COMMUNITIES CARE IN SOMALIA AND SOUTH SUDAN

"People around me sometimes ask, 'What happened to you? You have really changed. What have you done?...Whenever we see you, you are always talking about women's rights and social norms.' I tell them that I took a pill called the Communities Care programme, that's the change you can see. I really feel happy and more confident when someone asks me that question. I tell them that, apart from Allah, the other reason for my happiness is the community discussion meetings."

– Communities Care Programme Male Participant, Service Providers Group, Wadajir Village, 2019, Baidoa, Somalia

PROGRAMME AT THE GLANCE

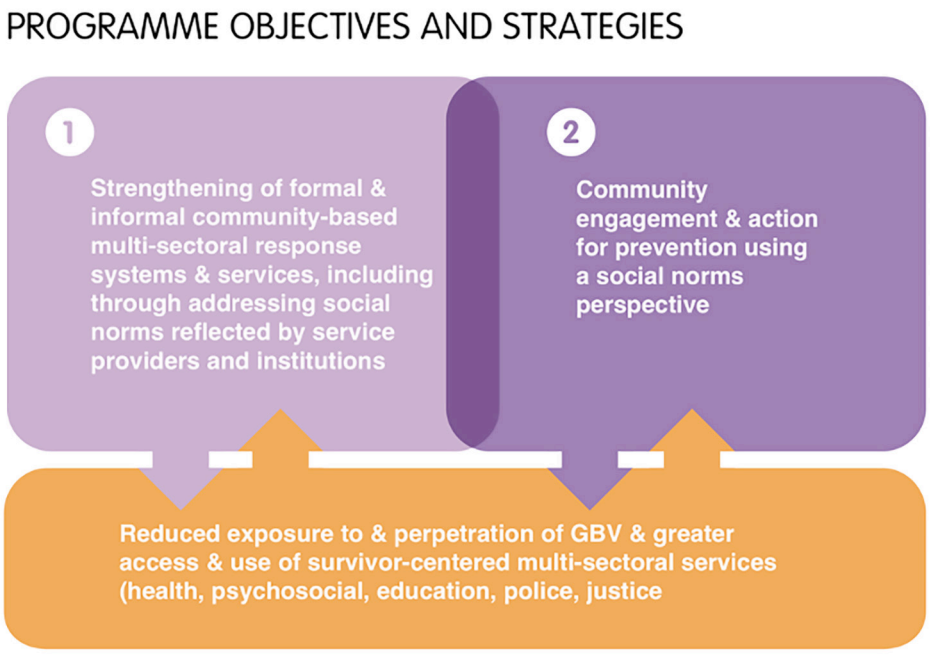
The Communities Care: Transforming Lives and Preventing Violence programme aims to create healthier, safer, and more peaceful communities for women and girls.[1] Through working with conflict-affected communities, the programme seeks to improve access to timely, coordinated, and compassionate care and support for survivors of sexual violence. It also aims to reduce the tolerance of violence against women and girls (VAWG) within communities and catalyse community-led actions to prevent such violence, with a focus on preventing sexual violence both in the home and the wider community. The programme has two main components:

- A **community-based care component** that trains and mentors gender-based violence (GBV) service providers.
- A **community action component** that is delivered through community dialogues led by trained community discussion leaders.

Evaluation results from the pilot programme in Somalia and South Sudan demonstrate the promise of community-based and led initiatives to prevent VAWG, shift harmful social norms, and strengthen response services in humanitarian settings. For example, in Somalia, the programme

reduced tolerance of the belief that husbands have the right to use violence against their wives and shifted norms that promote family honour at the expense of supporting survivors of sexual violence.[2] The programme has also demonstrated effectiveness in increasing community members' confidence in the quality of existing GBV services.

Figure 1. Programme objectives and strategies diagram.



BACKGROUND

Women and girls are exposed to many forms of violence during armed conflict.[3] Sexual violence perpetrated by armed groups as a systematic tool of warfare is one of the most common forms of violence in such contexts. Additionally, women and girls in conflict-affected settings experience violence that commonly occurs within families and communities globally, including intimate partner violence (IPV), sexual assault, child abuse, and forced marriage.[4]

Preventing and responding to VAWG is a relatively new and evolving field of practice in humanitarian contexts. Prevention efforts in these settings typically focus on raising awareness of VAWG within affected communities and implementing risk reduction initiatives to address situation-specific risk factors. This may include building safer refugee camp environments and promoting safer access to goods and services.[5,6] This emphasis, while necessary, does not address many of the key drivers of VAWG, including power differentials, gender inequalities, and harmful social norms.[4,7]

Against this background, UNICEF developed the **Communities Care: Transforming Lives and Preventing Violence** programme to increase urgently needed access to quality care and support services for survivors of sexual violence, and to develop and test strategies to prevent VAWG in conflict-affected communities.

