



Draft (14 September 2006)

Somali Joint Needs Assessment

**SOCIAL SERVICES AND PROTECTION OF
VULNERABLE GROUPS
CLUSTER REPORT**

CURRENCY EQUIVALENTS

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ACRONYMS AND ABBREVIATIONS

DDR	Demobilisation, Disarmament and Rehabilitation
EMIS	Education Management Information System
FAO	Food and Agriculture Organization
FEWSNET	Famine Early Warning Systems Network
FSAU	Food Security Analysis Unit
GDP	Gross Domestic Product
GED	Generic Essential Drug
GNP	Gross National Product
GRH	General Referral Hospital
HC	Health Center
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICRC	International Committee of the Red Cross
IDA	International Development Association
IEC	Information-Education-Communication
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IRC	International Rescue Committee
MCTP	Mother to Child Transmission Prevention
MDG	Millennium Development Goal
MPA	Minimum Package of Activities
NBTP	National Blood Transfusion Programme
NGO	Non-Governmental Organization
NHCP	National HIV/AIDS Control Programme
NHIS	National Health Information System
NTCP	National Tuberculosis Control Programme
OECD	Organization for Economic Cooperation and Development
OVI	Objectively Verifiable Indicators
PHC	Primary Health Care
PNC	Prenatal Consultation
RHC	Referral Health Centre
RHZ	Rural Health Zone
SPA	Supplementary Package of Activities
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHZ	Urban Health Zone
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WB	World Bank Group
WDI	World Development Indicators
WHO	World Health Organization
WASH	Water, Sanitation, Hygiene
WEDC	Water, Engineering and Development Center
WESC	Water and Environmental Sanitation Committee
WFP	World Food Programme
WHO	World Health Organisation
WSIC	Water Sanitation and Infrastructure Committee
WSISC	Water and Sanitation Inter Sectoral Committee
WUA	Water Users Association

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I. Foreword

This draft cluster report is part of the technical work of the Somali Joint Needs Assessment and is being circulated in draft to seek comments and suggestions as part of a quality assurance review process. It is stressed that at this stage all six draft cluster reports are technical assessments and should not be thought of as a final output of the Somali Joint Needs assessment. Prioritization is a two-part consultative process, first technical and second political, and this draft cluster report is primarily concerned with technical prioritization. Political prioritization will come in finalization of the integrated Reconstruction and Development Program (RDP).

To ensure the highest possible quality of this cluster report we look forward to your comments and suggestions, with specific reference to the accuracy of information, the within-cluster prioritization of needs, and the suitability and feasibility of proposed actions to address these needs. To generate the best possible Reconstruction and Development Program it is important that Somali authorities and people, and developing partners, contribute to this review process. Guidelines for this quality assurance review have been issued separately.

This draft cluster report is the outcome of an exhaustive technical exercise involving extensive consultations with Somali stakeholders, ranging from civil society groups to national and local authorities and parliamentarians. It has been produced by an integrated team of Somali and other technical experts drawing on information from (a) existing sources, (b) consultation workshops, (c) selected field visits and meetings with a wide array of Somali groups and individuals, and (d) questionnaire-based fieldwork undertaken by Somali experts in all regions, to review priority needs and develop reconstruction and development proposals to address those needs. It responds to specific local needs by providing differentiated suggestions for South and Central Somalia, Puntland and Somaliland. Moreover, it reflects the importance of three key cross-cutting issues – peace-building and conflict prevention, capacity building and institution development, and human rights and gender – by addressing them as an integral part of the proposed initiatives to achieve desired reconstruction and development objectives.

The team is now focusing on reviewing the full array of priority needs and proposed suggestions from all six cluster reports to prepare an integrated Reconstruction and Development Program (RDP). This RDP will present a proposed set of initiatives to address priority needs from among the wider set of needs. Clearly, not all needs can be addressed immediately or within the five-year time frame of this RDP. Implementation capacity and likely resource availability will both be considered in developing RDP initiatives. But behind all this is the fundamental objective of supporting Somalis in deepening peace and reducing poverty as quickly as possible in a sustainable way.

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II. Executive Summary

1. Civil war in Somalia started with the destruction of the Northwest in 1988, and culminated in the collapse of central government institutions and infrastructure throughout the country from 1991. As a result, the provision of social services such as health, education, water, sanitation, food and nutrition was seriously disrupted or abandoned. Everyone has the right to a standard of living adequate for the health and well being of himself/herself and of his/her family, which is not possible without the above mentioned social services.¹ Many skilled and professional people fled the country, leading to a lack of capacity further undermining the quality of social services provided to the Somali people.

2. Despite this situation, some social services continued to be provided. Relative peace and stability in Puntland and Somaliland has allowed for reconstruction and development efforts - driven mainly by the commitment and investment of the Somali Diaspora and the private sector, and supported by the international community - to exist, if not thrive. The recent installation of the Transitional Federal Government (TFG) in South and Central Somalia provides a unique opportunity to reconstruct and rebuild in the conflict-affected areas of Somalia, and establish the structures necessary to provide for regions that have suffered isolation, poverty and under-development. It is in this context that the Somali JNA process was launched, in the belief that there is a better future for the Somali people.

3. The Social Services Sector in all Somali regions faces many challenges regarding access, availability and the quality of the required social services. Substantial assistance has been provided but challenges still exist particularly with gender. Despite initiatives made by local communities, UN agencies and international NGOs, the coverage and quality of provision is extremely low. In education, for example, enrolment is one of the worst in Africa. Less than 22% of school-going age children are in school, and only one third of them are girls. The dropout rates are high, and there is no standardized curriculum for all levels of education in South and Central Somalia. There has been progress in Puntland and Somaliland but schools lack vital resources and materials. There is a very large number of untrained teachers (in primary and secondary education), and it is recognised that almost all interventions have been addressing this by in-service training, which has been lacking co-ordination

4. Islamic organisations have provided education and the Diaspora has been critical in investing in and developing all sectors of services. A number of local and international NGOs have been involved in healthcare delivery, and in supporting community water supply and sanitation. The major donors active in services development are the European Union (EU), European Development Fund (EDF), African Development Fund (ADF), World Bank (WB), the International Fund for Agricultural Development (IFAD), Islamic Development Bank (IDB) and other institutions: UNICEF, UNDP, WFP, FAO, WHO, NGOs, and various associations.

5. Social services need to be delivered equitably to all sections of the population, particularly to vulnerable and marginalised groups, in both rural and urban communities. Vulnerability and exclusion are manifestations and further cause lack of capacities within families, communities and governments to fulfil their obligations as duty bearers against claims made by citizens. It is vital to remember children and women are particularly threatened in situations of instability and crisis. The provision of social services by the private and public sector and the related need to charge for these (cost recovery mechanisms, necessitated by the need to achieve sustainability) has placed a heavy burden

¹ *Universal Declaration of Human Rights*, Article 25(1); Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services.

on the poor.² Being free from fear and want can only be achieved if conditions are created whereby everyone can enjoy their economic, social and cultural rights as well as their civil and political rights.³

6. Women's social indicators consistently lag behind those of men. Although all estimates should be treated with caution, the adult literacy rate is estimated to be 27% for females compared to 50% for males. The gross enrolment rate for girls is 15% compared to 27% for boys. Statistics underestimate the significant contribution of women to the economy, especially in agriculture, food security and the informal sectors. Improvement of women's situation at all levels – including at managerial level - is an important policy objective of the JNA; it will involve making special provisions to ensure access to social services, education, maternal health and family planning, and improved quality and access.

7. Somalia also faces other social problems that undermine development and require urgent attention. These include HIV/AIDS, Female Genital Cutting/Mutilation (FGC/FGM) and the chewing of khat (an intoxicating plant, classified as an illegal drug in some countries).

8. FGM remains deeply embedded in Somali culture. Many organizations have been working at the national and regional levels for many years, but there is limited implementation of FGM eradication activities at community level. FGM messages need to be included in health institutions' and schools' curricula in order to make any impact upon a practice said to have been inflicted upon 98% of the population. Coordination in programming and public message education needs to be improved and its dissemination intensified. There is a proclamation against FGM in Puntland; but otherwise there are no existing FGM policies, guidelines or legislation. Female children find themselves subjected to harmful practices such as FGM in order to satisfy cultural norms. Parents as duty holders are in violation of their obligation to their children who are rights holders when they are forced into doing something that is both dangerous to their future wellbeing and against their will.⁴ What is vital to remember is that it is women who carry out the surgery and most often it is coerced and deemed necessary as a right of passage. Eradication of this practice must be approached extremely sensitively as the custom has been apparent for generations. Women must not be faced with the stark choice of 'your culture or your rights.' Educating women, who carry out the surgery, on the harmful effects of FGM will empower them to raise social consciousness in order to put a permanent stop to it.

9. The chewing of khat is an entrenched and destructive social and economic problem that drains Somali household income. Women and children most often bear the brunt of the suffering. Daily consumption causes serious socio-economic and health related problems that challenge future development. Culture sensitive reduction programmes targeted at young males, alternative social and sporting activities, and mandatory working hours in government and public institutions are critical to addressing a problem that costs South and Central Somalia, Puntland and Somaliland hundreds of millions of dollars every year.

10. Education and Training proposes two strategic thrusts are proposed: (i) improving access and quality at all levels. These should be guided by a process approach that would seek to capitalize on the policy and actual implementation assets on-the-ground. These assets have managed to provide

² The lack of capacity within the authorities, the administrative institutions and the lack of governance in South and Central Somalia leads to duty-bearers being unable to fulfil their obligations as providers of assistance and services to those who need it the most.

³ International Covenant on Economic, Social and Cultural Rights, Preamble.

⁴ There are three guiding principles in the *Convention on the Rights of the Child* which are crucial in terms of FGM; the first is what is in the best interest of the child (Article 2), the second is the right to life, survival and development of the child (Article 6) and thirdly is respect for the views of the child (Article 12). According to these three principles the parents and communities are in violation of their duties to these children as none of the above mentioned have been taken into consideration when FGM takes place.

significant gains throughout the education sectors of all parts of the country, especially in the supply of educational provision. This includes the mobilization of communities and the Diaspora, know-how on the ground, Islamic charities, traditional educational institutions such as the Koranic schools; (ii) improving the system's capacities for governance and management, such as capacities for data collection and planning. This would be a more traditional capacity development and planning approach. Also, given the apparent dynamism of the local and other decentralized initiatives at all levels of education, along with the relative weakness of central ministries, it will be necessary to find a balance between the two. The Islamic/Koranic providers need to be encouraged through incentives (for instance Teacher Salaries payment and recruitment etc) to continue their work; the government capacity will need to be developed.

11. A fund approach is proposed for the financing required for scaled-up efforts for improving access and quality. The advantages of this approach are that it enables local initiatives to develop from their strengths and it can avoid the pitfalls of top-down approaches; it is much more demand-driven than supply-driven. It recognizes the current dynamics of the local initiatives and the quasi-absence of strong central capabilities. It also leaves open possibilities for holistic approaches that go beyond the provision of purely educational inputs. Integrated solutions (e.g., that include elements and inputs related to water and sanitation, health, food security, economic/productive activities, etc.), could easily be accommodated. In this context, it would be important to avoid managerial complexity that could deter applicants that do not have the administrative and accountability capabilities often expected from international organizations.

12. Capacity development of government ministries and associated institutions would consist of direct support to them in order to enable effective operations of their core functions, such as statistical reporting, curriculum development, assessment and certification, teacher training (mainly in-service), pedagogical support to teachers and school directors through a system of inspection; and the strengthening of district offices. It is important to develop the capacity of government and civil society in order to continually assess and analyse the situation of individuals and most importantly marginalised and vulnerable groups in relation to the human rights instruments of the UN system and to monitor and evaluate progress.

13. The equitable provision of social services as a whole requires appropriate policies, financing, and legislation to govern the management of the service sector. It also requires appropriate incentives, skills training, programmes for gender equity, and clear ownership of social services provision.

14. The organization and management of the social services system in Somaliland and Puntland must be made sustainable: the established structures are understaffed, under-funded and under-performing. The development and implementation of services in South and Central Somalia depends greatly on donors and private providers; policy implementation capacity with the new government needs to be established and developed.

15. The delivery of basic health services will focus on the needs of women and children by expanding care and preventive and promotion programmes at the community level. Budgetary allocations in both the health and education sectors will favour primary level services, with primary education taking over 45 percent of the total expected education sector budget; allocations to hospital rehabilitation will amount to only 35 percent of health spending. Provision of drinking water in urban areas will, initially, be made on a cost-recovery basis. Local governments will be encouraged to support future investments. Budget allocation for education and health needs to be drastically increased at the expense of the safety services budget.

16. Service provision and trade are currently in the hands of the private sector. There has been significant private investment in trade and marketing, money transfer, communications, airlines, construction and hotels, education, health, and fishery equipment, all funded largely through remittances. The report advises that lessons learned by these private sector stakeholders should be applied in the emerging public sector.

17. It is recommended to expand on the development support approach (applied in almost all interventions) in the management of service provision. The report acknowledges that the public institutions in South and Central Somalia, and to a lesser extent in Somaliland and Puntland, cannot be the sole providers of basic social services if they are to achieve the desired levels of coverage and access.

18. The report encourages general improvement in local government partnerships with religious and humanitarian organisations, NGOs and with the private sector, as well as community participation in service provision planning and implementation in areas such as education, health and rural water supply. The people should be recognised as key actors in their own development, rather than passive recipients of commodities and services. Sustainable human development places people at the core, and views humans as both a means and an end of development.

19. The authorities should develop legal mechanisms for community participation in local government decision-making and service management, developed under the Governance Sector. This would define responsibilities for funding and implementation decisions not just at community-level for schools, water and health facilities but throughout the system from individual beneficiary to governmental level. Participation is therefore not only a means but a goal too. Other cross-cutting priority actions include:

- survey and publication of the population estimates.
- coordinate legal, civil service, human resources and policy actions.
- support Somali identity and registration at birth and at service delivery points;
- establishment of the institutional framework for service provision planning,
- designation of sector focal points in each line department or Ministry in key areas such as education, health and justice
- establishment of the structure to coordinate participative approaches to planning, implementation and monitoring of planning exercises.

20. The report promotes the creation of incentive partnerships between the public-private sector, religious organisations, UN, WB, NGOs and communities which are based on mutual respect and shared values in order to fully promote and secure human rights. The challenge is to build partnerships and strengthen complementarities between public and private entities. Services need to be delivered to the population at large and to the poor and vulnerable in particular, with gender equity as a common goal. Successful partnership will greatly increase the absorption and implementation capacity generally.

21. A few basic background factors need to be kept in mind when developing future strategies in Somalia:

- i) The population is Muslim with Somali as the official language. This language has been used for the first cycle of primary education since about 1974. It was also associated with a successful mass literacy campaign at that time.
- ii) Approximately 60% of the population consists of semi-nomadic pastoralists, many of whom have varying levels of attachment to a base location.
- iii) Organized, central government in Somalia ceased to exist with civil war and the downfall of the Said Barre regime in 1991. Since then, what government there is has been exercised at the

levels of the three major areas: the South & Central Somalia, the Northeast (Puntland); and the Northwest (Somaliland).

- iv) Nonetheless, the economy has been growing, with the private sector taking the lead in providing services such as water, telephones and electricity (Cummings & van Tonningen, 2003).
- v) Spurred on by local (communities and local governments) initiatives, education has managed to grow in recent years with primary school enrolments more than double their pre-1991 levels. Furthermore, there appear to be a variety of delivery modes on the ground, ranging from formal schools to alternate/non-formal to Koranic schools. Nonetheless, there are concerns for the quality of education and school participation remains very low.
- vi) International and local development agencies, NGOs, the private sector, and the Diaspora have remained active and have contributed to the survival and growth of the education, water and health sectors.

22. Public and donor funds should be invested in holistic interventions that require capital and technology beyond the means of the community. Clear intervention priorities should also be decided upon to implement and sustain the intervention. Overall these interventions should strive to achieve the UN Millennium Development Goals with account taken of the different realities in both urban and rural areas. It is unrealistic to expect attainment of these goals in accordance with the MDG timetables, but it is the basic human right of all Somalis to have a better way of life⁵ and – in many cases – the MDGs describe only the bare minimum to which they are entitled.

23. **Millennium Development Goals:** The table on the next pages highlight the challenges of meeting the Millennium Development Goals (MDGs) for South and Central Somalia, Puntland and Somaliland. The feasibility of achieving the MDGs is outside the scope of the five-year period due to the destruction that has blighted South and Central Somalia, Puntland and Somaliland over the past two decades. Efforts under the RDP will provide a critical base for meeting these essential goals in the longer term and for continued assistance and intervention. Large research gaps – particularly in relation to disaggregated figures for South and Central Somalia, Puntland and Somaliland - need to be filled so that interventions are made from an informed stance.

Table 1: Millennium Development Goals with relevance to Social Services

	Somalia	Somaliland	Puntland	South-Central	Target for 2015
Eradicate extreme poverty and hunger					
Population living below \$1/day	43% (2002)	..	..	..	22%
Poverty gap ratio at \$1/day	18.3%(2002)	..	..	..	9%
Share of poorest quintile in national consumption	4.1% (2002)	..	..	..	2%
Children underweight for age (percent of children under 5)	26% (2000)	21% (1999)	26.8%(1999)	27.5% (1999)	13%
Achieve universal primary education					
Gross primary enrolment ratio (% of school age population)	22% (2005)	33%(2005)	24%(2005)	16%(2005)	100%
Youth literacy rate (% ages 15-24)	20% (2004)	..	..	..	100%
Promote gender equality and empower women					
Ratio of girls to boys in primary & secondary education	0.55 (2000)	0.44 (2004)	..	..	1.0
Ratio of literate females to males (ages 15-24)	0.52 (2002)	..	..	..	1.0
Proportion of seats in parliament held by women	25/275(2003)	0/82 (2003)	5/68 (2003)	..	Promote gender equality and empower women.
Reduce child mortality					
Under-five mortality rate (per 1,000)	224 (1999)	188 (1999)	225 (1999)	231 (1999)	75
Infant mortality rate (per 1,000 live births)	133 (1999)	113 (1999)	133 (1999)	137 (1999)	44
One-year-olds immunized against measles (%)	40% (2004)	..	..	..

⁵ Article 55 of the UN Charter states according to the principle of equal rights for all peoples the UN shall promote higher standards of living, and conditions of economic and social progress and development, including health. The UN will also promote solutions of international economic, social, health, and related problems.

Improve maternal health					
Maternal mortality rate (per 100,000 live births)	1,100 (2002)	1,600 (2005)	..	..	275
Births attended by skilled health staff (%)	25% (2002)	27% (1999)	49.2 (1999)	27.6 (1999)	
Combat HIV/AIDS, malaria, and other diseases					
HIV Prevalence (% adults ages 15-49)	0.9% (2004)	1.4% (2004)	0.9% (2004)	0.5% (2004)	
HIV Prevalence (% females ages 15-24)	3% (2001)	..	..	..
HIV prevalence among 15-24 yr old pregnant women	..	1.4% (2004)	1% (2004)	0.9% (2000)	Halt and begin to reverse spread of HIV/AIDS, incidence of malaria and other major diseases.
Contraceptive prevalence (% of women ages 15-49)	7.9% (1999)	9.3% (1999)	8.3% (1999)	6.1% (1999)	
Prevalence associated with malaria (per 100,000)	118 (2000)	..	113 (2005)	..	
Death rates associated with malaria	81 (2000)	..	..	..
Incidence of TB (per 100,000)	412 (2003)	460 (2000)	..	..
TB cases detected under DOTS (%)	42% (2003)	..	..	..
Percentage of children under 5 treated with anti-malarial	19% (2001)	12% (1999)	27.6%(1999)	14.6% (1999)	
Ensure environmental sustainability; land, air and water					
Proportion of land area covered by forest	12% (2002)	..	..	..	Integrate principles of sustainable development into policies; reverse loss of environmental resources.
Ratio of area protected to maintain biological diversity to surface area	0.01% (2002)	..	..	..
Energy use per unit of GDP	50.43 kg p.a. (2000-02)	..	..	..
Proportion of population using solid fuels (%)	97% (2000)	..	..	..
Access to an improved water source (% of population)	29% (2002)	31.3%(1999)	25.9%(1999)	17.8% (1999)	64.5%
Access to improved sanitation (% of population)	25% (2002)	47.4%(1999)	41.5 (1999)	50.8 (1999)	62.5%
Develop a global partnership for development					
Fixed line and mobile phones (per 1,000 people)	15 (2002)	20 (2004)	..	..	With the private sector, make available benefits of new technologies.
Personal computers in use per 1,000 people	0.5 (2002)	0.5 (2004)	..	..
Internet users per 1,000 people	9 (2003)	6.7 (2003)	..	..

Source: WB World Development Indicators 2006; UNDP MDG Report Somalia, 2004; UNDP and the WB, Somalia Socio-Economic Survey 2002; UNDP Somalia Human Development Report, 2001; Multiple Indicator Cluster Survey, 1999; Conflict Analysis Regional Report: Puntland, 2004; UNICEF Primary School Survey 2004/05; UNICEF, The State of the World's Children, 2004; Ministry of Planning of Puntland, Facts and Figures 2004; WHO Annual World Health Report, 2004; WHO Report on Sero-prevalance Sentinel Sites, 2004.

24. The interventions in the RDP will assist the people and governments of South and Central Somalia, Puntland and Somaliland to consolidate the peace process and pursue conflict prevention strategies, in order for South and Central Somalia, Puntland and Somaliland to become peaceful, developing and prosperous.

25. **Action plan:** The interventions in this report will be translated into a more detailed action plan during the first year. The action plan will set out targets, re-defined priorities, responsibilities and implementation mechanisms. It will consider what reforms must be made to promote and enable greater activity from public institutions. An outline of any legal changes considered necessary to effect reforms will be considered and reviewed and will include both how to build up capacity within a possibly new institutional structure, as well as rehabilitation and upgrading. The report assumes a review of past and current institutional arrangements at the time of implementation, which entails a detailed study of the institutional arrangements including organization, staffing, skills levels, operational procedures, performance and funding.

III. Introduction and Methodology

26. When Mohammed Siad Barre's regime collapsed in 1991, Somalia was already one of the poorest countries in the world. Over the next fifteen years, civil war and absence of government meant that most people in Somalia struggled without basic services. In some parts of the country, conflict continued and the population suffered displacement, poverty and insecurity. In other areas, rudimentary administrations or traditional councils of authority were established and people began to re-build their lives.

27. South and Central Somali, Puntland and Somaliland remain greatly impoverished, a situation aggravated by the civil war and the absence of a fully functional national government since 1991. The impact of state failure on human development has been profound, resulting in differentiated destruction of social and economic infrastructure and political institutions. In times of crisis and instability it is the women, children and the most vulnerable and marginalised of society that are particularly threatened. South and Central Somalia has pockets of peaceful communities that remain

threatened by the intermittent insecurity in Mogadishu, Kismayo and by proximity to the Middle and Lower Shabelle regions. Puntland has been semi-autonomous since 1998 and experienced recent disturbances in December 2005 – March 2006. Somaliland has seen much of the peaceful conditions necessary for the re-establishment of governance and with it, expansion of both demand and supply of social services.

28. Since 1991, Somaliland and Puntland have achieved a significant level of economic and political stability. Somaliland, in the north-west, unilaterally declared independence in 1991, after much of the area was destroyed by the central government in 1988. The returning population used traditional forms of governance to reach consensus and overcome divisions, and has made significant progress through Diaspora investment and commitment combined with local steadfastness and dedication.

29. Puntland, in the north-east, declared itself an autonomous regional state in 1998 and is also heavily dependent on the Diaspora. While it aspires to be part of a federated Somali government, its relative success has in large part been a result of its *de facto* separation from the political developments of the centre. Puntland has benefited from the trade and work generated by its thriving Red Sea port, Bossaso; but it has also suffered from the huge number of displaced and migrant people it attracts, as well as loss of potential revenue from smugglers and illegal foreign shipping.

30. Overall the cost in loss and disruption of human lives has been staggering; inadequate access to basic services and infrastructure has seriously damaged the general welfare of the population and exacerbated poverty and vulnerability. Even taking into account the progress in Somaliland and Puntland, social indicators show that Somalis are at the bottom of the list in most critical areas, particularly health, which is linked to the right of life, and education. Most health indicators place South and Central Somalia, Puntland and Somaliland among the worst places to live in Africa. Under-five and maternal mortality rates are among the worst in the world at a shocking 224 and 11-16 per 1000 live births.⁶ In many areas, hospitals and health centres function without necessary drugs or trained personnel, at a cost that is prohibitive to most. Reducing child mortality and improving maternal health are MDGs that can be achieved through basic service provision.

