] Gaashaan MEL Systems Review, p. 5.

workshop were captured using an interactive whiteboard. Further insights were gained through meetings with Gaashaan staff and engagement with experts on the evaluation Steering Committee, including consideration of how Gaashaan intersects with other programming in its locations.

Consideration of global literature, lessons from Somalia, and expert observations further highlighted what kinds of change may lead to the outcomes and what factors may influence this, including the following:

The need for an integrated approach to addressing multiple GBV and child protection risks. We note that in discussions the Gaashaan team explicitly linked GBV and child protection, based on an underlying assumption that GBV and child abuse are interlinked, particularly in relation to GBV that affects girls and boys, though this does not appear to be explicitly stated in the design documents.

Survivors and those at risk need to have improved access to a range of services. This may include the following types of services.[41] For GBV: health services (particularly the clinical management of rape); psychosocial support and safe spaces; protection services; cash assistance; and hotlines. For child protection: case management; family tracing and reunification; recreational activities for children; legal services;[42] and psychosocial counselling. Access to services may be determined by a range of factors, including location, cost, stigma, lack of information, provider attitudes, and physical security concerns.

Service coverage and capacity is inconsistent across the project locations[43] and there are multiple and varied barriers to survivors and those at risk benefiting from appropriate services. This calls for a context-dependent approach.[44]

Effective protection relies on a complex system, only some parts of which can be influenced by the project. Gaashaan seeks to address gaps in service provision, community engagement, and policy change, working alongside formal services and other programmes and responding to changes in the operating context, such as heightened or decreased insecurity, displacement, or violence. For example, improving GBV-related services should be coordinated with wider healthcare support. It is envisaged that the systems-strengthening approach reinforces complementarity, efficiencies, and integration with other social service systems (including healthcare, legal, law enforcement, education) at all levels.

The ability of Gaashaan to enhance protection across the wider humanitarian sector will depend on engagement with coordination structures across the sector, including the GBV AoR and Child Protection AoR, as well as wider engagement with women's rights organisations and organisations of persons with disability.

In the longer term, enabling protection depends on progress at legal and policy levels. Outcome 4 aims to create an environment in which women's and girls' collectives,

[41] Drawn from service mapping undertaken by Gaashaan during the inception phase.
[42] Legal services are a key need/challenge identified by Gaashaan but no legal services are currently available.
[43] Highlighted by mapping during the Gaashaan inception phase.
[44] In remote and hard-to-reach districts, work will primarily take place in urban areas and will focus on response activities due to the sensitivity of GBV and prevention topics in these areas and associated risks for project staff and beneficiaries.

alongside civil society actors and entities like women's rights organisations, become pivotal advocates for gender equality and civilian protection, by enhancing their abilities, and the resources they have, to instigate change. This could include efforts to influence protection policy reforms such as endorsement of the Sexual Offences Bill and FGM ban, as well as influencing how government institutions at different levels implement these policies. It may also include advocating for the centrality of protection within humanitarian coordination groups and local communities, and with policymakers, such as relevant line ministries and lawmakers. However, achieving results at these levels is beyond the scope and objectives of the Gaashaan project.

B.3 Development and testing the Gaashaan ToC

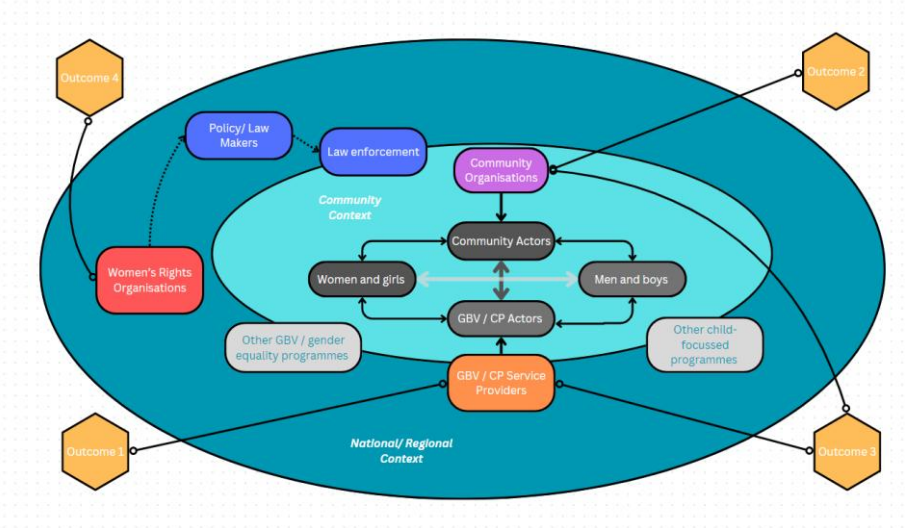
In this section, we suggest ways in which the Gaashaan ToC may be developed, with a view to identifying and testing key elements of the causal pathways.

B.3.1 Representing the context of implementation

Figure 2 provides a representation of the key causal pathways through which the four Gaashaan outcomes are expected to lead to the intended impact of improved protection and high-quality response. This builds on and develops the ToC as set out in Figure 1, addressing the points in the previous section, which emphasise the following:

1. the critical importance of both the national/regional and the community context within which action occurs;
2. the routes for interaction between the outcome areas in which Gaashaan is working;
3. the need to understand how community actors and GBV/child protection actors (i.e. case workers in the field) interact with women and girls and men and boys (including GBV survivors and at-risk children) and how the specific factors in the community context influence these interactions; and
4. the way in which other GBV/gender equality and child-focused programmes affect the context within which Gaashaan's interventions occur, including the underlying social relationships and interactions.

Figure 2: Gaashaan: causal pathways and context



Some key features should be highlighted:

- Actions directed to achieving Outcome 1 mainly engage with GBV/child protection service providers and hence with the specific GBV/child protection actors (e.g. frontline field workers) who are based within communities.
- Actions directed to achieving Outcome 2 involve working with both formal and informal community organisations (including community-based structures) and hence with specific community actors.
- Strengthening protection monitoring and response systems (Outcome 3) requires engagement through both service provides and community-based structures.
- Outcome 4 focuses on strengthening women's (and child) rights organisations. The ultimate aim of this is to influence policy, law, and law enforcement; however, this is outside the immediate objectives of the project (and so the causal pathways are shown with dotted lines).

The diagram shows how the national/regional and community context will be crucial for determining how causal pathways function. It also represents other GBV and child protection programmes that may be operating and influencing both the national and community context.

The ultimate achievement of results (at least for Outcomes 1–3, and at the impact level) depends on how effectively the project's activities engage with the local nexus of gender (and age) relations through community actors (e.g. elders) and GBV/child protection actors.

B.3.2 Mechanisms by which results are achieved

Within a realist evaluation framework, 'mechanisms' refers (in the context of social interventions) to 'cognitive or emotional reasoning of members of the target group responding to the resource, opportunity or constraint provided by the programme'. The extent to which these mechanisms function in different contexts will determine the extent to which outcomes are achieved.[45]

The review of literature highlights the importance of **knowledge**, **attitudes** (particularly gender attitudes), **skills**, and **motivation**, as key mechanisms that influence the effectiveness of service provision for GBV and child protection frontline staff, with the effectiveness of training and management playing a key role in developing these mechanisms. The degree to which survivors and at-risk individuals will be receptive to using, and will be able to make use of, support will depend on how **empowered** they are. For instance, to take actions for their own protection, their **trust** in the service provider and the wider community, and their own **knowledge**, will matter. Some of these mechanisms should be directly influenced by Gaashaan's interventions (through training and organisational support, for example) but others (such as community and individual attitudes) are less directly the focus of Gaashaan's activities and so form part of the context within which Gaashaan is working.

These mechanisms may apply at each level at which Gaashaan operates, as summarised below.

- **Service provider level:** Training and capacity building at the level of service providers is expected to lead to changes in knowledge, attitudes, skills, and motivation relating to providing services in accordance with best practice guidance, leading to increased availability, access, quality, and acceptability of services, as users can expect survivor-centred or child-centred services in line with need, can access these when needed, and can trust those services.
- **Community level:** Training and accompaniment at community level is expected to lead to changes in knowledge, attitudes, skills, and motivation around GBV and child protection risks, including for groups of women and children and for community leaders who act to support survivors and those at risk. This is expected to change attitudes positively towards supporting survivors and to create community-based mechanisms for reporting and responding to risks. This will also increase the engagement of community members in providing data and responses to risks, and will provide reassurance for survivors in reporting abuse and seeking support.
- **Government level:** Mechanisms of change include increased knowledge, attitudes, skills, and motivation amongst advocates for policy and legal change and amongst public officials making and implementing policies relating to the safety of women and children.

[45] See: Public Health England (2021) 'A Brief Introduction to Realist Evaluation'.

B.3.3 Testing key assumptions and causal pathways

Drawing on the findings from the ToC workshop, the following key assumptions can be identified for each outcome.

Outcome 1: Strengthened capacity of GBV and child protection actors, ensuring improved access to and availability of GBV and child protection services

Sufficient technical capacity within the consortium and with service providers.

Effective coordination/collaboration with other humanitarian or development organisations providing programmes directly or indirectly related to GBV and child protection.

Effective coordination with government.

Effective community engagement (including the willingness of communities to accept services).

Outcome 2: Empowered communities and enhanced community-based protection structures

Effective community engagement, ownership. and trust (building on pre-existing community structures).

Effective engagement to change inequitable attitudes.

Effective engagement with women's rights organisations.

Sufficient access to services and resources.

Effective referral coordination.

Outcome 3: Strengthened protection monitoring that triggers effective evidence-based GBV and protection responses

Effective coordination in the use of data between GBV and child protection actors.

Training that succeeds in improving knowledge and skills.

Ability to establish and maintain routine monitoring and evaluation systems.

Outcome 4: Enhanced capacity and collective action among women's and girl's groups, civil society actors, and platforms to advocate for social change and policy reform

Ability to strengthen the technical capacity of women's groups.

Ability to build and engage with wider networks.

Ability to overcome lack of agency and representation of women, inequitable gender norms, and extremist threats to women's rights organisations.

The evaluation will test the extent to which these assumptions are holding during implementation along the causal pathways for each type of intervention in each outcome area, and to what extent the mechanisms identified (for survivors and those requiring protection, and service providers) are functioning in different contexts.

Annex C Expected Gaashaan impact and outcomes, with indicators

C.1 Impact and outcome statements and indicators

Impact statement	Indicator
Women, girls, and boys are better protected against GBV and child abuse (including family separation and child recruitment) and receive a high-quality response where needed	**Impact Indicator 1:** **Percentage** of communities reporting increased safety from GBV[46] **Additional qualitative description:** • GBV risks and protective factors related to these, including how these work and how effective they are, including specific consideration of links between GBV and child protection • Ways in which wellbeing of sexual violence and GBV survivors is supported (through GBV and child protection services, in the community and in the home), and how this has changed due to Gaashaan interventions • Changes in attitudes towards GBV and child protection risks and towards support for survivors and children at risk[47]
	Impact Indicator 2: **Percentage** of communities reporting reduced exposure to child protection risks and/or increased safety for children in their homes and community[48] **Additional qualitative description:** • Different groups within communities describe increased protective factors (and their effectiveness) for a range of identified child protection risks • Women, men, girls, and boys describe ways in which recruitment to armed groups is reduced in the community, such as lower acceptance of armed groups in communities and reduced movement of children alone in isolated areas for collecting wood/water (a proxy for community protection as risky activity is reduced) • Boys and girls describe ways in which they feel an improved sense of safety in the community/school/home from both child protection and broader GBV risks
Outcome statements	
Outcome 1: **Strengthened capacity of GBV and child protection actors ensures improved access to and**	**Indicator 1.1: Percentage of communities** with improved **access to, and improved availability, quality, and acceptability** of, services for GBV and child protection[49] **Additional qualitative data:**

[46] Based on the existence and effectiveness of protective factors defined during the baseline process.
[47] A positive shift in these attitudes is assumed to increase protection from secondary harms through community support.
[48] Based on the existence and effectiveness of protective factors defined during the baseline process. Assessed through a capacity assessment tool.
[49] Expectations for capacity improvements to be established during the baseline.

availability of GBV and child protection services	• Descriptions of capacity improvements supported for different services, what supported these improvements, and how these changed outcomes for survivors • Descriptions of how services can be accessed, including improvements to any factors blocking access • Descriptions of improved willingness to use (or support for those using) services
Outcome 2: **Empowered communities and enhanced community-based protection structures effectively prevent, mitigate, and respond to GBV and child abuse (especially family separation and child recruitment)**[50]	**Indicator 2.1: Percentage of communities** with established community mechanisms to make women and children safer from GBV and child protection risks **Indicator 2.2: Percentage of communities** reporting improved coverage and effectiveness of community actions/mechanisms to make women and children safer from GBV and child protection risks **Additional qualitative data:** • Community members surveyed describe actions being taken in the community to make women and children safer from different forms of sexual violence and GBV, including efforts to raise awareness and change attitudes • Surveyed community members in target locations describe actions in the community to address child protection risks, including describing how these work and what makes them effective • Descriptions of community-based structures, systems, and processes established to make women and children safer
Outcome 3: **Strengthened protection monitoring triggers an effective GBV and child protection response and ensures better protection outcomes**	**Indicator 3.1: Percentage of targeted communities** where monitoring data are utilised to develop localised and coordinated GBV and child protection programme activities **Additional qualitative data:** Description of how data are used to support early warning, coordination, and decision-making and to improve provision, including how this is seen to contribute to improve outcomes for women and children
Outcome 4 **Enhanced capacity and collective action among women's and girls' groups, civil society actors, and platforms to advocate for social change and policy reforms that promote gender equality and protection of civilians**	**Indicator 4.1: Percentage of supported women's rights organisations/civil society organisations** with increased capacity to advocate for social change and effectiveness in doing so **Additional qualitative data:** • Descriptions of ways in which women's rights organisations and wider civil society have enhanced capacities, including knowledge, skills, networks, and processes • Description of actions to influence policy and how Gaashaan support enabled these

[50] Although there are separate indicators for GBV and child protection, the linkages between these are recognised and will be explored by the evaluation.

C.2 Outputs and activities contributing to outcomes

C.2.1 Outcome 1 :Strengthened capacity of GBV and protection actors ensures improved access to and availability of GBV and child protection services

Through this outcome the project aims to create an inclusive and supportive environment for those affected by GBV and child protection risks. The project will work with existing community structures and service providers, including health workers in mobile and fixed health facilities, to build their capacities in identification and referrals. Table 12 details outputs and planned activities under Outcome 1.

Table 12: Planned outputs and activities contributing to Outcome 1

Output 1.1: GBV and child protection services are mapped, gaps in provision are identified, and referral pathways are strengthened.
Mapping existing service providers (including private providers), referral pathways, services for children outside family care, resources (such as women-/girl-friendly spaces, child-friendly spaces, shelters, multi-purpose centres and mental health and psychosocial support (MHPSS) service providers), and existing community child protection structures to identify gaps in service delivery (Activity 1.1.1).
Establishing new and strengthening existing referral pathways and clinical case management, in collaboration with the GBV AoR, Child Protection AoR, women's rights organisations, and organisations of persons with disabilities (Activity 1.1.2).
Developing gender- and disability-inclusive communication materials (booklets on available services and referral pathways) in different accessible formats, to increase community awareness of available GBV and child protection services and referral pathways, disseminated through community structures (Activity 1.1.3).
Conducting a conflict-sensitive gender and social inclusion analysis to inform project development and implementation – designed to map prevailing gender roles, relationships, power hierarchies, and access to vital resources, and to uncover the different impacts of conflict on various demographics, ensuring that the nuanced experiences of all groups, including marginalised groups and clans, are taken into consideration (Activity 1.1.4).
Output 1.2: Sexual violence and GBV survivors have improved accessibility and increased availability of clinical management of rape and intimate partner violence services.
Providing specialised training for medical teams on clinical management of rape and intimate partner violence, to equip them with the necessary skills to provide appropriate medical care and support to survivors (Activity 1.2.1).
Training health workers in existing fixed and mobile teams to identify signs of abuse and provision of primary care for GBV survivors (Activity 1.2.2) – to include emergency lifesaving healthcare services, psychological first aid, and safe referral protocols, as well as how to reduce barriers to accessing services for people with disabilities.
Raising awareness on GBV and child abuse prevention through community health workers providing women, girls, men, and boys with information about available services and guiding them on how to access these resources. To ensure bilateral referrals among health facilities and protection service providers, Gaashaan will train GBV focal points at health facilities and Ministry of Health district-level offices on referral and documentation, for effective coordination of services (Activity 1.2.3).
Primary healthcare staff (especially nurses and doctors) will receive training on the Mental Health Gap Action Programme (mhGAP) to enable them to carry out assessments and clinical management for those identified with priority mental, neurological, and substance use conditions. Referral will be made to more specialised mental healthcare centres, such as at the nearest health centre (district or regional hospitals/general health facilities/mental health facilities) (Activity 1.2.4).
Creating secure environments for survivors through the construction or rehabilitation of multi-purpose private rooms designed to accommodate only one client at a time. These rooms will serve

various purposes, including clinical management of rape and intimate partner examination and treatment within primary and secondary health facilities (Activity 1.2.5).
Supporting and complementing health facilities and mobile health units with incentives for identified focal points, as well as resources such as post-rape care kits, examination supplies for the clinical management of rape, and essential equipment/furniture for service providers and GBV/child protection mobile units (Activity 1.2.6).
Establishing or supporting existing one-stop centres which bring together multiple services, including medical, legal, psychosocial, and legal services, to ensure survivors receive holistic support (Activity 1.2.7).
Establishing GBV information and referral desks at health facilities and centres (Activity 1.2.8). The GBV information and referral desks will be operated by trained healthcare personnel and social workers who are equipped to provide essential information and guidance to individuals affected by GBV.
Output 1.3: GBV and (child) protection survivors receive timely, high-quality, inclusive, comprehensive, and age-appropriate care services.
Revising, updating, and improving the existing national inter-agency case management guidelines and tools to incorporate best practice and to include caring for child survivors of sexual abuse, UASC, and former CAAFAG. The consortium will also support the implementation of the recently updated and developed CAAFAG standard operating procedures, which the Child Protection AoR has revised (Activity 1.3.1).
Conducting training for local case management service providers, including child protection and GBV mobile teams, on implementing case management guidelines and tools to ensure standardised and effective support for survivors of GBV, child abuse (including child labour, corporal punishment, emotional abuse, and neglect), UASC, and former CAAFAG, including family tracing and reunification (Activity 1.3.2).
Facilitating referrals to multi-sectoral support, as required – including to MHPSS; alternative care; and identification, documentation, tracing, and reunification (IDTR) and medical services – for UASC, and CAAFAG, and specifically for girls associated with armed forces (Activity 1.3.3).
Providing one-off multi-purpose cash assistance to GBV survivors and women and girls at risk of GBV to address specific needs identified in the case management process (Activity 1.3.4) and to support cases of children who need specialised support. This will complement the support provided to women, girls, and boys through the GBV and child protection case management systems.
Improving reporting channels and encouraging survivors to seek support by establishing and supporting the operation of dedicated 24/7 hotlines to provide individuals with support and information relating to GBV and child protection services (Activity 1.3.5).
Identifying, training, and supporting foster care families within local communities, based on the assessed needs of the children and foster families (Activity 1.3.6).
Providing alternative care support and family tracing and reunification services (Activity 1.3.7) for UASC.
Sustaining and enhancing existing safe houses for GBV survivors (Activity 1.3.8), collaborating with the relevant ministries or agencies to provide support, in alignment with the project's objectives and the minimum standards for women's safe homes.
Developing and conducting specialised training programmes on GBV and child protection referral pathways and case management, and CAAFAG rights, for law enforcement officials (police), prosecutors, judges, lawyers, and gender desk staff (i.e. gender focal points in police stations, social welfare/children's departments, the judicial system, etc.). This will focus on existing laws and policies that promote prevention and response to GBV and child abuse to strengthen capacity and change attitudes in responding to GBV incidents (Activity 1.3.9).
Distributing dignity and female hygiene kits to women and girls of reproductive age to mitigate the risk of further GBV incidents and to provide essential items for their wellbeing (Activity 1.3.10).