PROGRAMME CONTENT

South Sudan and Somalia are characterised by ongoing instability, violent conflict, and high levels of humanitarian need. Working in these communities presents many challenges common to other conflict-affected settings, including insecurity, lack of basic infrastructure, limited access to communities for programme implementation, and low capacities to deliver health and other social services.[8]

South Sudan is currently facing one of Africa's most significant refugee crises, with an estimated 2.3 million refugees and asylum-seekers in neighbouring countries, and a further 2 million South Sudanese internally displaced within the country due to conflict or natural disasters.[9] In Somalia, at least 6.9 million people, almost half of Somalia's population, require immediate life-saving humanitarian and protection assistance.[10]

In South Sudan, two communities in Yei County, Central Equatoria State, and Gogrial West County in Warrap State, as well as in southern and central Somalia, specifically the districts of Yaqshid and Bondhere in Mogadishu, were part of the Communities Care pilot, which was implemented from 2012 to 2015. These communities were selected based on several criteria: high prevalence of GBV, including sexual violence; safe access and security for participants and staff to conduct the project and establish relationships with national and regional governmental authorities and ministries; the presence of international and/or local non-governmental organisations (NGOs) with the capacity to provide GBV services in the targeted communities; and the interest and willingness of local leadership and authorities to host the implementation and research to evaluate the programme.

The targeted communities were also selected because they were considered relatively secure and calm when the pilot started, although security remained fluid and changed throughout the course of the pilot, which affected both implementation and evaluation efforts.

THEORY OF CHANGE

The **Communities Care** programme is underpinned by a theory of change[11] (ToC), which suggests that abandoning harmful practices in communities requires changes in both individual attitudes and wider social expectations. The theory posits that once people collectively feel that change is in their best interest, have access to information from credible sources, and the opportunity to identify and reflect on the implications of VAWG and gender inequality, they are more likely to identify viable alternatives, be committed to and actively pursue changes.

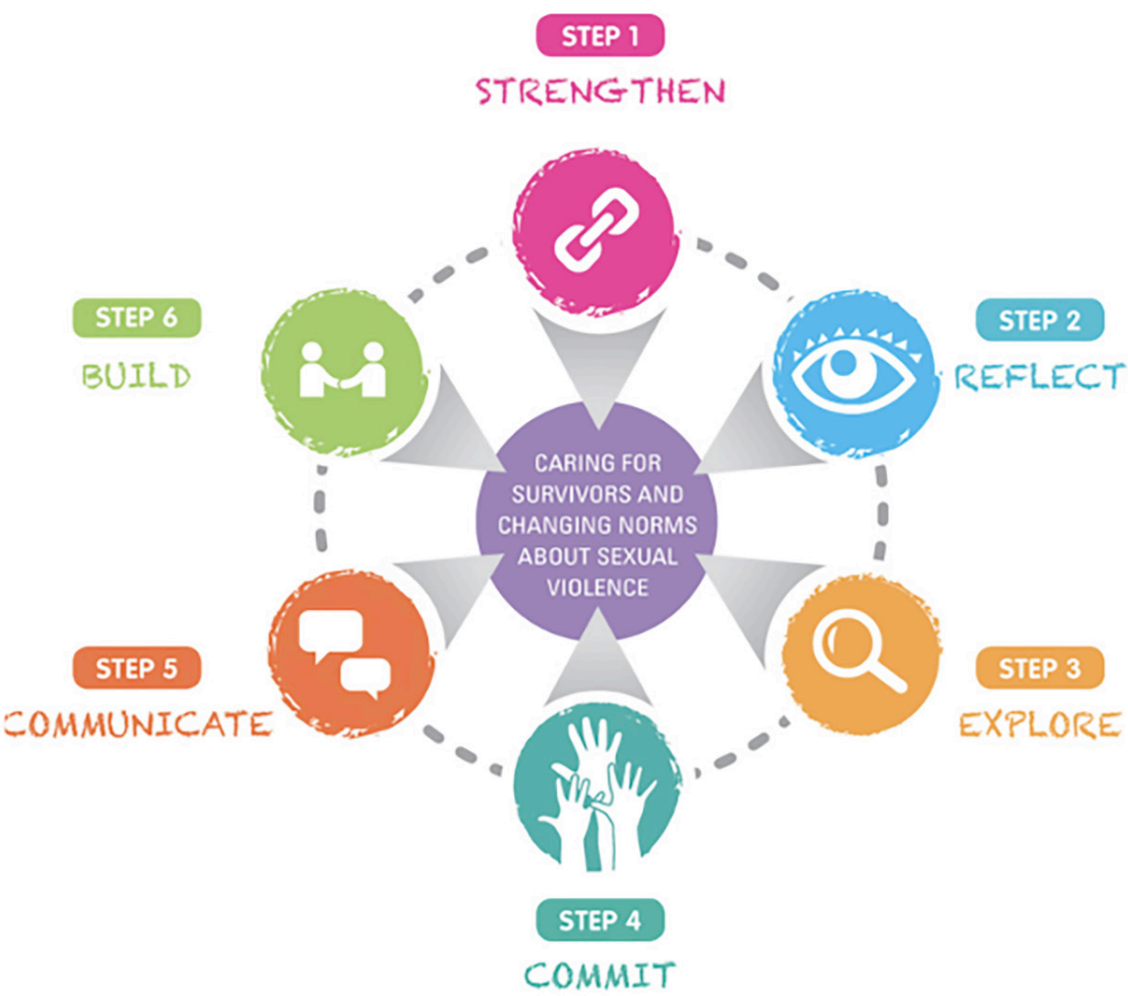
The ToC also suggests that new beliefs and expectations that emerge from this collective process must be widely diffused to communicate new expectations and demonstrate that change is