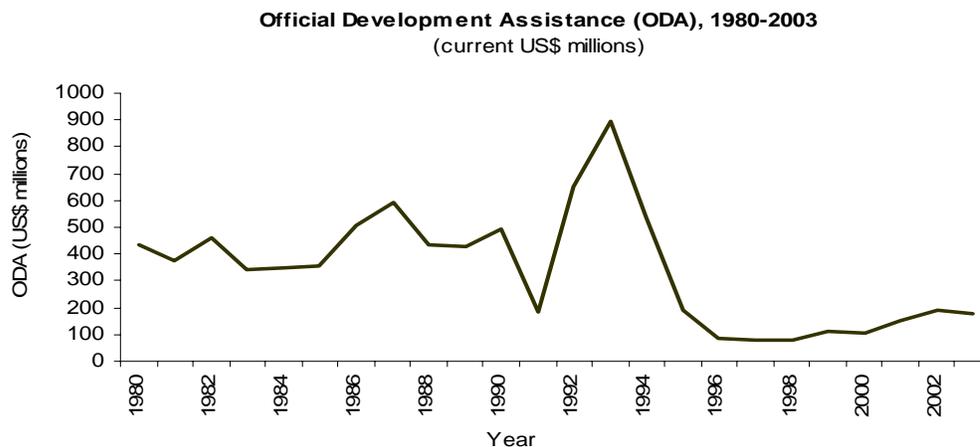
31. Primary school gross enrolment in 2004/05 was under 22% for South and Central Somalia, Puntland and Somaliland together - the lowest in the world. In the absence of formal education structures and materials, a whole generation is forced to rely primarily on the Koranic system for education. One of the Millennium Development Goals is to receive universal primary school education in all of Somalia by 2015.

32. The overall population is estimated at 7.7 million, with a little over one million concentrated in Mogadishu. Two decades of civil war has caused major changes in the movement of people, in clan boundaries and in the ownership and use of land. The majority of Somalis are still pastoralists. There are some farming communities in riverine regions, small groups of artisans in some areas and fishing communities line the long coastline.

33. Lack of services and livelihoods has contributed to the increasing concentration of people in urban and semi-urban areas. Poverty in the urban environment has been made worse by inflation after warlords introduced substantial amounts of foreign-printed currency. Average inflation in South and Central Somalia was 12% in the period 1994 to 2004. South and Central Somalia, Puntland and Somaliland have had no financial relations with international creditors for two decades and there has been no active lending programme from the World Bank since 1990. Despite interventions from the European Commission, the absence of lending and the persistence of insecurity, means that South and Central Somalia, Puntland and Somaliland have received little international aid. The major flow of aid has in fact come from Somalis themselves. Remittances from the Diaspora have in recent years overtaken official international assistance by up to ten times.

⁶ A range estimate is used because the higher estimate is reported in the published UNDP Somalia Human Development Report, 2001, while the lower figure is reported in the draft UNDP Millennium Goals (MDG) Report Somalia, 2004 (see the CER Statistical Annex).

Figure I: Official Development Assistance



34. The *Social Services and Protection of Vulnerable Groups Cluster Report* describes the urgent need for all social services in Somalia. It takes into account the needs and priorities of other clusters so that inter-cluster linkage is effective and efficient. The anticipated return of refugees and the Diaspora, for example, must be preceded by access to social services to provide necessary support and to avoid over-concentration in urban areas. Moving home to rural areas will be determined to a great extent by the availability of services, as well as access roads, security and livelihoods.

35. A human rights-based approach to programming lies at the core of this Joint Needs Assessment and informs the resulting Reconstruction Development Programme. The human rights based approach recognizes that individuals have rights and not only needs, which ought to be respected by duty-bearers (e.g. by the State, by non-State actors, by the community, by other individuals). At the same time there is a need to recognise that secondary duty-bearers such as parents and communities may have unfulfilled rights due to poverty and instability. Therefore strengthening their capacities will contribute not only to sustainable development but also rights based development. Interventions are therefore focused on strengthening the capacity of duty-bearers for respecting human rights and towards the empowerment of rights-holders to claim their rights. A causal analysis explaining the origin of the deprivation of rights is at the base of this approach as well as the principles of non-discrimination, participation, accountability and community-based interventions. While developing and strengthening the capacity of both duty holders to meet their obligations to fulfil, protect and respect rights and rights holders to claim their rights, rights must always be understood to be indivisible and interdependent. All rights have equal status, no right is more important than another.

36. Sound national governance institutions - legislatures, executives and judiciaries - are crucial to establishing enabling environments for eliminating poverty, promoting equality and protecting the environment. Strengthening governance through human rights-related capacity development will help achieve these goals.

37. The scope and impact of interventions recommended in this report will depend on local government structures and as such are prioritised and sequenced with consideration of complementarities of implementation across clusters, but using existing comparative advantage. In Somaliland and Puntland this means using existing structures, institutions and partners to improve and expand social services. In South and Central Somalia the success of the proposed interventions must be linked to supporting the development of the Transitional Federal Government, and its relationship with traditional local authorities. In both cases the development process will be locally owned. The report recommends utilizing the necessary resources and commitment to provide Somalis with basic human rights of education, health, and clean water, in an environment that supports their general welfare and offers them the basic opportunities and protection they deserve.

38. Methodology: In order to capture the needs of the social services sector in the different regions of Somalia a number of approaches were adopted. Quantitative and qualitative approaches were adopted for the design of the assessment of the needs of the education sector. This consisted of the following components.

- *Literature Review:* was made of the various sectors (education, training, health, nutrition, food security, FGM, HIV/AIDS, protection of vulnerable groups and khat). Desk reviews of current literature on Somalia were carried out and discussions held with NGOs, the UN and WB on project experiences in South and Central Somalia, Puntland and Somaliland.
- *JNA inception Retreat and Consultative Workshops:* an inception retreat was held in Nairobi from 23-26 November 2006 and was attended by participants from Puntland and Southern and Central Somalia. Participants included the Prime Minister of the TFG, the Ministers of Education, Health, and Social Security of the TFG and Puntland, and interest groups. Consultation Workshops were held in Jowhar in December 2005 and in Hargeisa in January 2006.
- *Stakeholder consultations:* Stakeholder workshops were held in Puntland and Somaliland for Health and a Rapid Assessment Analysis and Action Planning Process (RAAAP) devised.
- *Field Questionnaires:* In order to reach those areas inaccessible (for security reasons) to international staff, a questionnaire was drafted with the help of the Regional JNA teams. The regional teams then visited the inland districts and coastal areas and compiled a database of needs and priorities according to regions and districts; these have been consulted in the drafting of the Cluster report.
- *Field assessment in Somalia:* Interviews/discussions were carried out in urban and rural areas of South and Central Somalia, Puntland and Somaliland. These included meetings with teachers, pupils, parents, women, pastoralists, local authorities and NGO education personnel.

39. The first draft of the report was produced with contributions from Sub-cluster reports from each of the partner agency consultants. The sub-cluster reports were compiled after a desktop review and field visits to South and Central Somalia, Puntland and Somaliland. Security considerations restricted visits by JNA staff to the villages and larger cities, but the Social Services team managed to visit outlying settlements some 120 km from larger villages. The Zonal Technical counterparts extended the scope of the outreach by visits to inland areas and coastal regions, and supplying the JNA consultants with questionnaire results. Current and past Somali technocrats were contacted for contributions to the report.

40. The SACB inter-agency working group mechanism was used to supply specific information related to the sub-cluster reports, with stand-alone reports individually presented to the Health, Water and Education Thematic Committees. The working groups provided substantial inputs on the major achievements and activities of the respective sub-cluster issues. The World Bank contributed to the report by providing the overview of the recent macro and socio-economic trends in the country, and the International Labour Organisation drafted inputs on vocational education training.

IV. Vision and Objectives

41. The lack of social services is fundamental to South and Central Somalia, Puntland and Somaliland's protracted humanitarian crisis. The devastation of public and private institutions and assets over the last two decades has resulted in South and Central Somalia, Puntland and Somaliland, being among the poorest in the world. Most people live on less than \$2 a day; this means that even where the private sector manages to establish health clinics, hospitals, or schools, very few people can afford to use them. Lack of disposable income is a major deterrent to the utilisation of fee-based services. So are the incidental costs such as transport and waiting time. Overall infant mortality has reached 133

per 1,000 live births; enrolment in primary school is no more than 22 percent; and less than 30 percent of the population has access to safe water.⁷

42. The vision for the social services sector is to expand access to basic social services across all regions by 2011, with particular attention being paid to vulnerable groups. The recent establishment of the Transitional Federal Government (TFG) in South and Central Somalia provides a unique opportunity to develop a framework for social service delivery while supporting recovery, reconstruction and development.

43. Delivery of essential services is inter-linking and self-reinforcing: it contributes to training opportunities and livelihoods, and builds capacity in the planning, management and implementation of social development policies. Human rights training will also be essential in building in a culture of promoting duty bearers to recognise their responsibilities to respect, protect and fulfil their obligations towards the realisation of rights. Duty bearers will include heads of family, community leaders, the TFG, ministries relating to education, health and water and also judges and law enforcement officers. Stressing the values of a rights based approach right from the beginning in all service provision will ensure not only a good development process but also sustainable outcomes. It will also enable rights holders such as women and vulnerable groups to make claims on unfulfilled obligations. Strengthening the capacity of duty holders to fulfil their duties is therefore essential. Investing in social services and protection of vulnerable groups will improve productivity both now and in the future – as well as directly contribute to the realization of the MDGs and economic and social rights. Providing social services reduces poverty by ensuring access to education, health, sanitation, and water; and it requires the participation of civil society, particularly vulnerable and marginalised groups. Although economic growth is crucial for sustainable improvements in human welfare, it is not a sufficient condition. Moreover, there is agreement that development is not solely economic growth or human development - it is both. This approach will include three important components which are crucial to sustainable human development and improving human capabilities. The first is the capability to be well nourished and healthy. The second is the capability for healthy reproduction, and the third is the capability to be educated and knowledgeable. Improving human capability is the key component, both for duty bearers and rights holders in social service provision.⁸

44. The Social Services and Protection of Vulnerable Groups cluster is a critical priority of the overall need to improve and direct the capacity of the governments, in strengthening their legal frameworks, institutions and policies. There is clear need for improved management and accountability in the services sector, which requires an effective legal and policy framework.

45. Access to social services and the protection of vulnerable groups is a basic human right and requires urgent action. Pragmatic planning should ensure that strengthening service delivery is not held back by central policy development and political and legislative barriers. This can be achieved by taking into account the implementation capacity of the strong private sector, the experience of NGOs, the EC and the UN/WB; and building on models of development and success in Somaliland and Puntland.

46. **South and Central Somalia** suffers from a chronic lack of services and initiatives; this is linked to insecurity and the absence of formal government structures. All educational facilities are few and inadequate and most are concentrated in urban areas. School enrolment is extremely low at 16 per cent, and the enrolment rate for girls is one of the worst in the world. The quality of basic health services has substantially deteriorated over the last fifteen years, with access heavily restricted by ability to pay. Health infrastructure is small, concentrated in secure areas, and frequently dilapidated.

⁷ See table 1: Millennium Development Goals

⁸ Jonsson, Urban; Human Rights Approach to Development Programming, UNICEF, Nairobi (2003), also see UNDP, Human Development Report (1996)

Water and sanitation provision is entirely in unregulated private hands or reliant on traditional sources. The workforce is limited, under-skilled and often works without remuneration. Somalis have been resilient and innovative, relying on tradition, and institutions linked to religious networks – as in the case of providing for orphans and widows – but urgently need support to continue the slow improvement of these basic services.

47. **Puntland** has established social service policies within the government ministries, and put in place the basic elements of a health care delivery system. It has benefited from some donor support, but requires more resources, materials and help in capacity-building to sustain the initiative. Puntland has made rapid improvements in water and sanitation service coverage, but has requested extra capacity to drill and maintain boreholes, and to train personnel. Relative stability and existing government structures in the northern areas have also given humanitarian agencies and donors the opportunity to examine and develop social service policies, which may be applicable in the less accessible areas of South and Central Somalia.

48. **Somaliland** has established relevant ministries and policies for social services delivery, but lacks the resources to fund them. For example, in 2002 the operational management of the new water and sanitation systems was handed to the private sector when the new Water Act supported “the notion of a Ministry of Water that guides rather than implements, and monitors rather than manages.” Rehabilitation and development of government ministries is inhibited by lack of funds. Policies and initiatives need international support to be sustainable. In the sphere of education, Somaliland leads with 33% of primary school aged children enrolled. In addition, Somaliland has 26 government secondary schools, compared with a dismal number in South and Central Somalia; it has also established tertiary institutions, including the University of Burao. This development has been supported by the EC and DANIDA but still depends heavily on Diaspora investment and initiative. Stability has attracted a number of donor-funded projects to support education in Somaliland, but education continues to suffer from poor teaching materials, inadequate facilities, and a lack of trained teachers.

49. The objective of the *Social Services and Protection of Vulnerable Groups Report* is to significantly improve the accessibility, quality and effectiveness of vital social services and protection in all regions, focusing on key areas of concern:

50. **Protection of vulnerable groups:** protection strategies must be applied for vulnerable groups, especially children, IDPs, the elderly and the disabled, and those traumatised by conflict. Vulnerable groups constitute a disproportionate share of the population that lives below the poverty line. Investment in social development provides opportunities to tackle imbalances and inequalities. The situation of orphans and other vulnerable children (OVC) is a rapidly worsening crisis in South and Central Somalia, Puntland and Somaliland; it demands immediate action. Existing investments from government, civil society, religious groups and the private sector are only reaching a small proportion of those in need. In order to reverse their fate, the authorities need assistance in identifying vulnerable groups, so as to articulate the claims of poor and marginalised people especially women and children, and in providing assistance for them. This includes access to all services necessary for survival and development, and a human rights based multi-sectoral approach to planning and implementation, thus strengthening accountability mechanisms and local national capacities to demand the realisation of children’s, women’s and other marginalised group’s rights.

51. **Water and sanitation:** the fact that more than 70% of the Somali population was without access to improved water sources in 2000, and 75% had no toilet facilities, indicates to what extent water and sanitation issues must be a priority. Water availability affects other critical sectors, like health, education, and vulnerable groups – for example, in walking long distances to find water every day women and girls are exposed to sexual violence, ill health and are deprived of education opportunities. The high drop out rates for girls in poor countries has often been attributed to their being overburdened with domestic responsibilities such as fetching water. Access to clean water and

sanitation are linked to the enjoyment of the right to housing, life, health, food, an adequate standard of living and protection. The overall aim is to increase sustainable and equitable access to improved and affordable water and sanitation facilities, and develop services to satisfy basic domestic needs. Promoting health education in tandem will reduce water and sanitary-related diseases. **By 2015 according to the MDGs 64.5% of the population must be able to access an improved water source, and 62.5% must be able to have access to improved sanitation. (MDG Somalia 2005).**

52. Food Security and Nutrition: to ensure that all households have access to adequate and safe food at all times of the year; and to contribute towards the availability of adequate, safe and nutritious food. There will be a focus on vulnerable households. Children have a right to adequate food and parents have an obligation to provide food for their children. However parents may fail to meet their duties to provide food due to poverty or a lack of income due to crisis or instability. They may also have their rights violated by the community or the state who can not meet their correlated duties. One of the MDGs is to eradicate extreme poverty and hunger and this can only be done through complete food security for all especially for women and girls. Due to poverty it is often adult males and sons who get preference in terms of nutrition thus endangering the health and well being of women and girls.

53. Health: health authorities in South and Central Somalia, Puntland and Somaliland share a common vision. The aim, by 2011, is for national and regional health authorities to have a stronger technical, managerial and financial capacity, and with the support of partners, increase the quality and coverage of basic health care. There are four elements necessary in the effective provision of health care; availability, accessibility (including affordability), acceptability and quality. Availability relates to having health facilities and goods available in sufficient quantities, therefore health infrastructure at both rural/community level as well as in urban areas should be developed in all the different parts of Somalia. Accessibility implies non-discrimination, physical accessibility, economic and information accessibility. Policies and mechanisms should be in place which ensures equal access of low income families, the disabled, IDPs, women and girls to health facilities. Acceptability pertains to the provision of health services that are culturally and ethically acceptable to all, while quality implies good quality health services must be provided for all. To achieve this, support from the international community is vital, including investment in underserved areas and for neglected communities. Effort and resources should be put into consolidating and rationalising the existing health care delivery system, and upgrading the skills of staff. This will develop an equitable, effective and efficient package of health services that addresses priority health and nutrition problems, and reduces the high levels of mortality and morbidity in South and Central Somalia, Puntland and Somaliland. Access to MMR immunisation and anti-malarial drugs will help achieve the MDG of reducing infant mortality, while improving the availability of skilled staff during child birth will help reduce both maternal and child mortality. It is to be noted that that the right to health is linked to other rights such as the right to life, human dignity and freedom from discrimination.

54. Education and training: improve access, quality, and gender equity in primary, secondary and tertiary education, by rehabilitating schools and increasing the number of skilled and trained teachers especially female teachers, improving supplies of teaching material, developing an appropriate curriculum and improving the learning environment. Equality of access to and attainment of educational qualifications is necessary if more women are to become agents of change. The education of women is an important key to improving health, nutrition and education in the family and empowering women to participate in decision making in society. The Reconstruction and Development Plan anticipates that by 2011, the primary enrolment rate will almost double to 44%, and there will be a significant increase in the enrolment of girls at all levels. There will be an increased uptake of vocational, science and commercial subjects, and improvements in the provision of special education.

55. HIV/AIDS: HIV prevalence in South and Central Somalia, Puntland and Somaliland is low, but the infection rate is increasing, with UNAIDS estimating that 44,000 are currently infected. The general lack of awareness and collapse of the healthcare infrastructure, together with the high prevalence rate in neighbouring refugee-hosting countries make South and Central Somalia, Puntland and Somaliland highly vulnerable to an accelerated increase in HIV/AIDS prevalence in the next 5 – 10 years. Cultural practices such as early marriages and polygamy expose women to social vulnerability and further constrain women from negotiating safer sex therefore exposing them to STIs and HIV. There is a definite link between gender, poverty and HIV/AIDS which must be addressed through legal reform and policy action. HIV/AIDS has the potential to severely erode many of the developmental gains anticipated under the RDP, and there is an urgent need to develop consensus among different authorities and organisations for priorities in prevention and care, and also to address issues of HIV/AIDS facts and stigma. The regional vision is to prevent HIV transmission, improve the provision and delivery of prevention, treatment, care and support services; and strengthen the multi-sectoral institutional framework.

56. Khat: Khat chewing is a serious social and economic crisis in all Somali areas. Consumption of this mild brain stimulant destroys families, affects health, and siphons off much of the family income to sustain the habit. Money that could have gone into food, health care, education and other basic needs is channelled into khat therefore compromising the quality of care at household level. The result is that women and children suffer the most as chewing khat is a predominantly male preoccupation. Some \$250 million is spent every year on Khat imports. It is a major disruption of working hours and undermines the potential and efficiency of public and private institutions. Khat transportation and consumption also contributes significantly to insecurity. By 2011 the aim is to greatly reduce the consumption of khat by information and awareness programmes on its damaging health and economic effects. Traditional, socio-cultural alternatives, including sporting and recreational activities, will be introduced through youth-centred, culturally sensitive reduction programmes. It is also believed that an afternoon working day policy could significantly contribute to reduction in khat consumption. Over the next five years, Khat committees should be established in South and Central Somalia, Puntland and Somaliland to lobby for political and community support and to introduce khat consumption policies in public institutions.

57. FGM: It is estimated about 98 percent of young girls have undergone some form of genital mutilation in Somalia, with about 90 percent subjected to the most severe type. The custom is based on deep-rooted traditions and has an important influence on social behaviour. Girls and women 'suffer in silence' with a range of serious health problems. The overall vision is the total abandonment and eradication of FGM, primarily through education, legal capacity building and community empowerment. The paternalistic nature of the Somali social structure has to be addressed in a collaborative fashion in order to facilitate women's participation in decision making and policy formulation especially when it comes to traditional practices like FGM. It requires specific targets, including establishing a multi-sectoral community-based plan; work with religious leaders and cross-border linkages with the Somali Diaspora, refugees and returnees.

V. RECONSTRUCTION AND DEVELOPMENT PRIORITIES

Current situation and challenges

58. This section highlights some of the issues that are faced by people in South and Central Somalia, Puntland and Somaliland, and leads to the Sub-cluster inputs to the report. The overall cluster deals with traditional services such as education and training, health services and water and sanitation. Within these categories are some non-traditional cross-cutting sub-themes - anti-poverty, culture and heritage, khat, protection of vulnerable groups, food security, as well as anti-HIV/AIDS work. These require emergency, cross-sectoral and public-private participation.

General Service Delivery

59. In South and Central Somalia, Puntland and Somaliland, public sector service delivery is substantially worse for poorer people. Affordable access to private sector services is low. Evidence of this can be drawn from child mortality figures, which are substantially higher in poorer households. Children, particularly girls from poor households, are also less likely to start school and more likely to drop out. In a vicious cycle of life, children living in poverty become adults living in poverty (UNICEF 2005). Development efforts in the provision of basic social services and the realisation of human rights must go hand in hand. Using the human rights based approach promotes the concept of public sector accountability, good governance, and inclusive participatory societies.

60. The need to expand service delivery throughout South and Central Somalia, Puntland and Somaliland, including conflict affected areas, requires a broad-based service plan. Basic services need to reach the poor in rural and peri-urban areas; community infrastructure requires rehabilitating and re-equipping.

61. A major constraint to access is the poor state of the roads. An estimated 50-55% of Somalis is pastoralist and located an average distance of 90km from urban centres. Access roads to these settlements are often impassable for most of the year. Insecurity also imposes constraints and restricts delivery, particularly in South and Central Somalia.

62. In South and Central Somalia, Puntland and Somaliland, urban populations in the major towns and cities are growing at almost 3% annually, outstripping the pace of delivery of urban services. Basic services for water, sanitation, health and education are primarily dependent on Diaspora financial and technical support, or upon local NGOs and religious organizations. While charitable actions are good in themselves, they are insufficient in developing public sector capacities in service provision. Using a human rights based approach in developing public sector capacities not only encourages good governance, but also empowers rights holders thus leading to the sustainability of development results.

63. In Somaliland and Puntland, local government assumes as yet limited responsibility for the delivery and provision of services, but lacks resources and capacity. In South and Central Somalia, the current constraints on local government are reflected in the uneven distribution of services; this leaves some districts hugely neglected.

South and Central Somalia

64. South and Central Somalia has a largely non-functioning district structure. Rehabilitation and reconstruction efforts by the Diaspora and humanitarian actors have frequently failed to bring services to the poorer rural and semi-urban communities. As a result, unregulated, small-scale private providers have emerged, particularly in the areas of telecommunications, electricity and water supply. The result is the further marginalisation of already poor and vulnerable groups.

65. In conflict-affected areas of South and Central Somalia, particularly Mogadishu and its environs, services are frequently controlled and provided by warlords or local security providers. Humanitarian aid is focused on recovery-oriented interventions in limited areas, mainly Jowhar, Mogadishu, Wajid, Beletwyne and Merka. In these areas, service providers are more likely to be humanitarian agencies.

66. Efforts to access hard-to-reach communities, like nomadic groups, using mobile health units and trained nomadic health workers have been limited. The main constraint continues to be insecurity and political instability. There is also a distinctly urban focus within most political groups and organizations.

Puntland

67. Puntland, like Somaliland, allocates a very small proportion of its restricted budget to social services and disadvantaged groups and a disproportionate amount of public resources are

concentrated in a few major urban centres. This inhibits efforts at equitable distribution of available funds, and offsets the potential impact of funds on poverty alleviation strategies, child poverty and efforts at peace building and reconciliation.

68. The concentration of resources and services in the urban areas increases the rural-urban migration trend. Increased decentralization – or de-concentration – in both Puntland and Somaliland should be a priority issue.

69. Puntland has taken recovery and development initiatives in the education, health and water sectors. There is an increasing demand from the ministries for greater involvement and participation in a private-sector led services sector. New institutions are emerging with quality assurance frameworks, with an incipient government presence at most levels of intervention.

70. Access to services however, is restricted to urban centres and mostly fails to reach the huge numbers of displaced and homeless people in areas like Bossaso. Service tends to be available only to those who can afford the high delivery, connection or installation costs. For example, water was made available on the Garowe and Bossaso supply lines, but most people – particularly IDPs – could not afford the \$60-80 connection fee. Most households resort to water drawn from riverbeds or delivered by small-scale water suppliers.

Somaliland

71. Relative peace and significant reconstruction in Somaliland has opened up considerable opportunities for development and recovery in the services sector. However, Somaliland continues to suffer from the destructive legacy of the civil war, which profoundly affected human resources, infrastructure, management, service delivery and support systems.

72. Diaspora investment and commitment continues to play a major role, and has expanded into water supply, health centres, pharmacies and educational institutions. There is a growing quality assurance framework from both clients and providers, and a visibly expanding government role in policing and ensuring decentralized service delivery.

73. Local government is taking over more responsibilities in education, health and water supply, and government authorities are defining their role in sectors where private providers are inadequate.

74. At the district level, services are often dysfunctional, and are being gradually taken over by returning or investing Diaspora members. This is mostly the case in urban centres where investment returns are most encouraging.