C.2.2 Outcome 2: Empowered communities and enhanced community-based protection structures effectively prevent, mitigate, and respond to GBV and child abuse (especially family separation and child recruitment)

The project design document states: 'By engaging community members and traditional institutions, the project aims to ensure a greater focus on community-led prevention of GBV and child abuse, promotion of gender equality, and an effective, survivor-centred approach to GBV and child protection at the community level especially focusing on children affected by family separation and child recruitment'. Table 13 details outputs and planned activities under Outcome 2.

Table 13: Planned outputs and activities contributing to Outcome 2

Output 2.1: Women, girls, and boys receive essential MHPSS and support to reintegrate into their communities.
Establishing women-, girls-, and child-friendly spaces, and providing essential psychosocial support materials for safe spaces (Activity 2.1.1).
Implementing SAFE and SEL modules in safe spaces, ensuring activities complement each other and address specific needs of children from various age groups. Provision of psychosocial support through the Healing and Education through the Arts (HEART) Programme to survivors of sexual violence and GBV and child abuse and CAAFAG who are suffering from severe trauma and stress (Activity 2.1.2).
Implementing targeted curricula, such as 'Women Rise' for women and 'Girls Shine', within the women's/girls' safe spaces, to empower women and girls by providing them with knowledge about their rights, enhancing their self-esteem, and building their capacity to protect themselves (Activity 2.1.3).
Supporting existing community women's and girls' groups and associations in developing and implementing GBV and child protection action plans in coordination with Child Welfare Committees. These action plans will target issues such as FGM, child, early and forced marriage, intimate partner violence, and other prevalent forms of violence (Activity 2.1.4).
Output 2.2: Communities are better able to prevent GBV and protect women, girls, and boys from serious violations.
Mapping individuals and structures within the community that can play a key role in addressing attitudes towards GBV and child abuse, and that can play a transformative role in supporting recovery, reducing stigma, and promoting social cohesion and reintegration of GBV survivors, former CAAFAG, and others, including traditional and religious leaders who shape community perceptions (Activity 2.2.1).
Identifying risks (to the project or communities) associated with the monitoring and reporting mechanism on grave violations and actions to address grave violations in the community (Activity 2.2.2)[40] and planning strategies for countering or alleviating threats, enabling consortium members to make an informed choice regarding their degree of involvement in the monitoring and reporting mechanism.
Establishing and strengthening community-based protection platforms (VAWG committees and Child Welfare Committees) bringing together community influencers, religious leaders, and focal points within the community (Activity 2.2.3).
Training protection community structures on GBV and child abuse prevention, response training (GBV and child protection basic principles, case management, and GBV and child protection referral pathways), and CAAFAG prevention, to enable them to identify and respond to GBV and protection cases in their communities (Activity 2.2.4).
Acting to change attitudes towards GBV survivors, unaccompanied children, and former CAAFAG, and to reduce stigma and promote acceptance, including sensitisation campaigns and community dialogues, in collaboration with women's and girls' rights organisations (Activity 2.2.5).
Supporting community protection structures to develop and implement action plans to combat GBV and child abuse, including UASC and child recruitment (Activity 2.2.6).

Facilitating community dialogues between male and female religious leaders on the interpretation of religious teachings regarding some types of GBV, such as child, early and forced marriage, FGM, and child abuse, and how this intersects with protection policies and efforts to advance legislation (Activity 2.2.7).
Engaging community members, including women, girls, boys, and men, to develop and deliver key messages on respect for women's and children's rights and equality, and GBV and child abuse prevention, to address the normalisation of violence in the community, disseminated through various mediums, including radio stations, information, education, and communication materials, billboards, and posters, reaching a broad audience (Activity 2.2.8).
Engaging community members, including Child Welfare Committees and child-friendly space/safe healing and learning space facilitators, in identifying child protection and UASC cases and reporting them to the consortium, and enhancing awareness within target communities about their rights, entitlements, the prevention of sexual exploitation and abuse, and feedback and reporting mechanisms (Activity 2.2.9).

C.2.3 Outcome 3: Strengthened protection monitoring triggers an effective GBV and child protection response and ensures better protection outcomes

This outcome focuses on establishing disaster risk reduction-sensitive protection monitoring systems that track cases and document trends in sexual violence and child abuse. The project will also integrate gender, GBV, and child abuse prevention and response actions with early warning systems in Somalia. Table 14 details outputs and expected activities under Outcome 3.

Table 14: Planned outputs and activities contributing to Outcome 3

Output 3.1: Strengthened monitoring and reporting systems lead to a stronger evidence-based protection response.
Conducting an annual joint conflict-sensitive GBV and child protection assessment to gather updated information on the prevalence, trends, and forms of GBV and child abuse in the target locations to improve the response (Activity 3.1.1).
Assessing the linkage between existing GBV and child protection structures and disaster early warning systems, including food security early warning early action (FS-EWEA), by Save the Children and other actors, to understand gender and protection responsiveness and to identify successes, areas for improvement, and gaps in addressing gender, GBV, and child protection concerns and the link between violence and external triggers, such as drought and conflict. This will lead to recommendations on improvements to enhance detection and scale up the response to potential risks and threats (Activity 3.1.2).
Expanding, strengthening, and formalising existing coordination mechanisms among existing disaster early warning systems, including FS-EWEA, with community protection structures, GBV network champions, and GBV/VAWG working groups (Activity 3.1.3).
Providing capacity building to inter-ministerial, regional, and local government support groups to support GBV and child abuse survivors, including UASC and former CAAFAG, with referrals and access to case management services (medical, legal, psychosocial, and advocacy support) (Activity 3.1.4).
Establishing clear protocols and guidelines for coordinating between GBV and child protection services/stakeholders, displacement monitoring, and community early warning systems for disasters and food security shocks, ensuring seamless communication and collaboration among relevant stakeholders, and amplifying the efficacy of information sharing and streamlining referral processes. (Activity 3.1.5).
Ensuring that GBV and child protection are integrated into the inter-agency contingency, preparedness, anticipatory action, and El Niño response plans, both at the national and sub-national level, and linking with the Integrated Community Case Management (ICCM) cluster, displacement monitoring structures, and the Flood Coordination Advisory in Hirshabelle to ensure a comprehensive and coordinated approach (Activity 3.1.6).

Strengthening the utilisation and uptake of the existing GBVIMS and CPIMS+ (Activity 3.1.7).[41]
Strengthening inter-agency networks, focal points, and clear referral and reporting procedures in collaboration with the national Prevention of Sexual Exploitation and Abuse Task Force. This collaboration will ensure a cohesive response to prevent and address sexual exploitation and abuse and will enhance accountability (Activity 3.1.8).
Develop and disseminate standardised GBV surveillance tools and guidelines, which will establish a uniform data collection and reporting framework, promoting a standardised approach among governmental officials and GBV actors (Activity 3.1.9).

C.2.4 Outcome 4: Enhanced capacity and collective action amongst women's and girls' groups, civil society actors, and platforms to advocate for social change and policy reforms that promote gender equality and protection of civilians

This outcome aims to create an environment where women's and girls' collectives, alongside civil society actors and entities like women's rights organisations, become pivotal advocates for gender equality and civilian protection, by enhancing their abilities and the resources they can use to instigate change. The evidence-based advocacy initiatives seek to influence the wider humanitarian system through humanitarian coordination groups, local communities, and policymakers, such as relevant line ministries and lawmakers, to push for policy changes and actions that address GBV and child abuse in Somalia. Furthermore, this outcome emphasises the critical need to weave women and their representative bodies, such as women's rights organisations and girls' movements, into protection policy reforms, such as endorsement of the Sexual Offences Bill and FGM ban. This will contribute to promoting the principle of the centrality of protection at the forefront of humanitarian coordination. Table 15 details outputs and planned activities under Outcome 4.

Table 15: Planned outputs and activities under Outcome 4

Output 4.1: Women's and child rights organisations take evidence-based action to call for improved policies that protect women's and girls' rights and promote children's rights.
The consortium, in collaboration with women's rights and child rights organisations, will conduct a formative study to deepen understanding of violence (GBV) and child abuse in Somalia (Activity 4.1.1).
Train women's rights organisations and women and children's rights defenders, including female journalists and lawyers, on GBV, gender-sensitive evaluation, child rights, advocacy, and strategic communication (Activity 4.1.2).
The consortium will also support women's rights and child rights organisations to develop advocacy materials, including policy briefs, fact sheets, and reports, to highlight evidence-based findings on GBV and child protection risks and trends (Activity 4.1.3).
Output 4.2: Strengthened platforms for social change and policy reforms address GBV and promote child rights.
Utilising findings (from Output 4.1) to inform feedback sessions on prevalence and trends with relevant stakeholders such as the GBV AoR, Child Protection sub-cluster, women's rights organisations, and relevant ministries to share and analyse the findings and facilitate evidence-based decision-making for programming improvements (Activity 4.2.1).
Facilitating high-level dialogue sessions that include representation from religious and traditional leaders, and community members and leaders, to encourage discussions on GBV and child abuse response, prevention, and mitigation (Activity 4.2.2).
Establishing media collaborations to raise public awareness about GBV and child abuse risks and trends through a national radio and TV campaign, and to educate the public, challenge harmful attitudes and behaviours, and mobilise support for protection initiatives by reaching a wider audience (Activity 4.2.3).

Advocating for the adoption and institutionalisation of a child-centred social accountability framework through policy engagement and collaboration with policymakers (Activity 4.2.4).
Updating and adapting the national/clinical management of rape/intimate partner violence protocol with key stakeholders and policymakers (Activity 4.2.5).
Supporting humanitarian coordination groups (Activity 4.2.6), such as the Gender in Humanitarian Action Working Group (GiHA WG).

Annex D Framework for the initial evaluation

Criteria for assessment	Evaluation questions and sub-questions	Data sources
Relevance The extent to which Gaashaan's objectives and design: • respond to the protection needs of women and children in communities across a range of contexts within Somalia; • reflect theory and/or evidence around how change happens in the Somali context, including consideration of the social, economic, and political/policy context; • adapt as circumstances change over time, including during periods of heightened humanitarian crisis; • reflect international best practices and evidence around effective approaches to improving protection for women and children in humanitarian contexts.	1. To what extent does the ToC provide an appropriate and valid framework for the implementation of Gaashaan? • Does the ToC cover all relevant aspects – is anything missing? 2. To what extent, and how, does the project respond to the identified needs of survivors of, and groups at risk of, GBV and child abuse, and their communities, in different locations? • What are the main health, MHPSS, economic, and social needs of GBV survivors and children at risk in different communities? • How are these needs/risks currently addressed and what does the project design contribute in regard to addressing gaps? 3. To what extent does the project design respond to the accurate identification of service capacity gaps? • Are appropriate mechanisms in place to identify and respond to gaps? 4. To what extent does the project design respond to identified needs and opportunities for action at the community level? Are appropriate mechanisms in place to identify and respond to gaps and opportunities at community level? 5. To what extent does the project design reflect the policy and institutional context, including opportunities for and challenges to influence at different levels? 6. To what extent does the project design reflect the complexity and changeability of the Somali context, including provision for periods of acute crisis?	Project documentation and background literature. KIIs with Gaashaan staff, BEM staff, and key stakeholders from the wider protection/humanitarian sector.
Coherence The extent to which Gaashaan complements and supports other protection and humanitarian programmes, and vice versa, including:	7. What, if any, other interventions and organisations are providing related GBV and child protection services or addressing norms around GBV and child protection? • How does Gaashaan coordinate with other protection programming?	Project documentation KIIs with: • Gaashaan staff; • BEM staff;

• synergies and interlinkages with other interventions implemented by Gaashaan partners; • complementarity and coordination with other protection and wider humanitarian programming in Somalia, including avoiding duplication; and • coherence with Somali government policy and implementation where relevant.	• What evidence is there of coherent approaches? • What efforts are there to avoid duplication? 8. In what ways does/should Gaashaan intersect with wider humanitarian programming? • How is improved protection expected to contribute to the wider sector?	• stakeholders from the wider protection/humanitarian sector; and • stakeholders from Somali institutions.
Effectiveness The extent to which Gaashaan has achieved, or is expected to achieve, the outputs and outcomes, measured through indicators set out in its revised results framework. This assesses progress along the causal pathway and should consider whether these results have been achieved equitably across different target groups and locations, taking into account their different contextual circumstances – recognising that the starting point and potential for change will differ across locations due to contextual factors.	9. To what extent are **quality** GBV and child protection services **accessible, available,** and **acceptable** for different at-risk groups and in different contexts at baseline? [Outcome 1] • What is the baseline coverage, capacity, and preparedness of GBV and child protection actors? • To what extent do survivors and community members have information about services available and referral pathways? • What are the barriers to survivors accessing services in different locations? 10. To what extent are communities empowered to prevent, mitigate, and respond to GBV and child abuse, and to what extent are community-based protection structures effective in this regard? [Outcome 2] • What **structures and systems** exist at community level and where are the gaps? • To what extent do **attitudes** in the community support GBV survivors and children at risk? • What is the capacity of existing structures and how could this be improved? 11. What are the protection monitoring arrangements and to what extent do they contribute to an effective GBV and child protection response?	**FGDs** with different groups (women, community elders, girls, and boys etc.) in sampled communities. **Site visits** for a range of services. **KIIs** with service providers, humanitarian actors, coordination structures, and government officials at different levels. Review of **service provision data from project reporting.**

	• How are data on GBV and child protection risks and needs collected and used across the humanitarian system? What data are available and how are they used by community structures and the community-driven early warning systems? How does this link to the wider humanitarian system? What are the gaps? 12. What is the baseline capacity of women's and girls' groups, civil society actors, and platforms to advocate for social change and policy reforms that promote gender equality and the protection of civilians? [Outcome 4] • What knowledge and skills are there for advocacy on GBV and child protection? • What networks and platforms exist and how do these work? • What access do women's rights organisations have to decision-making processes in the political and humanitarian spaces? • What are the key changes needed and how do advocates expect to achieve change?	
Efficiency The extent to which Gaashaan delivered, or is likely to deliver, results in an economic and timely way, taking into account the operational complexity and changeability of the Somalia context.	13. What data are available and being collected to enable the cost effectiveness of interventions to be assessed? 14. To what extent is the project MEAL framework, including intended data collection, appropriate to guide project implementation?	Project documentation. Consultations with Gaashaan staff and BEM staff.
Impact The extent to which Gaashaan generates, or is expected to generate, its stated impacts, measured through indicators in the revised results framework. This should include identification of any unintended impacts. This should also consider the contribution of Gaashaan, alongside other influences in the operating context.	15. What are the baseline levels of protection for women, girls, boys, and men from GBV and child protection risks? • How safe do women and children feel? • How do communities perceive the existence and effectiveness of protective measures? • How does this differ between contexts of implementation?	FGDs within selected communities (covering a range of location types, and disaggregated by age and gender). KIIs with community leaders, operational staff, and representatives of women's and children's rights organisations. KIIs with humanitarian agency staff and government representatives at all levels.

		Review of any secondary data available.
Sustainability The extent to which the benefits of Gaashaan are likely to continue, including through social-economic and institutional capacities at different levels (from community to national levels).	16. To what extent has the project design considered the long-term sustainability of outcomes, including the capacity and preparedness of the organisations who will need to sustain results and the commitment of key stakeholders?	Project documentation and consultations with Gaashaan staff.

Annex E Approach to location-based primary data collection

E.1 Sampling approach

Sampling was conducted in three stages: first, the selection of sites for data collection; second, the selection of respondent types within each site; and third, the identification of individuals to be interviewed at the site level. Our sample size of 18 locations was determined to ensure coverage across all districts; it represents one-third of Gaashaan's overall implementation sites. With this number we were able to consult a range of stakeholder types within each location, as well as a range of sites.

Our approach to sampling sought to ensure that data were collected from a range of location types, including rural, urban, and IDP/camp settings. Following an assessment of site accessibility, one site was selected within each of the 18 districts where the Gaashaan project is being implemented.[51] These sites were randomly selected from a list of sites provided by Gaashaan, while ensuring a proportionate representation of rural, urban, and IDP sites within the total pool, and maintaining a spread across project activities. The table below lists the final sites selected.

Table 16: Locations for primary data collection and distribution of FGDs and KIIs

State	Region	District	Site	Type	FGDs	KIIs
Galmudug	Galgaduud	Adaado	Galinsoor	Rural	3	2
Galmudug	Galgaduud	Dhusamareb	Marergur	Rural	3	2
Galmudug	Mudug	Galkio South	Bandiiradley	Urban	3	2
Banadir	Banadir	Daynile	Barwaaqo	IDP/returnees	3	2
Banadir	Banadir	Howlwadaag	Saqawadin	Urban	3	2
Jubaland	Lower Juba	Kismayo	New-Kismayo	Urban	3	2
Jubaland	Lower Juba	Dhoobley	Camp Kaafi	IDP/returnees	3	2
Jubaland	Lower Juba	Afmadhow	Afmadow Town	Urban	3	2
Jubaland	Gedo	Dollow	Kabasa	IDP/returnees	3	2
Jubaland	Gedo	Beled Hawo	Tula Amin	IDP/returnees	2	3
Southwest	Bay	Baidoa	Salaamey Lidaale	IDP/returnees	2	3
Southwest	Bay	Dinsoor	Kacaan	IDP/returnees	3	2
Southwest	Bakool	Hudur	Garasweyne	IDP/returnees	3	2
Southwest	Bakool	Wajid	Mubarak IDP	IDP/returnees	2	3
Southwest	Bakool	Elbarde	Barako IDPs	IDP/returnees	2	3
Hirshabelle	Hiran	Mataban	Guuled	IDP/returnees	2	3
Hirshabelle	Hiran	Beledweyn	Nasiib	IDP/returnees	2	3
Hirshabelle	Middle Shabelle	Jowhar	Isnay Biyaso	IDP/returnees	3	2

In selecting respondent types within each site, efforts were made to reach a spread of informant types overall. However, due to time and resource constraints, the number of consultations per community was limited to five, meaning that not all types of respondents could be interviewed in each location. The final sample included a total of 48 FGDs and 42

[51] An accessibility assessment resulted in the exclusion of Wargarwyne IDP in Elbarde from the pool of sites due to security concerns.

KIIs. Each FGD was conducted with 6–10 respondents, with a total of 396 respondents across sites (158 men, 150 older adult women, 96 younger adult women).

FGDs were conducted in single-sex groups: one group for men, one group for older adult women, and one group for younger adult women (aged 18–20) in each sampled community. No collection of primary data from children was attempted in this round of the evaluation as previous experience suggested it would not be possible within the constraints of the evaluation to ensure the participation of children or to collect reliable evidence.[52] An exception to this was made for communities in which only male researchers were available (six out of 18 locations).[53] In these communities, an additional KII replaced the younger adult women FGD in order to reach a wider spread of stakeholder perspectives. Furthermore, to ensure participants felt comfortable sharing their views and to facilitate open discussion, a female facilitator accompanied the male researcher during the FGDs with older women. The original intention had been for one of the focus groups to be for adolescent girls. However, this proved not to be possible as only women in the 18–21 range were prepared to participate, due to reticence among younger women (or their guardians).

As planned at inception, we sought to include children in pre-testing of FGD tools to understand whether it is possible to gain useful data from them against the specific evaluation questions. Our previous experience in Somalia showed that the perspectives of children can be highly variable based on their limited direct experiences and ability to understand broader questions. Following this pre-testing it was decided to approach adolescent girls for FGDs but not younger children.

KIIs were conducted with individuals from the following groups: service providers; Gaashaan staff/partners; community leaders; and district-level authorities. In selecting key informants across sites, it was ensured that each site had at least one interview with a service provider or Gaashaan staff, and one interview with either a community leader or local authority. Additionally, to ensure coverage at the state level, at least one local authority interview was conducted in each state. The remaining interviews were randomly spread across categories, with care taken to achieve a good spread of respondent types overall, even though there was insufficient resourcing to interview all types in all locations.

At the site level, respondents were sampled in a purposive way, with the support of local focal points and Gaashaan partners. Table 17 provides a breakdown of the number of each type of informant who were interviewed.