happening. The programme is also premised on the idea that while armed conflict causes immense suffering for those affected, the disruption it brings can also present opportunities for positive shifts in social norms which can contribute to gender equality and reduce GBV. For example, the disruption of traditional gender roles in a humanitarian setting can make it more socially acceptable for women to work outside of the home.

The Communities Care change pathway comprises six steps, based on UNICEF's careful analysis and research of what has worked to shift harmful social norms and practices in other contexts.

- **Step One:** Strengthen community-based care and support for survivors of sexual violence.
- **Step Two:** Enable reflection among core groups in the community about human rights and sexual violence.
- **Step Three:** Explore shared beliefs and practices.
- **Step Four:** Support a collective public commitment and action to make changes.
- **Step Five:** Communicate change.
- **Step Six:** Build an environment that supports change.

Figure 2. Programme Theory of Change diagram.



PROGRAMME DEVELOPMENT AND ADAPTATION PROCESS

UNICEF (Programme Division, Child Protection in Emergencies) developed the Communities Care programme and implemented it in partnership with two national NGOs in South Sudan: *Voice for Change and The Organization for Children Harmony*, and the Italian NGO, *Comitato Internazionale per Lo Sviluppo dei Popoli (CISP)* in Somalia.

To support UNICEF and its partners with information, guidance, and capacity strengthening resources, the **Communities Care Toolkit** was designed, comprising four parts[12]:

- **Part One:** Building knowledge and awareness.
- **Part Two:** Information and guidance for planning and monitoring.
- **Part Three:** Strengthening compassionate, community-based care and support for survivors of sexual violence.
- **Part Four:** Guidance and resources for engaging the community in collective reflection and action for change.

As the toolkit was being finalised, a research team from the Johns Hopkins University School of Nursing conducted formative research with various stakeholders in South Sudan and Somalia, including government officials, women's groups, and religious leaders, to identify:

- Norms that sustain GBV in households and the community.
- Content/topics to stimulate critical reflection on addressing harmful social norms that underlie GBV in households and the community.
- The roles of women and girls in education, leadership, and peacebuilding in the community.
- Factors influencing household and community acceptance of GBV, and barriers to disclosing GBV to authorities.

The research team then collaborated with implementing partners in both countries to analyse the collected data and refine the toolkit. This was done through a joint five-day workshop to adapt the toolkit to the different contexts of South Sudan and Somalia. Not every exercise in the toolkit was suitable for both contexts, and some tools were used more than others. For example, one exercise required the use of newspapers, which was not applicable in the South Sudanese context, as the project community did not have access to newspapers. Implementing partners identified other creative ways to conduct the exercise.