75. In Somaliland, a large part of the budget is dedicated to defence and very little is left for the provision of services. The share of government spending on education was 2% in 2004. The government recognizes its own limitations in service provision and has encouraged the role of the private sector and the Diaspora. A new role for government and local authorities could be to formulate policies and mechanisms of efficient and effective monitoring in the already-decentralised service delivery sector. Locally-appointed service commissions could be encouraged to fulfil this role until the authorities have the capacity to take control.

76. Gender disparity There are wide differences in social services delivery, determined by a variety of factors, including gender: fewer girls access education and training opportunities in South and Central Somalia, Puntland and Somaliland. Girls drop out of primary and secondary education and get married as early as 14 and 15 years old. Enrolment rates for primary, secondary and tertiary education are all lower for girls in South and Central Somalia, Puntland and Somaliland. Similar statistical representation exists in access to other services such as health and psychosocial care.

77. Maternal mortality ratio: Statistics on maternal health are restricted in the absence of uniformly collected data. The available estimate of the MMR for South and Central Somalia, Puntland and Somaliland, combined, is one of the world's worst: 224 per 1000.

78. Service facilities and infrastructure Many of the inequalities and inadequacies in access and coverage can be addressed by a more holistic approach to basic social services. Issues of institution building, capacity building, appropriate skills training, and strategies for mobile communities, should be considered. Schools with adequate water and sanitation encourage female enrolment: educated women are statistically less likely to die in childbirth: and women with access to primary healthcare give birth to children who are more likely to be healthy.

79. Children suffer the effects of poverty in particular ways, which require special understanding and support. Poverty means they are unable to go to school, or have to drop out, that they miss out on critical health care, or may be stigmatized by their peers for the consequences of poverty, like wearing old or torn clothing. Children are likely to suffer permanent consequences from not having access to basic social services and family resources.

80. In the absence of strong central government, many figures are perforce educated estimates. That said the incidence of extreme poverty⁹ is high at 43%, with extreme inequality in per capita income between rural (54%) and urban areas (24%). General poverty¹⁰ afflicts 73% of Somalis — 61% of urban and 80% of rural dwellers. Urban labourers earn around \$2 per day. Income inequality is significant among households as well as at state level. Household surveys suggest that the poorest 10% of the population receives only 1.5 % of the total income generated in South and Central Somalia, Puntland and Somaliland, while the top 10% of the population receive 35.6% of the total income (UNDP 2003). It is generally accepted that improved access to basic services such as education, health, water and sanitation leads to poverty reduction.

81. The resilience of Somali society should be harnessed into the planning and implementation process. Community leaders, NGOs and professional groups have joined to address many of the social, political and economic issues, challenging the notion of a “helpless” stateless society. Building capacity within communities and recognising the relationship between them and higher levels of society can play a vital role in the realisation of human rights. Some duty bearers may live in the community while others live outside it, therefore it is important to create the ability to claim rights from the appropriate duty bearer. The ability to influence decisions is dependant on the claim holders capacity to communicate. Groups that can not communicate effectively, especially in formal settings such as women and children often become marginalised. Communication is a process that is vital to the realisation of rights in that it creates an interaction between claim holders and duty bearers

82. The burden of social protection in South and Central Somalia, Puntland and Somaliland rests with the extended family and the clan. Money transfers from the Diaspora range from US\$18 to US\$200 per month; they count on cohesiveness and trust within clans and sub-clans for redistribution. A recent survey also showed a wide variety of civil society organizations providing different forms of social protection. They play an important role in South and Central Somalia, filling the governance-vacuum and, in the case of Somaliland and Puntland, stepping in where government is weak because of limited resources and management capacity.

83. Sustainable service provision through private-public partnership requires accountability between all actors in the service chain. District and regional levels of government fail to exercise responsibility for public services, manage public finances or maintain proper accounting procedures. Clear local governance structures with role allocation, function distribution and responsibility definition are needed. A decentralised education service delivery system for the districts, for example, could have

⁹ Extreme poverty is percentage of total population living on \$1 per day or less, measured in purchasing power parity terms.

¹⁰ General poverty refers to percentage of total population living on \$2 per day or less, measured in purchasing power parity terms.

school teachers remaining as employees of the provincial authorities, while the district would have minimum authority over their hiring, firing, evaluation and placement.

84. Gender analysis suggests that the situation of women has deteriorated in many ways, such as education and health, but has improved in terms of participation (UN/WB Socio-Economic Survey, 2002). Somali women are becoming more active politically, economically and socially. Women however, represent the largest illiterate proportion of society, which inhibits their access to information. Maternal mortality rates remain among the highest in Sub-Saharan Africa. Human rights violations are endemic and women and minorities constitute the most vulnerable groups. Challenges in many other areas lie ahead: access to sanitation, health facilities and safe drinking water in particular.

85. Revenue collection will remain one of the major challenges for planners. Finding a balance between basic social service provision at all levels and uncertain resource availability will be hard. Even when service delivery has been fully decentralised, central government will still have an important role to play in terms of policy and standard-setting. Local government bylaws must be consistent with national policies regarding sector services implementation. General policy setting within a sector will be a central responsibility. How that service should be delivered is the responsibility of each local government; the method may vary from locality to locality.

86. *Financial support:* Improving access to basic social services and social protection requires well-targeted pro-poor spending in the public budget of Somaliland and Puntland and will be an expectation in South and Central Somalia. This is a necessary condition for improving access to social services in the short term.

87. Vulnerable groups, or 'the poorest of the poor', should be identified through the vulnerability tools approach. The emphasis should shift from reactive interventions for an unspecified few 'lucky beneficiaries' to more pro-active safety nets for all the vulnerable. Broad-spectrum multi-sector joint-interventions should target complementary macro-economic-productive services, like support to the reorganisation and revitalisation of the public financial and agricultural sectors.

88. Service priorities for South and Central Somalia, Puntland and Somaliland should be based upon needs identified at local level, for those targeted by public institution budgets, such as education and training and health services. In the initial transition period it will be critical to map existing community and NGO-based service delivery to ensure that increased engagement and emerging central and regionally managed systems do not undermine the delivery of essential services at the local level¹¹.

89. The approach to social services rehabilitation and expansion in South and Central Somalia, Puntland and Somaliland would follow the following schedule:

- **Years 1-2:** A continuation of private sector involvement in the construction and rehabilitation of health, water and education facilities with the South and Central Somali, Puntland and Somaliland authorities filling gaps left in this private sector-led service delivery approach. To achieve the vision for service delivery, there is a need to promote immediate incentives and capacity building of public-private partnerships to minimize the adverse effects of fiscal constraints, weak monitoring, implementation and management capacity of public institutions;
- **Years 3-5:** With capacity based building strategy, there will be an increase in functional and operational responsibility to the government agencies, state-owned utilities and clearer policy

¹¹ key services: Essential services normally provided by the Government structure and currently offered together with various actors in Somaliland, Puntland and South and Central Somalia include: Primary / Secondary school , Health services/ Psycho-social services , Pharmaceutical support and Dispensary , Water supply / Sanitation , Garbage collection and waste management , Market place / Local area road maintenance

and regulations on roles and opportunities in service delivery and increased provision to vulnerable groups.

90. It is expected that the policies and regulations and local governance structure will be articulated in the later stages of the implementation phase of reconstruction; and that institutional capacity building undertaken for policy-making in key ministries will lead to clearly defined ministerial and institutional roles and that there will be sufficient funding for social service delivery to be expanded noticeably at the district level.

91. By 2009 community awareness of and participation in decision-making processes and service delivery will have significantly increased and by 2010, the Government capacity at all levels should have strengthened to formulate and implement appropriate policies to support the expansion of delivery of quality services, especially to areas of lowest coverage, incorporating community inputs.

Peace initiatives, conflict prevention and visible private-public participation

92. Any lasting peace and reconciliation efforts in South and Central Somalia, Puntland and Somaliland should be linked to ongoing humanitarian interventions and efforts to alleviate poverty among the poorest sectors of society. Gaps in humanitarian funding, as experienced in late 2005 through the first quarter of 2006, led to slower reactive capacity for NGOs in the health and nutrition sector at a time when the effects of the drought were extreme, and renewed human migration from rural and pastoral lands to urban and semi-urban centres.

93. Quick-impact/broad-impact projects can stimulate wide participation and ownership, encourage social accountability from the lowest levels of the local economy and help towards gender-balancing through vulnerable groups targeting¹². Examples of replicable broad impact services interventions with immediate effect include water and environment management in rural/pastoral settings, waste management and garbage clearance and rural/community road maintenance projects that improve market access. Proposed interventions in social services in the first two years are envisaged to build on and create civil society confidence in the new Government and local governance structures, by providing immediate tangible benefits to some of the most vulnerable members of society.

94. It is anticipated that forums will be established for participatory project planning between local councils/district administrations and community based organisations; as such, training courses will be established for local institutions and NGOs to build capacity and to ensure that the rehabilitation and development initiatives continue and expand to new districts as security improves.

Constraints and way forward

95. Challenges in the expanding access to service delivery are:

- South and Central Somalia: limited areas of access because of insecurity, and the need to make the delivery system pro-poor in the absence of local governance structures, to ensure that all sections of the population are reached, including isolated and marginalised communities. The absence of political representation can be a major determinant for effective access to social services, both in terms of directing services and resources to under-privileged populations, and of being able to use a service. Displaced people often suffer significant marginalisation.¹³
- Somaliland: ensuring that the delivery of social services benefits all sections of the population where the private sector plays a large financial role.

¹² See ANNEX

¹³ Programme Policy and Procedure Manual, UNICEF (2005)

- Puntland: strengthening the role of local authorities through direct collaboration with implementing NGOs and UN agencies and with the private sector.

96. The need to introduce a comprehensive local governance structure offers the perfect opportunity to begin the process of expounding and strengthening emerging market-led roles and channels for social service delivery. In Puntland and Somaliland, public institutions have emerged to take on a quasi-monitoring and advocacy role. There is a clear division of what public institutions, currently without much funding or qualified personnel, can effectively offer in service delivery. Well-drafted and rigorous policies and mechanisms are needed that empower not only the local authorities, but the communities, beneficiaries and the service sectors themselves.

97. While many of the Diaspora-funded private sector and internationally funded NGO service interventions have proved competent in delivery, the lack of regulation and policy has seen many reported cases of non-compliance to international standards, particularly with regard to drugs and pharmaceutical products. In order to overcome some of the world's worst social indicators, there is a clear need to establish stringent policies and regulations to govern the delivery of key services, particularly in traditional service sectors such as health, nutrition, education and training, and water and sanitation, but also targeting non traditional areas such as protection and human rights.

98. The following table shows the need for interventions in South and Central Somalia, Puntland and Somaliland and the complexities therein.

Table 2: South and Central Somalia, Puntland and Somaliland and their different realities

	Characteristics	Priority Needs
South/Central	<ul style="list-style-type: none"> ❖ Complex emergency ❖ Dependence on humanitarian assistance ❖ Access and security difficulties with pockets of stability ❖ Increased IDPs ❖ Food insecurity ❖ Minimal quality frameworks 	<ul style="list-style-type: none"> ❖ Large-scale humanitarian and recovery ❖ Access expansion ❖ Quality standards ❖ Coverage
Puntland	<ul style="list-style-type: none"> ❖ Relative stability ❖ Functioning regional administration/ institutions ❖ Early stages of recovery ❖ Disruption of livelihoods ❖ Access: Sool and Sanaag¹⁴ ❖ Emerging quality assurance frameworks ❖ Incipient government presence ❖ Limited institutional capacity 	<ul style="list-style-type: none"> ❖ Reconstruction and capacity building ❖ Access expansion ❖ Quality standards ❖ Coverage
Somaliland	<ul style="list-style-type: none"> ❖ Relative political stability and social opportunity ❖ Early stages of development ❖ Functioning Parliament ❖ Functioning regional administration/ institutions ❖ Disruption of livelihoods ❖ Access: Sool and Sanaag¹⁵ ❖ Growing quality assurance framework ❖ Visible government role ❖ Lack of sustainability or institutional capacity ❖ Strong private sector participation 	<ul style="list-style-type: none"> ❖ Rehabilitation and development-based interventions ❖ Capacity building ❖ Access expansion ❖ Quality standards ❖ Coverage

Policy and service delivery standards

¹⁴ For the purpose of this report the Population of Sool and Sanaag is programmatically accounted equally between Somaliland and Puntland

¹⁵ For the purposes of this Report, the Districts of Sool and Sanaag are considered as equally divided between Somaliland and Puntland. Their population figures are thus equally distributed to both Regions for the calculation of the overall budgets. In the absence of a census or reliable demographic data in South and Central Somalia, Puntland and Somaliland, population figures raise constant controversies. Nonetheless the Polio Programme, which targeted all Somali population including scattered pastoralists and small, remote settlements, provides a useful baseline, in the absence of more accurate figures and puts figures at: Sool – 149,000 - and Sanaag – 191,000.

99. There are no laws that require line ministries to issue national service delivery standards and still no capacity to enforce such guidelines. There is also the problem of agreeing on the operational definition of service delivery standards between the public institutions and private sector providers. There is a mix-up between design specification and service delivery in terms of quality, quantity and accessibility of services by the population.

100. The governments: One lesson learnt from most post-conflict situations is that while initially it is desirable to have the private sector provide services, if the efforts of the 5 year intervention plan are to significantly lead towards meeting MDG goals, in social services delivery, the local governments have to increasingly fill the provision gap to those sectors and population groups that do not attract the private entrepreneur service industry. Not only will line ministries have to develop the design specifications but also provide guidelines on service delivery parameters. The private sector has been collaborating in service delivery in two areas: i) as contractors; and ii) as private providers.

101. Provision of services by the private sector has been limited to those sectors that attract user charges such as water, education and health services¹⁶. The donors will need to support to some extent public service delivery via the public sector (public schools and hospitals). In rural/pastoral areas there is a lack of private sector implementation and absorptive capacity. Rural local governments in most countries therefore usually have difficulty attracting and retaining qualified private providers. The trend in Somaliland and Puntland suggests that even Diaspora investments have been concentrated in urban centres (Hargeisa, Bossaso and Garowe).

102. Sector ministries should build on the experiences of, for instance, Kenya and Uganda in the education, health and water sectors and start to develop appropriate service delivery standards in their sector.

A. PROTECTION OF VULNERABLE GROUPS

Current status, challenges and opportunities

103. Assisted by a highly complex extended family structure, Somali communities have traditionally responded to catastrophe with tremendous resilience. Remittances are often channelled to a single source in the extended family that then has the responsibility of ensuring that those in need are assisted. In addition, a mechanism called the *hadith* raises money for the handicapped, less fortunate or ill. It is argued however, that these and other coping systems have reached their capacity due to recurrent drought, famine and most recently the tsunami.

104. These traditional coping strategies are increasingly overburdened. The Diaspora, community organizations, religious bodies and other civil society members have stepped in to provide financial and human resources, information, vocational skills training, basic education, medical care and counselling.

105. Children are affected economically, socially and psychologically. Economic and social impacts include malnutrition, reduced access to education and health care, child labour, migration and homelessness. Psychological impacts include depression, guilt and fear, possibly leading to long-term problems. The various impacts of AIDS in children combine to increase their vulnerability to a range

¹⁶ "Provision activities involve decisions generally associated with "governing." These include decisions regarding (a) what services to provide and to whom, (b) the quantity and quality of services to be provided, (c) how to finance those services, (d) how to ensure that the services are produced. Production, on the other hand, is the process of converting inputs into outputs.

(L. Schroeder et al, 2001).

of consequences including HIV infection, illiteracy, poverty, child labour, exploitation and unemployment.

Characterizing Child Vulnerability in South and Central Somalia, Puntland and Somaliland / Conceptualizing vulnerability

106. Vulnerability is essentially the ability of an individual or household to manage risks or to prevent a severe decline in their living standards. Given the volatile socio-political circumstances that render families destitute it is important to determine the factors that cause vulnerability.

107. UNAIDS and the US Census Bureau estimated the number of orphans at 870,000 (0-17 years), roughly 11% of all children in South and Central Somalia, Puntland and Somaliland (2003)¹⁷. Maternal orphans were estimated at 310,000, paternal orphans at 460,000 and double orphans at 90,000. This number is estimated to grow to 850,000 by 2010. Whilst these numbers were not as high as those in neighbouring countries (Ethiopia: 3,900,000; Kenya: 1,700,000 and Uganda: 2,000,000¹⁸), the socio-economic and political environment described above could easily result in a sharp increase in the number of orphans. It is thus extremely important to aggressively and effectively meet the rights of these children whilst making efforts to prevent orphanhood.

Table 3: Estimates of orphans by year and type for South and Central Somalia, Puntland and Somaliland

Estimates of Orphans by Year and Type for South and Central Somalia, Puntland and Somaliland						
	2005	2006	2007	2008	2009	2010
Maternal Orphans						
AIDS	15,156	16,835	18,356	19,699	20,859	21,847
Non-AIDS	290,151	290,865	291,678	292,713	294,028	295,605
Total	305,306	307,699	310,034	312,412	314,887	317,452
Paternal Orphans						
AIDS	14,361	15,894	17,328	18,646	19,844	20,919
Non-AIDS	424,516	426,136	428,300	431,085	434,525	438,611
Total	438,877	442,030	445,627	449,731	454,368	459,531
Dual Orphans						
AIDS	8,183	8,998	9,565	9,927	10,147	10,311
Non-AIDS	102,675	99,917	96,975	93,818	90,564	87,317
Total	110,858	108,915	106,539	103,745	100,710	97,628
Total Orphans	633,325	640,815	649,122	658,398	668,545	679,355
All AIDS orphans	23,570	26,132	28,656	31,064	33,287	35,251

Source of Data: UNAIDS 2006 (Spectrum projections)

108. Programmatic considerations:

- All orphans are vulnerable by virtue of their orphan status since all children suffer in some measure from the loss of a parent, at least psychologically. However, from a socio-economic point of view, not all orphaned children are vulnerable, especially if their extended family can absorb them and keep them in school or provide services for them, without their absorption into the new household causing an inadvertent negative effect on the child or absorbing family.
- Within the Somali context, an orphan is defined as a child (up to 15 years of age) who has lost a father only (*agoon*).

¹⁷ Children on the Brink 2004. UNICEF, UNAIDS and USAID.

¹⁸ Children on the Brink 2004. UNICEF, UNAIDS and USAID.

- With the majority of orphans being paternal orphans, the surviving mothers of orphans are therefore a key population whose health and wellbeing will be paramount to the survival of the orphaned child.
- The care and support of orphans is strongly engrained in Islamic religion. It is a duty for orphans to be cared for and not exploited¹⁹ by their caregivers in Islamic *hadith*.

Definition of Vulnerable Children

109. A vulnerable child is defined as one who, based on a set of criteria when compared to other children, bears a substantive risk of suffering significant physical, emotional or mental harm. Vulnerability, defined broadly, encompasses almost all children in South and Central Somalia, Puntland and Somaliland. Vulnerable children defined more specifically by the workshop participants include maternal orphans, child labourers, street children, child refugees, child returnees, children living with HIV/AIDS, children in institutional care, children in conflict with the law, nomadic children and child IDPs.

Situation of Orphans and Vulnerable Children

110. In order to ensure the local relevance and appropriateness of support for children, it is crucial that policies facilitate local driven and guided responses that are able to encompass local social knowledge, understanding, and experience of child vulnerability.

111. Somali communities have traditionally responded well to the duty of looking after OVC and absorbed them principally within the extended family system. However, there is evidence that these households' capacity and other related socio-cultural systems to provide and care for orphan children is over extended with dire consequences for the children and the families within which they reside. Increasingly, caregivers in such households are overburdened and lack the socio-economic capacities to provide adequate care and support for orphaned children. Community organizations, religious bodies and other civil society members have stepped in, providing information, vocational skills training, basic education, medical care and counselling. However, these groups often lack the human and financial resources to fully respond to the scope of the problem.

112. Responding to local experiences, needs, and understandings is fundamental to solid community level interventions. Following a needs-based approach ensures that children with special needs, such as those living with HIV/AIDS, are protected. The community is the best place to start making changes as these are the most effective systems of governance in place across all three parts of Somalia.

113. The situation of orphans and other vulnerable children is a rapidly worsening crisis that demands immediate action in South and Central Somalia, Puntland and Somaliland. These children's lives and the households they reside in are characterized by increasing exclusion, vulnerability, and destitution. Participation by marginalised children and their families and accountability to them must be treated as integral if their situation is to improve.

114. *Orphans and Vulnerable Children (OVC):* An OVC Rapid Assessment Analysis and Action Planning Process (RAAAP) was conducted in January – April 2006. A regional steering committee is now studying the RAAAP in order to determine the magnitude and nature of the OVC problem in South and Central Somalia, Puntland and Somaliland. They are analyzing and summarizing existing data, to establish baseline data for planning and monitoring scale up, assessing critical gaps and constraints to scale up, identifying actions and resources required to address these gaps within the next 12-24 months.

¹⁹ Dispossession strongly prohibited by Islamic religion.

115. Other needed activities include: mobilize leaders, partners, and resources around these actions and develop a framework that unites key stakeholders across Ministries in Government, NGOs, donors to improve the response to OVC; develop an approach for formulation of informed policy development and modification of programme interventions; and consolidate action plans developed through a consultative process – seen as key in resource mobilization.

116. The community is best placed to identify the most vulnerable children amongst them. Vulnerable people are not only IDPs and returnees; there is a large number of invisible communities in the rural and urban centres that are supported by relatives and neighbours. The invisibility of already marginalised groups further limits their claim to services such as health care, water and sanitation, food nutrition and education. This is where it is important to conceptualise vulnerability for programmatic targeting so that the most marginalised are empowered to make claims for their survival.

117. The categories on the next page have been agreed upon to assist with state level planning with the authorities in South and Central Somalia, Puntland and Somaliland.

Table 4: Orphans and vulnerable children

Orphans and Vulnerable Children
<ol style="list-style-type: none"> 1. Orphan (<i>agoon</i>)²⁰ 2. Maternal orphans (<i>rajay</i>)²¹ 3. Child labourers 4. Street children (focus on glue sniffers and khat chewers; distinction between those living and working on the street) 5. Child refugees 6. Child returnees 7. Children living with HIV/AIDS 8. Children in institutional care 9. Children in conflict with the law 10. Nomadic children 11. Children that are IDPs 12. Children with disabilities

118. Adapting the concept of vulnerability to the Somali context is contingent on noting that:

- Defining vulnerability is difficult since the concept is so dynamic (for example, the numbers of IDPs goes up and down due to on-going displacement factors such as the drought);
- There are many causes of vulnerability – both discrete and overlapping.
- A vulnerable child is defined as one who, based on a state of ‘agreed’ criteria when compared to other children, bears a substantive risk of suffering significant physical, emotional or mental harm.

The assumption that orphans are more vulnerable than other children is incorrect since the situation for children varies depending on, among other things, the local economic and political context.

119. **Protection Issues and HIV/AIDS:** Presently, there is no policy, nor regulations and enforcement mechanisms to ensure the protection, non-stigmatization and non-discrimination of PLWHA, their relatives and communities. Strict respect for confidentiality and informed consent does not seem assimilated as a professional routine yet. The need to protect individuals against HIV/AIDS stigmatization and exclusion should be embedded in all actions. Women and girls are

²⁰ Within the Somali context, an orphan is considered as a paternal orphan less than 15 years or age.

²¹ In Somaliland, a maternal orphan was considered to be more vulnerable than a paternal orphan.

especially in need of protection as often they do not have control over what happens to their bodies as is the case with forced early marriages and the culture of polygamy. In these cases women are not able to compromise safe sex practices therefore exposing them to STIs and HIV and putting their health and well being at risk. A monitoring and enforcement mechanism to ensure respect for human rights in relation to HIV and AIDS, according to a national policy is required. Training is an essential component to changing attitudes towards HIV/AIDS and thus ensures that monitoring and enforcement is done effectively.

120. **Giving voices to women:** Customary law is embedded in all Somali communities; local clan leaders (almost entirely men) have absolute authority over decision-making and clan resources, including those related to women's rights. This limits the capacity of women to participate in local-level decision-making and restricts their access to services and opportunities without the accompaniment or participation of a male relative.

121. Special gender challenges across sub-clusters include:

- Promoting community participation (particularly women's groups) and involvement in education, health, water supply, sanitation services and law enforcement.
- Increasing the representation and participation of women at all decision-making levels in conflict resolution, public sector formation and post-conflict reconstruction
- Livestock, land and water issues have played a recurrent conflict-creating role in Somali society and special attention must be paid to them in the post-peace period. The current clan tradition-based customs - including community ownership of land and property – have been undermined. Since there are no clear land ownership policies and regulations, some land has been bought out of community ownership by individuals; this has limited the ability of the community to respond to the demand for land from its members.
- Promoting initiatives to counter the voiceless status of women in clan structure and at household levels. Female groupings that are particularly vulnerable include female heads of households, women and girl children involved in armed conflict support roles for the militias, or as ex-militia, and disabled women.

122. **Children/youths DDR programme:** There is no conclusive study on the number of children associated with armed militia in South and Central Somalia, Puntland and Somaliland. Child specific demobilization and reintegration programmes advocate against the joint containment of children and adults during demobilization or reintegration phases. Two inherent limitations to joint adult/child DDR programmes are: Children's potential access to DDR services is limited by their inability to understand the process and secondly the implementation tends to focus on issues of the larger group (adults).