Table 17: Types of key informants interviewed

Respondent type	Number consulted	Comment
Service provider at community level	11	Includes healthcare workers, providers of psychosocial support services, providers of cash assistance, etc.

[52] Alternative approaches to obtaining evidence directly from children will be explored in future rounds of the evaluation.
[53] These districts were Beled Hawo, Baidoa, Wajid, Elbarde, Mataban, and Beledweyn.

Gaashaan staff/partners at community level	12	
Community leader	13	Local leaders, including elders, imams, camp leaders, and leaders of women's groups
Local/district-level authority	6	
Gaashaan staff/partners at national level	7	
Protection Cluster representatives at national level	2	

E.2 Data collection tools

Tailored data collection tools were developed for each type of consultation and stakeholder to ensure that the researchers targeted lines of questioning appropriately. Tools included the following:

- FGDs with 6–10 community members (men and women). These focused on understanding safety and security risks and the availability, quality, accessibility, and acceptability of services at community level, as well as on assessing perceptions of safety and of service provision/utilisation (scored against a rubric).
- KIIs with community-level service providers. These focused on understanding how services are delivered, their capacity gaps and needs, and how respondents engage (or expect to engage) with Gaashaan.
- KIIs with community leaders. These focused on exploring how GBV and child protection issues are dealt with by communities and what mechanisms exist for monitoring and for supporting survivors and those at risk.
- KIIs with district-level authorities. These focused on understanding the provision of services for GBV and child protection within a district and the role of district authorities in delivering and monitoring these, as well as their coordination with different actors in the protection sector.
- KIIs with Gaashaan staff and partners. These focused on understanding how the project operates at local levels, including how needs are assessed and how activities are planned, as well as coordination with other actors in the protections sector and wider humanitarian space.
- KIIs with national-level stakeholders. These focused on understanding Gaashaan's role within the wider protection and humanitarian space, including the potential for advocacy and support to women's rights organisations, and how Gaashaan coordinates or complements the wider protection and humanitarian sector. However, difficulties were encountered in obtaining responses from government ministries (for instance, the Ministry of Family and Human Rights Development) and it was not possible to carry out the planned government interviews during this phase.

Prior to the full data collection process, the draft tools were piloted with a community in Hargeisa to see whether they were able to provide appropriate information. Based on reflection following this pilot, the tools were simplified to better aid their use by researchers. The final tools are included in Annex FAnnex G.

E.3 Researcher selection and training

Researchers were selected from Consilient Research's network of local researchers. All researchers were locally based, to ensure dialect and contextual compatibility with respondents. Due to the sensitivity of the research topic, we prioritised female researchers conducting interviews with female community members, and this consideration guided the researcher selection process. However, in six out of the 18 locations female researchers were unavailable. In these locations, FGDs with younger adult women were replaced with additional KIIs, and a female facilitator accompanied the male researcher during the FGDs with older women.

Prior to data collection, all researchers underwent a two-day, project-specific training conducted remotely from Hargeisa. Topics covered during the training included an introduction to the Gaashaan project and evaluation methods, details of the data collection tools and fieldwork procedures, and expectations regarding recording data. Ethical considerations, including gaining informed consent and safeguarding measures, were also covered, including protocols for handling distress and responding to situations where disclosure of violence or abuse occurs. The tools were also piloted at that stage to ensure that all researchers understood the approach.

E.4 Ethics and safeguarding

As set out in the inception report, our approach to ethics and safeguarding is in line with the FCDO (previously Department for International Development) *Ethical guidance for Research, Evaluation and Monitoring Activities*,[54] while also being informed by international best practice guidance for ethical research and our team's experience of previous research in Somalia and in other humanitarian contexts in relation to GBV and child protection. These general research principles were complemented by specific considerations related to research of sensitive subjects, including the World Health Organization's *Ethical and Safety Recommendations for Documenting and Monitoring Sexual Violence in Emergencies*[55] and the UNICEF-funded Ethical Research Involving Children (ERIC) initiative guidance.[56]

The primary data collection protocols for KIIs and FGDs included providing guarantees of confidentiality, respect of privacy, and awareness of the sensitivity of the information provided. Participants were asked to provide their informed consent to taking part in the evaluation, as well as to the recording and transcription. Moreover, all participants were provided with safeguarding pocket cards containing phone numbers for reporting. Survivors of GBV were not specifically targeted for interviews as part of the evaluation. No disclosures

[54] UK Department for International Development (2019) 'DFID ethical guidance for research, evaluation and monitoring activities'. https://assets.publishing.service.gov.uk/media/5d9ee055e5274a5a29d7c26a/DFID-Ethics-Guidance-Oct2019.pdf
[55] WHO (2007) 'WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies'. https://www.who.int/publications/i/item/9789241595681
[56] Ethical Research Involving Children (ERIC) (no date) 'About'. https://childethics.com/child-rights/

of GBV or other harm were made to the research team during data collection. However, had any such disclosures occurred, they would have been referred appropriately, in line with the safeguarding and incident management protocols described in Annex L of the inception report.

Fieldworkers were provided with training that covered the principles of research ethics, safeguarding, and respecting cultural sensitivities, as well as the application of the primary data collection protocols.

All data were anonymised prior to analysis.

E.5 Challenges and limitations

Time and resource constraints: The number of consultations per community was limited to five, meaning that not all types of respondents could be interviewed in each location. Due to the small sample size, the fact that data may be skewed by outlying opinions needs to be considered.

Impact of Ramadan on data collection timelines: Although efforts were made to complete fieldwork before the start of the fasting period in February 2025, most research activities took place during Ramadan. This necessitated adjustments due to shorter workdays and increased difficulty in locating respondents, which impacted the overall timeline.

Interviews with adolescent girls: The original intention had been to have FGDs covering adolescent girls. However, the researchers reported that they were not able successfully to secure the participation of adolescent girls as only older adolescent girls/young adult women responded to local mobilisation efforts (likely due to reticence among family members about allowing participation). In practice, this resulted in having two focus groups for women in each location: one comprising young adult women (generally 18–20 years old) and one (the main female focus group) comprising older adult women – though there was a small amount of overlap in the age composition of the groups.

Security challenges: Security challenges arose during fieldwork in some locations. This required modifications to fieldwork planning throughout the assessment period. In one project site – namely, Wargarwyne IDP in Elbarde – security was known to be a concern prior to data collection, and this site was replaced with an alternative site within the same district. In Beledweyne, security risks led to temporary pauses in data collection as researchers took shelter until conditions improved.

Connectivity issues in remote locations: Connectivity issues posed challenges to communication with field teams and delayed their ability to submit data to our central servers. This limited the team's ability to monitor the quality of incoming data and caused delays in completion of the overall work.

Cultural and knowledge-based determinants: Several factors may make measurement against the indicators challenging or misleading. It is hard to assess the accuracy of stated perceptions and descriptions as there are strong cultural barriers to disclosing sensitive issues to researchers: for example, admitting the presence of some forms of violence or the attitudes that underpin these. Further, opinions given during the first round of data collection may have been determined by the lack of understanding of GBV and child abuse at that

time. It is not uncommon to find that perceived safety goes down instead of up over time as informants become more aware of risks and are better able to identify these, as well as potentially broadening their definition of risk.

Annex F Baseline assessment against impact and outcome indicators

This annex presents data collected from community FGDs during the initial evaluation in relation to the indicators in the Gaashaan revised results framework for Outcomes 1 to 3. The intention is that further rounds of FGDs will be conducted in the same communities in the next two phases of the evaluation to provide evidence on progress against results. This evidence will be in part related to changes in the recorded scores (derived from the rubric-based assessment), though these will need to be interpreted with caution. These scores are complemented by qualitative descriptions of experiences and perceptions.

F.1 Baseline for impact

The overall impact statement is as follows:

'Women, girls, and boys are better protected against GBV and child abuse (including family separation and child recruitment) and receive a high-quality response where needed.'

Progress towards this impact will be assessed through two proxy indicators based on perceptions of safety within communities and support for survivors and those most at risk. Improved perceptions of safety are assumed to reflect better protection and response systems for both GBV and child abuse.

For the baseline, data collected in focus groups have been quantified to give an overall sense of the level of safety within sampled communities. Alongside this, a qualitative description of risks and protective factors is given to illustrate how safety is understood locally.

F.1.1 Impact Indicator 1

Percentage of communities reporting increased safety from GBV.[57]

Additional qualitative description:

GBV risks, and protective factors related to these, including how these work and how effective they are, including specific consideration of links between GBV and child protection.

Ways in which the wellbeing of sexual violence and GBV survivors is supported (through GBV and child protection services, in the community and in the home) and how this has changed due to Gaashaan interventions.

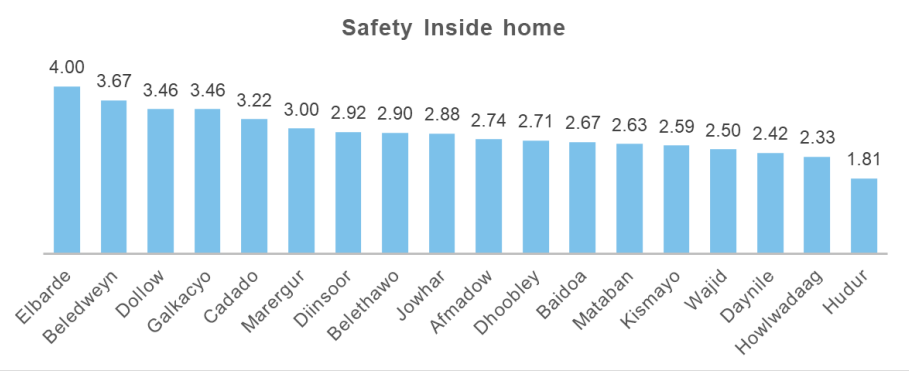
Changes in attitudes towards GBV and child protection risks and towards support for survivors and children at risk.[58]

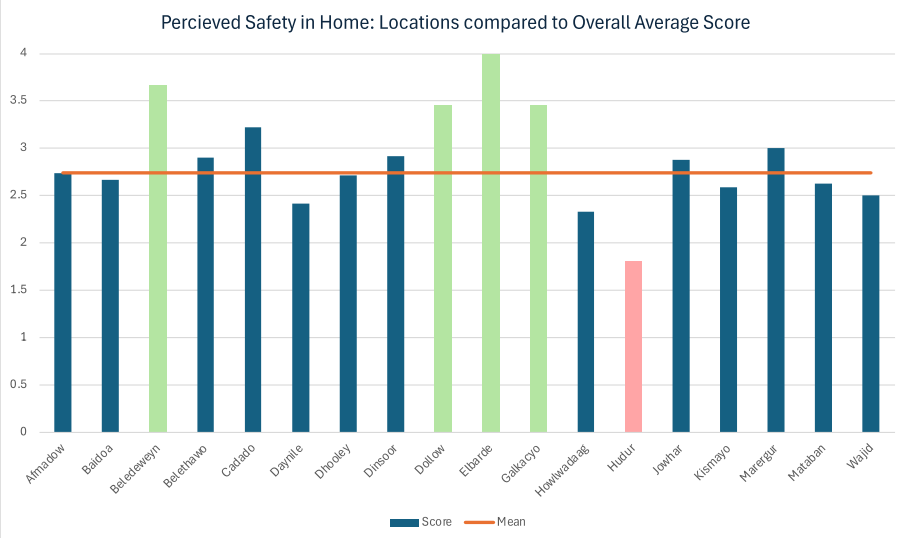
In FGDs, the average rubric-based scores for the indicator 'Safety inside the home' reveal variation across the 18 assessed locations. The highest score, 4.00, was

[57] Based on the existence and effectiveness of protective factors defined during the baseline process.
[58] A positive shift in these attitudes is assumed to increase protection from secondary harms through community support.

recorded in Elbarde, indicating unanimous selection of the most positive response – suggesting that all participants agreed that most women and girls feel safe in their homes and that incidents of violence are rare. In contrast, Hudur recorded the lowest score, at 1.81, suggesting that most participants in that location selected responses reflecting widespread concern about violence or safety risks in the home. Howlwadaag and Daynile also scored below 2.5, indicating more mixed or negative perceptions. Most other locations fall within the 2.5–3.0 range, suggesting moderate levels of perceived safety, with some variation across communities.

Figure 3: FGD score on whether informants think most women and girls in their community generally feel safe in their homes

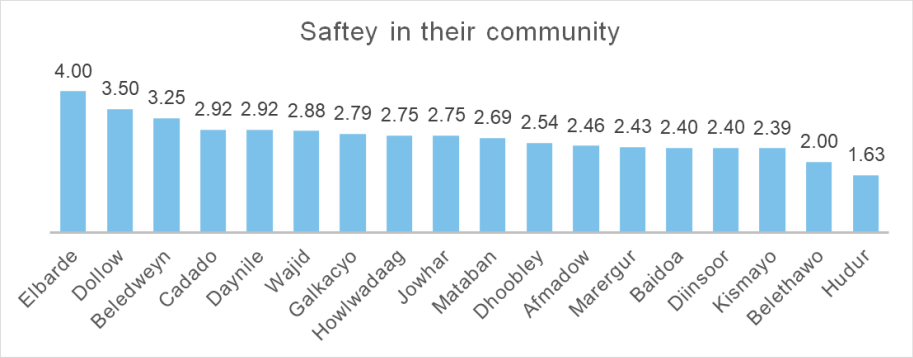


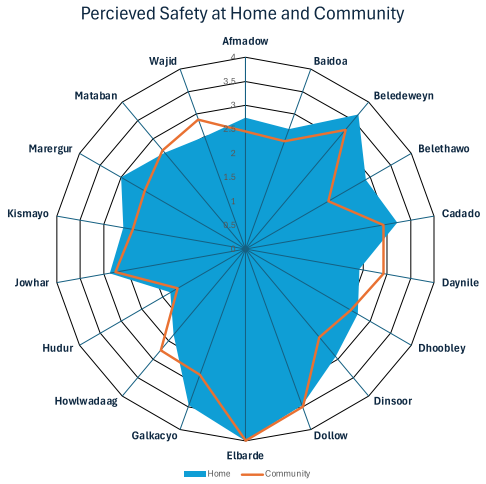


Community perspectives on safety in the community

Respondents in Elbarde reported the highest levels of perceived safety in the community, with a score of 4.00, indicating widespread agreement that the community is a safe environment. This was followed by Dollow (3.50) and Beledweyn (3.25), where views were also largely positive. In contrast, Hudur reported the lowest score, at 1.63, suggesting significant concerns about the safety of women and girls in public spaces. Beled Hawo (2.00) and Kismayo (2.39) also reflected lower levels of confidence in community safety. Most other locations, such as Afmadow (2.46), Baidoa (2.40), Dhoobley (2.54), and Wajid (2.88), fall in the moderate range, indicating mixed perceptions, where some respondents reported feeling safe while others did not.

Figure 4: FGD score on whether informants think most women and girls in the community generally feel safe in the community





In nearly every location, women FGD participants reported that girls are at heightened risk in public spaces due to their age, mobility, lack of protection, or social norms that expose them to violence, harassment, and discrimination, particularly IDP women and girls without male

or adult protection.[59] The findings highlight regional variation in perceived threats, ranging from verbal harassment in markets to sexual violence and limited freedom of movement. There were common concerns amongst both men and women around public spaces and events, with risks heightened for girls without family protection and during key times and activities, such as school commutes or work. Real security concerns coupled with patriarchal norms likely contribute to women's perceptions of risk. Discrimination based on clan identity also features.

Perspectives on the risks and needs relating to GBV

For community leaders, GBV concerns at the household level centred around domestic violence, forced marriage, verbal abuse, neglect of girls' education, and the persistence of harmful traditional practices such as FGM. The GBV risks faced by women and girls in the community were considered to be even greater. Sexual violence, including rape and harassment during daily activities, such as collecting firewood or travelling after dark, was mentioned by leaders in multiple locations. Some leaders, such as those in Beledweyn, highlighted that minority clan and internally displaced women and girls face compounded risks of discrimination and abuse. In addition to these physical dangers, leaders described psychological impacts, such as fear, stress, and depression resulting from persistent violence and insecurity.

Poverty and limited access to education were commonly cited as underlying drivers of GBV risks. Several leaders noted that families struggling economically were more likely to marry off daughters early, limit girls' access to education, and expose women and girls to greater vulnerabilities. Several leaders emphasised that harmful traditional practices, particularly FGM and the prioritisation of boys' education over girls', persist in their communities despite awareness efforts. Many respondents also explained that poor security infrastructure, such as a lack of street lighting and the absence of protective community systems, exacerbates the threats faced by women and girls. Community leaders portrayed VAWG as rooted in intersecting problems of poverty, cultural norms, weak institutions, insecurity, and lack of education.

Economic hardship emerged as a central theme across interviews. Poverty was seen as creating household tensions but also as forcing decisions that expose girls to risk, such as early marriage or unsafe work. Many noted that poverty-driven practices, like accepting dowries from wealthy older men in exchange for young girls, remain common.

Social norms and cultural practices also featured prominently. Several leaders explained that FGM and forced marriage continue to be widely accepted, albeit with some reduction due to growing awareness efforts. Discriminatory attitudes that value boys' education over girls' futures, and the acceptance of physical punishment or abuse within households, were also cited as persistent barriers to change. In several accounts, the lack of education and community-wide awareness was highlighted as an underlying reason why harmful practices persist and why survivors hesitate to seek help.

[59] It is worth noting that the 'protection' of women and girls in insecure contexts may involve controlling their mobility and presence in public spaces.

Clan-based conflicts, displacement, and weak law enforcement compound risks. Leaders described how conflicts between clans, or displacement from rural to urban areas, increases the vulnerability of women and girls, leaving them in insecure shelters with little protection. Some mentioned that in the absence of strong governance, local elders often resolve serious cases like rape through informal negotiations, rather than pursuing justice through formal legal channels.

Urban infrastructure was another cited concern. Poorly lit streets, insecure housing, and a lack of secure public spaces were said to create opportunities for violence, particularly after dark. However, across multiple locations, women in FGDs consistently identified domestic (home) environments as spaces of vulnerability and burden.

The majority of women described experiences of gender inequality, domestic labour, lack of education, physical and sexual violence, forced and early marriage, FGM, and neglect – particularly in households affected by poverty, displacement, divorce, or physical separation. The structural insecurity of homes, especially in IDP locations such as Wajid, was cited as a risk factor. Girls were again highlighted as being more at risk than older women. Risks were seen as higher for rural and displaced girls, those in polygamous households, and those without adult protection. FGDs in Cadado and Elbarde reported little to no concerns; however, this was not reflective of data from KIIs in these locations and may indicate either a lack of awareness or a reticence about describing the situation to an outsider. In Elbarde, respondents uniformly stated that there were no concerns within the community. However, this unanimity may signal social conformity in responses, a lack of trust regarding sharing challenges with outsiders, or the fact that VAWG is not understood as a problem but instead is seen a normal facet of life. Over time, with continued awareness raising through the project, these attitudes may shift and participants may become more aware of VAWG and inequities between men and women being problematic.

F.1.2 Impact Indicator 2

Percentage of communities reporting reduced exposure to child protection risks and/or increased safety for children in their homes and the community.[60]

Additional qualitative description:

Different groups within communities describe increased protective factors (and their effectiveness) for a range of identified child protection risks.

Women, men, girls, and boys describe ways in which recruitment into armed groups is reduced in the community, such as lower acceptance of armed groups in communities and reduced movement of children alone in isolated areas for collecting wood/water (a proxy for community protection as risky activity is reduced).

Boys and girls describe ways in which they feel an improved sense of safety in the community/school/home from both child protection and broader GBV risks.

[60] Based on the existence and effectiveness of protective factors defined during the baseline process. Assessed through the use of a capacity assessment tool.