In Somalia, the pilot version of the toolkit had little content on Female Genital Mutilation or Cutting (FGM/C), so additional information was added during the toolkit refinement process. Throughout implementation, feedback was gathered from facilitators through self-evaluations and from participants through qualitative interviews. This feedback helped assess comprehension and the effectiveness of programme materials and informed revisions to parts of the toolkit during implementation as needed.

PROGRAMME DESCRIPTION AND ACTIVITIES

PROGRAMME COMPONENTS

1 Community-Based Care (CBC) Component

This component focuses on strengthening community-based services for GBV survivors by identifying and addressing gaps in the availability of essential services and the barriers survivors face in accessing those services. This component also aims to improve the quality of care by offering a 3 to 5-day training and ongoing mentoring of service providers across sectors, including policy, justice system, healthcare, psychological services, community health workers, and community leaders. This component aims to strengthen collaboration among different service providers.

In many conflict-affected and low-resource settings, such as South Sudan and Somalia, there has been limited investment in building the capacity of health, social service, and law enforcement workforces to respond to sexual violence and other types of VAWG. Training and support for these providers and for others who offer care, support, and protection to survivors are therefore vital.[8]

This component also addresses harmful personal beliefs and social norms among providers (for example, blaming a woman or girl for experiencing assault) that can negatively influence the quality of care, treatment, and referrals provided to survivors.

2 Commnity Action Component

This component is delivered through 13 structured and facilitated dialogues with community members, using the Communities Care Toolkit and led by trained Community Discussion Leaders (CDLs).

- **Commnity Discussion Leaders (CDLs)**

  CDLs are recruited by local partners, sometimes with the aid of community leaders or government representatives, based on the following criteria:

  - Well-respected within the community or among peers.
  - Committed to gender equality.
  - Excellent interpersonal communication skills and the ability to engage with diverse community members.
  - Knowledgeable about cultural beliefs and attitudes related to gender and violence, as well as those promoting gender equality, justice, and fairness.
  - Capable of facilitating discussions on sensitive issues.
  - Demonstrate leadership and problem-solving skills.
  - Possession of a high school-level certificate.

The initial CDL training spanned 14 consecutive days, following a curriculum included in the Toolkit. This duration ensured participants had sufficient time to internalise the knowledge and skills required for their roles. The first three days of the training focused on building a strong foundation in the core concepts of the Communities Care programme, including social norms and sexual violence. The remaining 11 days focused on community dialogue content and developing participants' facilitation skills, particularly how to create inclusive and open environments to discuss GBV and related social norms.

During the training, CDLs were also introduced to reporting and monitoring tools to help track and evaluate the progress of their activities. While CDLs serve on a voluntary basis, they receive a stipend to cover logistics, such as refreshments for group discussions or communication costs to organise meetings.

CDLs identify (with the aid of community leaders or representatives) and recruit participants for the community discussion groups. Recruitment is purposefully determined by the implementing organisation, in agreement with the local community, based on the intended group demographics. For example, if the intent is to host a youth group, youth from the community are purposefully selected.

A related challenge is that if a CDL drops out, this can hinder the continuation of the discussion groups. To mitigate this, local leaders or implementing partners may need to provide support for recruitment so that community group participants are committed independently from the CDLs. It is also ideal to have two CDLs co-facilitate each community discussion group, to support each other and mitigate any challenges resulting from CDL turnover or drop-out.

- **Commnity Discussion Groups**

  Groups of 20 participants per cohort are brought together over 26 bi-weekly sessions (for 13 weeks) to collectively reflect on and explore shared values and aspirations, connect their experiences of violence and injustice to those of others, and analyse how certain social norms contribute to GBV. Formal and informal leaders, women, men, young people from diverse backgrounds, and others who play important roles in shaping community norms, such as teachers and healthcare workers, are encouraged to attend these dialogue series. Once selected, the same community group members participate throughout the 13-week discussion cycle; replacement of participants is not allowed.

  Discussion groups may be mixed by sex and age or segregated, for example, older married women may be separated from young women, and young men from male elders. Different group compositions offer various advantages and disadvantages. Disaggregated groups often create safer spaces in which age-based and gendered power relations are minimised, allowing individuals to discuss sensitive issues more

openly. However, mixed groups involving people of different ages and sexes can empower diverse and influential community members to work together to recognise GBV as a community problem and identify social norms that support gender equity, safety and well-being.

Refreshments are provided at every group session, and participants are reimbursed for transport costs. During the pilot phase, eight community discussion groups were formed in each intervention site, reaching a total of 320 people. Retention rates were generally high, with an average of 90 percent of participants remaining engaged throughout the 13 weeks of dialogues.