123. Children do not always identify themselves as having been involved in armed conflict and are not always identified by armed groups as requiring a process of demobilization and reintegration. They often miss out on services that are afforded them under general DDR programs. To avoid stigmatisation and discrimination, children often do not admit to coming from an armed group. The challenge is thus to implement actions allowing girls and boys to benefit from DDR programmes but avoiding any detrimental effects for them. At the same time the public must be educated in minimising any discrimination levelled at these children in order to make it easier for them to seek help. Most importantly, without child specific DDR, children are put at risk and exposed to further pressures, abuses and mistreatment, thus hampering their future development and creating the potential for future conflict.

124. A number of activities need to be put in place, including:

- Advocacy and awareness raising (including training on human rights issues) among children, communities, the state authorities, militias and the actors involved in demobilization about the special needs of children in armed conflict;

- Identification procedures and culturally sensitive mechanisms for boys and girls associated with armed groups;
- Interventions corresponding to the particular needs of vulnerable populations, including children/youths, which offer suitable livelihood alternatives, comparable to those offered to adults in the DDR programme.

125. The following table illustrate the status of international instruments related to social services and governance that will need to be signed and ratified. These instruments will help inform the standards by which the development process must take place.

International Standards	Summary of Associated Rights	Somalia	South & Central Somalia	Puntland	Somaliland
Universal Declaration of Human Rights	Life, liberty and security; public services; adequate standard of living; education				
Charter of the United Nations	Adequate standard of living; economic & social progress; development; employment; health; discrimination against colour, sex, race, language or religion; education				
African Charter on Human and Peoples' Rights	discrimination against colour, sex, race, language or religion; education; equality before the law; freedom from torture or other cruel, degrading or inhuman treatment; liberty & security of the person; employment; equitable working conditions; life; healthcare; development;				
International Covenant on Economic, Social and Cultural Rights	Equality between women & men; work & working conditions; social security; food; housing & living conditions; physical & mental health; primary education; cultural life; freedom from torture or other cruel, degrading or inhuman treatment; development of the child	X	-	-	-
International Covenant on Civil and Political Rights	Discrimination against colour, sex, language, disability; liberty & security of person; water; housing; education; life; healthcare; equality before the law; freedom of thought, conscience & religion;	X	-	-	-
Convention on the Rights of the Child	Discrimination against colour, sex, language, disability; care & protection for well being; life, development & survival; freedom of expression, views, thought, conscience & religion; protection of the law; physical & mental health; education; freedom from violence; pre-natal & post-natal care of mothers; adequate standard of living; nutrition; rest & leisure; economic & sexual exploitation; freedom from torture or other cruel, degrading or inhuman treatment	-	-	-	-
Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict	Freedom from recruitment in armed conflict. Age stipulation 18 years.	-	-	-	-
Convention on the Elimination of All Forms of Discrimination Against Women	Discrimination on the basis of sex; education; work; health & well being; protection during pregnancy; social security; equality before the law; reproductive & sexual rights;	-	-	-	-

South and Central Somalia

126. There is currently no local capacity for monitoring human rights abuses and still no community-based monitoring mechanisms. Issues of cultural context, which include FGM and equal rights for girl children to attend school, need to be incorporated. Human rights and protection should be an integral part of the future South and Central Somalia Constitution.

127. Vulnerable groups often lack the human and financial resources to respond to social or economic problems, without assistance. The absence of a local governance structure therefore, greatly affects how disadvantaged and vulnerable populations access services or even negotiate for services.

128. South and Central Somalia (Gedo, Middle and Lower Juba and areas of Bay and Bakool) is facing a severe drought. The resulting food shortage takes place against a backdrop of extreme poverty, weakened health status and systems and weak emerging governance. These factors are reinforcing each other to create a humanitarian crisis rivalling any in the last ten years. An estimated 1.7 million people, (estimated to rise to 1.8 million) including 800,000 highly vulnerable children in South and Central Somalia are facing an acute food and livelihood crisis and humanitarian emergency.

Puntland

129. Special attention should be paid in Puntland to women's rights, which is complicated by a variety of customary, religious and civil laws constraining land ownership and inheritance. The three overlapping laws requires a review of current interpretations and legislation on women's rights to determine their status, rights to shelter, land, and property in marriage, divorce and inheritance.

130. Systemic strategies and mechanisms for increasing women's access to services in general demand performance impact indicators and legislation that any new public institution should show a minimum of 12%²² representation for women.

131. Other key issues for advocacy and dialogue include empowering, extending and recognizing the full rights of women, the endorsement of the MDGs and a number of international treaties and conventions including the Convention on the Rights of the Child (CRC), by South and Central Somalia, Puntland and Somaliland. Other key international conventions and declarations require ratification (including those dealing with political and civil rights, elimination of racial discrimination, and standards and rights at work) and global and regional treaties and conventions dealing with trade, pollution, and sustainable management of ocean resources.

132. Intermittent conflict in all South and Central Somalia, Puntland and Somaliland deprives children of basic needs - education, shelter, proper nutrition and healthcare. Uncertain jurisdiction issues over Sool and Sanaag affect access by humanitarian and development actors to children in the districts. These children need special attention, which traditional emergency response and anti-poverty programmes may not recognize. Investing in women's education is also central to reducing poverty among children and promotes economic development as women are the primary care-givers in the traditional Somali family unit.

Somaliland

133. Somaliland has a strong service-providing private sector. Except where donor funds are used to pay for start-up of services, these services must be paid for by communities and individuals. Thus the poorest and most vulnerable people are often unable to pay and have no access to basic services.

²² The TFG Charter commits to implement 12% female representation in all its representative structures.

134. In many countries where user fees are removed and exemption or waiver systems are in place, public services have become more accessible to the poor. User fees limit access. Vulnerable groups such as IDPs, orphans, HIV affected households and returnees are often unable to afford them. In some regions IDPs and refugees were paying more per litre of water than consumers accessing water from the main supply.

135. The legal and penal systems are heavily influenced by traditional and *sharia* law. Continued violations of individual rights including early girl marriages thus often go unpunished. In South and Central Somalia, Puntland and Somaliland, discourse on human rights is invariably strained and textured by references to foreign influence versus Somali culture.

Vision and Priority initiatives

136. The transition vision for protection focuses on: Strengthening the capabilities of the authorities to better identify vulnerable groups, providing assistance for them and ensuring the monitoring of social conditions.

137. Children must be provided with appropriate basic services such as food security, shelter, health-care, education, water and sanitation, and with a voice in the community (UNDP, 2004). In South and Central Somalia, Puntland and Somaliland, children require the basic resources and services to develop mentally, physically and emotionally. They need all the above services and a supportive family environment to fully develop into healthy productive adults. However, “children living in poverty face deprivations of many of their rights: survival, health and nutrition, education, participation, and protection from harm, exploitation and discrimination” (UNICEF, 2005). Increasing all children’s access to basic social services must have the human rights principles of universality, indivisibility and interdependence of rights, participation and accountability as a basis.

138. These basic services will enhance children’s wellbeing and give them the basic tools to escape child poverty and break the generational poverty cycle. Children are the most vulnerable group in any post-conflict and emergency situation.

139. A protective environment for all children needs to be created in which basic social services are improved, rights are respected, and child protection is promoted at local level. This not only implies improving basic services for all children but also making sure that their “duty bearers” can ensure their protection. Establishing and supporting families and/or community-based networks for the care and protection of children involves targeting the support structure for the child.

140. *Child specific DDR*: Priority should be given to the demobilization and reintegration of boys and girls associated with the military. Child specific demobilization procedures need to be conceived and implemented throughout, that ensure that children are separated from adult militia.

Implementation and monitoring arrangements

141. *The community approach to child protection*: Since children will be integrated in their clan/family communities, reintegration should encourage a community-based approach, with the community actively participating in the reintegration process.

142. Protection of IDPs, as well as minority groups, remains a major gap in South and Central Somalia, Puntland and Somaliland. Returning refugees and Internally Displaced People will have their protection needs catered for under the Livelihoods and Solutions for the Displaced Cluster. Services to improve IDPs’ food security and livelihood opportunities are thus closely linked between the two clusters.

143. In Somali society, protection is the responsibility of the clan and this generally works well, however IDPs and other minority groups, being outside their clan areas, have no such protection,

exposing them to exploitation (both sexual and economic). They are denied access to services, forced to relocate, pushed into forced labour and their movements are restricted. Women and children within these already marginalised groups are the most at risk in this case. It is proposed to establish three Protection Technical Working Groups that will monitor the implementation of the protection of vulnerable groups' interventions. The role of human rights must be understood as a way of empowering of individuals and communities. By protecting these rights, the prevention of many conflicts based on poverty, discrimination and exclusion (social, economic and political) that continue to plague humanity and destroy decades of development efforts can be helped. The vicious circle of human rights violations that lead to conflicts-which in turn lead to more violations-must be broken. It can be broken only by ensuring respect for all human rights.²³

144. Generally the Ministry of Education, the Ministry of Social Affairs, the Ministry of Women and Family Planning, the Ministry of Labour and Ministry of Finance (or equivalents), need to be as much as possible involved in the development, implementation, and monitoring of the associated demobilization and reintegration programmes for children involved with armed forces or groups.

B. OVC RAPID ASSESSMENT, ANALYSIS AND ACTION PLANNING (RAAAP)

145. An RAAAP process into the situation and needs of OVC in South and Central Somalia, Puntland and Somaliland was undertaken in the first four months of 2006. Workshops were held in Somaliland and Puntland for both adults and children but it was impossible to have a similar process in South and Central Somalia. This was a major constraint but the RAAAP consultant gathered information from many different sources through interviews and an extensive literature review.

Current situation

146. Children – particularly vulnerable children and orphans - are disproportionately affected by the prevailing harsh conditions in South and Central Somalia, Puntland and Somaliland. Psychologically, economically and socially they suffer great hardship as a result of being at the bottom of what is already a highly disadvantaged society. Reducing marginalisation lowers the risk of social unrest and increases the chances of social stability and peace.

147. Somali communities traditionally absorb the disadvantaged in society, looking after OVCs, widows, the elderly and the sick. They continue to do so but it is ever more apparent that this community welfare safety net is under increasing strain and it is OVCs that suffer in particular. Ever more children are falling through the gaps in the mesh. In addition there are certain child protection matters deemed essential by child-centred agencies and NGOs that do not exist or are often deemed a luxury in the Somali context.

148. At the two workshops in Puntland and Somaliland before any discussion could take place, an explanation of what psychosocial support is had to be given before the workshop could discuss the matter at all. This highlighted the fact that even before children can be given the most basic psychosocial support, many Somalis need to be sensitised about its advantages.

149. After 15 years of civil war, seasoned with crushing poverty, displacement and recurrent natural disasters, the need for OVC psychosocial support is apparent to most observers. There are however, few programmes in South and Central Somalia, Puntland and Somaliland that address the psychosocial needs of OVCs. In a UNDP survey on psychosocial support (2003), 66% of the 177 women interviewed in Somaliland had been exposed to an 'extreme traumatic event'. In the UNICEF Study on Child Protection (2003) a higher exposure of traumatic events was reported in Central South than in either Somaliland or Puntland.

²³ Mary Robinson, former United Nations High Commissioner for Human Rights

150. The right to primary education is strongly engrained in the Constitutions of South and Central Somalia, Puntland and Somaliland. Somaliland and Puntland have taken matters a step further in the development of education policies that recognise and advocate for the right to education for OVC. Both policies commit to ensuring the disadvantaged, vulnerable and under-represented groups – within the limited resources available - will be supported to access education. Emphasis is placed on primary education. Unfortunately, both policies are still in draft and are not legal documents; budgetary contributions from Government are insignificant.

South and Central Somalia

151. The consultant was unable to hold a workshop in South and Central Somalia between 27 February and 2 March 2006 as planned, because Parliament was convened in Baidoa. Eleven of the 18 regions of pre-1991 Somalia and roughly 60-70% of the population live in South and Central Somalia so this was highly unsatisfactory. Taking this into account, the OVC RAAAP Consultant carried out an information gathering process which included meeting with Governor Mohamed Dhere, UNICEF programme staff (Education, Health, Nutrition, Child Protection and Water and Sanitation), the Acting Permanent Secretary for Health, UNOCHA staff, WFP staff, a local primary school – Sheikh Hassan Barsame School - and local hospital – InterSOS Hospital - (MCH, TB site, VCT centre) and International and local NGOs (e.g. Red Cross and Red Crescent Societies and WOCA). In addition the consultant made an extensive review of the available literature.

152. This analysis gap - more often caused by a lack of humanitarian access due to insecurity – must be addressed. IDPs for example are a particularly vulnerable group yet there are no reliable figures for the number of IDPs in South and Central Somalia.

153. South and Central Somalia – as the Republic of Somalia – is signed up to many international conventions on the rights of the vulnerable and the Interim Government signed the Convention on the Rights of the Child in May 2002. Interventions to protect OVCs should be based on human rights but they should be reinforced by linking them conventions already signed.

Puntland

154. An RAAAP workshop was convened in Garowe and was attended by 50 adults and 30 children (of which 12 were girls). The children's ages ranged from 15 – 18 years of age. Adult participants were from the Ministries of Family Affairs and Women's Development, Education, Health, Religions and Endowment, Interior and Planning; UNICEF, UNHCR, UNOCHA; local and international NGO's (Somali Welfare Community – Lasanod and Garowe, KAALO relief and development, Puntland Minority Women Development); Water NGOs (Ocean Training and Promotion), Community Education Committees (Gardo), the Police, IDP representatives, Child Protection Network representatives (Mudug and Nugal), representatives from the Legal Aid Clinic and the Vice Commander for Custodial Corps. Child participants were from youth networks, youth forums, IDP groups, minority groups, student committees and student associations.

155. OVC are on the agenda in Puntland but fall prey to a lack of funding. The Ministry of Interior, Department for the Poor, Orphans, and Vulnerable Groups, has allocated 100 million shillings a month of the central budget - 50 million for orphans and 50 million for 'poor' households. There are no formal targeting strategies for these funds other than that they should be focused on the elderly without extended families, widows, widowers, disabled persons and beggars. The Ministry also has the mandate to support the target groups with vocational training and income generation activities but it lacks funding and capacity. The Ministry is not present at regional or district level where the majority of vulnerable populations live. The Department for the Poor, Orphans and Vulnerable Groups has only six members of staff of which five are in Garowe and one is in Bossaso. The Ministry of Finance, which does have a presence at regional level, carries out the cash distribution at these levels. Each family (which tends to have 7–9 children in the household) receives US\$50 per month.

The members of staff in the Ministry of Interior said that beyond human and financial resources they lack the basic materials to carry out their work - such as desks, tables and computers.

156. The Ministry of Women Development and Family Affairs has the mandate to realise the rights of women and children in Puntland. This Ministry has the following departments: Child protection, Psycho-social support, Administration and Finance, Gender and Documentation. However they have only one office. It is in Garowe with 23 staff of which six are male. This Ministry – based on mandate – should be responsible for the coordination of the implementation of the Puntland OVC Plan. Significant capacity building will be required but the political will is apparent.

157. There is an estimated IDP population of 270,000 in Puntland of which 40,500 are children²⁴.

Somaliland

158. The Hargeisa RAAAP workshop had 33 adult and 30 children (of which eight were girls). The children's ages ranged from 11 – 18 years of age. The adults were from the Ministries of Agriculture, Health, Justice, Planning, Water, Youth and Sports, Family; Local and International NGOs (Havoyoco, Kaalmo, CRF, Barko Family Health and Education and World Vision); UNICEF, UNDP; religious leaders, and representatives from the Legal Clinic. Child participants were from minority groups, children with disabilities, children that are IDPs, orphans and street children.

159. In Somaliland, the Ministry of Family Welfare and Social Development was created in October 2002²⁵. They have a document (strategy/plan) in place whose objective is to address issues related to women, children and vulnerable groups (include minorities, disabled persons, IDPs and returnees). However, they have only 20 staff members and only two operating offices (Hargeisa and Sanaag). Of the 20 staff members, only two are social workers. The Minister says that she has the lowest budget compared to the other Ministries.

160. Somaliland has committed to abide by the principles of the Convention on the Rights of the Child. It has an estimated IDP population of 200,000 of which 60,000 are children.²⁶

Priority areas

161. It is proposed that for the day-to-day activities of the implementation of the OVC Action Plans, an implementation unit be set up. This can either be an autonomous body or preferably be established under the Ministry that is mandated to respond to OVC. A key guiding principle of the RAAAP is not to create 'new' bodies, if there is one that already covers these types of activities.

162. Three priority intervention areas have been highlighted throughout the RAAAP process. In addressing these priority areas, OVC stakeholders will be able to show results over the five-year period, and intervene in a sustainable and mutually reinforcing manner.

- *Improving the Socio-Economic security of households in which orphans and vulnerable children reside* - This will allow households that support orphans and vulnerable children to provide adequate nutritionally balanced food at appropriate intervals and provide basic needs and access to services for members of the household;

²⁴ UNDP, RRIDP 2006

²⁵ Other Ministries set up in 1991.

²⁶ UNDP, RRIDP 2006

- *Investing in the improved education of orphans and other vulnerable children* - ensuring that children go to and stay in school will provide psychosocial interventions through peer groups and protection of other rights, such as immunisation and birth registration (that could be done through school).

Ensuring the health and well-being not only of orphans and vulnerable children, but also of their primary caregivers - Focusing on health, particularly nutritional status, requires that food security and the nutritional status of the household is maintained and that the health of the adult caregiver is taken into consideration at the same time as the health of the children.

163. The RAAAP has put OVCs at the forefront of the Protection of Vulnerable Groups sub-cluster. Further research into the unique situations of South and Central Somalia, Puntland and Somaliland is required to bring well-directed assistance to OVCs but the RAAAP has made important strides towards serving the children of the region. Over the next five years their protection will be the main priority of the Protection of Vulnerable Groups cluster.

Implementation and monitoring arrangements

164. The Ministry of Planning, Department of Statistics in Puntland was willing to monitor the situation of OVCs and to include these indicators in Puntland Facts and Figures. The Ministry of Planning in Somaliland should also be approached to include OVC indicators in Somaliland Facts and Figures and the transitional government in South and Central Somalia should be assisted to collect such figures.

C. WATER AND SANITATION

Current status, challenges and opportunities

165. The majority of Somalis live in rural areas; they are pastoralists and semi-sedentary agro-pastoralists with some permanent village dwellers. Water needs are met by rivers (seasonal and two permanent), springs, rainwater harvesting facilities²⁷, shallow wells and deep boreholes. The network of pastoral water supply structures is highly inadequate and the water points sharing for domestic and livestock use remains the major cause of conflicts between pastoralists and farmers. Having a secure water supply for all people has the potential to prevent future conflict prevention, which is a part of good development process. Water shortages are usually experienced during the long dry season (Jilaal) when the population can only rely on the two permanent rivers (the Juba and Shabelle) and ground water supplies (permanent springs, boreholes, permanent wells). Drought and internal displacement severely constrain access to water, with supply needs often met through costly water trucking to water storage facilities in permanent settlements or directly to grazing areas.

166. Nearly four out of every five Somalis in 2000 had no access to improved water sources or to sanitary means of excreta disposal. In rural areas, women, especially girls, spend two to three hours every day hauling a 20-litre container over two or more kilometres, often from a source that yields poor quality water. This not only compromises the health of the family but it also has knock on effects on the safety of women and girls exposing them to physical attacks and rape. Women and girls often share the unequal burden of domestic duties and having to travel long distances to look for water has a negative consequence on the education of girls. Buying water from a small commercial vendor costs up to ten times more than water piped directly into a home by an urban water utility. Even where a connection provides good access to decent quality water, households spend 10% of their annual budget on drinking water alone.

167. Due to such barriers to access, there is competition for water that has developed into conflicts from clan to household level. An inadequate network of pastoral water structures that supply both domestic and livestock water remains the major cause of conflict between pastoralists and farmers.

²⁷ Surface reservoirs or balleys and cement lined tanks or berkedes.

Recurring droughts, a common natural feature of semi-arid countries, combine with internal displacement and a deteriorated network of water points to compound access, forcing supply needs to be met through emergency operations, such as water trucking that cost nearly US\$3 million in 2006.

168. The basic water needs of over three million Somalis are met from water sources that are unprotected and often contaminated with micro-organisms. Rural water supply sources are practically uncontrolled, and most urban reticulated waste disposal systems have been destroyed. There are simply not the facilities for sanitary means of excreta disposal, and while 15% of the rural population have access to a pit latrine that has been improved by the installation of a slab, all others rely on household trenches or open spaces. Public health is of grave concern in this case, particularly in the market place where women are the majority. Therefore combined with the lack of clean water open sewers, poor toilets and in some cases open air toilets seriously affects the health of women and children which in turn affects the whole family.

Table 5: Access to Water

	Year 2000 (UNICEF, MICS)		
	Somaliland	Puntland	South/Central
Access to "safe" drinking water	31%	26%	18%

169. Combining lack of access to water and hygiene behaviours, with poor sanitation, impacts directly upon infant and child mortality and morbidity as well as maternal health. These and related dehydration, respiratory infections and malaria are identified as the lead cause of under five morbidity, and account for more than one half of infant deaths in Somalia. Areas of particular health risk are those with large population concentrations and without regular checks on standards. This has been the case particularly in the few areas in South & Central Somalia controlled by warlords and militia, with little or no access by NGOs and the international assistance system. Continued lack of access to clean, safe drinking water will hamper the achievement of the MDGs related to reducing infant and child mortality and improving maternal health.

170. The public water supply system is weak or very poorly maintained in most of South & Central Somalia, Puntland and Somaliland. The capacity of the state service providers has been weakened by feeble financial flows that have barely covered recurrent costs of the mandated line Ministries. For over a decade, former staff members of the pre-war Water Development Agencies have maintained a skeleton of the formerly state-managed water infrastructure. Access to safe water for vulnerable groups is below survival needs in all three areas of South & Central Somalia, Puntland and Somaliland and therefore life threatening. There is a duty therefore on state authorities to put into place policies and strategies to ensure that all have access to a sufficient and continuous supply of clean water for personal and domestic use as a human right.

171. In urban areas, a strong, but largely unregulated, local private sector has emerged as the principal service provider. Backed by external finance and ten-year concession agreements, ten urban water supply systems have been rehabilitated, providing direct household connections and metered water, but mostly supplying water kiosks that have significantly reduced the burden of water haulage, and importantly increase the volumes of water consumed by households for domestic needs (typically 27 litres per day).

172. The reviving public service agencies in Somaliland and Puntland have been able to rehabilitate parts of the debilitated water supply network. Supported by the international assistance system, very many local interventions have been pursued where the local security situation has permitted action to be taken. During the period 1994 to 2005, the European Commission, the dominant external financier, supported the improvement of water supply for nearly three quarters of a million rural inhabitants, at a rate of over 60,000 per year.

173. Achieving the Millennium Development Goal of halving the proportion of people without access to safe drinking water by 2015, however, would require service provision for nearly five million Somalis. The MDG gap in water supply amongst the rural and nomadic population is twice that in urban areas, and a delivery rate of 200,000 people per year would be required in rural Somalia alone, three times the recent trend. With just 150,000 beneficiaries of investments into sanitation improvements between 1994 and 2005, a sea change is required in approaches to sanitation and hygiene.

Table 6: Indicative coverage of access to safe drinking water in 2000

	Indicative coverage of access to safe drinking water in 2000				
	Population	% Served	Numbers served	% Un-served ²¹	Numbers Un-served
National	6,408,000	26.6	1,706,000	73.4	4,702,000
Urban	2,258,000	56.2	1,269,000	43.8	989,000
Rural/nomadic	4,151,000	10.5	437,000	89.5	3,714,000
South & Central	4,108,000	27.3	1,121,000	72.7	2,987,000
Urban	1,339,000	66.1	885,000	33.9	454,000
Rural/nomadic	2,769,000	8.6	236,813	91.4	2,532,000
Somaliland	1,564,000	25.1	393,000	74.9	1,171,000
Urban	657,000	39.8	262,000	60.2	395,000
Rural/nomadic	907,000	14.4	131,000	85.6	776,000
Puntland	737,000	26.0	192,000	74.0	545,000
Urban	262,000	46.8	123,000	53.2	139,000
Rural/nomadic	475,000	14.5	69,000	85.5	406,000

174. Goals in water, sanitation and hygiene stand with high social, economic and environmental justifications in their own right. Yet, improving the access to improved water, sanitation and hygiene will make major contributions to other development objectives. The right to water is linked to the right to life, family protection and economic and social development such as an adequate standard of living, food, housing, health and human dignity. Therefore without access to clean water human development would be unrealisable. Among many other benefits, the reduction of the burden of disease on families and public health services could be significantly reduced at source, girls could be freed from the drudgery of hauling water to attend school and also be safe from sexual gender based violence, household time could be freed for investment into productive activities, and reduced expenditure on buying expensive water would enhance purchasing power for other social and commercial services.