Perspectives on child protection risks

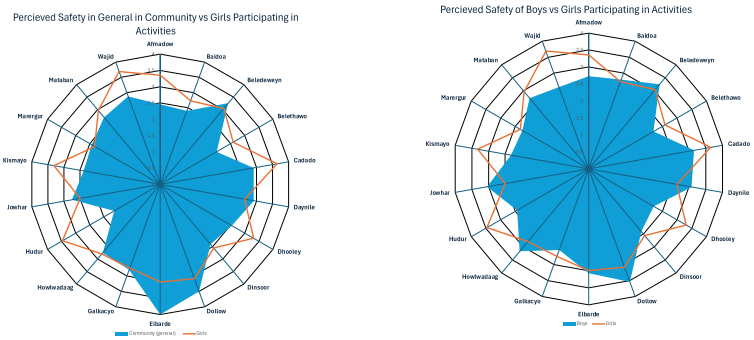
Concerns for the safety of children remain a major issue for all stakeholders, though the nature of these concerns varies across locations and populations. Poverty, family separation, displacement due to conflict, and deeply entrenched social norms (e.g. favouring boys over girls for education) continue to fuel the cycle of vulnerability among children in many districts.

All community leaders consistently reported that child protection risks arise from a combination of social, economic, environmental, and conflict-related factors. Children in IDP camps were seen to be particularly vulnerable to recruitment, neglect, abuse, and exploitation due to their marginal status and lack of access to education or formal protection systems. A few leaders noted that orphaned girls face the greatest danger. Leaders reported that access to education plays a crucial protective role. Frequently cited drivers of risk of child abuse were the following:

- Clan-based conflicts.
- Poverty and economic hardship.
- Location and timing. Seasonal factors, such as drought and displacement, were cited as external conditions that heighten children's vulnerabilities, either through forced migration or disruption of protective family and community structures.
- Lack of education. Children who are not enrolled in school or Quranic classes were viewed as more likely to be recruited by armed groups, to engage in substance abuse, or to fall prey to exploitation. Areas with strong education systems (e.g. urban centres like Dusamareeb) were perceived as safer compared to rural regions that are without access to schooling.
- Drug abuse and lack of community protection. Cadado and Kismayo leaders specifically mentioned that playgrounds and poorly supervised public spaces expose children –especially boys – to drugs, recruiters for armed groups, and criminal elements.
- Displacement due to droughts and conflict. Respondents from Beledweyn, Kismayo, Afmadow, and Dollow highlighted how children in IDP camps face amplified risks, including risk of abduction, malnutrition, separation from parents, and reduced community protection.

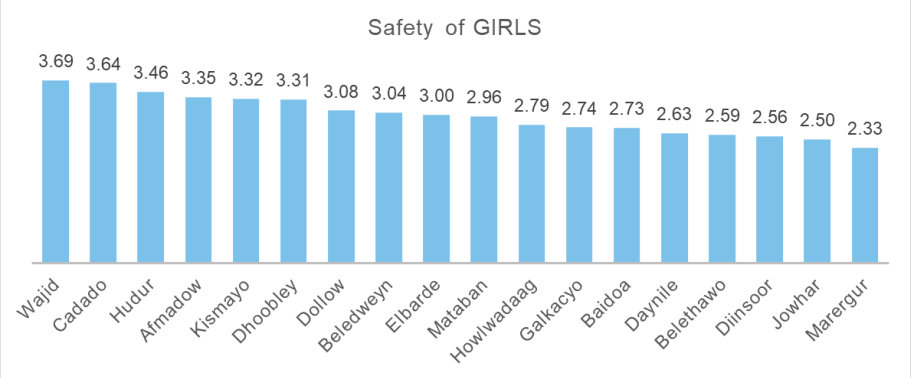
A consistent theme was that the types of risks faced by boys and by girls differ significantly, and the overall perception of safety in public spaces and activities is higher in relation to girls than for boys. This may reflect particular concerns around the risk of abduction, unsafe labour, or recruitment into armed forces.

Figure 5: Perceived safety of girls (compared to safety in communities and to boys)



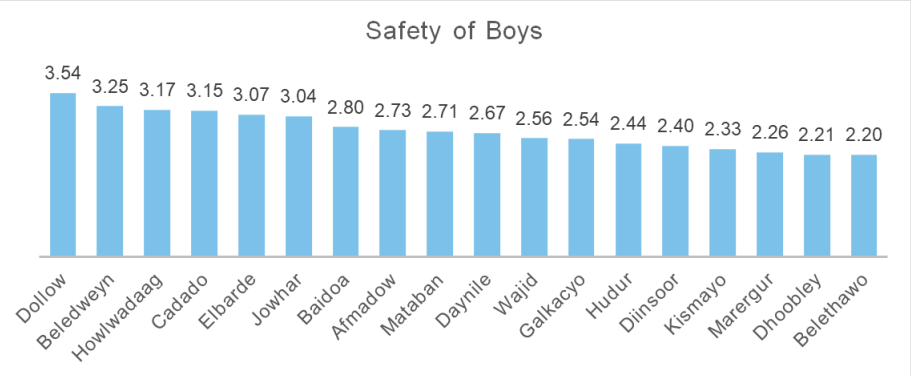
Girls were viewed as more vulnerable to sexual violence (rape, harassment, forced marriage), while boys were reported to face greater risks of recruitment into armed groups and hazardous child labour. Some leaders noted that orphaned girls are at even higher risk compared to orphaned boys. Girls were reported to be at particular risk of rape, forced marriage, domestic servitude, and harassment when they are sent to perform household labour, such as fetching firewood or working in strangers' homes. Leaders from Mataban, Daynile, and Dollow highlighted that girls, particularly young adolescent girls (12–15 years), face increased dangers when moving outside, especially when poverty or the collapse of family structures force them into precarious work or travel. Several leaders, including those from Kismayo and Beledweyn, emphasised that girls often lack protection and are more vulnerable to violence if they live without secure housing or without adult supervision.

Figure 6: FGD score for informants' perception of whether MOST girls in the community are safe participating in activities in public spaces



Boys were commonly described as more vulnerable to risky child labour and armed recruitment by militias or radical groups, particularly in contexts of displacement, poverty, or conflict. Leaders from Mataban, Marergur, and Cadado specifically highlighted the risks of child soldiering, noting cases of boys as young as 12–13 carrying arms. Boys were also seen as more exposed to engaging in informal child labour in risky environments to support family incomes, such as working in markets or shoe shining.

Figure 7: FGD scores for informants' perception of whether MOST boys in the community are safe participating in activities in public spaces



F.2 Baseline for Outcome 1

The expected Outcome 1 is: **Strengthened capacity of GBV and child protection actors ensures improved access to and availability of GBV and child protection services**.

Indicator 1.1: Percentage of communities with improved **access to, and improved availability, quality, and acceptability** of, services for GBV and child protection.[61]

Additional qualitative data:

Descriptions of capacity improvements supported for different services, what supported these improvements, and how these changed outcomes for survivors.

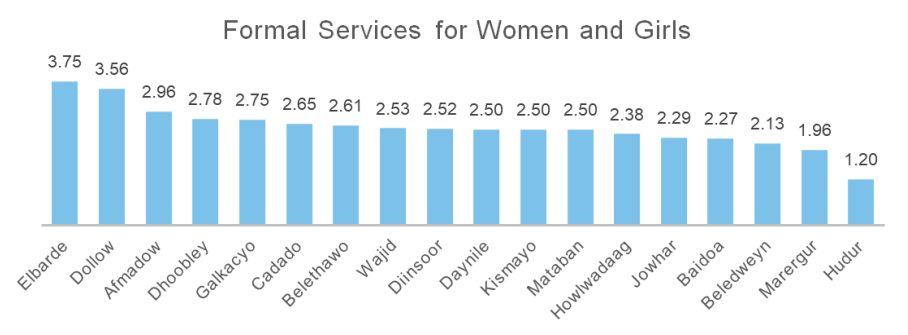
Descriptions of how services can be accessed, including improvements to any factors blocking access.

Descriptions of improved willingness to use (or support for those using) services.

[61] Expectations for capacity improvements to be established during the baseline.

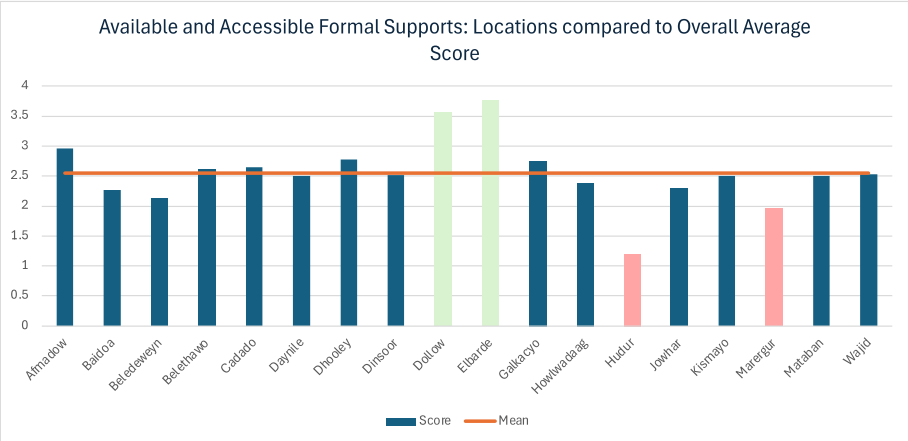
GBV – formal service availability and accessibility

Figure 8: FGD score on whether informants think that the necessary formal support services are available and easy to access for women and girls



Scores in Elbarde and Dollow suggest good availability of services while respondents in Hudur and Maregur reported very low scores, indicating widespread concern about the lack – or inaccessibility – of formal services. Other locations reflected more moderate to negative views, with perceptions of availability and accessibility likely shaped by issues such as distance, affordability, or stigma. In these locations, while some services exist, gaps and barriers to full accessibility remain a concern.

Figure 9: Available and accessible formal support



Notes: Green indicates areas more than 1 standard deviation greater than the average (services were seen as more available and accessible than average). Red indicates areas more than 1 standard deviation less than average (services were seen as less available and accessible than average).

The availability and structure of services vary by district

In Elbarde, a local authority mentioned that there are no dedicated services specifically relating to GBV. Instead, survivors are primarily directed to hospitals through coordination

with the Ministry of Health, reflecting a generalist approach rather than a specialised protection system. Integration of GBV services into wider health provision was also noted by national stakeholders and may have a greater likelihood of ensuring sustainability. District authorities emphasised the need to strengthen and expand current services, ensuring that survivors can access support without needing to leave communities. Authorities highlighted the importance of enhancing connections between survivors and services, improving collaboration with organisations, and raising awareness among perpetrators about accountability and the consequences of violence.

Health services were a widely mentioned formal service and were seen at the national level to be the key lynchpin for the provision of GBV services, but national-level views on their quality and accessibility differed from those of stakeholders closer to the communities. In Marergur and elsewhere it was noted that even though clinics exist, the lack of trained staff, medicines, or affordable treatment makes these services inadequate. Some leaders reported that survivors need to travel long distances, sometimes without proper transport, to access decent medical care.

NGOs and civil society organisations also provide wider support to survivors, such as psychosocial counselling, cash assistance, distribution of dignity kits, provision of hotline numbers, and awareness-raising activities. The lack of sufficient MHPSS was noted by multiple national stakeholders as a key gap in overall service provision. There are plans to roll out IRC's Women's Rise Toolkit in Year 3 to help address this gap.

Police services were mentioned in nearly every community as the primary point of contact for survivors seeking protection or legal recourse. Leaders from Mataban, Cadado, Marergur, Wajid, Dollow, Dhoobley, and Beledweyn emphasised that survivors can report abuse directly to police stations. In some areas, police are also responsible for arranging transportation for survivors to reach hospitals, especially where medical services are not readily available. However, some key informants also mentioned that police do not always follow appropriate procedures to ensure confidentiality (for example, they may call on a phone and give the name of the survivor they are transporting, etc.).

Local and district authorities identified police and justice services as the primary government mechanisms addressing GBV, through monitoring, reporting, and referrals, indicating an established – though basic – legal response framework. In Beled Hawo specifically, authorities noted the involvement of female police officers leading GBV response efforts and a structured referral mechanism linking police services to the district hospital. Healthcare services were also highlighted. Authorities observed that while most rape cases proceed through formal channels like courts, some incidents are still mediated informally by traditional elders, potentially affecting access to formal justice. For domestic violence cases, these were more often seen as falling under the remit of traditional elders rather than formal courts.

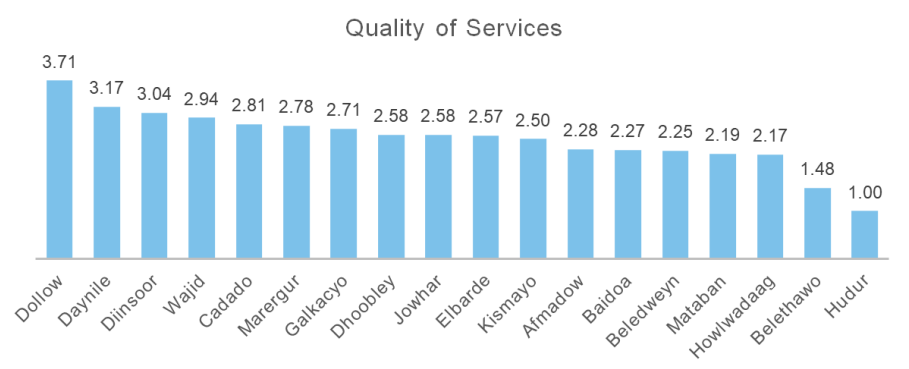
Leaders from Daynile and Afmadow described broader types of support, including education, vocational training, and livelihood support for survivors, aiming to promote long-term resilience rather than only emergency responses. However, national stakeholders noted that economic and livelihoods interventions for survivors are often a gap in referral pathways. Key informants noted that the provision of mental health support is one of the major gaps in service provision, and particularly support to address deep trauma. Gaashaan

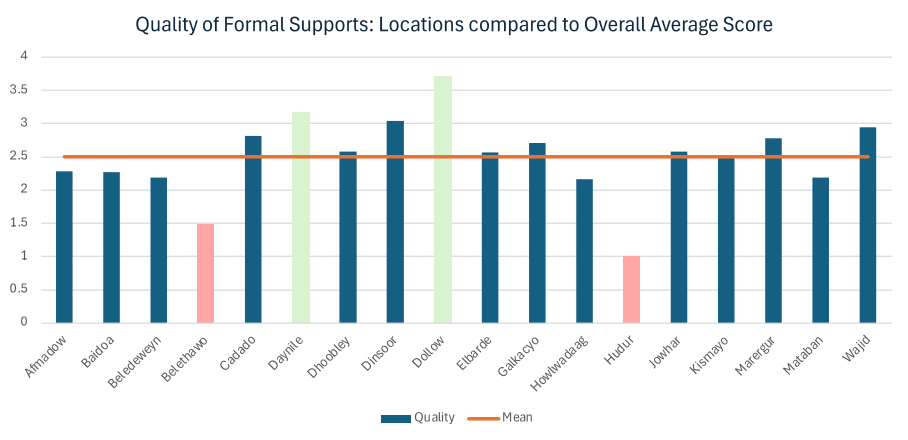
is seeking to fill some of this gap through the introduction of the Women Rise approach and the Girl Shine approach this year, and efforts to engage the mental health working group coordinator from the World Health Organization.

While community leaders across different locations reported the presence of formal services, such as police stations, hospitals, or clinics, and NGO services (like those of Gaashaan, Save the Children, and WARDI), the accessibility of these services remains uneven across communities. Barriers like distance, cost, and social stigma persist, especially for rural or displaced populations. In Mataban, Beledweyn, Jowhar, and Wajid, leaders noted that services are generally available, and survivors can contact authorities at any time. In Mataban, services such as the police, justice agencies, health centres, and humanitarian organisations like Save the Children and Gaashaan operate 24 hours a day. In Beledweyn, collaboration between the police, NGOs, and health centres has improved urgent responses, with hotline numbers available for emergencies. In Wajid, victims can seek immediate help by reporting cases to leaders or to Gaashaan, who respond quickly. However, barriers persist even in these areas. Distance and transportation costs were cited as significant challenges, particularly for survivors in rural villages far from urban service centres. Even when survivors are willing to seek help, they may be unable to afford travel or to find timely transportation, as highlighted in Beledweyn, Dhoobley, and Marergur. In Dhoobley, the community leader pointed out the lack of ambulances as a gap, which means survivors must reach health centres by their own means even during emergencies. Survivors living far away are systematically excluded. In Dollow, leaders highlighted that while services are present, delays in transportation can cause a deterioration in the survivor's health before they reach a health centre. Leaders from Afmadow and Diinsoor were more optimistic, noting that services are largely accessible and that barriers mainly relate to social stigma rather than infrastructural gaps.

GBV – quality of GBV services

Figure 10: FGD score on quality of existing services for women and girls



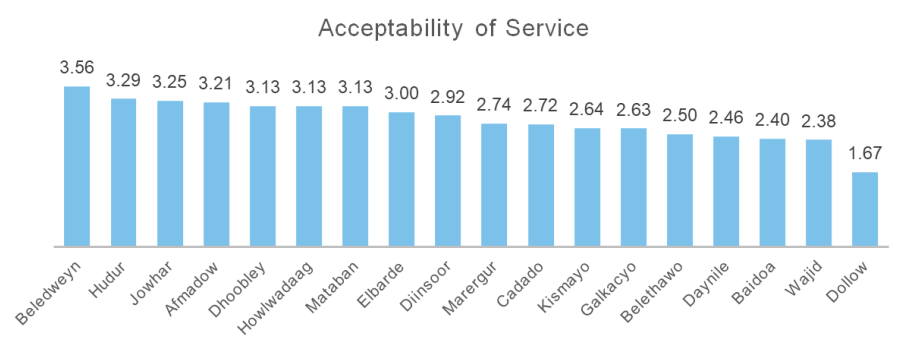


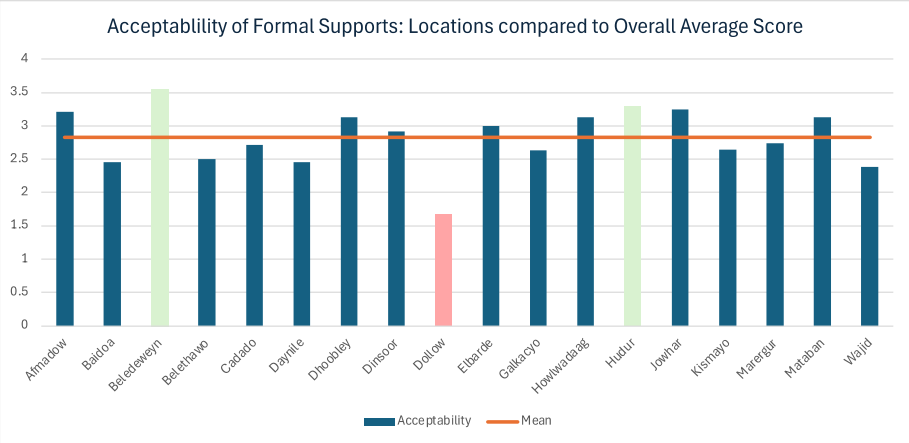
Perceptions of the quality of services available to women and girls – such as whether services meet survivor needs, are confidential, and have appropriate staff and facilities – ranged from positive to deeply concerning across locations. Dollow recorded the highest score, indicating that respondents perceived services there as being generally of a high quality. Relatively positive ratings were seen in Daynile, Diinsoor, and Wajid, suggesting that services in these locations were more often considered adequate or effective. Mid-range scores reflect mixed views, where participants may have encountered both strengths and limitations in available services. On the lower end, low scores in Hudur and Beled Hawo indicate the view that most services are of a poor quality or ineffective.

The perceived quality of services for women and girls experiencing violence varied across districts. Authorities recognised that security and health services are available and are generally of a good quality in some areas, particularly where collaboration between organisations and government agencies is strong. GBV centres, the Ministry of Family and Human Rights Development, and district women's groups were cited as providing a range of important services, including counselling, medical support, and dignity kits for survivors. In Beled Hawo, the quality of services was viewed as poor. Major gaps were noted, including the absence of continuous awareness-raising activities, a lack of hotlines for reporting and referrals, and the strain placed on existing services by the surrounding IDP population. There are also challenges due to the wide geographic coverage of districts, with a need for expanded staff and resources to ensure accessibility across over 100 villages.