BOX 1: SUMMARY OF THE TOOLKIT DISCUSSIONS

The Communities Care discussions aim to support participants to take collective action against VAWG in their communities by:

- Bringing the issue of VAWG into the public domain, rather than allowing it to remain surrounded by shame and secrecy.
- Safely revealing what people think about VAWG but may be afraid to share due to social norms that foster silence.
- Facilitating collective reflection on shared values and social norms that enable gender inequality, discrimination, and violence.
- Helping communities identify gender-inequitable and violence-supportive norms they want to change.
- Supporting the identification and promotion of gender-equitable, non-violent expectations and behaviours that protect against violence.
- Building collective commitment and actions against VAWG.

A variety of participatory exercises are used during the first four sessions to build trust and help participants feel comfortable as a group. These activities include group exercises, small and large group discussions, music, drawing, and drama to generate collective visioning. This initial phase sets the foundation for the second phase, which fosters dialogue on core values such as human dignity, fairness, and justice, and how these relate to people's shared aspirations as well as their cultural and religious frameworks. At this stage, groups are encouraged to examine and discuss abstract concepts and relate them to their lived experiences, including how gender norms shape people's experiences of violence, inequality, and discrimination.

The final phase of discussions focuses on deepening understanding and dialogue about VAWG and the social expectations that contribute to its prevention. Participants

are encouraged to identify concrete actions they can take together to prevent VAWG and identify a variety of communication methods to publicise their actions.

Community discussion group members who demonstrate a commitment to changing harmful behaviours and are willing to publicly share ideas with others in the community are identified as **'champions for change'**. Influential community leaders, including opinion leaders, are also encouraged to become 'champions for change', using their positions to promote the benefits of non-violence and respectful, equitable relationships between men and women. Community opinion leaders and networks are mapped to understand how best to transmit and diffuse positive messages.

CDLs support the collective actions and sensitisation activities conducted by group members. Examples of collective actions taken during the pilot in both countries include public declarations and meetings, workshops with religious, traditional, and government leaders, activities with civil society organisations, radio programmes, storytelling, drama, and songs to raise awareness. In both settings, community members also advocated for the adoption of laws, policies, protocols, and mechanisms to support respectful and non-violent practices and behaviours.

For example, in South Sudan, teachers, school principals, head teachers, student representatives, school management committee members, members of parents-teachers associations, and representatives from the State Ministry of Education came together to develop action plans to prevent and respond to sexual violence in their schools. The plans included:

- Establishing reporting and referral mechanisms for incidents of sexual violence.
- Training teachers on the Code of Conduct.
- Implementing a 'zero tolerance policy' on sexual exploitation and abuse.
- Starting a fundraising campaign to build latrines and changing rooms for girls at school.
- Dedicating safe spaces within schools where girls could consult with a trained female staff member.[13]

BOX 2: PROGRAMME REACH IN SOMALIA:

Between 2014 and 2019, the Communities Care programme reached:

- 17,071 people through discussion groups, public declarations, and house-to-house visits in internally displaced persons (IDP) camps and host communities
- 2,282 teachers and students during school visits
- 34 religious leaders
- 128 youth group members
- 154 midwives and nurses through healthcare visits
- 10,000 community members through radio messaging in the intervention districts.[2]

MONITORING AND EVALUATION

Communities Care includes a Monitoring and Evaluation (M&E) Guide, which provides tools that implementing partners can use to monitor programme activities. The guide includes tools to facilitate the observation of community dialogue sessions and to collect feedback for CDLs. Observations of community dialogues are conducted weekly during the first month of implementation, then reduced to bi-monthly during the second and third months. The guide also includes tools for collecting qualitative input from participants to assess their experiences with the programme.

In addition to routine programme monitoring, Johns Hopkins University conducted a rigorous evaluation of the Communities Care pilot in South Sudan and Somalia. Formative research was conducted to inform the programme's inception phase (as noted earlier) and to develop and evaluate a **Social Norms Index**, designed to measure changes in norms that sustain sexual violence and other forms of GBV in humanitarian settings. At the time of the evaluation, there were no existing social norms measures specifically designed for GBV in humanitarian settings.

Applying this index, a randomised control trial was conducted to determine the effectiveness of the Communities Care programme within targeted communities in Somalia and South Sudan. This involved surveying adult men and women residents in both intervention communities and comparison communities (not participating in the discussion groups) at three time points over approximately 18 months. In addition, service providers, community dialogue participants, and women and girls who accessed services were interviewed to examine changes in social norms and satisfaction with GBV services across both intervention and control communities.