175. Statistics for Somalia, based on the 2000 End Decade Multiple Indicator Cluster Survey (UNICEF, 2000) inform that 23.1% of the total population across the South and Central Somalia, Puntland and Somaliland had access to safe drinking water in 1999, leaving 76.9% without access. The MICS reports that a total of 48.5% had access to sanitary means of excreta disposal, leaving 51.5% without access. The 2000 MICS presents further breakdown of coverage in South and Central Somalia, Puntland and Somaliland and by urban, rural and nomadic sectors, but only aggregated across the three zones.

176. The table below presents an analysis of best available data to derive coverage estimates in urban and rural sectors that are each disaggregated between South and Central Somalia, Puntland and Somaliland, with a clear statement of assumptions. Coverage that is normally expressed as a percentage of the population are expressed as absolute numbers of population, based on estimates of urban and rural population, again disaggregated geographically. It is important to note that this

coverage presented has been constructed based on means of access to water and sanitation, and an accumulation of the total from the three geographical estimates. For this reason, coverage estimates differ (but often by less than 5% in population terms) from coverage otherwise derived from applying national coverage percentages to national population data.

177. Notwithstanding the serious limitations that apply to the precision of these estimates²⁸, their derivation as *indicative* coverage are significant to setting the framework for accelerating progress towards MDG attainment, and to defining the general framework for outcomes to be achieved during the investment period up to 2011. It is patterns and trends that are of greater significance than precise numbers.

South and Central Somalia

178. Due principally to the larger size of its population, South and Central Somalia presents the biggest gap in service delivery, and thereby poses the greater challenge. Nearly four million people lacking access by 2015 represent the target of the MDG, and that target is only to halve the number of un-serviced.

179. The recent drought caused shortages of even basic water requirements for domestic as well as productive and livestock use. Increased coverage will require careful planning that takes account of multipurpose users of water points (especially the livestock sector if environmental unsustainability is to be avoided). Close coordination with plans to reinstate the major irrigation areas of the Juba and Shabelle rivers could yield significant benefits to local investment and improved purchasing power.

180. While progress has been made elsewhere in water governance, South and Central Somalia has been faced for long periods with a lack of effective institutions. IN its place, an unregulated local private sector has developed a strong commercial platform. Water governance requires rapid and major attention if up-scaled service delivery is to be secured by the medium-term. In the short-term, implementation may have to by-pass non-functioning local government systems and contract out service delivery to local NGOs, CBOs and communities. At the same time, regulation must be introduced amongst the many private sector service providers (over 400 in Mogadishu alone).

Puntland

181. The proportionally smaller population of the Puntland means that the combined un-serviced urban and rural population represent 10-15% of the target population of the MDG across the three zones. Significant recent investments have been made, delivering service improvements for nearly 130,000 urban residents during 1999-2003.

182. Notwithstanding these factors, Puntland faces challenges that are significant in their own right. Substantial numbers of rural and nomadic inhabitants share the constraints to their social, economic and environmental development, and simple definitions of service coverage mask a range of service standards such as distance, affordability, reliability and safety of water. Lacking the extent of

²⁸ The primary limitations on these data are that 1999 coverage estimates are based on a sample of 22,413 people, less than 0.004 of the total population; Coverage is highly dependent on seasonal access, such that the MICS survey represents only a snap-shot in time. Surveys conducted at a different time of year may yield significantly different coverage. MICS percentage coverage reported by either i) geographic area, and/or by ii) urban and rural sectors, when summed, do not equal percentage coverage reported for the total population. Dis-aggregation by geographic area and by urban/rural sector necessitates mixing of data from different years (between 1996 and 2002), and from different sources. There is not universal agreement on the definition of what constitutes coverage. The principal difference between the derived coverage used in this report, and the coverage presented in MICS is the acceptance of the assumption, proposed by Joint Monitoring Programme, that 50% of traditional pit latrines do not constitute a sanitary means of excreta disposal. This has the major effect of significantly reducing (almost by half) the headline coverage on sanitation coverage.

permanent water sources of Somaliland and South and Central Somalia, significant competition for scarce water is compounded by large numbers of livestock en route to export facilities on the coast. Provided that challenges that are inherent in sharing common water sources can be overcome, cost recovery from the commercial livestock sector raises the prospect of improved sustainability of investments in rural water.

183. *Governance systems require attention.* There is no National Water Policy or Strategy and laws are weak or lack enforcement. No comprehensive sector plan has yet been developed for the water sector. The line Ministries (of Health, Water and Energy, Education and Women and Family Affairs) have no common coordination meetings on cross-cutting issues such as water provision to schools and health facilities or construction of separate public sanitation facilities as found at Mosques.

184. Progress has yet to be made on the foreseen sanitation plan. There is neither policy nor a plan developed for sanitation although this was foreseen in the 2006 – 2010 National Development Plan. There remains scope for clarification of institutional roles, and for strengthening mandated public services to transform from traditional service providers to enablers of development.

185. As in Somaliland, donor supported community-based operations and maintenance interventions have developed an ever-expanding rural coverage and sustainable water provision strategy with the involvement of NGOs and UN agencies in implementation.

Somaliland

186. The MDG target in Somaliland represents approximately 1.1 million people, 60% among the rural and nomadic population. An embryonic water policy and strategy have been developed since 2000, but no comprehensive sector plan has been developed. Human resource capacity is low and inter-institutional coordination is consequently weak. No policy or plan has been set for sanitation and hygiene. Externally financed community-based operations have been advanced with the involvement of NGOs and UN agencies in implementation.

187. Functioning urban water supply systems have been re-established in the large towns of Hargeisa, Berbera and Burao with local commercial operators under concession agreements to the public service agency. Boroma has recently seen 14,000 new household connections, but household access to water is principally through kiosks. Vendors drawing from urban water sources are important suppliers to outlying rural communities. Given the significant increases in cost down the supply chain, affordability is an issue for the urban and rural poor, especially during times of drought when the price of water rises several-fold.

188. Local investment in water services as a whole is mostly restricted to urban centres where returns on investment are assured. Private water services have varying standards of delivery but they have made progress in addressing service gaps. Access still remains problematic in urban centres with few able to afford high connection costs.

189. The private sector has been increasingly led towards considering new Private Public Partnerships (PPP) initiatives in urban areas with considerable success; this new approach offers prospects in rural areas in close collaboration with local communities and the government, by extension and outreach that supports communities, especially for the more advanced technologies.

190. Groundwater resources in Somaliland depend significantly upon recharge from water sources that originate in Ethiopia, and, as is the case for South and Central with respect to the Juba and Shabelle rivers, further flow reductions could lead to greater water shortages.

Vision and Priority Initiatives

191. The overall purposes of interventions in water and sanitation are to:

- Increase equitable, efficient and sustainable access to improved and affordable water and sanitation supplies to satisfy basic domestic needs
- Promote improved water sources, hygiene and environmental education, simple water treatments and regulation of the private sector service delivery to contribute to the reduction of water and sanitary-related diseases.
- To increase and promote community and in particular women's participation and involvement in water supply and sanitation services.

Interventions are founded on a Framework that is based on achieving outcomes that accelerate progress towards the Millennium Development Goals, paying special attention to the most vulnerable. Interventions are prioritised into those social groups for whom progress towards the Millennium Goals is least advanced. Interventions are framed within six components:

Tale 7: 6 Components for interventions

Component	Objective
1. Governance and Institutions	To strengthen the enabling environment of policy and legislation, institutions, and the implementation environment
2. Increase social service coverage in rural water supply	To improve and secure access to safe rural water for 830,000 beneficiaries, the majority of whom are not currently served
3. Increase social service coverage in rural sanitation and hygiene	To improve access to improved means of excreta disposal and to improve hygiene behaviour for one million beneficiaries in rural areas
4. Increase social service coverage in urban water supply	To improve access to safe urban water for 400,000 beneficiaries, in smaller urban centres and those in larger urban centres who will not be served in the medium term by expanded reticulated systems
5. Increase social service coverage in urban sanitation and hygiene	To improve access to improved means of excreta disposal and to improve hygiene behaviour for 200,000 beneficiaries in smaller urban centres and those in larger urban centres who will not be served in the medium term by expanded reticulated systems
6. Emergency preparedness for probable drought	To prepare for a probable moderate or severe drought during the period of the RDP, prior to upgrading to more reliable service provision.

192. A reasonable growth in activity is viable given the prevailing absorptive capacity. Early activities will work within an implementation modality that is well-established and that responds to the reality on the ground, recognising significant social and geographic differences. Strengthening the enabling environment of governance (institutions, policies and legislation) early on will enable the absorptive capacity to increase over time, to the benefit of the sustainability of investments. Early activity will consolidate past experiences of interventions to advance best practices, minimise bottlenecks to progress, and ensure effectiveness and efficiency in deliverables.

193. Guiding principles that underpin the framework are

- Human rights to basic services, as proposed in the 1990 draft Somali Water Law Training will benefit service providers not only private, but public too in providing acceptable services thereby avoiding water and sanitary diseases.
- Action amongst the poor and vulnerable and most notably where the commercial market cannot satisfy basic needs, either due to weak regulation, low levels of service extension, affordability or poor reliability.

- ‘Some for more, rather more for some’, meaning getting some improved water to the many who are currently un-serviced rather than getting more water to the few that are already served. Alongside investments in essential Social Services, growth in the productive and livelihood sectors will likely increase the purchasing power amongst wealthier social groups, enabling self-finance into the means by which they improve their access water and sanitation.
- Giving greater prominence to the number of beneficiaries of improved sanitation than water, and ensuring that benefits from the trinity of interventions in water, sanitation and hygiene are maximized.
- Incremental improvements in technologies, given that international experience shows that the largest gains in social, economic and environmental outcomes for large numbers of people are attained by incremental, and often small, improvements in the means of technology.
- An enabling environment in which consensus can be reached on realistic service standards among Government as future regulators, suppliers of services, and beneficiary communities. Standards are likely to include distance/time, quantities of water, sustainability, reliability, affordability and safety.

194. Interventions in water, sanitation and hygiene tackle 1.2 to 1.6 million people, the majority benefiting from combined water, sanitation and hygiene interventions. A preliminary budget of US\$75.5 million is estimated based on estimated per capita beneficiary costs of US\$30 and US\$35 in rural and urban water respectively, and US\$12 in sanitation (composed of US\$5 for technology improvements and US\$7 for hygiene awareness, education and training). Beneficiary costs are based on past local experience and broadly conform to international experience.

Table 8: Proposed beneficiary numbers during the five-year period

Proposed beneficiary numbers during the five-year period				
	All	Somaliland	Puntland	South & Central
Water Supply				
Rural and nomadic	830,000	180,000	100,000	550,000
Urban	~400,000	87,000	50,000	265,000
Sanitation & Hygiene				
Rural and nomadic	~1,400,000	305,000	170,000	940,000
Urban	~250,000	53,000	30,000	170,000

195. Interventions in rural sanitation and hygiene have to build from a very low base of around 170,000 beneficiaries during the period 1994-2005. A sea change in approaches to sanitation is required if progress is to be made. Progress towards attaining the MDG in urban areas will depend mostly on the coverage attained by new reticulated systems in the large urban centres. Interventions through investment in social services by 2001, expected to be mostly in peri-urban areas of the larger cities, and throughout small towns, would add an additional 10%-15% onto the 2000 coverage statistics in water (60%) and sanitation (80%).

Priority Initiatives

a) Component I Governance and Institutions

Objective: To strengthen the enabling environment of policy and legislation, institutions, and the implementation environment.

196. *Enable government institutions to fully transform to enablers of development*, with mandates and responsibilities for development, including strengthening of institutions, policies, legislation and participatory approaches, and especially implementation through community-based approaches and in partnerships with the local private sector.

197. *Information Management, Water Knowledge Fund and Networking* acknowledges the scope for objective analyses (and M&E) based on more rigorous information and the opportunity to benefit from a consolidation of best practices, to be tackled through an Information Management System, in

support of policy-relevant information and evidence-based decision taking. A small Water Knowledge Fund will be established to commission studies that tackle gaps in the knowledge base and stimulates new research. Following years of fragmentation, and in pursuit of bridge building across previously isolated communities, specific actions will be directed at networking.

b) Component 2 Increase social service coverage in rural water supply

Objective: To improve access to safe rural water for 830,000 beneficiaries, the majority of whom are not currently served

198. *Upgrade Strategy A:* To provide safe access to the currently un-served that are accessing unimproved water sources by upgrading and rehabilitating to improved water sources (Strategy A1, most likely to be prominent in Somaliland and Puntland), or through replacement by new improved sources (Strategy A2, most likely to be prominent in South and Central).

199. *Upgrade Strategy B:* To provide safe access to the currently un-served that are accessing unimproved water sources by upgrading to Mini Water Supply Systems, or by the installation of new Mini Water Supply Systems (most likely to be prominent in larger sedentary communities)

200. *Upgrade Strategy C:* To maintain safe access by sustaining existing improved water sources amongst those currently served. (Note that this does not constitute progress towards the MDG, but rather targets keeping served populations within the served category, to prevent them falling back into the 'un-served category')

201. *Upgrade Strategy D:* To provide safe access to the currently un-served that are accessing unimproved water from vendors (due to unsafe sources or contamination during haulage) by regulation of vendors.

202. In line with an implementation environment that is foreseen to promote demand-responsive approaches, the future composition of interventions (e.g. borehole rehabilitation vis-à-vis replacement, shallow wells or berkedes etc) cannot yet be forecast.

c) Component 3 Increase social service coverage in urban water supply

Objective: To improve access to safe urban water for 400,000 beneficiaries, in smaller urban centres and those in larger urban centres who will not be served in the medium term by expanded reticulated systems

203. *Upgrade Strategy A:* To provide safe access to the currently un-served that are accessing unimproved water sources by upgrading and rehabilitating to improved water sources, especially in peri-urban areas of large urban centres and smaller centres not covered by the 'Infrastructure' Cluster.

204. *Upgrade Strategy B:* To provide safe access to the currently un-served that are accessing unimproved water from vendors (due to unsafe sources or contamination during haulage) by regulation of vendors.

205. *Upgrade Strategy C:* To provide safe access to the currently un-served that are accessing unimproved water sources by upgrading sources to, or installing new, Mini Water Supply Systems and kiosk distribution systems, especially in peri-urban areas of large urban centres and smaller centres not covered by the 'Infrastructure' Cluster.

206. Very close interactions will be required with Infrastructure interventions that extend the reticulated supply systems if service gaps are to be avoided.

d) Component 4 Increase social service coverage in rural sanitation and hygiene

Objective: To improve access to improved means of excreta disposal and to improve hygiene behaviour for 1.4 million beneficiaries in rural areas

207. *Upgrade Strategy A:* To provide improved means of excreta disposal to the currently served that are using unimproved 'traditional' pit latrines by upgrading to improved 'traditional' pit latrines (especially amongst sedentary rural populations). Principal activities are likely to include community ownership, contributions and management, with slab provision.

208. *Upgrade Strategy B:* To provide improved means of excreta disposal to the currently un-serviced that are practising open defecation by upgrading to improved 'traditional' pit latrines (especially amongst sedentary rural populations). Principal activities are likely to include community ownership, contributions and management

209. *Upgrade Strategy C:* To upgrade the means of excreta disposal among the currently un-serviced that are practising open defecation by upgrading to defecation fields (especially amongst nomads).

210. *Hygiene Awareness, Promotion and Training:* Training of trainers in PHAST and CHAST, and onward training to beneficiaries; Mass media campaigns. Water Safety

e) Component 5 Increase social service coverage in urban sanitation and hygiene

Objective: To improve access to improved means of excreta disposal and to improve hygiene behaviour for 170,000 beneficiaries in smaller urban centres and those in larger urban centres who will not be served in the medium term by expanded reticulated systems

211. *Upgrade Strategy A:* To provide improved means of excreta disposal to the currently served that are using unimproved 'traditional' pit latrines by upgrading to improved 'traditional' pit latrines. Principal activities are likely to include community ownership, contributions and management, with slab provision.

212. *Upgrade Strategy B:* To provide improved means of excreta disposal to the currently un-serviced that are practising open defecation by upgrading to improved 'traditional' pit latrines (70% of beneficiaries, especially amongst sedentary rural populations). Principal activities are likely to include community ownership, contributions and management. Promotion of defecation fields in small urban centres with destroyed infrastructure, and hence available space.

213. *Upgrade Strategy C:* To upgrade the means of excreta disposal among those currently served by improved traditional pit latrine to household 'Pour-Flush' or Septic Tanks, especially in settlements with vulnerable shallow aquifers.

214. *Hygiene Awareness, Promotion and Training:* Training of trainers in PHAST and CHAST, and onward training to beneficiaries; Mass media campaigns. Water Safety

f) Component 6 Emergency preparedness for probable drought

Objective: To prepare for a probable moderate or severe drought during the period of the RDP, prior to upgrading to more reliable service provision.

215. Acknowledging the high probability of a moderate or severe drought occurring before extended social services coverage has been attained, and acknowledging that the RDP tackles only a proportion of those currently lacking services, this Component will install capacity in contingency planning, provide for replacement of already pre-positioned stocks and provide predictable finance for emergency water trucking.

216. If achieved, the additional 1,230,000 people accessing safe drinking water will increase the coverage from below 20% in 2000 to over 30% by 2011. Achieving coverage for over 800,000 rural inhabitants within 5 years is considered a reasonable extension of basic services, given that 730,000 people benefited from investments during the 12-year period 1994-2005. The higher rates of service delivery achieved by 2011, if implemented during the period 2012-2015 as enabled by an improved enabling environment, will mean that interventions will fall short of, but make significant in-roads into,

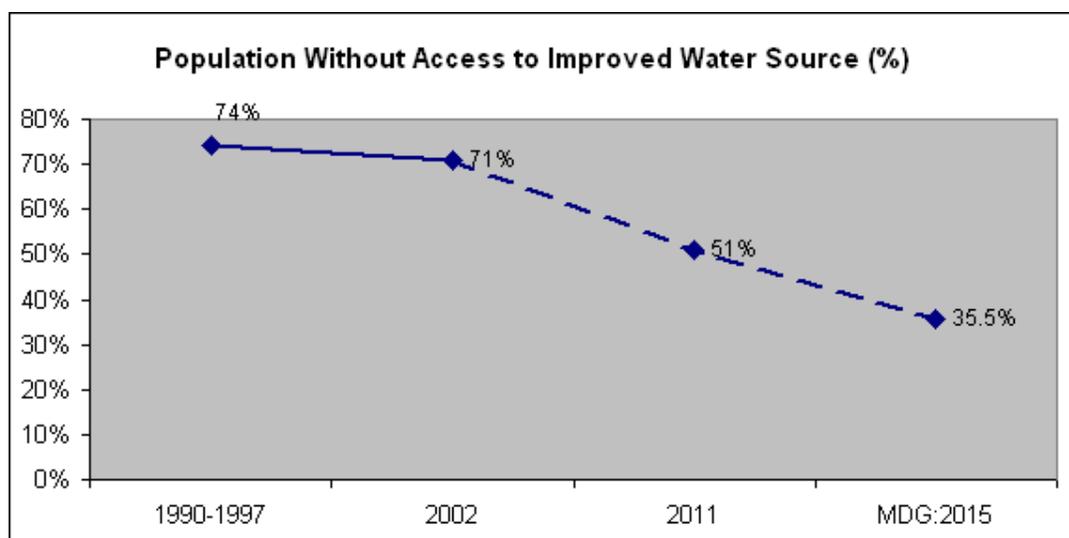
Target 10 of the Millennium Development Goals (in this case, 63% coverage in rural areas). However, achieving the target would require tackling the basic needs of nearly five million people within eight years, which is considered unrealistic.

217. The combined targets for the 5 year plan for rural/nomadic settlements and urban populations' water and sanitation needs are to increase equitable, efficient and sustainable access to improved and affordable water and sanitation supplies; and to promote improved water sources, hygiene and environmental education, simple water treatments and control of private sector service delivery in order to reduce water/sanitary related diseases.

Figure 2. People without Access to an Improved Water Source (% of population)

Target: Halve by 2015.

1990-1997	2002	2011	MDG:2015
74%	71%	51%	35.5%



218. **Priority should be given to rural/nomadic populations where coverage gaps in improved water supplies and hygienic sanitation facilities are considerable.** Major efforts should be put into reducing the distance to permanent water and therefore expenditure on unregulated water trucking through rehabilitation/ replacement/ construction of pipe systems or rehabilitation/ replacement/ construction of new permanent sources of water:

219. Activities should be supported that improve water quality, through complementary protection of water sources and promotion of hygiene, environmental sanitation and simple water treatment programs; these are essential to reduce the incidence of water/sanitation related diseases.

220. Special attention should be given to **urban and peri-urban poor** currently highly dependent on unregulated water vendors. For urban populations, the rehabilitation and extension of urban/mini water supply distribution networks through public kiosks or community management connexions to piped systems should be supported. In peri-urban areas cross-subsidy and the development of pipe networks to private dwelling and yards (house connections) should be mandated by all municipalities via Regional Water Laws.

Implementation and monitoring arrangements

221. The improvement of water quality through the regulation of the private sector and promotion of simple water treatment, promotion of hygiene and improvement of sanitation facilities is essential to future rehabilitation/development. Sanitary rainwater storage facilities will also reduce water/sanitary related diseases.

Table 9: Delivery options

	Role	Opportunities up-scaling	Constraints on up-scaling
Local Governments Ministries	Planning, Policy, management	Willingness to manage Capacity to manage	Lack of human and financial resources, lack of regulatory framework
PPP	Management	Willingness to invest, especially diaspora	Lack of information on potential investments, lack of regulatory framework
Private sector	Implementation and management	Willingness to invest, especially diaspora	Lack of information on potential investments, lack of regulatory framework for service delivery
INGOs	Implementation	Capacity to implement	Donor funding, lack of regulatory framework, security
LNGOs	Implementation	Willingness to implement	Lack of regulatory framework, Lack of human and financial resources. Lack of skills
CBOs	Management	Willingness to implement	Lack of regulatory framework, Lack of human and financial resources. Lack of skills
Self-help	Implementation and management	Willingness to implement and manage	Lack of regulatory framework, Lack of financial resources and lack of skills

222. Throughout the Social Services sector and beyond it is important where appropriate to give state actors a lead role so as to build, bolster and reinforce the state.

223. High priority should be accorded to ensuring that any new or rehabilitation intervention of public infrastructure use a harmonized strategy. Provision should be made for separate gender sanitation facilities and handicap-friendly entrances and facilities. This will help cross-sector strategies such as in the enrolment and retention of pupils, especially girls, in school and assisting access of the handicapped to social services.

224. Provision of rural water services should be covered in a future Local Governments Act with non-urban/rural water supply services focused on well-defined geographic locations.

225. UNDP has recently conducted a settlement survey and will soon release their results. UNICEF will conduct a MICS 2006 in July-August. A specific evaluation for the sector will be required in 2008 and 2011. It is proposed that interventions in South and Central Somalia, Puntland and Somaliland use the following indicators.

226. Sector evaluations will be required in 2008 and 2011 as follows:

Table 10: Sector evaluations

State	Baseline	2006 Actions and Cost in MUSD	2007 Actions and Cost in MUSD		2009-2011 Actions and Cost in MUSD	
South and Central Somalia	UNICEF MSIS 2000 WB/UNDP Household Survey 2002	UNICEF MSIC 2006 UNDP settlement survey 2006	Evaluation	0,1	Evaluation	0,1
Puntland	UNICEF MSIS 2000 WB/UNDP Household Survey 2002	UNICEF MSIC 2006 UNDP settlement survey 2006	Evaluation	0,1	Evaluation	0,1
Somaliland	UNICEF MSIS 2000 WB/UNDP Household Survey 2002	UNICEF MSIC 2006 UNDP settlement survey 2006	Evaluation	0,1	Evaluation	0,1

227. The creation of South and Central Somalia, Puntland and Somaliland water and sanitation inter-sectoral committees (WSISC), divided into two sub-committees (on urban water and sanitation, and on rural/nomadic water and sanitation), is proposed. There should be representation from: the Ministries of Water and National Resources, Forestry and Range Livestock, Agriculture, Rural Development, Environment, Health, Education, Interior and Directors of any autonomous Water Development Agencies²⁹, local and international NGOS/CBOs and private sector associations.

228. Their mandate for the first two years would include:

- Commission and supervise compulsory inventories and studies
- Participate in an international workshop
- Review/Formulate state water, sanitation guidelines and legislation based on best practise. Sanitation policies should include environmental safeguards. In South and Central Somalia special attention should be given to trans-boundary river cooperation for the management of the Shabelle and Juba rivers.
- Discuss and approve any rehabilitation and construction of water supply.

229. In response to the lack of a functional water quality monitoring system, we recommend the establishment of common water quality guidelines and standards associated with the support to three quality laboratories. At least three Water and Sanitation Training Institutes should be built in Hargeisa/Burao, Garowe/Bossaso and Jowhar/Mogadishu.

D. HEALTH

Current status, challenges and opportunities

230. While South and Central Somalia, Puntland and Somaliland remain some of the poorest in the world, a situation aggravated by the civil war and the absence of fully functional national government for 15 years, the impact of state failure on human development has been profound, resulting in differentiated destruction and re-establishment of political institutions, social and economic infrastructure. South and Central Somalia has pockets of peaceful communities but remains threatened by insecurity in a number of regions. Puntland has declared itself as semi-autonomous since 1998 but recent disturbances stressed the fragility of the local peace. Somaliland has been peaceful since 1992, embryonic governance assets are in place and both demand and supply of social services has increased.