Acceptability of GBV services

Figure 11: FGD score on acceptability of services for women and girls





Perceptions around the acceptability of service use – that is, whether it is considered socially acceptable for women, girls, and children to seek formal support after experiencing violence – also varied across locations. Beledweyn recorded the highest score, at 3.56, indicating strong community support for women and girls accessing services. Other locations scoring over 3, where acceptability was seen as relatively high, included Hudur, Jowhar, Afmadow, Mataban, Howlwadaag, and Dhoobley. These scores suggest a generally supportive social environment and that there may be lower levels of stigma towards survivors seeking help. In contrast, Dollow stands out with a low score of 1.67, suggesting strong social barriers or disapproval around service use. Baidoa (2.40), Daynile (2.46), and Wajid (2.38) also reported more constrained perceptions, where community norms may discourage formal help-seeking. Most other locations fell in the mid-range (2.5–2.9), indicating mixed social attitudes that may vary by age group, gender, or other contextual factors.

Social stigma and fear of shame remain barriers. Leaders from Cadado and Marergur reported that survivors often hide their experiences due to fear of public judgement, confidentiality breaches at health facilities, and discrimination. A few leaders, especially

those from Marergur and Kismayo, highlighted that while survivors appreciate the services, stigma and fear of exposure continue to discourage some from accessing help, particularly where services involve medical reporting. Community leaders viewed services positively across the locations. Formal support – including police assistance, healthcare, NGO services like Gaashaan, and justice agencies – is seen as appropriate and needed, especially given the safety risks faced by women, girls, and children. In Mataban, Daynile, and Diinsoor, services were welcomed because they address critical needs, such as medical care, legal protection, and awareness raising about practices like early marriage and FGM. Leaders noted that the 24/7 availability of hospitals and police stations has helped strengthen trust in these systems. In Afmadow, Beledweyn, and Dhoobley, the community valued emergency responses and referrals, although leaders pointed out that limited night-time security and a lack of nearby health facilities (e.g. no mother and child health centre within 5 km in Beledweyn) create gaps.

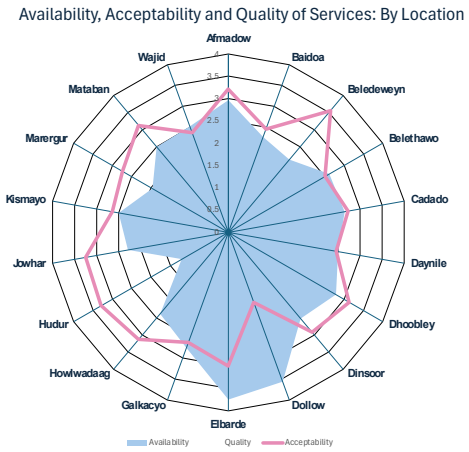
There are some limitations in the community-based approach to GBV, due to strong cultural norms and traditional approaches. GBV cases are viewed as having multiple levels, some can be handled at the community level while others need to be addressed within the formal justice system. Respondents spoke of the use of these community protection structures to solve issues such as intimate partner violence, early marriage, FGM, etc. Only cases of GBV that are viewed as more 'serious', such as rape, would be referred to the police or the legal system. This presents a barrier to pursuing legal justice and survivor-centred outcomes in what are seen as domestic issues.

District authorities stressed the need for increasing community awareness and education on GBV prevention. They suggested expanding the number of GBV centres, particularly in underserved areas, and employing more women officials in courts and police stations to help survivors feel more comfortable and confident when reporting cases. In Howlwadaag, a district-level authority described a particularly well-organised sectoral system involving women's and youth organisations that are actively engaged in case identification, reporting, and coordination with district and regional authorities to ensure continuous service delivery and survivor support.

A significant barrier to access that was mentioned was a lack of financial resources, with authorities noting that survivors often lack the means to seek help, access health services, or pursue legal remedies, which severely limits their ability to obtain justice and support. Social and cultural barriers were consistently reported. Respondents explained that traditional elders sometimes interfere with justice processes by arranging marriages between survivors and perpetrators to avoid community shame. Such arrangements often disregard the needs, rights, and wellbeing of the survivor, prioritising family reputation and financial exchanges over justice and recovery. Traditional leaders often prefer resolving cases through the customary *Xeer* system, which discourages the formal reporting of VAWG. This practice was linked by respondents to community concerns about protecting the reputation of girls and was reported to be further compounded by high levels of illiteracy among women and girls, which limits their ability to navigate formal systems of support. Authorities noted that marginalised groups, such as those without influential social connections, face greater neglect by formal authorities, and that dissatisfaction with court and police decisions sometimes leads communities to distrust formal systems. These patterns of interference and inequality compromise survivors' access to services and undermine the effectiveness of protection mechanisms.

Overall provision of services

Figure 12: Availability, acceptability, and quality of services by location



The availability and quality or services generally overlap. Where there is good availability, the services are seen as of a good quality; where services are limited, they are seen to be of a limited quality, except in Beled Hawo, Elbarde, and Afmadow, where focused efforts to improve quality may be needed. Acceptability is generally high, even where services are not very available or of a high quality (e.g. Hudur). Some locations (Dollow and Daynile) have an acceptability gap, indicating the need for activities to raise awareness and change attitudes.

Community leaders widely agreed that increasing the availability, reach, and awareness of services is key to ensuring women and girls access and use them effectively. Leaders from Mataban and Marergur called for trained personnel, medical facilities, and police presence in rural areas, with one leader specifically urging Gaashaan to extend its operations into underserved zones.

Improving community awareness was another frequent recommendation. Leaders across districts suggested frequent public education sessions, community mobilisation activities, and the use of schools and religious institutions to deliver messages on protection, rights, and available services. Leaders in Marergur proposed integrating GBV topics into school curricula, while those in Jowhar and Dollow emphasised the need for regular awareness meetings. Leaders in Kismayo proposed forming community-level focal points who are well-known and would be approachable for survivors. Several leaders recommended infrastructure and service delivery enhancements, such as establishing safe centres for survivors (Cadado), dedicated offices for women to seek information (Daynile), and mobile outreach teams, as well as comprehensive follow-up care.

Economic empowerment, MHPSS, and legal services were viewed as gaps to be considered in strengthening referral pathways for protection. Leaders in Beledweyn suggested supporting the creation of small businesses for vulnerable women and girls, while those in Afmadow highlighted the need for quality and sustainable services to reduce long-term risk.

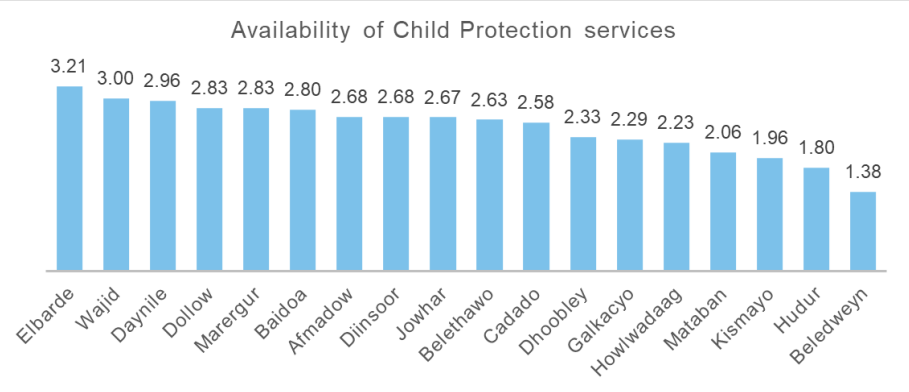
Across all areas, both district and local authorities described efforts to bridge gaps through community mobilisation and local initiatives. However, they also acknowledged that without broader investment and systemic support, existing services remain inadequate to meet the protection and welfare needs of vulnerable children. Ongoing weaknesses in service provision were primarily seen in areas of service provision less directly under the control of Gaashaan – for example, issues of privacy and confidentiality – particularly when cases are reported to the police and/or where the legal system is still seen as a challenge, or due to turnover of staff at referral services.

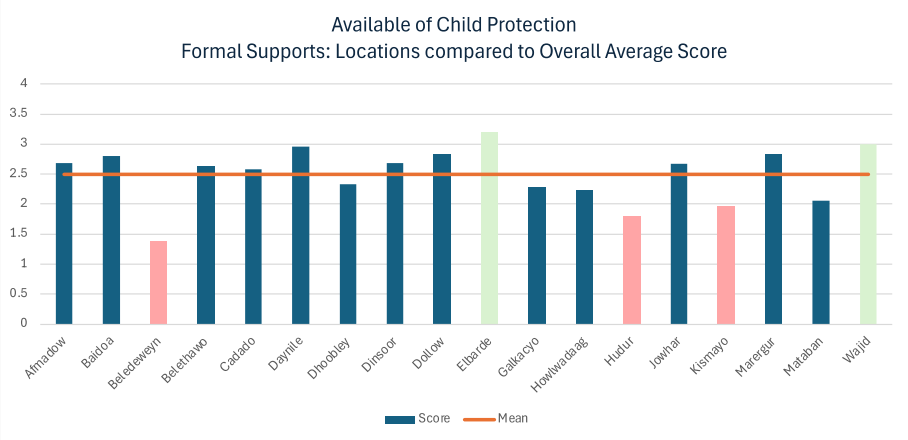
Delayed reporting of cases impacts the ability of survivors to receive timely care. Barriers to reporting were reported to be a key aspect determining service uptake and are affected by multiple factors. There is stigma associated with being a survivor of abuse. There is also fear that a survivor will be seen as having lied to get financial support and that reporting may be harmful to clan and community dynamics. When perpetrators belong to very powerful clans and the survivor is from a minority group or hails from a less powerful clan there are power dynamics which determine responses. Police are pressured to drop cases linked to clan elders, who are very influential and are often linked to governments or key line ministries. There are also financial constraints that affect the ability to report, as well as safety, security, and access constraints.

Child protection

Availability of child protection services

Figure 13: FGD scores for whether the necessary formal support services exist to protect children





The highest score was reported in Elbarde (3.21), followed by Wajid (3.00) and Daynile (2.96). These scores suggest that while services are perceived to be present and somewhat accessible in these areas, they are not seen as fully available. Most locations scored between 2.0 and 2.7, reflecting perceptions of limited or uneven service coverage. Beledweyn (1.38), Hudur (1.80), and Kismayo (1.96) received the lowest scores, suggesting widespread concern about the lack of effective child protection services.

Across districts, both local and district authorities described a range of services aimed at protecting children, supported by numerous providers, although the availability and strength of services was reported to vary. Child-safe spaces, particularly in IDP camps, boarding schools for orphans and poor children, and specialised centres for disabled children, such as the deaf and blind, were reported in some districts. In Howlwadaag, a particularly structured approach was described, including a child protection committee, regular training, outreach activities for street children, and efforts to promote school enrolment. In Mataban, some assistance was reported to be available through the Gaashaan office and Save the Children, but it was acknowledged to be insufficient to meet widespread needs. However, in more rural areas like Mataban, services were said to be significantly more limited. In Beled Hawo, the situation is particularly concerning, with large numbers of children engaged in child labour rather than education, and many vulnerable to community violence.

Both local and district authorities reported barriers to accessing these services. A lack of financial resources, long distances to service centres, and transportation challenges were cited across several districts, including Galkacyo South, Mataban, and Elbarde. In Baidoa and Beled Hawo, low awareness among families and the economic pressures that push children into labour were also said to be significant challenges. Security-related barriers were reported to be critical in areas like Beled Hawo, where the presence of Al-Shabaab undermines access to government services and fosters harmful practices, such as FGM.

Authorities across districts assessed the quality of existing child protection services as ranging from inadequate to moderate. In Galkacyo South and Mataban, the gaps are particularly severe: extreme malnutrition rates, shortages of basic support services, and a lack of psychological care were reported. In Baidoa and Beled Hawo, services were judged to be more developed but still far from sufficient, with many children still sleeping on the

streets, working in unsafe conditions, or at risk of exploitation. In Howlwadaag and Elbarde, while efforts are made to improve child protection through advocacy and community mobilisation, a lack of specialised infrastructure and formal support systems continues to limit impact.

In most locations, schools were cited as one of the primary protective spaces for children. However, gaps in recreational spaces, trained facilitators, and awareness curricula were reported. Police services and conflict resolution structures were frequently mentioned as central to child safety. Health services were cited in Afmadow, Beledweyn, and Dollow as part of protective infrastructure, often working alongside NGOs such as Gaashaan, Save the Children, and the Norwegian Refugee Council. Psychosocial support and referrals to medical treatment are available in some communities, although not universally.

Some communities – such as Hudur – reported an absence of any formal services for child protection, highlighting persistent gaps in reach. Similarly, several leaders highlighted the lack of trained personnel in rural areas, limited child-friendly spaces, and a need for more consistent awareness and support systems.

At the district level, authorities placed particular emphasis on providing child-safe spaces, especially for vulnerable children living in IDP camps. Respondents described the presence of safe spaces where children could play, boarding schools for orphans and children from poor families, and specialised centres for disabled children, including the deaf and blind. These services were viewed as critical for offering protection, education, and structured support for the most at-risk groups.

In Howlwadaag, district authorities described a particularly coordinated and structured approach to child protection. A committee has been formed across three districts, which receives regular training from the Ministry of Justice and Constitution. The committee works closely with street children, those subjected to forced labour, and youth at risk of recruitment into extremist groups. Authorities also promote positive engagement strategies, such as organising sports competitions, and community efforts are made to encourage school enrolment as a protective measure. Additionally, innovative suggestions – such as encouraging families to sponsor vulnerable children – were put forward by district authorities to strengthen community-based child protection systems.

Some authorities reported that the availability of child protection services is more limited. In Mataban, while some support is available through the Gaashaan office and Save the Children, authorities acknowledged that assistance does not fully meet community needs. In Elbarde, no specialised child protection services were reported; instead, child safety concerns are primarily addressed through general coordination with hospitals and relevant organisations, indicating a more *ad hoc* – rather than a targeted – approach.

The situation in Beled Hawo appears to be particularly concerning. Local authorities described a lack of specialised child protection services and highlighted that many children, especially those from IDP communities, are engaged in child labour, rather than attending school, reflecting gaps in child safety infrastructure and protective support systems. In Galkacyo South and Mataban, authorities described particular deficiencies. In Galkacyo South, while basic health and security services are available, authorities stressed the lack of psychological support, limited wellbeing services, and an overall shortage of support

resources. Similarly, in Mataban, extreme gaps in basic child welfare services were reported. In Baidoa and Beled Hawo, services were assessed as moderate but insufficient. While child-safe spaces, boarding schools, and some protective structures exist here, authorities noted that the scale of need vastly outstrips available resources, particularly among IDPs and vulnerable urban populations. Reports from both areas highlighted the children continuing to live on the streets, child labour, and exposure to harmful environments, with specific calls for free schools, childcare centres, and expanded outreach to address growing vulnerabilities.

In Howlwadaag and Elbarde, authorities highlighted different but complementary challenges. In Howlwadaag, district authorities pointed to severe budget constraints, noting that the lack of retained tax revenues restricts their ability to deliver more formal services. As a result, authorities focus primarily on awareness raising, advocacy, and improving education access through partnerships with Quranic schools. In Elbarde, local authorities stressed that the absence of specialised child protection centres means that survivors of violence are primarily routed through general hospital systems, limiting the availability of privacy-sensitive and child-focused care.

Most key informants noted that the weakest component of referral pathways is the provision of legal services. Gaashaan can provide medical assistance and cash assistance but is not able to offer legal aid. This was identified as a key gap. It was noted that this is a gap across other protection programmes also. Respondents also noted that sometimes referrals break down due to weak documentation or a lack of feedback between service providers. Limited tracking mechanisms across agents means some referrals fall through the cracks, especially in remote and hard-to-reach areas.

Local authorities identified several barriers that parents, children, and caregivers face in accessing child protection services, often linked to distance, transportation, and security challenges. A major barrier identified is the lack of financial resources among families. In Galkacyo South, authorities reported that many individuals struggle to reach service points due to insufficient transportation options, limited financial means, and security concerns. Distance to the nearest service centres was also cited as a major challenge, making it particularly difficult for vulnerable families to seek timely assistance. Many vulnerable families, especially among IDPs, are reluctant to seek help due to low levels of awareness and the economic necessity of sending children into labour activities, such as shoe shining. Howlwadaag authorities described a community-organised approach to overcoming barriers. Efforts are made to build trust in district services and create pathways for accessing support. However, challenges remain, particularly for displaced families, refugees, and those struggling with basic needs, who depend heavily on sporadic donations and *ad hoc* community support. While authorities in Howlwadaag reported stronger outreach efforts compared to other districts, the overarching challenges of poverty, distance, low awareness, and limited infrastructure remain common across all districts. Of note is that in Beled Hawo, while physical access barriers were considered minimal, security-related barriers linked to the presence of Al-Shabaab were reported to be significant. The respondent reported that Al-Shabaab positions itself as an alternative authority, supporting harmful practices such as FGM and intimidating communities into not engaging with government services. An incident was cited where, following an FGM case, the perpetrators fled to Al-Shabaab-controlled areas, demonstrating how security threats can severely undermine access to protection services.

Overall, while basic services do exist in most communities, their effective use continues to be hindered by a combination of distance, affordability, social stigma, and infrastructure gaps – particularly in rural and under-resourced settings. Most community leaders reported that formal child protection services – such as police, health centres, and awareness initiatives – are available and, in many cases, accessible when needed. However, accessibility is not universal. Barriers vary across communities and include both logistical and social constraints. A frequently cited challenge was geographical distance, especially for families living in remote or rural areas far from service centres. Lack of transportation was a commonly reported issue, particularly in emergencies, during which response times are delayed or families are unable to reach health facilities or police stations. Financial constraints also play a significant role. Even where services are technically available, costs related to medical treatment or transportation prevent some families from seeking help. In a few instances, services require referrals or documentation from local leaders, which can further delay or complicate access. Social barriers are also present.

In some communities, shame, stigma, or fear of exposure discourages survivors or families from using available services, particularly in cases of abuse. A lack of confidentiality, and a lack of trust in service providers, were also noted to be deterrents. Some leaders expressed concern about the limited scope or consistency of services, noting gaps during weekends or the absence of key services like child-friendly spaces, safe shelters, or specialised support for children affected by violence.

Respondents identified a consistent set of improvements that are needed to strengthen child protection. Priorities include the development of district-wide child protection plans (Galkacyo South), an increase in child protection centres and better resource provision (Baidoa), and the creation of large educational centres for vulnerable youth (Howlwadaag). Local authorities also called for broader interventions. In Mataban, there is an urgent need for comprehensive care, including clean water, healthcare, nutrition, and education, especially amid ongoing drought conditions. In Beled Hawo, authorities emphasised the need for specialised teachers, caregivers, and child-friendly spaces, while in Elbarde, they highlighted the need for dedicated child protection centres and expanded community awareness efforts. A point to note is that, across all surveyed districts, authorities consistently emphasised the importance of moving beyond emergency responses towards structured, long-term investment in child protection systems, education, psychological support, and safe environments for children.

Community leaders consistently emphasised the need for a more structured, responsive, and accessible support system to protect children and ensure that available services are trusted and utilised by the wider community. A key recommendation was the recruitment and training of specialised police officers to handle cases of violence, including the establishment of women-staffed police stations, to make it easier for survivors, particularly children and women, to report incidents in a safe and supportive environment. Leaders also stressed the importance of equipping health centres with trained professionals and creating dedicated spaces within these facilities where survivors can access medical and psychosocial support without delay or referral barriers. Within the justice system, community leaders called for the placement of trained personnel in separate, survivor-sensitive spaces to ensure cases are handled appropriately. In addition, they highlighted the importance of empowering women and girls through rights-based education and advocacy training, enabling them to better understand, claim, and protect their rights. Continuous awareness campaigns – especially in

remote and underserved areas – were viewed as critical to increasing community knowledge about available services and how to access them. Leaders emphasised that these campaigns must be sustained, culturally sensitive, and delivered in local languages to be effective. Finally, to enable a swift response in emergency situations, the availability of ambulances or community-based transport options was seen as vital to ensure timely movement of victims to safe locations or healthcare facilities immediately after an incident is reported.