Ongoing insecurity presented challenges for the research. For example, due to fighting and displacement in one of the pilot districts in South Sudan (Yei), most of the longitudinal study participants had fled the area and could not be reached during endline data collection.

Key Findings

In Somalia:

- The evaluation showed **positive changes in social norms** in the districts that participated in the Communities Care programme, compared to control group districts.[2,15]
- Male and female participants in intervention districts showed **statistically significant improvements** in norms related to GBV, both over time and in comparison with control groups.
- The **greatest change** was seen in social norms related to family honour. For example, more participants reported believing it is wrong to discourage women/girls from reporting rape to protect family honour.
- There were also **significant shifts** in norms related to the right of husbands to

use violence against their wives and negative responses towards survivors of sexual violence. For example, more participants reported the belief that it is wrong to blame a woman who has been raped.

- Participants in intervention districts showed a **greater increase in confidence** in GBV services, including both formal and informal services, such as the police, justice actors, traditional elders, psychosocial providers, health care providers, and community health workers.

In South Sudan:

- Due to disruptions in endline data collection, a follow-up survey was conducted two years after implementation with a random sample of community members in both pilot districts. This survey showed positive changes in personal beliefs and social norms that sustain GBV among both women and men.[14]
- There was a reported increase in the number of people who had conversations about GBV, including more people reporting that someone had spoken to them about GBV. There was also an increase in the number of people who believed the community's attitude towards GBV had improved in the past year.
- There was a reported reduction in personal beliefs supporting:
  - The right of husbands to use violence against their wives.
  - Protecting family honour at the expense of survivors
  - Negative responses toward survivors of sexual violence
- Messages from the Communities Care discussion groups continued to spread throughout the community. Individuals who heard the messages, even if they did not participate directly, were more likely to hold positive personal beliefs compared to those who had not heard the messages.
- There was a decline in confidence in service providers among some participants in intervention sites, which may suggest that continued booster sessions with service providers are needed.

Scale-Up and Evaluation of the Communities Care Programme in Somalia

From 2017 to 2019, CISP partnered with local NGOs in nine districts across Somalia to scale up Communities Care, with funding from UNICEF.[15,16] The areas selected for scale-up varied by location and setting (rural or urban), population size, and the degree of ongoing conflict. A 15-day training was provided to local NGO partners to equip them with the knowledge, skills, and tools needed to scale up the programme. These partners then transferred their knowledge and skills to CDLs, who were selected and trained to lead the community discussion groups.

Throughout the implementation, CISP provided extensive and ongoing support to partners, enabling consistent monitoring of progress, addressing challenges or concerns as they arose, and supporting quality implementation. This hands-on support was an important aspect of the scale-up's success, as CISP brought extensive experience in implementing and monitoring the Communities Care programme. After the discussion groups were

completed, partners also received mentoring from CISP to develop **action plans**, including tailored **information, education, and communication (IEC)** materials and messages that reflected the specific needs of the discussion groups and communities. From 2021 to 2023, a **second phase of the scale-up** was launched, involving 10 partners across 20 districts in Somalia.[17]

Evaluation of the First Scale-Up Phase

To evaluate the feasibility and effectiveness of the first phase, the partners conducted surveys to examine changes in **personal beliefs** and **social norms** among Communities Care participants and members of the wider community. The evaluation also assessed changes in **confidence in GBV service providers** across the nine scale-up sites.

The results suggested that Communities Care improved personal beliefs and social norms related to GBV in multiple regions of Somalia. The most significant shifts were seen in attitudes toward **responses to sexual violence, protecting family honour, and child marriage.** Smaller, but significant improvements were seen in norms related to **husbands' use of violence against their wives** and **FGM/C**. Since FGM/C is a deeply rooted cultural practice in many settings, often tied to perceptions of women's respectability and marital eligibility, greater emphasis may be needed on its harmful consequences.[16]

Communities that experienced the most significant changes were those that implemented **strong community action plans** and received active support from local authorities and religious leaders. Conversely, in communities facing insecurity, such as those affected by violence from groups such as Al Shabab, it was not possible to hold large gatherings or enact certain action plans.

When community members were asked where they had heard messages about GBV:

- 80 percent cited through **community events** organised by the local implementing partners.
- 70 percent heard messages via **radio**.
- 68 percent mentioned **social gatherings**.
- Only 18 percent reported hearing such messages in **mosques.**
- Just 19 percent heard messages from **government officials.**[16]

These findings suggest that increasing **buy-in and participation** from **religious and government officials** could strengthen the reach and impact of the programme.