231. Good health must be a priority for women and girls who are often the most marginalised in poor societies that lack basic service provisions such as education, sanitation and clean water. Often they are subject to inequalities within the social structure which results in unequal access to and the use of basic health resources which means they are unable to protect, promote and maintain their health. The feminisation of poverty, lack of influence in decision making, limited power over their sexual and reproductive lives, inadequate distribution of food to women and girls, inadequate access to safe water and sanitation all have negative effects on the lives of women and girls.

232. Despite an emphasis on primary health care, many health care programmes are still managed in a project dependent vertical or top-down fashion. Health care services also remain of poor quality and project "cash budget" based from irregular and low external funding. This makes the projects themselves and the present fragmented health system erratic and unsustainable. In the pastoral communities, some health services are seen to originate from outside the community. Advocacy against FGM for example, is seen as not locally owned and therefore not supported by nomadic dwellers.

²⁹ This was the composition of the former National Water Committee (NCW)

South and Central Somalia

233. South and Central Somalia is the state most affected by 15 years of civil war. A vibrant private sector has developed in the capital Mogadishu (population approx. 1 million) but elsewhere this is not the case. However the privatisation of healthcare does not guarantee universal access that is affordable to all.

Table 11: Health Facilities South and Central Somalia

Health facility	Bakool	Banadir	Bay	Galgaduud	Cedo	Hiran	Lower Juba	Lower Shabelle	Middle Juba	Middle Shabelle	Total
Hospitals	1	25	2	2	5	2	2	3	0	5	47
Specialised Centres	0	1	0	0	0	0	0	0	0	0	1
MCH/OPD	6	16	9	7	12	7	11	14	7	10	99
Health Posts	68	0	72	9	53	30	39	15	34	0	320
Total	75	42	83	18	70	39	52	32	41	15	467

234. Health infrastructure, where still existing, remains closed for most of the time. The largest public hospitals of Somalia (including Forlanini, Martini, Benaadir, Madina, and Kesseney) are concentrated in Mogadishu. There are no salaries, no supplies, no supervision, no training or guidance. In Bay, Bakool, Middle and Lower Juba regions, health and education services are practically absent, due to the fact that the poorly functioning pre-war facilities have been abandoned and / or destroyed. The only health services the areas have been afforded are polio and measles surveys.

235. Over half of South and Central Somalia 2,383 health staff is unskilled and most of the professional staff receives no structured in-service training. Mogadishu has some private health institutions, such as the SOS Kinderdorf missionary hospital and nursing school, the ICRC supported Keseny and Madina war-surgery specialized hospitals. Chronic insecurity has always hampered the consolidation of a well-conceived bottom up state health programme elsewhere.

Human Resources	South and Central Somalia
Doctors	146
Ass. Pharmacists	50
Midwives	200
Nurses	414
Lab Technicians	82
Ass. Lab Technician	184
Sanitarians	432
CHWs	291
TBAs	467
Total	2,383

236. The TFG/MOH is grappling with enormous difficulties to establish itself (no resources, no qualified staff, poor capacities, political instability). The MOH has produced a preliminary Health Policy document that has yet to be discussed extensively to understand its operational implications and how best to translate its strategies into implementable initiatives.

237. Despite the differences in policies for the development of the health system, the enormous challenges in South and Central Somalia, Puntland and Somaliland, and their current unequal, fragmented funding levels and projected needs, the health authorities share, at least theoretically, a common vision of the future, which should be based on highly decentralized health services.

Puntland

238. Population estimates in Puntland raise constant controversies; the JNA figures are based on UNDP population estimates and projections and show a figure of 600,000. Puntland has 19 Hospitals, with approximately 600 beds still functioning, and a total health staff of 1123; 641 (57%) are not qualified (i.e. auxiliary nurses, CHWs and TBAs). There are 72 registered Doctors, operating mainly in Garowe, Bossaso and Galkayo.

239. Unregulated pharmaceutical outlets are concentrated in urban centres. Health infrastructure is appalling with a lack of basic sanitation blocks, lack of maintenance, and an absence of basic equipment.

Table 13: HEALTH STAFF (Public and Private Facilities).

	Doctors	Nurses	Midwives	Lab Technicians	X-Ray Technicians	Auxiliaries	TBA	CHW	Total staff
Public	30	128	29	13	14				
Private	42	208	18	NA	NA	NA	NA	NA	
Total	72	336	47	13	14	159	287	195	1123

NA: not available. Some of the doctors who work in public hospitals run a private clinics or pharmacy.

240. The private health sector is de-regulated and concentrated in the major towns. It provides mainly curative health care. Mapping of the existing facilities and human resources – possibly in conjunction with other cross-sector research - is essential before implementation of projects under the five year period.

241. Puntland has one nursing school (also training midwives) in Bossaso. It is mainly funded by Islamic charities and institutions; there is one private medical school in Galkayo. The Galkayo University in 2006 began a first year basic training for Assistant Physicians (3 years course), at the level of Clinical Officers; they are meant to be deployed to rural and remote areas.

242. As in Somaliland the Puntland MOH provides guidelines and regulations, but lacks capacity, funds and human resources to expand its role in the Health sector.

Somaliland

243. While many agencies collect data (WHO, UNICEF, FSAU, UNDP, ICD, CARE, WVI), there is no integrated and harmonized health management system. Information in the health sector is incomplete and unreliable. There is also no coordinated interaction with the semi-autonomous Somaliland local government structures.

244. The approximately 1.5 Million people³⁰ of Somaliland are served by 23 hospitals, 69 Health Centres and 157 Health Posts, with ten Hospitals and three specialised centres being located in Hargesia. Some main problems in the sector are: an absence of information, awareness and knowledge towards diseases and pharmaceuticals; widespread self-medication; and an inability to enforce the rule of law, and the regulations and guidelines issued by health authorities. The private health network is totally de-regulated. Certification norms for public and private practitioners are neither adequately constituted nor implemented.

³⁰ Polio Programme (CDC/WHO/UNICEF) NIDs.

Table 14: Human Resources. Only 422 cadres have a health qualification, with 82 Doctors and 215 Nurses.

Doctors	Nurses	Midwives	Technicians	Auxiliaries	TBA/CHW	Support staff	Total staff
82	215	35	90	216	447	392	1477

245. Training needs are high. Training for medical and paramedical staff is provided through one nursing school and two universities, funded by Diaspora, businessmen and Islamic organizations (i.e. Hargeisa and Boroma - Amuud School). The sector has so far been run by private sector providers and they oversee the level of quality provided.

246. On-the-job training is uncoordinated and not necessarily up to standard; it often focuses on inappropriate skills and project indicators are often agency-mandate-driven, un-coordinated and un-standardized. No proper follow-up is carried out as part of supportive supervision. The benefits of such courses are therefore limited.

247. A widely-endorsed essential drugs list for PHC facilities has been formulated with WHO support, but: (i) there is no agreed upon drugs list for hospitals, on the basis of an agreed upon minimum package of services, (ii) the drugs procurement system for public and private sub-sectors is totally de-regulated and highly fragmented, (iii) pharmaceuticals are often imported without quality control (iv) self-medication prevails, expired drugs are sold in the market and re-labelling of expired tins is a known practice, (v) more expensive brands versus generics are sold by hundreds of drugs sellers at a higher cost, (vi) there are no qualified pharmacists.

248. A Strategic Health Plan drafted in 1999 already exists. Under it, the Ministry has responsibility for re-organization, regulation, monitoring and evaluation of both public and private practices. Overall operational and financial decentralization to administration and Districts is forecast with State / District Health Boards and State/ District Health Management Teams becoming responsible for local financing and delivery of health services.

249. **General constraints** to be addressed in the health sector so as to set-up an harmonized and sustainable health system include health care financing, a scattered population, distance between referral facilities which create enormous problems of delivery of supplies and supervision, and paucity of qualified staff both in the health administrations and facilities. There are less than 15 qualified doctors per one million people, unequally distributed throughout the country - UNDP 2002.

250. **The Health Care Financing** System/s is affected by the very same flaws as the other components of the health sector: (i) negligible contribution by the health authorities, (ii) fragmented mechanisms of cost-sharing and cost-recovery, (iii) fragmented and un-coordinated donations from private businessmen and Diaspora, (iv) fragmented and irregular funding from agency and non-faith based donors, (v) irregular, uncoordinated and fragmented donations and funding from Islamic institutions and organizations

251. In South and Central Somalia (where the majority of the population reside), there is very limited access to health services due to destruction, looting and prevailing insecurity. In Puntland and Somaliland, health services are mainly situated in densely populated areas just like in Central and South Somalia.

252. Access to and quality of health care remains inequitable, with inadequate distribution of staff and resources to areas where vulnerable populations reside such as IDP camps and rural areas. Infant, child and maternal mortality rates in South and Central Somalia, Puntland and Somaliland are amongst the highest in the world. Community health work and midwifery services are currently being provided by women who rely on traditional knowledge to attend deliveries. Early child bearing

coupled with the inadequate, unresponsive or complete lack of services fails to meet women's reproductive and health needs further exposing them and their children to further health risks.

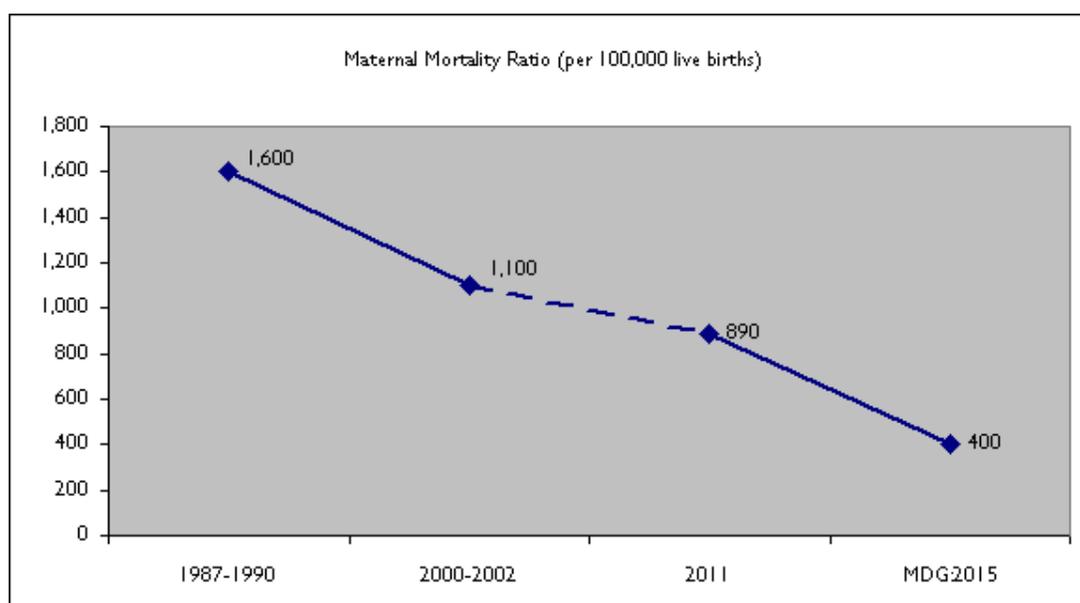
Vision and Priority initiatives

253. The Vision of the sector is to start reducing the high levels of mortality and morbidity, especially among women and children, through: (i) the development of an equitable, effective and efficient package of health services which are available, accessible, and of reasonable quality, especially in rural areas and (ii) the development of the capacity to deliver the necessary services, with improvements in the availability, accessibility, and quality of health services especially in rural areas.

Figure 3. Maternal Mortality Ratio (per 100,000 live births)

Target: Reduce by three-fourths between 1990 and 2015.

1987-1990	2000-2002	2011	MDG:2015
1,600	1,100	890	400



Note: Baseline for years 1987-1990 comes from UNDP Goals (MDG) Report Somalia, 2004.

254. The outcome targets are: By the end of 2011, national and regional health authorities will have acquired a stronger technical, managerial and financial capacity, will rely on improved management systems and will be able, with the support of other partners - including external agencies and private health care providers - to lead and sustain:

- i) the further increase in coverage and improvement of quality of basic health care,
- ii) the development of efficient health systems, and,
- iii) the progressive reduction of inequality in access to basic services.

255. The proposed strategy is three-pronged:

- i) *Consolidating and rationalizing the existing health care delivery system* by strengthening a set of health facilities selected according to agreed-upon criteria; improving supply systems, increasing funds for

recurrent costs, carrying out limited/urgent rehabilitation work, upgrading the skills of their staff and providing them with adequate incentives;

ii) *Filling some of the most serious gaps in service provision* by investing in underserved areas and neglected communities, to the extent allowed by security conditions and funding levels

iii) *Putting in place the building blocks for sustained recovery*, i.e. the institutions and management instruments necessary to ensure efficient, effective and equitable health care delivery. This will require filling key, strategic information gaps in order to ensure that the decisions on these institutions and instruments are based on solid evidence.

256. Targets have to be chosen against baselines still waiting to be estimated. Thus, the formulation of meaningful targets and indicators will have to be harmonized as work is done. Service consumption is expected to expand slowly, as resource levels increase, as funding becomes more predictable, as supply is strengthened, and as security improves. An annual growth of 5% of services volumes in the first two years and of about 10% afterwards would suggest very good progress. Increasing total health spending per head is a key to recovery. Health spending is likely to increase slowly during the first two years, because of the existing absorptive and implementation constraints.

257. Estimating the investment on health facilities, given funding and implementing constraints, is fraught with difficulties but it is clear that donors must concentrate on funding quality rather than just quantity.

258. The assumptions adopted to generate the targets proposed below are the following:

- i) The proportion of facilities reportedly closed that are functioning at unacceptable level is 30%.
- ii) The proportion of facilities reportedly non-essential because they are not strategic in their location or in their performance is 25%. They should not then benefit from the first wave of investment.
- iii) During the first years, only works aimed to raise facilities up to minimal functioning standards will be financed. Meanwhile, proper investment plans and architectural assessments will be carried out. A flat amount roughly equivalent to 20% of the average replacement cost is proposed for each category of facility.
- iv) A fully-fledged recovery package, envisaged towards the end of the transition period, is likely to demand a total resource envelope of between US\$ 20 and 30 per head / per year. This is not a fully fledged package, but a mere minimum. The actual costs will be much higher, given the documented deficiencies of the system in all core areas (equipment, human resources, management etc).
- v) A needs-based split by geographic region is considered unfeasible for this sector, given the inadequacy of the existing information. For the time being, the relative population share is suggested as the main criterion to distribute the proposed interventions. The UNDP population estimates assign 28% of the population to Somaliland, 20% to Puntland and 52% to Central and South Somalia.

259. In South and Central Somalia, Puntland and Somaliland, the following will be overarching concerns for the different health sectors. Different work plans will be drawn up during the first six months of the implementation:

- i) EPI (routine immunization) support and micronutrients promotion
- ii) NIDs (national immunization days) and upstream policy assistance
- iii) Integrated district delivery of MCH services and decentralized monitoring and analysis to the health centre level
- iv) Upgrading of district hospital services for refugees, including district dwellers in selected areas of return
- v) Innovative community-based orphan care networks taking into consideration Islamic organisation support to current orphanage structures

- vi) Broad youth-based initiative on substance abuse
- vii) Upgrading health facilities and extending family planning services

The two first year objectives are:

260. *Carrying out a health expenditure review*, to assess present funding levels, to forecast their evolution, to understand financing sources and to track financial flows. Concurrently, there is a need to *establish health sector aid management tools*, to improve financial flows and ensure that health service delivery is adequately funded. Introducing financial instruments to address the existing gaps and emerging ones of scaling up, collaborating with the Interim Support Fund for Somalia (ISFS).

261. *Inject funds to cover recurrent costs* in areas where there is enough management capacity (e.g. NGOs or technical assistance with supervision capacity). Clear criteria for the selection of the facilities to benefit must be set from the onset. Allocating scarce funds in the sensitive and competitive Somali context will prove contentious but will be eased by the transparent recording of inflows and outflows with clear cut rules and oversight roles for government and donors alike. Governments will require much administrative capacity building to fully assume an oversight role but such a role will also help to bolster the governments themselves.

262. To be brought up to acceptable standards, the health workforce needs a long-term, targeted intervention, upgrading and addressing shortages of key categories of health workers. A great deal of not always coordinated work has already been done by a variety of stakeholders. It should be reviewed and its lessons learned. The main tasks to focus on during the two first years are:

263. Establishing an autonomous certification body, recognised by the three health administrations, with the task of reviewing the qualifications of health workers, issuing standard diplomas, proposing training programmes aimed at attaining a recognised qualification for workers holding non-standard ones, and testing health workers without proper documentation, so that their skills can be certified. This body should also be tasked with reviewing training programmes and materials in use across South and Central Somalia, Puntland and Somaliland, and formulating recommendations aimed at improving and harmonising the health sector. It should be recognised and supported by Health Authorities (possibly through a legal mechanism, e.g. a (Training) Act).

- i) Before policies are developed and priorities set, sector labour skills surveys need to be assessed and then supplemented, possibly in conjunction with other sectors. At the same time a review of ongoing in-service training activities, in order to appraise their quality, contents, approaches and results should be carried out. Assessing the health training network, public and private, in regard to physical and technical capacity, outputs, costs and training tools.
- ii) Assembling a database of active health workers (within South and Central Somalia, Puntland and Somaliland and abroad), complete with personal data, professional qualifications, workplaces and duties. Once the structure of the Somali workforce is broadly understood, the categories of health workers in need of expansion should be identified. Related training programmes may be started at an accelerated pace.
- iii) Negotiating with concerned NGOs, UN agencies, other employers and employees a common salary scale and standard contract formats, to be applied across the health sector. Reviewing the salary scale of public health workers - together with that of other civil servants - within the budgetary constraints of the administration(s).
- iv) Developing a fair package of incentives, including the payment of allowances (cash or subsidies for housing and transport) for staff deployed to remote or difficult locations. Without adequate incentives, it is hard to foresee improvements in the motivation of health workers, and thus in the productivity of the system.
- v) Gender balance: Given the shortage of female health workers and the existing limits on their deployment, additional incentives should be introduced to reduce gender imbalances. There is believed to be not a single Somali female doctor practising in South and Central Somalia, Puntland

and Somaliland – an imbalance that is reflected across all sub-clusters. There needs to be visible mainstreaming in gender perspectives in policies and programmes in order to combat the link between inequalities in health status and inadequate health care services. Improving service delivery with gender in mind strengthens the role of women as health care providers making health care more accessible and acceptable to women.

264. The main tasks in the pharmaceutical sector during the two first years follow below. The EC and IT are currently researching this area and their help will be invaluable:

- i) Establishing an independent non-profit drug purchasing agency, in charge of supplying health care providers with essential generic drugs, in an open, competitive manner.
- ii) Encouraging the establishment of regional drug supply agencies, in charge of warehousing and distributing drugs within their geographic remits. Somaliland offers better conditions for starting the first of such drug agencies.
- iii) Finalising the work already done in formulating an essential drug list and standard treatment guidelines, and encouraging their adoption across the Somali health sector.

265. The main tasks in the area of health care provision during the first two years are:

- i) Formulate an interim basic service package, acceptable to health authorities and health care providers, and start testing its rationale and contents in the diverse delivery environments of South and Central Somalia, Puntland and Somaliland.
- ii) Carry out a study of private health care providers to discover their number, qualifications, distribution, business volume and models, contents and revenues of their operations, strengths and weaknesses; formulate realistic approaches to regulating their activities, as well as integrating them into the overall health sector framework.
- iii) Explore the field of providing health care to nomadic and semi-nomadic populations, in view of documenting the experience gathered so far by relevant health care providers, adjust the funding through the interim service package referred to above, in terms of staff required, costs incurred, and tools needed, to serve nomadic populations effectively.
- iv) Identify realistic measures aimed at improving quality of care. Exploring the feasibility and effectiveness of providing crash training to health managers should be included among the available options.

266. Existing facilities may need rehabilitation and even expansion; others might actually be abandoned as unnecessary, or in order to downsize. The main tasks to focus on during the two first years are:

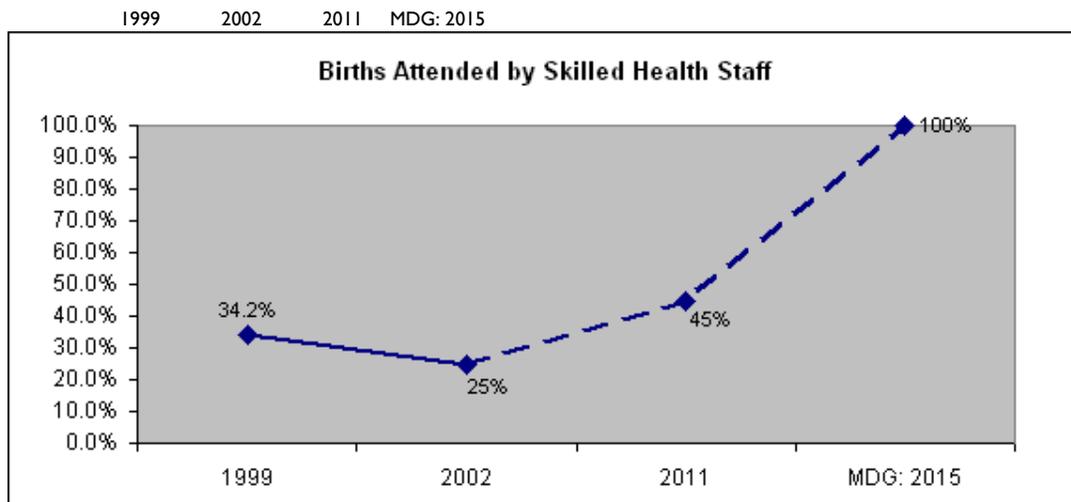
- i) Assembling a summary database of the health care network (by expanding, strengthening and regularly updating the (Healthcare Network Database WHO Somalia 2005) in conjunction with other sectors.
- ii) Making an inventory of the investment in health infrastructure now under way and under discussion.
- iii) Based on the review of the service gaps allowed by the database, identifying a sub-set of health facilities to be rehabilitated, strengthened or expanded, according to redefined needs and available funding, during the interim period. Investment criteria should include location, served population, comparative performance, security conditions and referral links.
- iv) Negotiating with stakeholders a portfolio of infrastructural interventions, to be implemented in a phased way. Attention must be paid to formulating investment plans compatible with realistic health recurrent financing forecasts.
- v) Developing standard layouts for health facilities, warehouses and offices, to be adopted by new investment programmes, once conditions and funding levels become favourable. Standard layouts should take the low population density characterising large parts of South and Central Somalia, Puntland and Somaliland and the nomadic lifestyle of a substantial portion of its people, into account.

The cost of building new facilities according to standard layouts must be estimated, and checked in the field across South and Central Somalia, Puntland and Somaliland.

vi) Preparing standard tender documents for civil works and procurement of equipment, and identifying potential contractors, in order to reduce the lead time for starting rehabilitation and construction works, once priorities have been identified.

Figure 4: Births Attended by Skilled Health Staff (%)

Target: Increase to 100% by 2015



Note: Data for 1999 come from the World Bank DDP, 2005.

267. Despite the apparent modesty of the package proposed for the first two years, the work to be done is enormous, and fraught with difficulties. Local expertise (which is sorely lacking), adequate resources, operational stability and political coherence are pre-requisites. Additionally, the proposed package will be implemented alongside the many humanitarian and disease-control programmes under way.

268. In relation to health information and health policy analysis, by the end of the second year, studies will allow analysts and users of the collected information alike to appreciate in full the functioning of the existing information-gathering arrangements, of their respective strengths and weaknesses, and of the main gaps to be filled. This analysis should be developed in a modular way and introduced incrementally, starting by the third year of the interim programme. Following the same rationale of building on what has been learned during the first two years of implementation by the third year a small, lean, autonomous health policy analysis unit should be constituted.

269. Somaliland, Puntland and the city of Mogadishu, in particular, are likely by the third year to have committed stakeholders that will have acquired the information and the capacity to embark on successful policy and planning work. Essential issues, like equity, gender, empowerment and participation will come to the top of the policy agenda and will be discussed on an informed basis. Considering its absorption capacity, the rest of South and Central Somalia will need more effort to get the following initiatives implemented at a fast-track rate:

- *Launching a health policy formulation exercise* - natural development of the work done during the first two years with a narrower scope.
- *Negotiating with stakeholders a comprehensive health financing strategy*, based on an appraisal of expected public revenues and allocations to health, an estimate of private contributions, and of the cost of delivering health care with sustainability concerns weighted against equity ones.
- *Formulating a health care network development plan*, aimed at reducing inequalities in access and

improving contents and quality of care.

- *Formulating a realistic and integrated pharmaceutical policy*, promoting use of generic drugs to reduce end-user costs.

270. Designing and introducing a performing management and regulation system stands out as the most challenging part of the recovery and reconstruction programme. The activities of the first two years will set-up financial, supply and management instruments. These will inform the experts and the decision-makers in charge of designing new management and regulation systems.