F.3 Baseline for Outcome 2

This section seeks to establish a baseline against which to assess progress towards the expected outcome: **Empowered communities and enhanced community-based protection structures effectively prevent, mitigate, and respond to GBV and child abuse (especially family separation and child recruitment)**.[62]

Progress towards the outcome will be assessed through two proxy indicators that seek to understand changes in the presence, coverage, and effectiveness of community mechanisms to make women and children safer. Progress towards this outcome indicator will be assessed through changes in perceptions in community-level FGDs, together with qualitative descriptions.

Indicator 2.1: Percentage of communities with established community mechanisms to make women and children safer from GBV and child protection risks

Indicator 2.2: Percentage of communities reporting improved coverage and effectiveness in community actions/mechanisms to make women and children safer from GBV and child protection risks

Additional qualitative data:

Community members surveyed describe actions being taken in the community to make women and children safer from different forms of sexual violence and GBV, including efforts to raise awareness and change attitudes.

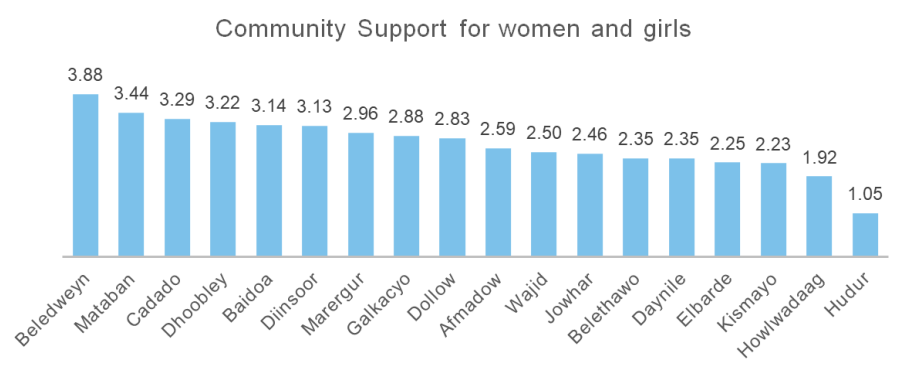
Surveyed community members in target locations describe actions in the community to address child protection risks, including describing how these work and what makes them effective.

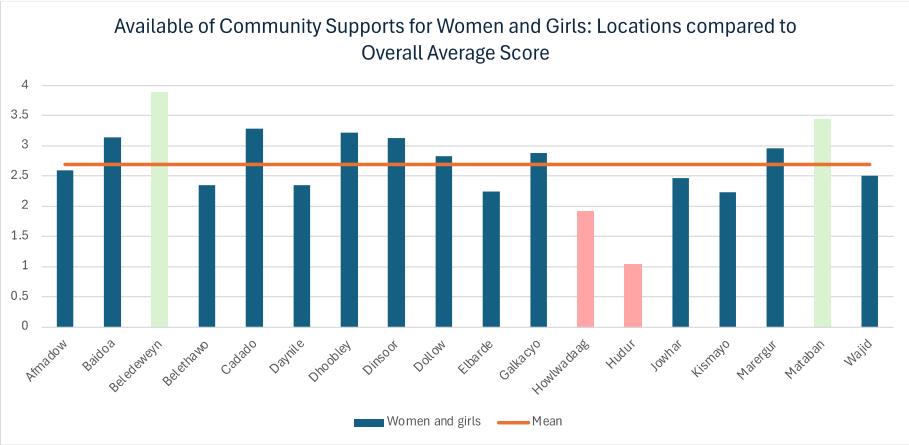
Descriptions of community-based structures, systems, and processes established to make women and children safer.

[62] Although there are separate indicators for GBV and child protection, the linkages between these are recognised and will be explored.

Community support for women and girls

Figure 14: FGD scores on level of support in the community available to women and girls who experience violence





Respondents in Beledweyn reported the most positive score, at 3.88, suggesting that participants viewed family and community support structures – such as elders, women's networks, and neighbours – as highly responsive and available. Other locations with relatively strong perceptions of support included Mataban (3.44), Cadado (3.29), Dhoobley (3.22), and Baidoa (3.14). In contrast, several locations reflected concerns about limited or absent community support. Hudur, in particular, recorded the lowest score, at 1.05, followed by Howlwadaag (1.92) and Elbarde (2.25), indicating that respondents in these areas perceived community-based support to be weak or unreliable. Mid-range scores between 2.5 and 2.9 – seen in Afmadow, Dollow, Galkacyo, Marergur, and Wajid – suggest mixed experiences, with some respondents who reported feeling supported while others did not. These results highlight disparities in informal support networks across communities, which may influence whether survivors are encouraged to seek help or discouraged from doing so.

Several community leaders emphasised the importance of community-based interventions, including volunteer committees and peer support networks. **Awareness raising** was a commonly cited mechanism, with religious sermons, community seminars, and culturally appropriate messaging identified as tools to shift attitudes. Some leaders stressed the importance of tailoring messages to different audiences – particularly women and youth – in languages and formats they can relate to. Leaders noted their obligation to raise awareness and **combat the stigma** that often prevents women and girls reporting abuse.

One of the most commonly cited responsibilities of community leaders was ensuring perpetrators are reported to authorities – either to the police or the justice system – while also **safeguarding the rights and dignity of survivors**. Many leaders stressed the importance of maintaining confidentiality when dealing with survivors, and, where needed, referring them to appropriate health, legal, or psychosocial services. In areas with NGO presence, leaders act as critical **liaisons between survivors and service providers** like Gaashaan. In some cases, they help mobilise resources, such as community donations for hospital care or emergency transport. Several leaders also noted their role in training and community mobilisation, including overseeing protection committees, delivering community education, and engaging in behavioural change efforts. Although roles vary by context, all leaders underscored their duty to act as protectors and advocates, especially for those whose voices are less often heard. National-level informants also noted risk mitigation activities that take place at the community level.

In many communities, cultural and religious leaders play a complementary role by raising awareness, promoting justice, and guiding reconciliation. Several communities undertake conflict mediation, especially in cases involving forced marriage, unwanted pregnancies, or family rejection. Religious and cultural guidance, especially within Islamic frameworks, is often used alongside customary law or formal legal systems, particularly in areas where trust in state institutions is limited. However, these mechanisms often bypass legal justice mechanisms and may privilege community harmony over the needs and rights of individual survivors. In these cases, community mechanisms may conflict with wider efforts to improve service access and outcomes for survivors.

Community structures were seen by respondents as a bridge that can link survivors to specialised services. When cases are identified they are then referred on to specialist care and cases are reported to the Ministry of Family and Human Rights Development. The community GBV and child protection committees need to have a good relationship with all the protection actors and clusters, and with community leadership and local authorities and religious leaders. In particular, local authorities and staff noted how working with these community-based gatekeepers would help build trust, and how they can serve as entry points to help individuals to get more specialised care – as well as building linkages between the community and the local government.

Some informants noted that some topics are particularly ‘hot’ and that they receive some pushback in the community when they seek to change attitudes and norms. In particular, the issues of FGM and early marriage were seen by one informant as particularly controversial, highlighting that a complete change in norms and attitudes takes time. Another informant noted that men are not necessarily as engaged in the protection structures as women.

A central recommendation was to expand community-based awareness campaigns to change harmful attitudes, educate people about GBV, and promote the rights of women and girls. Several leaders called for these messages to be delivered through trusted cultural and religious channels, including imams and elders, to ensure credibility and reach. Many emphasised the importance of training and deploying specialised personnel – including at police stations and health facilities – who are equipped to handle violence-related cases with professionalism and confidentiality. Leaders highlighted the need for safe, non-judgemental spaces where women and girls can report abuse, receive support, and access services without fear or stigma.

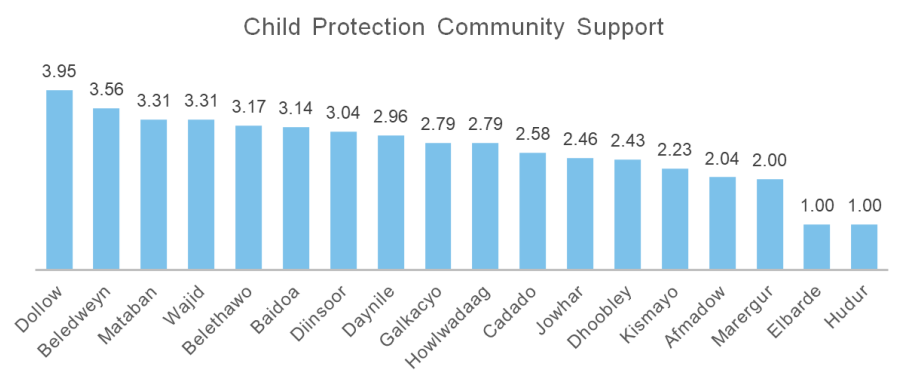
Community engagement and unity were frequently noted as key. Leaders called for stronger collaboration between families, local committees, and community stakeholders to detect risks early and intervene when needed. Several also recommended establishing or strengthening child protection and women's committees, holding consultative forums involving parents and youth, and actively involving men in prevention efforts.

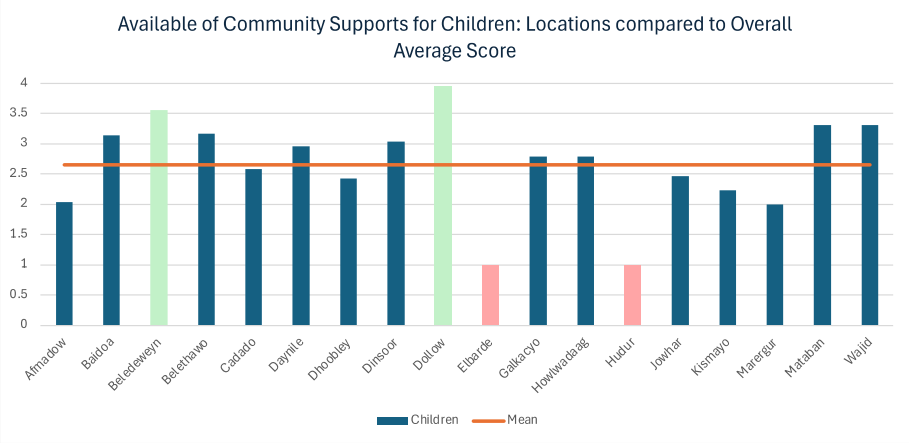
Livelihood support was identified as a way to reduce vulnerability. Proposals included providing cash assistance, vocational training, and business opportunities to women and girls. In addition, leaders called for greater collaboration with humanitarian organisations to meet basic needs like food, healthcare, and dignity kits, especially in conflict-affected or impoverished areas.

While some respondents pointed to larger structural needs, such as improved governance or healthcare infrastructure, the most consistent message was that prevention must start within the community, through education, coordinated support, and a culture that prioritises the safety and dignity of women and girls.

Child protection community support

Figure 15: FGD scores for level of community support available to protect children





Perceptions of the level of community support for child protection, such as help from families, community members, or informal structures when children face risks, varied across locations. Dollow recorded the highest score, at 3.95, indicating a strong perception that timely and appropriate support is available for children in need. Other locations with notably high scores included Beledweyn (3.56), Wajid (3.31), Mataban (3.31), Beled Hawo (3.17), and Baidoa (3.14), suggesting that participants in these areas saw their communities as actively engaged in child protection. In contrast, both Hudur and Elbarde received the lowest possible score of 1.00, pointing to widespread perceptions of absent or ineffective community-based support for children. A few locations, including Afmadow (2.04) and Marergur (2.00), also reflected weak support systems. Most other areas, such as Cadado, Dhoobley, Galkacyo, and Howlwadaag, scored in the 2.4 to 2.8 range, indicating moderate support with room for improvement. These findings suggest that while some communities demonstrate strong informal protection networks, others may lack the collective capacity or trust needed to respond effectively when children are at risk.

Leaders in border or high-risk areas, such as Dollow, emphasised the important role of cross-community coordination and regular meetings on child protection with neighbouring regions to prevent harm and share information. Others, like those in Hudur, acknowledged that resources are limited and called for safe play spaces or relocation of camps to more secure areas as key improvements. Community leaders commonly suggested increasing awareness campaigns, improving safe spaces for children, enhancing access to services, and strengthening collaboration across sectors, including parents, religious leaders, elders, and humanitarian organisations.

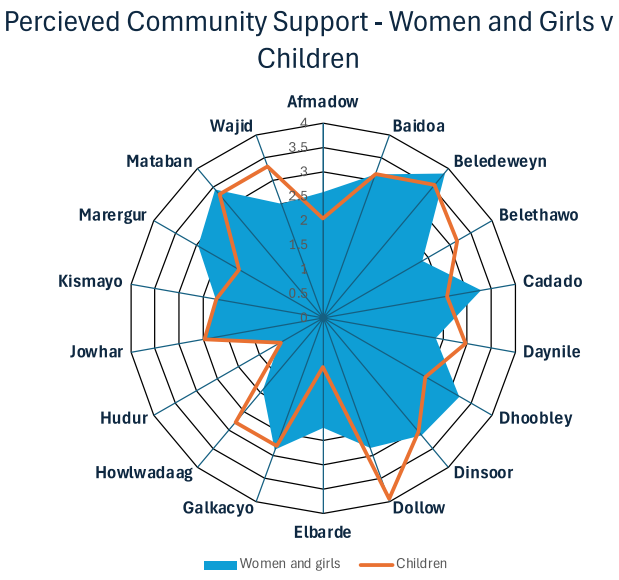
Leaders consistently noted that they raise awareness among parents and caregivers about child safety, discipline, and rights. Many explained that they use community forums, religious messaging, or household visits to engage families. In Cadado and Diinsoor, leaders emphasised awareness raising and follow-up efforts to prevent abuse and neglect. Several leaders highlighted their role in intervening directly during emergencies, including in cases of violence, abandonment, or illness. In Daynile, for example, a leader explained that they assist children when mothers are absent or deceased and ensure medical attention is provided where needed. Leaders in Dollow and Wajid also described systems of immediate

action and referral when harm occurs. Community leaders also noted their role in reporting cases to NGOs or local service providers. In places like Kismayo, Beledweyn, and Jowhar, leaders reported flagging cases to projects like Gaashaan and helping link children to health, education, or protection services. In addition to response and referral, some leaders highlighted their broader social roles, including mediating in local disputes, reducing discrimination, promoting inclusive access to resources, and even donating land for school construction. In Hudur, a leader called for the formation of dedicated child protection committees to expand the reach of these efforts, noting that only a few people currently understand their role in child safety. Across communities, leaders acknowledged that their role is vital but is constrained by limited resources. As a result, they rely heavily on collaboration with NGOs, parents, and religious leaders to address both immediate risks and the root causes of harm.

Other community-based support structures reported included the provision of alternative care arrangements, the use of trained and registered foster families, and family tracing and reunification. Material support was reported to be provided to the children placed in foster families to help with their maintenance while the tracing process is underway. Training on parenting without utilising violence was also said to be provided to parents. Foster mothers are registered under the Ministry of Gender and receive training. Security background checks are carried out on them and they receive supplies to support foster children (such as food and clothing). The foster mothers are closely monitored by Ministry staff.

Overall patterns of engagement at community level appear to be similar for GBV and child protection, and descriptions indicate strong overlaps in these mechanisms.

Figure 16: Perceived community support – women and girls versus children



F.4 Baseline for Outcome 3

Strengthened protection monitoring triggers an effective GBV and child protection response and ensures better protection outcomes.

Indicator 3.1: Percentage of targeted communities where monitoring data are utilised to develop localised and coordinated GBV and child protection programme activities.

Additional qualitative data:

Description of how data are used to support early warning, coordination, and decision-making, and to improve provision, including how this is seen to contribute to improve outcomes for women and children.

Community-level monitoring is primarily conducted through informal networks, direct observation, and collaboration with NGOs like Gaashaan. Community leaders, elders, youth, and religious figures are involved in gathering and responding to information shared by residents. Some leaders described more structured monitoring systems, including designated committees or volunteers who patrol communities, collect information, or track vulnerable groups.

While community-level monitoring is widespread, gaps exist in access to formal data or resources. Community leaders emphasised the need for timely, community-based information, routine monitoring by trusted local actors (police, religious leaders, volunteers), and follow-up systems to ensure survivors receive support. They also highlighted the value of confidential data collection, formal reporting systems, and direct community engagement for early risk detection. Barriers reported included limited data access when cases go directly to court or information is withheld by officials. Better communication between communities and humanitarian actors, clearer referral feedback, and consistent organisational presence are also deemed to be critical.

Formal early warning systems specifically for GBV and child protection risks are largely absent in the surveyed locations. While Howlwadaag has an informal, community-based reporting system, with designated representatives actively collecting information, other areas, like Mataban and Beled Hawo, rely on community awareness campaigns and the active role of local and religious leaders in prevention and referral. Community committees also contribute to awareness and deterrence efforts. However, in some areas, like Elbarde, early warning activities have reportedly decreased over time.

At the local government level, there are varying degrees of formalised reporting structures. In Baidoa, a decentralised reporting structure is in place, with focal points embedded within 10 settlements, who monitor incidents and violations and report back to the central administration. This system aims to ensure timely identification and referral of cases, although challenges related to capacity and resources exist. In Galkacyo South there is ongoing information sharing between local government bodies and organisations to identify and respond to incidents. Baidoa also has a more institutionalised structure, with the Ministry of Family and Human Rights Development operating specific departments focused on gender and child protection, and maintaining systems for tracking and responding to incidents. Howlwadaag has a community-based early reporting system whereby designated individuals in each neighbourhood immediately inform local authorities about incidents,

leading to collaborative action with security forces and district officials. However, in some locations, like Elbarde, there is a lack of clear awareness of, or formal tools for tracking and reporting, GBV or child protection incidents, even at the hospital level.

F.5 Baseline for Outcome 4[63]

Enhanced capacity and collective action among women's and girls' groups, civil society actors, and platforms to advocate for social change and policy reforms that promote gender equality and the protection of civilians.

Indicator 4.1: Percentage of supported women's rights organisations and civil society organisations with increased capacity to advocate for social change, and effectiveness in doing so.

Additional qualitative data:

Descriptions of ways in which women's rights organisations and wider civil society have enhanced capacities, including knowledge, skills, networks, and processes.

Description of actions to influence policy and how Gaashaan support enables these.

[63] Text on the baseline has been included in the main report in Section 7.6.

Annex G Interview guides and questionnaires

G.1 Community KIIs

Note to facilitator:

Find out which Gaashaan partners are present in the community and refer specifically to these during the introduction as that is the most likely interface with the project so far.

The intention of the community leader KII is to understand:

- specific threats to women and children in that community;
- ways in which community leaders or groups currently respond to GBV or child protection risks; and
- ways in which Gaashaan has engaged with the community to date.

May need to probe around different types of violence or risk.

- Please probe initial answers to get more detail on how things work.

Introduction of participants

Hello. My name is _____. I am conducting research on behalf of Consilient. We are studying the Gaashaan project, which started in 2024 and will run until 2028. Gaashaan is led by Save the Children. In your community, Gaashaan is implemented by _____.

Gaashaan aims to improve support for women and girls experiencing different types of violence, such as physical, verbal, or sexual attacks, in the home or community, as well as female genital mutilation and early and forced marriage. The project also aims to address wider risks relating to girls and boys at risk of violence, and separation, abduction, and other harms to children. It will support services for women and children who are at risk, including formal services and community responses.

The project started last year and will continue for four more years. This research will help shape Gaashaan and allow us to understand how it works. We plan to come back in two years and again in four years to ask about changes due to Gaashaan's support.

The discussion is expected to last between 60 and 90 minutes. Your name will be kept confidential – unless you tell us that you (or your child) face an immediate risk to your/their safety or have been asked to do something inappropriate by a Gaashaan staff member/representative. In those cases, we must report this information to our supervisor in order to get you the help you may need. No personal identifying information will be published or shared with anyone outside of the research team. We respect your privacy and understand the sensitivity of the information shared during the interview.