Adaptations of Communities Care to School-Based Programming in Kenya and Somalia

Communities Care has also been adapted to address **school-based violence** in both Kenya and Somalia:

- **In Kenya,** CISP supported an adaptation as part of the **Safe Communities for Safe Children and Adolescents in Kenya** project, implemented in Nakuru and Kakamega Counties. The three-year project (2019-2022) aimed to tackle the root causes of child abuse, violence, and exploitation, and to strengthen child protection systems. A variety of strategies were used, including child rights clubs, teenage mothers' support groups, school talk boxes, and adapted Communities Care tools and methodologies. The toolkit and group discussion approach were implemented both in the community with adults and in schools with children.
- **In Somalia,** under the second phase of the What Works to Prevent VAWG Phase II programme, CISP is collaborating with the International Rescue Committee (IRC) to mainstream Communities Care in schools, in partnership with the Ministry of Education. This school-based version of the toolkit will be implemented in schools alongside discussion groups hosted with adult community members, including parents of schoolchildren. The toolkit has also been adapted to support school-based discussion groups with adolescent boys and girls.

Evaluation results (conducted in both countries by Johns Hopkins University) and implementation lessons from these integrated school- and community-based adaptations of Communities Care are forthcoming.

PROGRAMMING LESSONS

- **Invest time to understand group dynamics in specific contexts** to guide the composition of community discussion groups. In Somalia, groups composed of individuals with similar interests or of the same sex were more likely to endorse one another's attitudes and beliefs without actively debating or questioning them. The programme later intentionally mixed groups and found that women were more active in groups that included men, women, religious leaders and elders. Similarly, when traditional birth attendants, who were initially grouped on their own, were subsequently placed in mixed groups with health workers and religious leaders, this brought diverse perspectives that enabled critical discussion around the practice of FGM/C. However, it is important to note that in some contexts, certain groups may not feel comfortable in mixed settings.
- **Public declarations focused on eliminating GBV in communities are a key component** for shifting harmful social norms. It is important to allocate sufficient time and use a range of strategies to widely disseminate messages and highlight community actions that demonstrate people publicly rejecting social norms that perpetuate GBV. Mapping appropriate opportunities and influential messengers is important for effective message transmission. Since many acts of IPV occur in private, it is harder for people to observe visible changes in social norms around the perceived right of husbands to use violence against their wives. This may explain the more limited shifts in related norms. Additionally, door-to-door awareness-raising had minimal impact on changing personal beliefs and social norms, as this strategy lacks the collective aspect needed

for communities to witness a broader shift in community social norms.

- **Ensure equitable partnerships for local ownership and sustainability.** Communities Care prioritised collaboration with local organisations in humanitarian settings. While international organisations may bring technical expertise, there must be intentional efforts to build capacities and foster mutual learning with local organisations. These groups often have better access to local authorities and community leaders, and they are more likely to be trusted and accepted by the communities they engage.

- **Partner with existing services, structures, and relevant government ministries.** Communities Care built on existing services and linked community members to available support services, including child protection and GBV services. Government ministries should be involved in the design, implementation and evaluation, so they understand the ToC and can support the programme, including the scale-up and mainstreaming. It is also critical to collaborate with other organisations working in the same communities to avoid conflicting messages. For example, in South Sudan, Communities Care messages sometimes differed from GBV-related radio messages from other organisations, which reinforced inequitable gender norms, such as stressing the importance of wives' obedience to their husbands.
- **Build a network of champions of change at different levels.** The programme worked with influential local leaders in the communities, including traditional and religious leaders, birth attendants, and government officials. The participation of religious leaders was identified as a key component in shifting harmful social norms. The Toolkit includes a public declarations process, which helped amplify messages from influential community members as champions of norms promoting non-violence and gender equality.

- **Have a continuous capacity development plan to support and mentor staff and facilitators.** To ensure adequate capacity and address high turnover among CDLs, it was important to train as many key stakeholders as possible and regularly conduct Trainer of Trainers (TOTs) sessions. Support should be tailored to facilitators' specific needs. For example, some CDLs were influential community members but illiterate and therefore unable to document dialogue sessions. The programme paired these CDLs with notetakers. Cross-country support was valuable, including how a team in Somalia provided training and technical support to South Sudanese partners during implementation of the pilot.