Implementation and monitoring arrangements

271. Stakeholders in the recovery of the health sector should not be intimidated by the political hurdles that have to be overcome to attain peace and stability in South and Central Somalia, Puntland and Somaliland. Preparatory work for reconstruction does not need to wait for a complete peace settlement to be reached. Instead, the next five years should be seen as providing a unique opportunity to lay the strategic and operational grounds for health sector recovery. Success will however not come smoothly and at low cost. Prerequisites are a long-term perspective shared by most actors, willingness to take risks in an uncertain environment, commitment to negotiate common actions with autonomous partners. Furthermore, adequate resources, persistence of efforts, sustained support by the international community, and openness to innovation are required to take advantage of the opportunities offered by the Somali transition in the health sector.

272. Given the complex nature of delivery in the sector, the focus of the five year intervention period is more on preventive health care and the treatment of common diseases such as malaria, TB and vaccinal diseases such as polio, measles etc. The services proposed are not highly specialized and therefore demand less skilled medical practitioners. The kinds of medical services initially provided should be standard and simple in nature.

273. The health sector is unique and complex. It includes Primary Health Care (PHC), at village, community and county; Hospitals and health clinics - at District; and Referral Hospitals at regional and national level. Each service level is a mix of many service components in terms of personnel, types of services provided, and the equipment used. It therefore requires co-providers.

274. The community can build health centres but the associated operations and maintenance costs such as staff and the drugs need to be budgeted for and provided by the District.

275. The Ministry of Health, on the other hand must be responsible for setting the policies and the standards and content of drug kits to be available at each level of health service delivery. This – and MOH involvement across the board - provides an important reinforcing effect for the state. Management and regulation systems should be designed keeping with the features of the health sector in mind. It has evolved over decades of turmoil. Since health care provision remains largely the responsibility of private for-profit and not-for-profit actors, and given the possible decentralised characteristics of a future health care delivery system, central authorities have to be kept slim, with monitoring and oversight responsibilities. They must however, have clearly defined responsibilities and duties that they can be seen to be performing

276. Monitoring internal imbalances will become increasingly important as security improves and health services are taken to areas previously deprived of them.

E. EDUCATION AND TRAINING

Current status, challenges and opportunities

277. Dramatic advances were made in Somalia as a result of the provision of free education in the mid 1970s (at all levels). After independence in 1970, primary education enrolments increased until about 1982, but then declined. This declining trend continued until May 1997 when the International Community resolved to undertake the rehabilitation of the education in Somalia. Since that time, there has been a significant expansion in terms of student enrolments and numbers of schools and teachers. This was made possible with the support of international donors and the efforts of UN agencies, the international and local NGOs, as well as the Islamic charities and Diaspora. This support has included, inter alia: support for setting curriculum policy, drafting syllabuses and writing textbooks; provision of in-service training and a pre-service teacher education; development of an Education Management Information System (EMIS); and development of alternative delivery channels and non-formal education (NFE) opportunities.

278. As a result of these efforts, the primary Gross Enrolment Ratio (GER) rose from around 12% in 1997 to about 22% in 2004/05; since 2001/2 the GER has increased by about two percentage points each year. The number of number of children enrolled in primary schools increased from about 151,000 in 1997 to about 348,000 in 2004/05, an increase of 130 percent. Girls are about 36% of primary enrolments, with a GER of about 16%. Girls' enrolments are lower in the higher grades than in the early years of primary school. Reaching excluded groups such as children with disabilities, orphans, demobilised children and unschooled youth are also a particular challenge when trying to establish equitable education for all. A rights based approach would address exclusion at all levels.

279. Secondary and tertiary education has also managed to grow: the number of secondary schools in Somaliland, for example, increased from four in 1999/2000 to 22 in 2003/04 (CfBT, 2004). As for tertiary education, whereas there was only one national university before 1991, there are now four private institutions in Somaliland and three in Puntland, along with one in Mogadishu in Central-South. Higher education promotes capacity development which translates into increased public participation that empowers people to demand claims as rights holders.

280. From a systemic/organizational perspective, the situation is paradoxical. On the one hand the "system" has collapsed: there is no central government with all that entails in terms of curriculum, examinations, standards, financing, data, etc. On the other hand, Koranic education systems have reached an estimated 90% of children up to the age of 7, primary enrolments have increased and are higher now than in 1991; financing is ensured by communities, the Diaspora, NGOs, international organizations, and charities; and school management, data collection and teacher training are ensured by community and zone (South & Central, Northeast/Puntland, and Northwest/Somaliland) authorities which have their own education ministries. Indeed, a major fact-on-the-ground is the importance of the Community Education Committees (CEC), which are present in about 95% of primary schools, up from 91% in 2002/03 (UNICEF, 2005).

281. In the late 1970s and early 1980s, the Somali government provided an innovative three-year education programme for nomadic and pastoralist children. A separate curriculum and attendance record was afforded them. Children attended school for six months each year, when the seasons permitted. During the rest of the year they accompanied their families with very little opportunity for schooling. Nomadic families who wanted their children to attend school throughout the year had to board them in permanent settlements or find an extended family member living close to school facilities to stand guardian to their children. A similar separate education strategy for this large group is proposed, for Somaliland and Puntland.

282. For the last nine years, the international community has provided assistance to revive the education sector but progress has been slow. The primary school gross enrolments ratio rose from 11.6% in 1997 to 19.9% in 2003/2004. According to UNICEF 2004/2005 Annual Primary School Survey, gross enrolment now stands at 21.9% (2005). This is one of the lowest in the world. It has also been hard to retain girls in secondary education where their achievement is also markedly low. Often girls and young women are expected to manage both domestic and educational responsibilities, often resulting in poor scholastic performance thus contributing to early drop-out from the educational system.

283. While it is true that the Diaspora remittances to these regions is considered the highest source of revenue, the exact proportion that go to education is not known but is acknowledged to be substantial (Lindley, 2005). Most of the remittances received are used to pay school fees for children. The Somali Diaspora has also played a significant role in financing education activities in the Somaliland, Puntland and in Central/Southern Somalia. The Diaspora have also contributed towards building and repairing of schools and colleges, paying teachers salaries, providing scholarships or shipping learning materials and equipment. Most of higher education institutions in Puntland and Somaliland have been set up through the support of the Diaspora.

284. Of the current primary school age population estimated at 1.5 million, 342,781 children are enrolled in primary schools (UNICEF Survey 2005). This represents a Gross Enrolment Ratio (GER) of 21.9%. Thus nearly 80% of school age children are out of school. Only one third of pupils are girls. Education is a human right and an essential tool for achieving the goals of equality, development and peace. Inadequate tertiary education is available in Somaliland and Puntland; there is one university in Mogadishu.

Table 15: Schools, pupils and teachers: 2004/5

Statistics of Primary schools in Somalia Number of primary schools, pupils, teachers, classes and basic statistics 2004/5

	Schools	Pupils	TEACHERS				Pupil/ Teacher ratio	Pupils per school
			Females	% Female	Males	Total		
South and Central Somalia	879	192,402	982	13.8%	6,126	7,108	27.1	219
Puntland	236	47,015	326	20.1%	1,297	1,623	29.0	199
Somaliland	397	108,995	271	10.4%	2,342	2,613	41.7	275
Total	1,512	348,412	1,579	13.9%	9,765	11,344	30.7	230

Source: Technical Report, UNICEF 2004/05: Note: The total enrolment includes Grade 9 pupils of the Arabic schools but the total enrolment used for the Gross Enrolment Ratio exclude the Grade 9 learners.

285. Government financing is minimal. In Somaliland, for instance, the Government allocated only 6.4% of its annual budget in 2001 to the ministry of education, about 90% of which went to pay salaries. Throughout the country, education is mostly financed by the communities and parents. According to the latest UNICEF Annual School Survey (2004/2005), the communities finance most expenses/services such as construction of new classes, rehabilitation of school facilities, school maintenance, salary and security. About 33% of primary school students did not pay fees, 49% in South & Central, 8% in Puntland; and 13% in Somaliland.

286. Overall, about 18% of the primary schools charge fees of more than \$3 per month for an eight month school year (7% in Somaliland, 40% in Puntland and 17% in South & Central); which is an increase of about 4 percentage points from the previous year. However, 33% of the schools charged no fees in 2004/5, which is up from 27% in 2003/4. In addition to fees, the textbook survey (Smart, 2004) finds that non-school fee costs per child (stationary, uniform, etc) are around \$34 in South & Central, \$30 in Puntland and \$69 in Somaliland. In other words, the annual costs of primary schooling to families appear to be in a range of \$34 (no fees + \$34 for materials) to at least \$93 (\$3/month fee + \$69 for materials) in a context where the average household income is \$250 per year and where families may have several school-age children.

287. In the post-primary sub-sector, financing is mainly through fees and support from parents/community, the Diaspora and the international community. In Somaliland, teacher salaries are paid by the Government and the communities. It is reported that Puntland has started to do the same.

288. Pre-service training was adversely affected by the fall of the Barre regime and for about ten years there was no teacher education programme in all of Somalia. Recently, private universities in Somaliland, Puntland and the South/Central have initiated pre-service training programmes. However, the numbers of students trained are few compared to the demand for teachers. Currently, in partnership with the education ministries, through the EC's SCOTT Project (Pfaffe & Smith, 2004), Save the Children UK, Save the Children Denmark and CARE are collaborating in spearheading the development of a systematic teachers training programme leading.

289. In-service training is the focus of the EC's SCOTT project where in-school mentoring and support will provide the basis for the programme. EC funding for this is being implemented by Save the Children UK, UNESCO and DIAKONIA Sweden.

South and Central Somalia

290. There is extremely limited early childhood development (ECD) in South and Central Somalia; a few Koranic schools take very young children but most education starts – and ends – at primary level. At this level, there are not enough schools, not enough teachers and not enough resources – all factors which contribute to a GER of only 15.7% (11.7% for girls). In the almost complete absence of a state system, most education is conducted in Koranic schools, some of which teach more than the Koran whose standards and curricula vary. Many children and adults who have slipped through the net during the civil war have no access to schools at all, even if there was funding available.

291. The exact number of secondary schools in Central/Southern Somalia is unknown. Statistics on the number of secondary schools, students, teachers, their qualifications etc. in South and Central Somalia are based on reports from various field assessments. According to them, some districts have no functional secondary schools at all. In Shabelle region, for instance, where statistics were obtained, there are only 370 secondary school students compared to 12,205 students leaving primary school.

292. Most school environments are not conducive for learning and this negatively affects the quality of education provided. Sanitation blocks are often inadequate and shared by both male and female pupils. Some schools, especially in urban areas, are overcrowded, so multiple-shifts systems have been introduced to cater for the large numbers.

293. There is an acute shortage of teachers across the system and where they exist, many are untrained and unmotivated. Teacher shortages are worst in rural areas but are still acute in towns and there is currently no plan to train people above primary level. Teacher training activities in South and Central Somalia will need to be revived and located appropriately in the districts. There is a shortage of experienced and qualified teachers. With only 30% of primary teachers qualified or trained, UNESCO, UNICEF and some NGOs with funding from the European Commission (EC), have conducted short in-service teacher training programmes in Somaliland and Puntland which is due to be expanded into South and Central.

294. Teacher trainees are mostly primary graduates or even lower, due to a lack of secondary school graduates. Since remuneration is low and work often voluntary, teacher training is currently not attracting higher qualified trainees. Teacher morale and retention rate is low due to poor remuneration, which further exacerbates the teacher shortage. Teacher salaries are approximately USD 20 and fees are collected from parents, since the local authorities do not have adequate revenue to pay recurrent costs. Some UN agencies and NGOs have assisted with small incentives for teachers; this had negligible impact and is unsustainable. Only 13.9% of primary school teachers are women – a fact that has knock on effects for female enrolment and retention.

295. There is currently only limited provision of Non-Formal Education (NFE) Programmes or alternative education programmes and most are offered to a few target beneficiaries in accessible districts of South and Central Somalia. The same applies to TVET, the limited provision of which is NGO-led and centred in secure areas. The provision of non-formal education is limited as this is provided only by a few agencies and NGOs. Literacy and numeracy are critical for sustainable development, as prerequisites for vocational training for different life skills, as well as for the economic and social reintegration of ex-militia.

296. Curriculum Development for all the sub sectors of education should take into account changing circumstances and the relationships/interconnections between the different education sub-sectors and the needs of the labour market. A curriculum for formal primary has been developed and the syllabuses, textbooks and teachers guides for the subjects have been completed in Somaliland and Puntland. However, the curriculum for Primary Alternative Education (PAE) is incomplete. These could be adapted for use in South and Central Somalia as well as Puntland and Somaliland. Curriculum development and related materials for South and Central Somalia should take into consideration current activities and experiences that will unravel with increased peace and access in Mogadishu, Merka, Kismayo and other towns.

297. Development of textbooks and production and distribution, as well as purchasing and distribution of textbooks is a critical component of the development of education in South and Central Somalia, Puntland and Somaliland. There are opportunities here for policy harmonisation and collaboration to earn economies of scale.

298. There is some private sector participation in the provision of secondary education in South and Central Somalia, Puntland and Somaliland but its extent is unrecorded. Technical and Vocational education (TVE) is being revived with support from UN agencies and a number of NGOs. Already the AVU, the WB and UNDP are supporting five universities in IT and teacher training as part of the rehabilitation of the higher education system in South and Central Somalia, Puntland and Somaliland as a whole³¹. There is however, no estimation of the kind of course demand required for TVE and efforts tend to be focused on accessible, peaceful communities rather than where the need is most acute.

299. Pastoral communities and agro-pastoralists in rural areas, which constitute 60% of the population, have particularly limited education facilities. Pastoralists tend to favour only a few boys for education opportunities. Girls provide domestic labour and move with the families in search of pasture and water and only rarely receive education opportunities.

300. As a result of continued insecurity in South and Central Somalia, Puntland and Somaliland, 240,000 refugees reside in camps in Kenya, Yemen, Ethiopia, Djibouti and Eritrea; there are IDPs in South and Central Somalia, Puntland and Somaliland. Particular notice must be taken of them and of vulnerable groups such as OVCs and children associated with the military.

Puntland

301. Puntland has limited ECD and teaching at pre-primary and primary is based around Koranic schools. The Puntland National Development Plan acknowledges challenges of "Affordability, ownership, gender disparities and unbalanced distribution in terms urban vs. rural are all some of the major challenges that education in Puntland currently facing" (Puntland NDP 2005 p122).

31 AVU,UNDP doc

302. There are a limited number of schools and very low enrolment ratio of primary school age children. UNICEF reports that of the estimated 192,635 of children in the primary school age group in Puntland, only 46,595 pupils were enrolled in primary schools in 2004/2005 school year, which is 24.2 % of all primary school children at 20.3% girls and 28.1 % boys. Even fewer children are enrolled at secondary level with a total of 19% of school-going age attending secondary school classes.

303. Similar needs such as school buildings, equipment, teaching and learning materials, curriculum development and human resources are registered in South and Central Somalia, Puntland and Somaliland.

304. Provision of secondary education is limited in Puntland, which has just 12 functional schools. Despite long-term EC support, schools do not yet have adequate teaching, learning facilities and materials. Teachers are mostly under-qualified and inadequately compensated; schools do not follow enough policies designed to attract and retain girls.

305. Technical and vocational education and training (TVET) is not developed yet even though TVET remains critical for the development of the skilled labour that is required for the development of the emerging Somali economy. Currently, there are about 50 privately run vocational training centres in South and Central Somalia, Puntland and Somaliland and there are hardly any technical schools. Those in Puntland are all NGO or Diaspora supported. Private and community initiatives have seen the establishment of three tertiary institutions and one teacher-training college; none receive more than perfunctory government support.

306. Education infrastructure is inadequate or no existent from ECD to MOE level and requires massive investment based on as yet commissioned research. Puntland has a draft education policy ready for ratification by Parliament but no Education Act prepared. It will require continued wholesale support to achieve the Somali wide goals of moving towards achieving its Millennium Development Goals.

Somaliland

307. As in Puntland and South and Central Somalia there is very little ECD and what there is tends to be based round religious schools. At primary level, there are not enough schools and the schools are poorly staffed and equipped. The government however, is taking an interest in the education sector and – although chronically under-funded – is working on the curriculum, financing teachers' salaries etc. There is a GER of 32.8% that is greatly skewed in favour of boys. GER for girls is only 23.2%.

308. Somaliland is working on Primary Alternative Education strategies for both nomadic children and adults (through NFE) but this is at an early stage, as is all non formal education for those who have missed out on education because of the war and the complete failure of many social services.

309. There are only 26 secondary schools in Somaliland. Most have a shortage of teachers and many of those in post are untrained. A review of the secondary schools curriculum has been conducted for both Somaliland and Puntland. It indicated a need to strengthen capacity for exam assessment and certification at the secondary school level.

310. Quite a number of NGOs run adult education and literacy programmes as well as vocational courses in Somaliland. These range from literacy and numeracy courses to skills programmes for women and youth. There is however, no overall strategy to these programmes and they reach only a limited and lucky few.

311. There is no plan for training any other than primary school teachers – a problem that needs to be addressed as it will lead to more and more people teaching with only primary school education themselves. There is an urgent need for teachers at every level of the education system.

312. Due to the relative peace prevailing there, Somaliland boasts four private universities; there are no wholly state funded tertiary institutions and none planned as yet. Despite being more advanced than South and Central Somalia and Puntland, facilities remain inadequate at all levels; there are insufficient statistics from which to extrapolate policy and make plans. Somaliland has a draft education policy awaiting ratification but the Education Act in which it will be encapsulated is not yet prepared.

313. There is recognition that reform of education is an incremental process that must be led from within the Somali community as agreement on necessary reform develops on the wider development vision of the emerging Somali governance structures. The report, at once, focuses on building capacity of the governance structures for reform that includes supporting the participation of communities, local authorities and other stakeholders; but also prioritizes primary/basic education within a decentralized system-wide approach with the central authorities that have the capacity to ensure an enabling environment for participation of returning refugees, IDPs and Diaspora, communities, women and youth, in education reconstruction.

Vision and Priority Initiatives

314. By the end of 2011, federal, national, regional and district education authorities will have acquired stronger technical, managerial and financial capacities and will be able, with the support of other local partners (public and private) and external partners:

To develop a vibrant, efficient and effective education system to improve access, quality, and gender equity in primary, secondary, and tertiary education; increase uptake of vocational, science and commercial subjects; increase the number of skilled people in technical and vocational education and training; improve provision of special education; improve the performance of support institutions in the education system; reduce gender inequality in access to education services and the quality of their provision.

Target Outcomes.

- i) Education for All and the Millennium Development Goals. The vision for the sector is guided by the desire to work towards achieving the EFA and MDGs set for 2015 as guiding parameters. While the MDG goal 2 (“achieving universal primary education and ensuring that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling”) will not be achievable, the adjusted MDG target for primary GER for Somalia is estimated at 71%, up from the current 22% and the primary target GER for grades 1 to 5 is estimated at 80%. The adult literacy rate target is estimated at 50%. An examination of primary enrolments in the last two years, especially in grade 1, points to significant increases compared to the higher grades. This is an indication that the intake rates are increasing thanks to the social mobilization and other interventions that have been carried out by all those involved in the provision of education in Somalia. With these scenarios and premised on more aggressive mobilization of the communities and substantial increase of international funding support, targets for the RDP are:
 - a. By 2008, a policy framework for expanding EC services is adopted, and ECD curriculum and methodologies developed. **Early Childhood Options: ECD/ECE/Koranic Education.** In order to encourage mothers and women to engage in livelihood activities, counter the resort to use girl-children as child-carers in the family (by removing them from formal education), in countries where these have been issues, short program for children of low-income, affected families have been successfully instituted. In most cases there were few other formal early child development settings providing services to these children. The programs could provide part-day care services during the regular school year. In other cases, however, programs provide either directly or in partnership with other providers, full-day, full-year services, thus opening other options for early childhood care and education.

- b. Children up to the age of 5 can be cared for in a range of settings from relative care to home-based child care, family child care, group care, and center-based care. With changes in Somali family structure and the necessity for many women parents to seek a living outside the home, children are spending significant amounts of time in "family care", with often the girl-child taking the role of nanny, away from studies. Promoting ECE is in response to changes in family structure, poverty, livelihood migration and mobility patterns, and community resources. For example, increasing numbers of ECE programs are expected in 2009 in providing direct or through referral full-day, full-year services, in response to new populations (IDP returnees and refugees) increase. Support services to pregnant women and families with infants and toddlers are normally taken in with ECD programs, on the basic premise that children benefit from quality early childhood experiences and that effective intervention can best be accomplished through high quality comprehensive services to needy children, along with their family and community involvement that addresses the unique needs of children, their families and their communities.
- c. To develop fully and to achieve social competence, children and their families need a comprehensive, interdisciplinary approach to services including education, health, nutrition, social services, family and community-based, with specific models of service provision flowing out of the needs of diverse communities. ECD/E curriculum normally has as target outcome school readiness incorporating five child development domains key to school readiness: physical well-being and motor development; social and emotional development; approaches to learning; language development and emerging literacy; and cognition and general knowledge; thus incorporating the interrelatedness of cognitive, emotional, and social development; physical and mental health; and nutritional progress of the child.
- d. In the case of South and central Somalia, Puntland and Somaliland, four core variables are identifiable, important during the development of the detailed program design. These core variables are:
- ◆ Region of the country;
 - ◆ Race/ethnicity (clan/sub-clan) sensitivity;
 - ◆ Urban/rural/(agro)-pastoral divide;
 - ◆ Population density; and
 - ◆ Depth of poverty in communities.
- e. In considering integration with the well-established Koranic system, equally important is variation on the dimension of quality, so that the programs offered reflect the existing range of quality. But, while quality is not likely to be feasible as an initial stratification variable, because it cannot be easily measured in advance of program area selection, further variables which can be put forward as sources of variation of impact:
- ◆ Design of program as a one-year or two-year experience for children;
 - ◆ Program options (e.g., center-based, home-based, part-day, full-day);
 - ◆ Aid community presence (e.g., Islamic community donors, Koranic center-based schools, functioning public school, non-profit organization);
 - ◆ Community-level resources and welfare support system;
 - ◆ Alternative child care options for low-income families; and
 - ◆ The nature of the child care market and the labour market in the community affected.
- f. Based on the unique situation and resources of the community and the needs of the children and families served, local ECD programs are free to vary their practices and approaches, provided that a minimum performance standards (to be agreed in Year 1 and 2). This flexibility to shape local programs to best address the needs of targeted children and their families, in community-specific environment is intended to keep the program relevant in an ever-changing Somali environment in the 5 year intervention period. For example, programs

serving new immigrant or refugee populations should adapt their services they provide and their curriculum so that they are culturally and conflict-prevention relevant. Unfortunately, there is little comprehensive information on the quality of care provided to young children across the country. Quality of care may vary both within and across different types of settings.

- g. By 2008, pre-school children in targeted communities receive ECD services, including psychosocial stimulation.
 - h. Increase gross primary enrolment on average from 22% in 2006 to 48% by 2011 (with a particular emphasis on access through alternative delivery channels);
 - i. Enrol 20 % of out of school over-aged youth in basic education programmes;
 - j. Provide 35 % of adults with access to literacy campaigns and accelerated learning programmes;
 - k. Improve the quality of basic education provided by recruiting and training more teachers, providing adequate teaching and learning materials and infrastructure facilities. Female teachers in particular can play a key role, both in providing a secure environment for girls and supporting gender relations generally;
 - l. Ensure that the education provided is contextually and culturally relevant which means including aspects of indigenous knowledge. This implies reviewing the curriculum to take these needs into account;
 - m. Ensure that special education/inclusive education is given its due attention and resources so as to cater for all the children with special needs and on basic education.
- ii) Organization and management of the education sector. An efficient and effective organization and management of the education sector is essential for successful implementation of the first 5 years. At the end of the first 2 years, planning, coordination, implementation mechanisms, effective management information systems, monitoring and evaluation capacities, and multiple sources for financing the delivery of education services will have been developed and operational.
 - iii) The whole vision of providing access, coverage and rapid expansion of quality opportunities for education depends on rapid expansion of teacher training opportunities. Key targets for this period are to: Establish teacher education training institutes and a network of training resource centres and school cluster centres as recommended by the EC funded SCOTT programme. But this should be considered in the wider context of all the three regions taking into account the security situation in the Southern/Central Somalia; and, Use the institutes and network to train primary school teachers and alternative education teachers targeting both existing teachers and secondary school leavers and using a mixture of school based and distance modes of delivery.
 - iv) Technical Education and Vocational Training. The economy throughout the country is developing and the reconstruction period will bring with it demands for skilled personnel. Employment in the public and private sectors will be limited by the economy's capacity to sustain it. For this reason the education and training provided should prepare students for the labour market or for self employment by:
 - a. Advocating for support to a relevant TEVT curriculum in tandem with the needs of the labour market.
 - b. Establishment of vocational training centres for out of school youth and targeting women.
 - c. Expanding the enterprise-based training programmes which have proved successful in past.