Do you consent to take part in this discussion? Yes / No

We would like to record this interview for our internal use. The recording will assist us in accurately transcribing the discussion and ensuring that the notes are comprehensive. We want to reassure you that any personal information you provide during the interview will be anonymised, and the recording will be kept strictly within our research team. Participation in the recording is entirely voluntary, and if you prefer not to be recorded, we respect this.

Do you consent for us to record this discussion? Yes / No

KIIs with community leaders	
1.	A. Had you heard of the Gaashaan project before today? • If yes, what have you heard about the project and from where?

	• If no, are you aware of other programmes to keep the community safe and respond to violence or risks? Please explain.
	GBV risks
2.	Now I would like to discuss the risks of violence against women and girls in this community. Gender-based violence is an issue that affects communities worldwide and can take many different forms; it can include violence at home against women and girls, as well as violence that occurs outside of the home. It includes verbal abuse and harassment, unwanted sexual attention, or sexual attacks or other physical attacks. It can also include early or forced marriage and female genital mutilation. As a leader in your community, we are interested in your perspectives on the challenges facing women and girls, as well as efforts to address these. A. **From your perspective, what are the main concerns in terms of violence towards women and girls at home or in the community?** Probe: Ask about the different types of violence mentioned above if needed. B. **What causes these risks of violence in your community?** Probe: Ask about social norms, identity (such as clan), economic issues, conflict. **C. How have risks changed in the past year? Why? Have these risks been affected by any programmes in the community (including Gaashaan)?**
	Child protection risks
3	Gaashaan also seeks to address the wider safety of children, including violence, as well as displacement and separation from families, harassment, abduction, or recruitment into armed groups. A. **What specific concerns, if any, does the community have around the safety of children?** Probe: Are these different for girls and boys? **B. What contributes to child protection risks in the community?** Probe: Are some locations, times, or circumstances higher risk than others? Probe: Is the risk affected by external factors like conflict or emergencies? **C. How have risks changed in the past year? Why? Has the risk been affected by any programmes in the community (including Gaashaan)?**
	Capacities of GBV services
4	One of Gaashaan's aims is to improve the availability of formal services for women and children, to increase access to them, to improve their quality, and to ensure that these services can be used when women or children need them. Thinking about services for women and girls who experience violence… A. **What formal services are available for survivors of violence in your community?** Probe: This includes services provided by government, such as police or health clinics, as well as services provided by aid agencies or civil society. B. **Are the services that exist to support women and girls after experiencing violence accessible to all those who need them when they are needed? What barriers are there?** Probe: This might include distance, cost, or other factors that prevent people from using the services when needed. **C. How do community members view these services? Are they seen as an appropriate or acceptable resource to use? Why/why not? Are they seen as being of good quality and as meeting key needs? Why/why not?** **D. Has anything related to these services (availability, access, etc.) changed in the last year? Do you know if these changes were related to Gaashaan-supported activities? If so, please describe.**

	E. What could be done to improve services and increase the likelihood that they are used by women and girls?
	Capacities of child protection services
5	Now, let's think about services that are available in the community to keep children safe. **A. What types of formal services are there in the community to keep children safe and respond to risks?** B. **Are these services accessible when needed? What barriers are there?** Probe: This might include distance, cost, or other factors that prevent people from using the services. **C. How do community members view these services? Are they seen as an appropriate or acceptable resource to use? Why/why not? Are they seen as being of good quality and as meeting key needs? Why/why not?** **D. Has anything related to these services (availability, access, etc.) changed in the last year? Do you know if these changes were related to Gaashaan-supported activities? If so, please describe.** **E. What could be done to improve services to protect children and increase the likelihood that they are used by the community?**
	Community mechanisms – GBV
6	Gaashaan aims to support community action in addressing violence against women and girls. **A. Are there any specific actions taken or mechanisms applied by this community to address violence towards women and girls in this community and to support their needs? To support survivors of violence?** Probe: This could be deterrents, the influence of religious leaders, efforts to change attitudes and behaviours, efforts to intervene. **B. What role do community leaders play in supporting women and girls who have experienced violence?** **C. What more could be done at the community level to keep women and girls safe and support their needs?**
	Community mechanisms – child protection
7	A. Gaashaan also aims to support community action in addressing wider risks to children. B. **What actions/mechanisms exist in this community to help keep children safe?** Probe: This could be deterrents, the influence of religious leaders, efforts to change attitudes and behaviours, efforts to intervene. Probe: Could you describe what these do and how they work? Who do they target? Who is involved? What more could be done? **C. What is the role of community leaders or community groups in supporting children at risk of harm?** **D. What more could be done at the community level to keep children safe and support their needs?**
	Data
8	Gaashaan will also support an increase in the use of monitoring and data to underpin responses. **A. Do community groups or leaders monitor the incidence of violence or risks, or use any data regarding risks to guide response? IF yes, how does this work?** Probe: This could include data or research coming from government or aid agencies regarding risks. If they do, how do they respond to risk warnings? **B. What kind of monitoring or data could be helpful?**

	Advocacy for change
9	**Gaashaan also aims to help organisations to influence policies or programmes.** **A. Are you aware of any local efforts to influence policies or programmes on violence against women and girls or risks to children?** **B. If so, ask for each:** · Who engages in this? · Are there women's rights organisations? · If so, what do they seek to influence and why? · From your perspective, is there more to be done in regard to influencing, and what would be needed to achieve this?
	Thank you for participating in this interview. We'll be sharing this information with the Gaashaan team in order to improve how the project is delivered. We appreciate your time and the information you shared with us during the course of this interview.

KIIs with service providers	
1	A. Had you heard of the Gaashaan project before today? If so, how have you heard about it or engaged with it?
	Service availability and quality
2	First, we would like to understand your own role in providing services in response to either violence against women and girls or child protection risks in the community. A. Could you please explain your role and the service or organisation you work within? B. What types of support does your organisation provide for survivors of violence? Probe: For providers providing GBV support: What support is provided for survivors of domestic violence? Sexual violence? Other violence? For providers providing support to children: What support is provided in cases of child abuse? Sexual violence? Other forms of violence? C. FOR GBV PROVIDERS ONLY: Do you have female staff who can provide care for female survivors of violence? If so, please describe their role. D. Do you generally have all the supplies (e.g. medicines, equipment, other supplies etc.) you need to support the survivors who come to you? If not, describe any gaps.
	Service accessibility
3	Next we would like to understand who uses the services and how they may choose to use them or not. A. How many cases do you typically support per month? [Note child protection and GBV cases separately] What types of violence generally are reported to you? What ages (children, adolescents, or adults) do you generally see? B. What changes have you seen in the number and types of cases over time? What do you think caused these changes? Probe: Please consider different types of violence. C. What barriers are there to women and/or children seeking this support? Probe: This might include distance, cost, social stigma, security, mistrust, or other factors that prevent people from using the services. D. What day/hours is your organisation open to support survivors?

	E. How far do survivors typically travel to get to your care? F. Is there a referral system connecting women and children in need to different services? If so, how does this work? G. From your perspective, what could be done to improve the likelihood that the service is used?
	Capacities of GBV and child protection services
3	A. Do you feel that you are able to deliver effective services within your role? What hinders you in being able to do so? Has this changed over the past year? B. If you have already benefitted from a Gaashaan activity, please describe this. For example, have you or colleagues participated in any trainings? What difference do you think this made to your ability to deliver the service or for individuals to use it?
	Other factors influencing service provision
4.	A. How do different services coordinate with each other? Is this coordination effective? Why/why not? B. Does your service or organisation use any data about gender-based violence or child protection cases or trends in order to plan and respond effectively? If so, where are these data collected and shared and how useful are they? C. Do you get financial or capacity-building support from any other programmes within the humanitarian sector or from government or any other source? If so, please describe.
	Engagement with Gaashaan
5	A. Do you have any other observations about engagement with Gaashaan to date or recommendations for future support?
	Thank you for participating in this interview. We'll be sharing this information with the Gaashaan team in order to improve how the project is delivered. We appreciate your time and the information you shared with us during the course of this interview.

KIIs with Gaashaan staff and partners	
1	A. Can you describe your role within Gaashaan? **<u>If staff:</u>** How long have you been with Gaashaan? What are your responsibilities? **<u>If partner organisation:</u>** How long have you been with the partner organisation and for how long have you worked with the Gaashaan team? Were you involved in the design phase or any earlier collaboration with Gaashaan partners? Which parts of Gaashaan do you implement?
	Relevance
2	We are trying to understand how relevant Gaashaan is to the needs in Somalia or in specific communities. *A.* **Could you tell me what the main needs that Gaashaan addresses are and how these have been identified to date?** *Probe: Do you use assessments? Other data? Discussions with government, community, other stakeholders?*
3	Next I'd like to understand how Gaashaan might change over time, either in response to changes in the context or due to observations around how the project is working.

	A. **Has the way that Gaashaan operates changed at all since it started?** Probe: What did this entail and why did it happen? B. **Were there any challenges in adapting activities?** Probe: Please describe what happened. C. **If something changes in the context in future what would you do to be able to respond appropriately? What more could be done to ensure responsiveness?** Probes: This might be in response to emergencies or to other changes in the context, such as the closure of other programmes or withdrawal of other funds.
	Coherence
4	We would like to understand how Gaashaan works alongside other projects or initiatives on protection. A. **What other organisations are addressing gender-based violence (GBV) and/or child protection in the area where you work?** Probe: This could include support for services as well as prevention activities. B. **Do different protection actors coordinate?** Probe: How does this work? C. **Are there challenges to coordination? What could make coordination more effective?** D. **From your perspective, how do you see Gaashaan's place within the wider protection sector?** Probe: Does it fill a specific gap that others cannot fill? How does it complement wider protection activities?
	Effectiveness
5	We would like to understand how Gaashaan seeks to strengthen the capacity of GBV and child protection actors, and what can make this more effective. A. **Have you been involved in planning or delivering any capacity building to service providers?** This might include training healthcare professionals on clinical management of rape, training community health workers on GBV response and psychological first aid, supporting foster care families in camps for internally displaces persons, and training case management service providers on standardised GBV and child protection protocols. **B. How were existing capacities assessed or needs identified?** **C. How are capacity-building interventions planned and delivered?** **D. What feedback or observations have there been to determine how the intervention changed service delivery or what additional support might be needed? Has Gaashaan collected any data to highlight this?** **E. Does Gaashaan plan to monitor service delivery over time for quality or for uptake? If so, how would they determine changes in service delivery?**
6	We would like to understand community mechanisms to make women and children safer from GBV and child protection risks. **A. What mechanisms exist to make women and girls safer from GBV or child protection risks? How did you identify these mechanisms?** **B. How has Gaashaan engaged with existing mechanisms so far?** **C. What activities are being planned to help improve service provision, and at what levels?** **D. What changes in services would be expected after Gaashaan? How would this be assessed?**
7	Gaashaan aims to improve evidence-based decision-making, community engagement, and public awareness on GBV and child protection through advocacy. **A. Have related advocacy activities already taken place?** **B. What advocacy activities are planned?**

	C. Could you describe how this would work and what change would be expected? Probe: This may not have occurred yet so you can explore what is planned and how it would be followed up.
8	How has Gaashaan tried to ensure that anyone who needs services can benefit? **A. What specific measures does Gaashaan take to reach groups that are most at risk or most excluded from accessing services?** **B. What more could Gaashaan do to improve inclusion over time?**
	Efficiency
9	When thinking about the efficiency of the project, we want to know about your existing monitoring, evaluation, accountability and learning (MEAL) systems. **A. What data are being collected to demonstrate what has been delivered and what changes this might lead to? What challenges have there been in regard to obtaining sufficient data?** **B. What data would you need to know to understand what has changed as a result of your work?** Probe: This might include documentation of needs, records of activities implemented, and feedback from or monitoring by those who engage with Gaashaan activities, such as service providers or community members.
	Impact
10	While it is too early to assess any impact, we are keen to understand how any potential unintended negative impacts are being avoided by Gaashaan. Unintended harms can include worsening conflict, or safeguarding incidents, such as sexual exploitation and abuse. **A. Could you describe any specific measures Gaashaan and partners are taking to identify and mitigate unintended negative impacts and ensure appropriate response where needed?**
	Sustainability
11	**A. Does the Gaashaan design consider how capacities can be maintained over time?** **B. What, in your opinion, can increase the likelihood of long-term benefits, and is Gaashaan doing this already?**
	Thank you for participating in this interview. We'll be sharing this information with the Gaashaan team in order to improve how the project is delivered. We appreciate your time and the information you shared with us during the course of this interview.

KIIs with district- and local-level authorities	
1	**Awareness of the Gaashaan project** **A. Could you please describe how your role(s) relate(s) to the protection sector, including addressing risks to women and girls, as well as child protection?** **B. Were you already aware of the Gaashaan project before today?** · If so, could you please describe how you have learned about it or engaged with it to date?
2	**First we'd like to think about the availability and accessibility of services**

	Thinking about gender-based violence (GBV) A. What services are there in your district to meet the needs of women and girls who experience violence? Prompt: (e.g. referrals, police/justice, safe spaces, hotlines, health services etc.) B. What barriers do people in this district face when trying to access these services? C. How would you assess the quality of the services provided to women and girls who experience violence? What could improve? D. What improvements would you like to see in addressing GBV? **Thinking about risks to children** E. What services are there in your district that help to keep children safe (e.g. safe spaces, family support)? F. What barriers do people (parents, children, other caregivers, etc.) in this district face when trying to access these services? Prompt: This could include distance, cost, security etc. G. How would you assess the quality of the services provided to keep children safe? What could improve? H. What improvements would you like to see in addressing child protection?
3	**Government coordination with other actors** A. How does the local government engage with other stakeholders in addressing violence against women and girls? B. How does the local government engage with other stakeholders in addressing risks to children? C. Has there been any engagement with Gaashaan to date? o If so, please explain. D. What types of engagement would you expect to have with a programme like Gaashaan? *Probe: This could include civil society organisations, community leaders, national governments, or the humanitarian sector or aid agencies.*
4	**Use of monitoring data and early warning systems** A. Are there specific tools or systems in place to track and report incidents of either GBV and child protection? Can you describe them? B. Are there any early warning systems currently in place to identify and respond to GBV and child protection risks in the community? If yes, please describe them. C. What steps are being taken to strengthen the capacity of local actors to collect and use monitoring data for GBV and child protection interventions?
5	**Advocacy for change** A. Have there been any advocacy initiatives or community dialogues in this district aimed at reducing GBV or child protection risks or improving services provided to survivors? · If yes, could you describe these? Who organised or implemented these? When did they take place? Who participated? · What role has the local government played in supporting these initiatives? **B.** How would you hope to engage with a project like Gaashaan for advocacy?

	Thank you for participating in this interview. We'll be sharing this information with the Gaashaan team in order to improve how the project is delivered. We appreciate your time and the information you shared with us during the course of this interview.

KIIs with Somali government ministries (e.g. Ministry of Family and Human Rights)	
1.	**Awareness of/alignment with the Gaashaan project** A. Were you already aware of the Gaashaan project before today? If so, could you please describe how you learned about it/how you have engaged with it to date? B. Could you please describe how your role(s) relate(s) to the protection sector, including addressing gender-based violence (GBV) or child protection?
2.	**GBV and child protection policies/frameworks** A. What policies or frameworks does the government have in place to address GBV and child protection risks? B. How do you think they can be improved? How do you see them changing over time? Probe: Are GBV and child protection seen as separate issues? Is there any coordination in addressing these?
3.	**Availability and accessibility of services** A. What are the primary barriers to providing effective services in response to GBV and child protection risks? B. What is being done at the government level to address these challenges? C. In your opinion, what improvements should be made at government level in how child protection and GBV are addressed? *Probe: Explore service coverage (where it is available), the referral system, and issues around access to, and the quality and acceptability of, services.*
4.	**Government coordination with other actors** A. How does the government coordinate with the wider protection sector? B. Is there engagement with a range of actors, i.e. civil society organisations, community leaders, and service providers (e.g. police, health workers), or non-government organisations/women's rights organisations in addressing GBV and child protection issues? Which actors seek to engage or influence your/government work on GBV/child protection? C. What does this engagement usually involve? How could it be enhanced?
5.	**Use of monitoring data and early warning systems** A. Are there any early warning systems currently in place to identify or monitor GBV and child abuse risks in communities? B. How does the government respond when early warning signals indicate heightened risks of GBV or child protection? C. What steps, if any, are being taken to strengthen the capacity of local actors to collect and use monitoring data for GBV and child protection interventions?
6.	**Future vision** A. How does the government envision the long-term approach to addressing GBV and child protection risks? B. What reforms or innovations should be prioritised to achieve this vision?

	Thank you for participating in this interview. We'll be sharing this information with the Gaashaan team in order to improve how the project is delivered. We appreciate your time and the information you shared with us during the course of this interview.

G.2 Community FGDs

Note to facilitator:
Find out from Gaashaan which partners are present in the sampled location and what activities have already been implemented, so that facilitators are aware of the local programming context and issues that may arise.
If any safety/safeguarding issues arise, report to the research manager from Consilient.
After discussion, summarise the key points raised during the discussion.
Capture as much contextual and descriptive information as possible under each section before discussing the rubric scoring.
If specific incidents of violence are mentioned remind participants that this should remain confidential and that names/identifiers will not be reported. Encourage them to speak generally rather than discussing specific cases.
Approximately 20 minutes per topic.
For rubric questions:
If participants agree on a score, document it as the consensus score. If there is disagreement, use a simple voting system, where participants raise their hands for a specific score (e.g. 1, 2, 3, or 4).
If participants are still divided after voting, record the range of scores (e.g. 2–3) and explain the differing perspectives in the summary.
If the group cannot reach a consensus and voting is inconclusive, the facilitator can define the score based on the dominant themes and evidence shared during the discussion.
Ensure that outlier perspectives are documented in the qualitative notes – document reasons given for scoring.
Introduction
Hello. My name is _____ and I am a researcher at Consilient. Thank you for your time and allowing us to speak with you today. This discussion will last between 60 to 90 minutes.
We are here to talk about Gaashaan, a project led by Save the Children and partners.
[For context, note any particular partners present in the location sampled, i.e. the International Rescue Committee, CARE International, Save Somali Women and Children, Somali Women and Development Centre, Somali Women's Studies Centre, and Gargaar Relief and Development Organisation.]
Gaashaan aims to improve support for women and girls experiencing different types of violence, such as physical, verbal, or sexual attacks in the home or community, as well female genital mutilation or early and forced marriage. It also aims to address wider risks for girls and boys at risk of violence, and separation, abduction, and other harms to children. It will support services for women and children at risk, including formal services and community responses. The project started last year and will continue for four more years. This research will help shape Gaashaan and allow us to understand how it has worked. We plan to come back in two years and again in four years to ask about changes due to Gaashaan support.