- **Social norms change is a long-term process, and measurement should reflect this.** The evaluation of Communities Care identified the value of formative research and developing a GBV-focused social norms index suitable for humanitarian contexts.[18] The pilot evaluation demonstrated the need for long-term measurement, as social norms change gradually. As discussion group participants become champions of change, they can become future CDLs and lead new community actions, propelling further change of harmful social norms.[18]

PROGRAMMING LESSONS SPECIFIC TO HUMANITARIAN SETTING

- **Displacement and insecurity influence programme diffusion and require adaptive programming and monitoring.** Communities Care is designed to be implemented in relatively stable environments for at least nine months. In South Sudan, conflict erupted during the pilot, displacing some communities. In Somalia, some communities were composed primarily of internally displaced people who returned to their original homes once they deemed it safe to do so. These movements disrupted the pilot programme diffusion, especially when some of those displaced were CDLs.

- **Organisational capacity and local context affect implementation quality.** CISP had 25 years of experience in Somalia, with established community relationships and strong implementation skills. In contrast, the South Sudanese implementing organisations, Voice for Change and the Organisation for Children's Harmony, were relatively young and had not previously implemented a programme like Communities Care alongside external research. Infrastructure was also a challenge: the Somali pilot had better internet access, which was unavailable in South Sudan, hindering engagement with local partners. In South Sudan, government staff were required to be hired for the programme (including as CDLs), but some had limited necessary skills, which affected implementation. Implementing partners in South Sudan worked under significant pressures given the state of conflict and contextual challenges. Given these constraints, more support during the readiness stage would have been beneficial for South Sudanese partners.

- **Consider the sustainability of maintaining quality GBV services:** Communities Care integrates GBV prevention and response, in order to support survivors who disclose violence and ensure they can access appropriate care and referrals. However, maintaining quality GBV services is challenging, particularly where existing support and infrastructure are limited. Sustainability planning is important, including identifying which aspects of the community-based care component can be feasibly continued even after projects end.

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15. The first phase of the scale-up, Communities Care, was implemented in 9 areas of Somalia: Quardho Puntland, Garowe Puntland, Bardhere Jubaland, Dhobley Jubaland, Dollow Jubaland, Dharkenley Mogadishu, Baidoa South West, Bual Burte - Hirshabelle, and Waberi - Mogadishu. Each of the areas have local and/or international NGOs with the capacity to provide services for survivors of GBV. The programme was implemented by local implementing partners Shilale Rehabilitation and Ecological Concern- (SHILCON), Tadamun Social Society – (TASS), Social-Economic Development and Human Rights Organization (SEDHURU), Community Empowernment and Development Action (CEDA), Somali Children Welfare Rights Watch SCWRW), Humanitarian Integrity for Women Action (HIWA), Somali Women Development Centre (SWDC), with support from CISP.
16. Perrin, N., A. Churicha, R. Litoroh, S. Abdille, W. Olawole, A. Abdi, and N. Glass. 2023. "Effectiveness of Communities Care Scale-Up to Change Gender-based Violence Social Norms in Somalia".
17. For the second phase of the scale up, Communities Care was implemented in 20 districts of Somalia- Marka, Barawe and Baidoa (Southwest State) Kismayo. Dollow, Dhobley, and Belet-Haw (Jubaland State), Beletweyne, Bula Buurte and Balcad (Hishabelle State) Dharkenley, and Waber (Banadir Region) Iskushuban, Qardho, Garowe, Bardhere, Badhan, Galkacyo (Puntland State) Lascanood, Hargaisa, Gibiley (Somaliland). The programme was implemented by local implementing partners Community Empowernment and Development Action (CEDA), Women Action for Advocacy and Progress (WAAPO), Tadamun Social Society (TASS), Shilale Rehabilitation and Ecological Concern (SHILCON), NAGAAD, Somali Women Development Centre (SWDC), Humanitarian Integrity for Women Action (HIWA), Somali Children Welfare Rights Watch (SCWRW), Social-Economic Development and Human Rights Organization (SEDHURO), NEW WAYS and SOS, with support from CISP.
18. Glass, N., N. Perrin, A. Clough, A. Desgroppes, F. Kaburu, J. Melton, A. Rink, S. Read-Hamilton, and M. Marsh. 2018. Evaluating the Communities Care Program: Best Practice for Rigorous Research to Evaluate Gender-Based Violence Prevention and Response Programs in Humanitarian Settings. *Conflict and Health*, 31:12 (5)