We want to understand your views on the safety and security of women and children at home and in your community. You do not have to speak about your personal experiences if these are private but please give your views on issues in the community generally.
Please speak freely. Your names and any information you give will be kept confidential by us – unless you tell us that you (or your child) face an immediate risk to your/their safety or have been asked to do something inappropriate by a Gaashaan staff member/representative. In those cases, we must report this information to our supervisor in order to get you the help you may need.
If at the end of this conversation you want more information about where to report an incident of violence yourself or what support services are available, we will share information about local resources in your area. We also ask that you don't repeat anything personal shared by others once you leave the discussion as we want you all to speak freely and we understand that this topic is sensitive.
Do you consent to participate in this discussion? Yes / No
Before we commence, we would like to record this interview, for our internal use only. The recording will assist us in accurately transcribing the discussion and ensuring that the notes are comprehensive. We want to reassure you that any personal information you provide during the interview will be anonymised, and the recording will be kept strictly confidential within our research team. Participation in the recording is entirely voluntary, and if you prefer not to be recorded, we fully respect your decision.
Do you consent for us to record this discussion? Yes / No
FGD guide
1. Had you heard of the Gaashaan project before today?
If yes, how have you heard about it? What do you know about Gaashaan activities?
If no, what other projects are there in your community addressing violence against women and girls or risks to children?
Safety from different types of violence against women and girls
The first thing we want to understand is how safe women and girls in your community feel. We want to understand what risks there are for women and girls from different types of violence and what they might do if they are at risk.
What safety concerns do women and girls have at home? Follow-up questions: How common are these fears? Are some women and girls more at risk than others? Why?
What safety concerns do women and girls have in public spaces? Follow-up questions: How common are these fears? Are some women and girls more at risk than others? Why? *Prompt: Explore risks in different places, like markets, when travelling, and at community meetings.*
What are common reasons why violence against women or girls occurs in homes and in the community? *Prompt: Encourage them to think about societal norms, economic pressures, behaviours, and external factors like conflict or humanitarian crisis.*
What factors in your community protect women and girls from violence? Follow-up: How do these work?
Services for women and girls who experience violence

Next we want to understand where women and girls who experience violence would seek support. This includes understanding what services are available, why individuals would choose to use them or not, and what they would expect from them.
What services are you aware of in the community to support women and girls who experience violence? *Prompt: Encourage them to think about formal services (police, women and girls' safe spaces, health clinics, etc) as well as informal community support (community leaders, elders, women's networks and family).*
Which formal services would women use? By formal services we mean police, safe spaces, health clinics, legal support. *Prompt: Ask about anything mentioned in the previous question.*
Follow-up: What would influence the decision to seek this help? How is the service seen? What would they expect from the service? Prompt: Ask about availability, access, quality, and acceptability.
Which formal services exist but might not be used? Follow-up: What would stop women from using this service? Prompt: Explore access (location, cost etc), quality (such as whether it is confidential and how well the service is delivered), and social stigma relating to using it.
What other sources of support would women or girls turn to in the community? Prompt: Ask about anything mentioned in question 7 – particularly community leaders/elders.
Follow-up: What would influence their decision to seek support from these groups and not report an issue to formal services? What response would they hope for/expect?
Now, thinking about everything we have discussed about the safety of women and girls from violence, we want to try to measure a few things so that we can see if this changes over the period of Gaashaan's support to this community. We will ask a series of questions and I'd like you to give a score on a scale from 1 to 4.
R1: SAFETY IN THE HOME
R1. First, I want you to think about the following question. Given everything we've spoken about today: Do you think MOST women and girls who live in this community generally feel safe or unsafe in their homes? We are going to vote on what you think overall. I am going to give you four options, I'll read out all four first and then we'll vote. Please pick the statement you MOST agree with:
Read out the following options:
MOST women and girls feel SAFE in their homes and incidents of violence there are rare. (SCORE: 4)
MOST women and girls feel safe in their homes but there are still some safety fears. (SCORE: 3)
SOME women feel safe in their homes but overall violence is still a concern. (SCORE: 2)
MOST women and girls feel UNSAFE in their homes and incidents of violence there are common. (SCORE: 1)
R2: Safety outside the home
R2. Now, let's move to the next question. Do you think MOST women and girls generally feel safe or unsafe out in the community (e.g. moving on roads, in public spaces, such as markets or schools, etc.)? We are going to vote on what you think overall. I am going to give you four options: I'll read out all four first and then we'll vote. Please pick the statement you MOST agree with:

Read out the following options:
MOST women and girls feel SAFE in their communities and incidents of violence there are rare. (SCORE: 4)
MOST women and girls feel safe in their communities but there are still some safety fears. (SCORE: 3)
SOME women feel safe in their communities, but violence is still a concern. (SCORE: 2)
MOST women and girls feel UNSAFE in their communities and incidents of violence there are common. (SCORE: 1)
R3: Formal services for women and girls
R3. Think about the services we identified earlier (e.g. police, women and girls' safe spaces) [FACILITATOR: NOTE THE SERVICES THAT WERE MENTIONED DURING THE DISCUSSION] to support women and girls after an incident of violence. Do you think that the necessary formal support services are available and easy to access for women and girls? We are going to vote again. Remember, please pick the statement you most agree with.
Read out the following options:
All the necessary formal support services are available and accessible to most women and girls. (SCORE: 4)
A range of services exist though some accessibility issues remain. (SCORE: 3)
Some formal services exist but they generally have major accessibility challenges for women/girls (due to cost, location, stigma relating to their use, etc.). (SCORE: 2)
No formal services exist or what does exist generally isn't accessible to most women/girls (due to cost, location, stigma, etc.). (SCORE: 1)
R4: Quality of services
R4. **Where services for women/girls exist, what is the quality of these services? Think about what women and girls (or their families/community) would expect to happen if these services are used. Do they provide what is needed, do they have the right facilities and staff, are they sensitive to survivors' needs, are they confidential etc.?** We are going to vote again. Remember, please pick the statement you most agree with.
Read out the following options:
MOST support services for women and girls who experience violence are of a high quality. (SCORE: 4)
Services are of mixed quality, but more are of a high quality than of a poor quality. (SCORE: 3)
Services are of mixed quality, but more are of a poor quality than of a high quality (SCORE: 2)
MOST services for women and girls who experience violence are of a poor quality (SCORE: 1)
R5: ACCEPTABILITY OF SERVICES

R5. **Where services for women/girls exist, how acceptable is it for women/girls to use these services? For example, would her community/family judge her if she used them? We are going to vote again. Remember, please pick the statement you most agree with.**
Read out the following options:
Most people in the community think it IS acceptable for a woman to seek formal support services after an incident of violence. (SCORE: 4)
Some people in the community think it is acceptable for a woman to seek formal support services after an incident of violence, but a minority don't think it is acceptable. (SCORE: 3)
Some people in the community think it is acceptable for a woman to seek formal services after an incident of violence, but many wouldn't agree. (SCORE: 2)
Most people in the community think it is NOT acceptable for a woman to seek formal support services after an incident of violence. (SCORE: 1)
R6: COMMUNITY SUPPORT FOR WOMEN AND GIRLS
R6. What level of support in the community is available to women and girls who experience violence? Think about the support we discussed earlier, from community elders, women's networks, family etc. We are going to vote again. Remember, please pick the statement you most agree with.
Read out the following options:
Appropriate support from families and the community is available for all women and girls who experience violence and require support. (SCORE: 4)
Good support from community members/families exists and is available to some women/girls. (SCORE: 3)
Limited support from community members/families exists and is available to some women/girls. (SCORE: 2)
There is little to no support from the community/families for women and girls who experience violence. (SCORE: 1)
CHILDREN
Next we want to think about wider risks for children – child protection risks. This might include family separation, risks of harassment, attack, recruitment, or abduction. We want to understand what risks there are for children and what they or concerned adults might do in response.
Safety of children in the community
Do families and other caregivers feel comfortable allowing children to participate in activities in the community? Prompt: Things like community events, being outside or moving around alone, joining children's clubs.
What do adults or other concerned people worry might happen? Why do they have this concern? Prompt: Explore the risk of different types of violence (physical or sexual violence and harassment, and abduction or separation). Explore whether certain locations or times are seen as more risky.
Have these incidents happened before or is there any specific evidence or warning sign for the risk?

Do people have different worries about boys compared to girls? Please explain the difference and why this is the case.
Are there factors in the community that help protect children? How do these work?
What measures or changes would make you or other concerned adults feel more comfortable about children's safety in these situations?
Services for children
If children are at risk in the community (such as where they are separated from family or at risk of violence, harassment, recruitment, or abduction), where would children or concerned adults seek help? Prompt: This could include formal services such as police or safe houses, or informal support from community leaders/elders.
Follow-up: Why would they do this and what response might they expect? If they would not, why not?
What would encourage children or concerned adults to seek support? What would discourage them from doing so?
Follow-up: Are there differences for girls and boys? Please explain.
Now, thinking about everything we have discussed about the safety of children from a range of risks, we want to try to measure a few things, as before, so that we can see if this changes over the period of Gaashaan's support to this community. We will ask a series of questions and I'd like you to give a score on a scale from 1 to 4.
R7: Safety of BOYS
R7. First, I want you to think about the following question: **Do you think MOST boys who live in this community generally are safe or unsafe participating in activities in public spaces? This includes moving around the community or participating in activities outside the home. We are going to vote. Remember, please pick the statement you most agree with.**
Read out the following options:
MOST boys are generally SAFE participating in activities in public spaces. (SCORE: 4)
There are occasional concerns for parents about boys participating in activities at specific times and places. (SCORE: 3)
There are significant concerns and parents restrict some activities for boys. (SCORE: 2)
MOST boys are generally UNSAFE participating in activities in public spaces. (SCORE: 1)
R8: Safety of GIRLS
First, I want you to think about the following question: Do you think MOST girls who live in this community generally are safe or unsafe participating in activities in public spaces? This includes moving around the community or participating in activities outside the home. We are going to vote. Remember, please pick the statement you most agree with.
Read out the following options:
MOST girls are generally SAFE participating in activities in public spaces. (SCORE: 4)

There are occasional concerns for parents about girls participating in activities at specific times and places. (SCORE: 3)
There are significant concerns and parents restrict some activities for girls. (SCORE: 2)
MOST girls are generally UNSAFE participating in activities in public spaces. (SCORE: 1)
R9: AVAILABILITY OF CHILD PROTECTION SERVICES
R8. Next, please think about the following question: Think about the services we discussed earlier – do you think that the necessary formal support services exist to protect children? We are going to vote. Remember, please pick the statement you most agree with.
Read out the following options:
All the necessary appropriate services are available to protect children and children or concerned adults can access help when needed. (SCORE: 4)
Appropriate services exist but they may not always function effectively or be accessible to all. (SCORE: 3)
Some services exist to protect children but these are only partially effective/used. (SCORE: 2)
There is little effective formal support in the community to help protect children. (SCORE: 1)
R10: CHILD PROTECTION COMMUNITY SUPPORT
Next, I want you to think about the following question: **What level of community support is available to protect children? Think about the support we discussed earlier from community elders, women's networks, Child Welfare Committees, family etc. We are going to vote. Remember, please pick the statement you most agree with.**
Read out the following options:
Appropriate and timely community support is available to all children who need help. (SCORE: 4)
Appropriate community support is available, though some gaps or barriers to getting help remain. (SCORE: 3)
Community support is available to some individuals or in some circumstances but with major limitations/barriers. (SCORE: 2)
No community support is available or families/children do not trust the existing support. (SCORE: 1)
Closing
As we come to the end of our discussion, I want to give you a final opportunity to share any additional thoughts, concerns, or insights that you feel are important for our research, particularly regarding the risks facing children and women in your community.
[Pause to allow participants to respond.]
If there are no further comments or questions, I would like to thank each of you for your time, openness, and valuable contributions. Your perspectives are crucial in helping us better understand these issues and work towards meaningful solutions.
As we close, I would like to give out this Safeguarding Pocket Card, which contains two numbers that you can call to raise any concerns, provide feedback, or seek further support. It is free to call

and help will be provided. If you have concerns about yourself, your children, or additional community members you can call for further advice.
[Hand out the cards to the respondents. Once they are handed out, READ what the cards say and allow the respondents to ask any questions. Respondents are welcome to keep the card but they must not be forced to take one.]
I will now stop the recording. Thank you again for your time and what you have shared with me today.

G.3 KIIs for national-level stakeholders

1 Introduction

Hello. My name is _____. I am conducting research on the Gaashaan project on behalf of Consilient. Thank you for your time in allowing us to speak with you today.

Gaashaan is a protection project led by Save the Children. It focusses on improving the safety and support for women, children, and others at risk in their homes and communities and works in 18 districts. We would like to discuss some of the issues that Gaashaan addresses from the perspective of your role.

The discussion is expected to last between 60 to 90 minutes, during which we will ask a series of questions. ***Your name will be kept confidential, and any personal identifying information you provide will not be published or shared with anyone outside of the research team.*** *We respect your privacy and understand the sensitivity of the information shared during the interview.*

Do you consent to take part in this discussion? Yes / No

*Before we commence, we would like to extend the option to record this interview for our internal use only. The recording will assist us in accurately transcribing the discussion and ensuring that the notes are comprehensive. We want to reassure you that any personal information or opinions you provide during the interview will be anonymised, and the recording will be kept strictly confidential within our research team****. Participation in the recording is entirely voluntary, and if you prefer not to be recorded, we fully respect your decision.***

Do you consent for us to record this discussion? Yes / No

S.N.	Key informant interview with Somali government ministries (e.g. Ministry of Women and Human Rights)
1.	**Awareness / alignment with the Gaashaan project** A. Were you already aware of the Gaashaan project before today? If so, could you please describe how you have learned about it or engaged with it to date? B. Could you please describe how your role(s) relates to the protection sector, including addressing gender-based violence or child protection?
2.	**GBV and child protection policies / frameworks** A. What policies or frameworks does the government have in place to address gender-based violence (GBV) and child protection risks? B. How do you think they can be improved? How do you see them changing over time? Probe: Are GBV and child protection seen as separate issues? Is there any coordination in addressing these?
3.	**Availability and accessibility of services**

	A. What are the primary barriers to providing effective services in response to GBV and child protection risks? B. What is being done at government level to address these challenges? C. In your opinion, what improvements should be done at government level in how child protection and GBV are addressed? *Probe: Explore service coverage (where it is available), referral systems, and issues around access to, and quality, and acceptability of, services.*
4.	**Government coordination with other actors** A. How does the government coordinate with the wider protection sector? B. Is there engagement with a range of actors i.e. civil society organisations, community leaders, and service providers (e.g. police, health workers), or NGOs/women's rights organisations in addressing GBV and child protection issues? Which actors seek to engage or influence your/government work on GBV/child protection? C. What does this engagement usually involve? How could it be enhanced?
5.	**Use of monitoring data and early warning systems** A. Are there any early warning systems currently in place to identify or monitor GBV and child abuse risks in communities? B. How does the government respond when early warning signals indicate heightened risks of GBV or child protection? C. What steps, if any, are being taken to strengthen the capacity of local actors to collect and use monitoring data for GBV and child protection interventions?
6.	**Future vision** A. How does the government envision the long-term approach to addressing GBV and child protection risks? B. What reforms or innovations should be prioritised to achieve this vision?
	Thank you for participating in this interview. We'll be sharing this information back with the Gaashaan team in order to improve how the programme is delivered. We appreciate your time and the information you shared with us during the course of this interview.

G.4 KIIs for Gaashaan staff and partners

Note to facilitator:

The intention of this key informant interview is to understand how Gaashaan has been designed and how it works from the perspective of either core staff or delivery partners, including how well the members of the consortium work together. When referring to Gaashaan this means both core staff and consortium partners.

- As this is a baseline we do not know the extent of activities so far – questions can be adapted if no activity has taken place, i.e. instead of asking what happened, ask what is planned and how they would go about this.

2 Introduction

Hello. My name is _____. I am conducting research on behalf of Consilient. Thank you for your time in allowing us to speak with you today about the Gaashaan project. This is part of a long-term evaluation being conducted over the life of the project. At this stage we are trying to understand how Gaashaan is designed and what needs it is addressing. This will help us to understand what has changed at the mid-point and end-point of the project.

We want to understand your views and experiences of working with Gaashaan so far.

The discussion is expected to last between 60 to 90 minutes, during which we will ask a series of questions. **Your name will be kept confidential, and any personal identifying information you provide will not be published or shared with anyone outside of the research team.** We respect your privacy and understand the sensitivity of the information shared during the interview.

Do you consent to participate in this discussion? Yes / No

Before we commence, we would like to extend the option to record this interview for our internal use only. The recording will assist us in accurately transcribing the discussion and ensuring that the notes are comprehensive. We want to reassure you that any personal information you provide during the interview will be anonymised, and the recording will be kept strictly confidential within our research team**. Participation in the recording is entirely voluntary, and if you prefer not to be recorded, we fully respect your decision.**

Do you consent for us to record this discussion? Yes / No

Gaashaan staff and partners	
1	A. Can you describe your role within Gaashaan? **If staff:** How long have you been with Gaashaan? What are your responsibilities? **If partner organisation:** How long have you been with the partner organisation and for how long have you worked with the Gaashaan team? Were you involved in the design phase or any earlier collaboration with Gaashaan partners? Which parts of Gaashaan do you implement?
Relevance:	
2	We are trying to understand how relevant Gaashaan is to the needs in Somalia or in specific communities. A. **Could you tell me what are the main needs that Gaashaan addresses and how these have been identified to date?** *Probe: Do you use assessments? Other data? Discussions with government, communities, other stakeholders?*
3	Next I'd like to understand how Gaashaan might change over time either in response to changes in the context or due to observations around how the programme is working. **A. Has the way that Gaashaan operates changed at all since it started?** Probe: What did this entail and why did it happen? **B. Were there any challenges in adapting activities?** Probe: Please describe what happened. **C. If something changes in the context in future what would you do to be able to respond appropriately? What more could be done to ensure responsiveness?** Probes: This might be in response to emergencies or to other changes in the context such as closure of other programmes or withdrawal of other funds.
Coherence	
4	We would like to understand how Gaashaan works alongside other projects or initiatives on protection. **A. What other organisations are addressing gender-based violence (GBV) and/or child protection in the area where you work?** Probe: This could include support for services as well as prevention activities. **B. Do different protection actors coordinate?** Probe: How does this work?

	C. **Are there challenges to coordination? What could make coordination more effective?** D. **From your perspective, how do you see Gaashaan within the wider protection sector?** Probe: Does it fill a specific gap that others cannot fill? How does it complement wider protection activities?
Effectiveness	
5	We would like to understand how Gaashaan seeks to strengthen the capacity of GBV and child protection actors and what can make this effective. A. **Have you been involved in planning or delivering any capacity building to service providers?** This might include training healthcare professionals on clinical management of rape, training community health workers on GBV response and psychological first aid, supporting foster care families in IDP camps, and training case management service providers on standardised GBV and child protection protocols. B. **How were existing capacities assessed or needs identified?** C. **How are capacity-building interventions planned and delivered?** D. **What feedback or observations have there been to determine how the intervention changed service delivery or what additional support might be needed? Has Gaashaan collected any data to highlight this?** E. **Does Gaashaan plan to monitor service delivery over time for quality or for uptake? If so, how would they determine changes in service delivery?**
6	We would like to understand community mechanisms for making women and children safer from GBV and child protection risks. A. **What mechanisms exist to make women and girls safer from GBV or child protection risks? How did you identify these mechanisms?** B. **How has Gaashaan engaged with existing mechanisms so far?** C. **What activities are being planned to help improve service provision and at what levels?** D. **What changes in services would be expected after Gaashaan? How would this be assessed?**
7	Gaashaan aims to improve evidence-based decision-making, community engagement, and public awareness on GBV and child protection through advocacy. A. **Have related advocacy activities already taken place?** B. **What advocacy activities are planned?** C. **Could you describe how this would work and what change would be expected?** Probe: This may not have occurred yet so you can explore what is planned and how it would be followed up.
8	How has Gaashaan tried to ensure that anyone who needs services can benefit? A. **What specific measures does Gaashaan take to reach groups that are most at risk or most excluded from accessing services?** B. **What more could Gaashaan do to improve inclusion over time?**
Efficiency	

Commented [hu1]: You could also ask the safeguarding procedures they have in place. This would give us a sense of how well known they are and well applied as an indirect proxy to the credibility of the project itself.

Commented [MM2R1]: This feels off scope for this questionnaire. I'd not add.

9	When thinking about the efficiency of the project, we want to know about your existing monitoring, evaluation, research, and learning (MERL) systems. **A. What data are being collected to demonstrate what has been delivered and what changes this might lead to? What challenges have there been to obtaining sufficient data?** **B. What data would you need to know to understand what has changed as a result of your work?** Probe: This might include documentation of needs, records of activities implemented, and feedback or monitoring from those who engage with Gaashaan activities, such as service providers or community members.
Impact	
10	Whilst it is too early to assess any impact, we are keen to understand how any potential unintended negative impacts are being avoided by Gaashaan. Unintended harms can include worsening conflict, or safeguarding incidents, such as sexual exploitation and abuse. **A. Could you describe any specific measures Gaashaan and partners are taking to identify and mitigate unintended negative impacts and ensure appropriate response where needed?**
	Sustainability
11	**A. Does the Gaashaan design consider how capacities can be maintained over time?** **B. What, in your opinion, can increase the likelihood of long-term benefits and is Gaashaan doing this already?**
	Thank you for participating in this interview. We'll be sharing this information back with the Gaashaan team in order to improve how the programme is delivered. We appreciate your time and the information you shared with us during the course of this interview.