Table 16: Student/Teacher Population Projections for South and Central Somalia, Puntland and Somaliland

Primary Education Student/Teacher Population Statistics for South Central Somalia, Puntland and Somaliland														
	Total and Gender	Current Population (2004)	Population 6-13 (2004)	Total Number of pupils (2004)	Current No of schools	Projected Pop 6-13 (2011)	Total Current GER 2004/05	Target No of Students 2011	Target GER for 2011	Target no of schools 2011	Current No teachers	Current Teacher Pupil Ratio	Target no of teachers 2011	Target Teachers Recruitment and training
TOTAL				342,768	1512	1,979,518	21.9%	877,799	44.34%		11,347	30.2	21,944 (1:40)	10597
South Central Somalia	Total	5,620,557	1,192,502	187,805	879	1,376,010	15.7%	560,036	40.7%	974³²	7,108	27.1	14,000 (1:40)	6892
	Female	2,801,286	594,343	69,552		685,803	11.7%	285,980	41.7%		982			
	Male	2,819,271	598,159	118,253		690,207	19.8%	293,338	42.5%		6,126			
Puntland	Total	907,935	192,635	46,595	236	222,279	24.2%	116,474	52.4%	259³³	1,623	29.0	2,912 (1:40)	1280
	Female	452,515	96,009	19,461		110,783	20.3%	62,371	56.3%		326			
	Male	455,420	96,626	27,134		111,496	28.1%	58,089	52.1%		1,297			
Somaliland	Total	1,557,196	330,387	108,368	397	381,229	32.8%	201,289	52.8%	447³⁴	2,613	41.7	5,032 (1:40)	2969
	Female	776,107	164,665	38,139		190,005	23.2%	104,503	55%		271			
	Male	781,090	165,722	70,229		191,224	42.4%	119,324	62.4%		2,342			

³² 95 schools (@ 575 pupils/school with double shifting) targeted for construction or rehabilitation

³³ 23 schools (@ 450 pupils/school) targeted for construction or rehabilitation

³⁴ 50 schools (@ 450 pupils/school) targeted for construction or rehabilitation

Priority initiatives

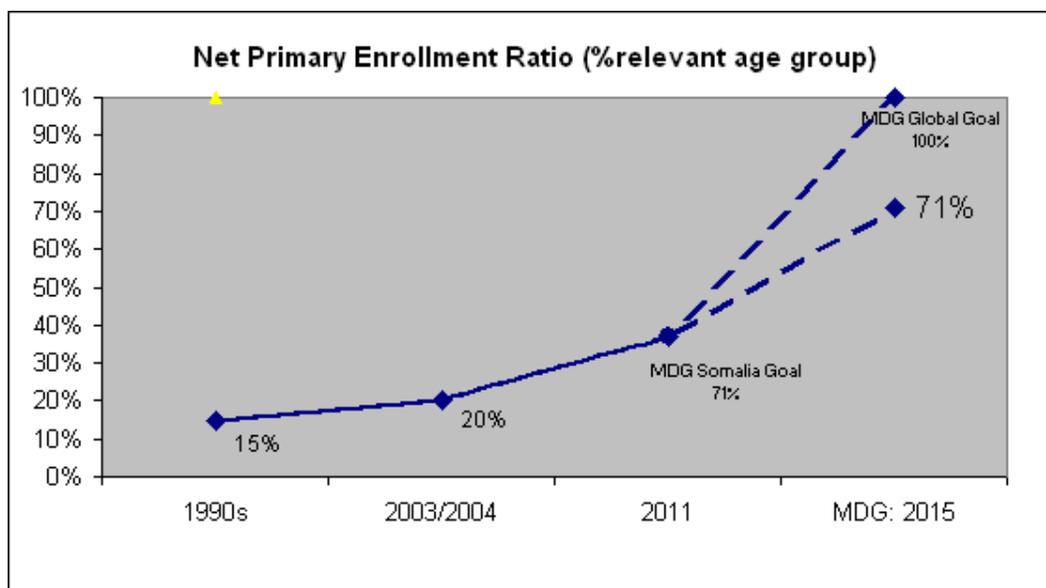
315. Support progress towards universal access to quality education by: Rehabilitating, supplying with teaching materials and revitalizing at least 25% of primary and 30% of secondary schools, and a substantial proportion of the vocational training and higher education system facilities. This should also target strengthening the quality and relevance of basic education by supporting improvement of primary school facilities, classroom teaching (including a participatory life-skills approach to Islamic Education, FGM, HIV/AIDS, hygienic and reproductive health) and Ministry supervision and support in progressively increasing districts' ability to achieve improved enrolment, retention, and completion rates, especially amongst girls. The creation of an educational and social environment where women and men, girls and boys are treated equally, and where non-stereotypical images of women and men are promoted, would be a step towards the elimination of the causes of discrimination against women and the inequalities between women and men.

- i) Addressing as a separate programme the low attendance rates of girls in education and women in training.
- ii) The Koranic schools: their role, operations, the number of children of what age that attend them, and their curriculum. In addition, it would be useful to examine their potential (and the willingness and capability) for curricular expansion to offering non-Koranic subjects such as maths, language, history, etc.: by learning from other countries (Mauritania, Nigeria, Malaysia, etc) that have successfully used the Koranic schools as vehicles for expanding access to the more "formal" school curriculum.
- iii) Continue support with development of Educational Policies and possible independent curriculum development (which exist already in Puntland and Somaliland, but need updating and broadening) as well as address the immediate needs for capacity building and institution building.

Figure 5: Net primary Enrolment Ratio (% relevant age group)

Target: Achieve 100% by 2015

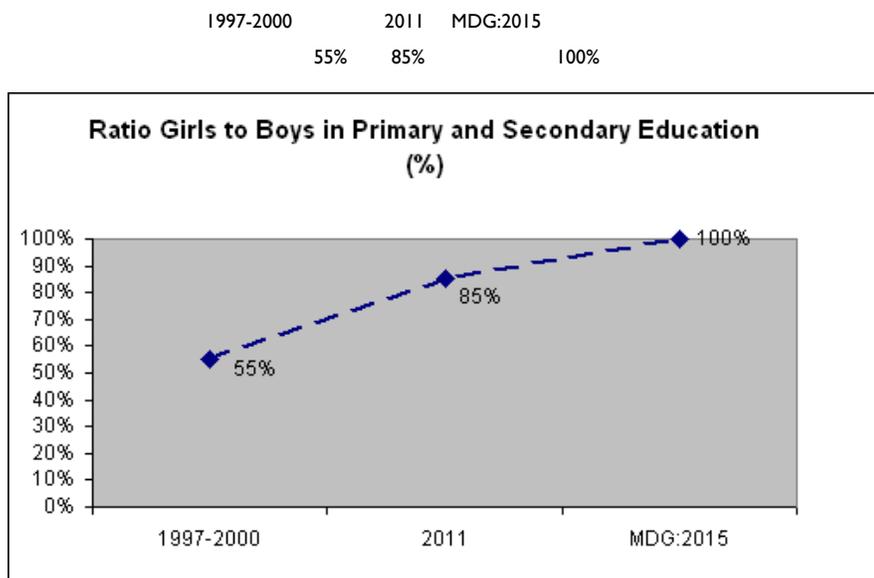
1990s	2003/2004	2011	MDG: 2015
15%	20%	37%	100%
15%	20%	37%	71%



Note: Baseline data for 1990s comes from UNDP MDG Report on Somalia (zero draft), 2004.
 The report also gives a lower 2015 MDG target to Somalia (71%) than the global target of 100%.

- iv) Supporting the MOE in defining and implementing a new education policy, defining teachers and education officers' training, continue reviewing curricula for all levels of the education system, procuring and developing teaching and learning materials, and a curriculum that includes education in water harvesting, forest conservation, grassland and wildlife protection, human and animal health targeting pastoral communities.
- v) Support structures aimed at expansion of community-based participation (parent teacher associations, on-going local entrepreneurs) to those districts and communities not yet constituted.
- vi) Strengthen non-formal adult education programmes, particularly for women and young people who have not been given the education opportunities that are their right. Formal (and non-formal) education and training for women and girls, with its exceptionally high social and economic return, are two of the best means of achieving sustainable development and economic growth that is both sustained and sustainable.³⁵ Literacy of women is an important key to improving health, nutrition and education within the family unit and in empowering women to participate in decision making in the family.
- vii) Policy development to allow children associated with armed conflict to pursue formal educational and/or professional development (apprenticeship or skills/vocational training) depending on their age, capacity and aspirations. This is to offer real alternatives to militia life for the children for successful reintegration into their communities. The alternative opportunities have to be feasible and long-lasting with respect to their dignity, rights and their protection, comparable to those offered to adults.
- viii) Providing pastoral mobile education system or rural village based schools that accommodate pastoral movements in schooling, having learned lessons from the Somali education system of the 70s and 80s and elsewhere.
- ix) Gender Equity and the Advancement of Girls' Education through creative use of food aid in school and out.

Figure 6: Ratio Girls to Boys in Primary & Secondary Ed (%)
Target: Achieve 100% by 2015



³⁵ Beijing Declaration and Platform for Action

316. In order to reduce school drop-out rates for girls and act as an income transfer to affected households thus reducing gender disparities in education. In this light, it is proposed to consider food aid for the first 3 years to: encourage school enrolment for girls (aiming at an increase of at least 1-2 per cent annually); taking into account sustainability issues, stabilize attendance, aiming at least 80% of whose families initially receive food aid. The programme could be piloted in two districts in each State and then replicated in the remaining districts of South and Central Somalia, Puntland and Somaliland from 2009 onwards.

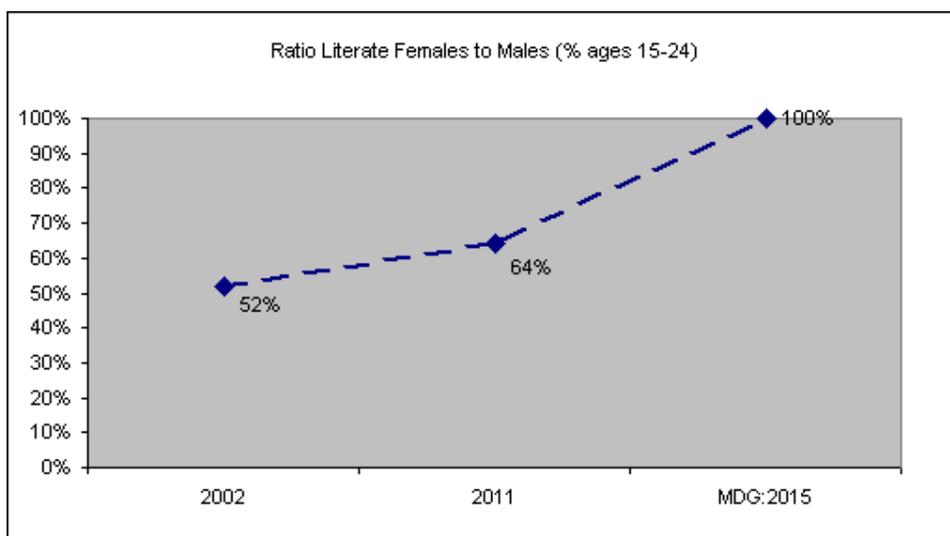
317. Priority Initiatives for Phase 2: Priorities have to be set as education needs are broad. The target outcomes below are to ensure that all children complete compulsory education (eight years) and have the opportunity to continue to higher levels, through:

- i) Expanding access and raising the quality of primary and secondary education nationwide;
- ii) Building a higher education system that responds to emerging reconstruction needs, creates new skills, certification, professional and income opportunities for Somalis and meets international standards to development needs;
- iii) Expanding citizens' access to special-needs, technical, vocational and informal education, with a specific focus on improving livelihood opportunities for vulnerable groups, including orphans, widows, the disabled, refugees, returnees and IDPs, demobilized militia and unemployed youths.

318. The RDP anticipates that by 2011, the primary enrolment rate will almost double from the current 21.9 % to 40 %, assuming an average annual GER growth rate of 4% for the 5 year period and assuming further that all the required interventions will be implemented and adequate funding and absorption capacity/implementation capacity is apparent. This will mean construction of more primary schools with health, water and sanitation facilities to meet the expected rising demand from returning Somalis in the Diaspora, refugees, IDPs and resident communities.

Figure 7: Ratio Literate Females to Males (% ages 15-24)
Target: Achieve 100% by 2015

2002	2011	MDG:2015
52%	64%	100%



319. To encourage gender equity for school-going children, it is planned that more girls be enrolled for primary and secondary schools. Equal educational opportunities benefits both girls and boys and thus contributes to a more equal relationship between women and men. Equality in access to and attainment of educational qualifications is necessary. If more women are to become agents of change. The enrolment of girls should increase from the current 15.9 % to 30 % in primary with an assumption of 3% increase per annum for the five year period. This should be seen only as a start; enormous effort is required to change the skewed system so that it reflects the needs and desires of all members of society.

320. Various far-reaching activities will contribute to redressing the current imbalances in girls' education especially with regard to gender gap enrolment and the high rate of drop out of girls from school in both primary and secondary. These include institutional capacity building, strengthening the Gender Education Department of MOEs in terms of staffing and implementation capacity, training of at least 10% of the staff, provision of administrative equipment, developing policy, advocacy, communication programmes, and gender sensitive curriculum instructional materials. It also envisages carrying out enrolment and retention campaigns through sensitization exercises via the media in the first 2 years.

321. An Education Fund approach is much more demand-driven than supply-driven and with the reality on-the-ground being that education is deeply decentralized throughout the country, this seems to suggest the best scenario for the immediate interventions. An **Education Fund** approach may well be the best mechanism for the larger-scale financing aimed at scaled-up efforts for improving access and quality. The advantages of this approach are that it enables local initiatives to develop from their strengths and it can avoid the pitfalls of top-down approaches. It also recognizes the current dynamics of the local initiatives and the quasi-absence strong central capabilities. In this context, it would be important to avoid managerial complexity that could deter applicants that do not have the administrative and accountability capabilities often expected from international organizations. The costing of the 5 year period is indicative and is based on the current rates of services as per the World Bank/UN estimation. Table below provides a breakdown of the estimated costs. Costing for salaries is included. Costs are based on the following assumptions:

- i) Although current teacher pupil ratio currently stands at 1:30 this is expected to rise to 1:40, which is an expected EFA average. Furthermore, the training of teachers may not match the rising demand for them. It is estimated 10,000 trained teachers will be in service by 2011.
- ii) The costing is also based on the assumption that some of the costs will continue to be met by the communities and that private participation in the provision of education services will be encouraged. In this scenario, teachers' salaries will continue to be shared by government and the communities but with the governments eventually taking over the full payment of salaries. Budget for salary supplementation of teachers is provided in all the sub sectors.
- iii) Early Childhood Education. The TFG and the MoE in Puntland expressed the preference to leave ECD to the communities and focus on policy development, curriculum and provision guidelines. Mapping of ECD services is also included. A minimal budget is indicated for support to infrastructure development.
- iv) Basic Education: Costing for water and sanitation is included in the costing for new schools; a budget for the repairs and replacement of water pumps is provided for existing schools. The budget assumes the replacement of existing textbooks for primary education and new ones for grade one.

- v) Higher education: The World Bank has recommended that this be left to the private sector. While this is accepted, a budget to support the sub sector in policy and coordination is provided. Similarly some budget is provided to support infrastructure development, which would be provided through the proposed fund.
- vi) That for the five year period, the GER for primary education will increase to about 48%. This will mean that the GER for South Central Somalia will rise from the current 16% (20% for boys and 12% for girls to 41% (42% for girls and 43% for boys); the GER for Puntland will rise from the GER of 24% (20% for girls and 28% for boys) to 52% (56% for girls and 52% for boys); while for Somaliland the GER will go from 33% (23% for girls and 42% for boys to 53% (55% for girls and 62% for boys). These projections are based on past three year GER growth trends in the three geographic regions since 2001/2002 plus expectations resulting from the proposed interventions. It is anticipated, however, that by the end of the 5 year period, the GER for girls will be almost at par with the boys given the implementation of the proposed interventions for increasing enrolment of girls in schools. Given the aggressive social mobilization for education and other proposed interventions necessary in post-conflict settings, it is expected that the targets set are realistic and could in fact be exceeded if the conditions (improvement in security and availability of adequate resources) are favourable. The projection for students and teachers are provided in Table 16 above provides an indication of projection targets.

322. Table 17. Estimated costs in \$US million

By sub-sector	Years			Totals
	1	2	3 – 5	
Somalia				
ECE	1.18	1.08	1.15	3.41
Basic Education	37.15	40.07	131.35	208.57
NFE	8.20	9.96	46.92	65.08
Secondary Education	11.19	13.58	50.50	75.27
TEVT	15.66	15.73	33.70	65.09
Teacher Education	13.86	18.07	39.36	71.29
Tertiary Education	11.63	13.60	36.74	61.97
Institutional Dev & Capacity Building	8.38	9.00	39.95	57.33
Totals	107.25	121.09	379.67	608.01
South/Central	52.12	57.7	176.26	286.08
Puntland	21.03	25.69	71.66	118.38
Somaliland	34.1	37.7	131.75	203.55
	107.25	121.09	379.67	608.01

323. Macro-economic collaboration in public finance allocation planning to favour re-allocation of expenditures on basic social services will need to be coordinated with the Ministry of Finance and Ministry of Planning. To achieve these outcomes will require further substantial mobilization of resources for capacity building, good management, sound policy development and the coordinated implementation of all partners in the education sector.

324. The private sector has been instrumental in supporting the development of education in Somaliland, Puntland and Central Southern Somalia. This sector has contributed in financing renovation of schools and establishing tertiary institutions. Le Sage (2004) reports that Islamic charities are active in supporting education institutions. However, the extent of the exact support is not available.

325. Given the proposed “fund” structure and mechanism for disbursing funds according to demonstrated demand and implementation capabilities, it is necessary to factor out, on an indicative basis, the proportion of these costs that would be managed by the fund. Table 7 provides an indicative view of how this could be done. The basic guiding principle here is that all activities other than those related to the core ministerial functions would be channeled through, and managed by the fund mechanism. Core ministerial functions include: planning, management, statistics, etc; curriculum development; social mobilization; 50% of the teacher training; salary payments to teachers and MoE staff. The more precise division of functions (between MoE and the fund) would be subject to negotiation over time, using experience (based on monitoring and evaluation) as a guide. The figures in Table 7 are derived from an analysis of those in Annexes 4-6. The funds would receive initial resource inputs that would be periodically replenished subject to adequate accountability (financial and programmatic, based on monitoring and evaluation data).

326. **Financing Strategies and Unit Costs:** It is recognized that funding of the education system must be sustainable in the long run from domestic resources. The table below shows a scenario based on an estimate of the wealth sharing agreement being discussed in peace talks. Given the years of war and neglect and the low starting base for income, it is understandable that there will be a substantial funding gap for the next decade or so. Without education there will be no growth and without growth there will be no stability.

Table 17: Indicative allocations between MoEs and the proposed Fund

	Amounts in \$US million							
	<i>South Central</i>		<i>Puntland</i>		<i>Somaliland</i>		<i>TOTALS</i>	
	Fund	MoE	Fund	MoE	Fund	MoE	Fund	MoE
ECE	0.02	1.2	0.02	0.95	0.02	1.15	0.06	3.30
Basic Education	141.56	85.38	40.55	21.69	68.00	38.51	250.11	145.58
TVET	23.00	0.53	9.00	0.53	18.00	0.53	50.00	1.59
Secondary Education	4.35	27.65	2.18	14.75	4.35	18.57	10.88	60.97
Tertiary Education	26.05	1.55	10.45	1.55	16.91	1.55	53.41	4.65
Assessment & Certification		6.20		3.27		6.20	-	15.67
Management		23.11		9.07		16.35	-	48.53
<i>Totals</i>	194.98	145.62	62.20	51.81	107.28	82.86	364.46	280.29

327. It appears that the education ministry of Somaliland has more operational control than in South & Central and Puntland. In any case, according to the TFG “Charter”, education is the responsibility of the “State Governments.” The education systems in Central Southern Somalia, Puntland and Somaliland are managed by their respective education ministries. The education ministry of the Transitional TFG is settling down in Jowhar/Baidoa. In Puntland and Somaliland, the ministries have established reporting lines from the central level down to the regional and district levels, with regional education officers and district education officers in charge of their respective areas. These officers are supported by Regional Education Committees and District Education Committees. Management of education at the local or grassroots levels falls under the Community Education Committees (CECs). Their main task is to run and monitor the schools. The committees are composed of volunteers selected in open meetings by communities and are present in 95% of the primary schools in Somalia. They work closely with the school head teachers to ensure that the schools are properly managed. Their tasks range from resource mobilization, school construction, school maintenance, to sensitising the community on education issues as well as attending to problems that face the schools.

328. All three ministries of education have established key departments/sections to administer key education areas. These departments are: Early Childhood Development, Primary Education, Non Formal Education, Secondary education, Technical and Vocational education, Teacher Training, and Tertiary Education/higher education. While these departments have been established, they are poorly staffed; UN agencies and NGOs have endeavoured to support these ministries.

F. CULTURE AND HERITAGE COMPONENT

329. The culture and heritage component falls under the Education and Training Sub-cluster but is treated separately below.

Current situation

330. The devastating impact of the Somalia civil war on culture is one of the most striking aspects of the Somali tragedy. Somalis are renowned for the richness of their orally-based culture, which normally constituted their most significant national asset and their most noticeable contribution to human knowledge. Given the oral nature of Somali society, verbal art constitutes the backbone of Somali traditional culture. Oral poetry, oral narratives, proverbs and words of wisdom were an integral part of every aspect of the daily life. No single activity of day-to-day life (herding livestock, sewing mats, sailing boats, harvesting crops, organizing feuds and debating political issues) was carried out without being accompanied by and reflected in one or more of these forms of oral culture, predominantly poetry.

331. Tangible culture too was not less important or less prominent in Somali life. Like the forms of intangible culture or verbal art described above, non-verbal cultural forms of expression were an integral part of the people's daily life. Virtually every object hand-crafted by a traditional Somali for practical use was crafted in such a way that made it a work of art as well.

332. In modern times, as part of the speedy urbanization, the cultural life of the country was greatly revitalized and remarkably modernized. The theatre, for instance, and other forms of modern performing arts became the backbone of the country's cultural life with tens of crowd-pulling performances running every night. Cultural infrastructure rapidly developed. Facilities such as cinemas, theatres, libraries and museums became prominent features of the country's cultural life.

333. Sadly, this once vibrant cultural life is now a thing of the past. Over one and half decades of civil war and anarchy wrecked everything and left the country with a tragic state of cultural impoverishment not seen anywhere else in modern world. The entire cultural infrastructure has been destroyed. All the theatres, libraries and museums are gutted. The entire storage of national heritage accumulated over the centuries is lost; all the records, documents and movable cultural properties have either been destroyed or looted. That means the memory of a nation is lost. Worse still, the talented people of the country (poets, playwrights, artists, writers and other cultural practitioners) had to flee the civil war and disperse all over the globe. Thus, the cultural life of a whole country has been brought to a halt since the outbreak of the civil war over 15 years ago. All these have resulted in a serious moral decadence and mental impoverishment among the present-day Somalis. This great loss of the collective memory constitutes one of the big problems facing the efforts of reconstruction and institution rebuilding in post-conflict Somalia.

334. No cultural policy or national strategy for cultural reconstruction has been developed as yet by any of the current political administrations: the TFG, Somaliland and Puntland, mainly due to the lack of capacity.

335. In light of the above, it is imperative to take an immediate action to preserve the endangered Somali cultural heritage in alignment with the provisions of the universal Convention on Safeguarding the Intangible Cultural Heritage (2003) and the World Heritage Convention adopted at the 17th Session of the General Conference of UNESCO in November 1972. It is also important to

reconstruct Somali cultural institutions and services and to make use of the great potential of Somali culture as vehicle for peace-building, and sustainable development; the Somali case offers a good example showing that culture is an effective tool for sustainable development and poverty alleviation as highlighted at the UN Millennium Summit (2005) as well as at the World Summit on Sustainable development (Johannesburg 2002).

Priority areas

336. The following areas of Somali culture and heritage are in greatest need for an immediate action of reconstruction and development; these are:

- Restoration, documentation and preservation of culture and heritage;
- Technical support to relevant ministries of the TFG, Puntland and Somaliland in capacity building, institutional reconstruction and the development of a national cultural policy and a clear strategy for cultural development;
- Rehabilitation and development of human resources in the field of culture and heritage; and
- Rehabilitation of the media and the development of media initiatives for peace-building, reconstruction and development.

Priorities in the first 2 years

- a. Start saving the endangered Somali memory by collecting, documenting and appropriately documenting the scattered audiovisual recordings of Somali culture, documents, manuscripts, films, photographs, posters, artefacts, and other movable heritage, with a view to provide the necessary base for the reconstruction of Somalia's national library and national museum.
- b. Arrange for an adequate premises used as a temporary custody for the collected heritage materials.
- c. Create general awareness of the importance of documentation and cultural preservation among people, including Government officers through workshops, seminars and media.
- d. Provide the TFG and the cultural services in Somaliland and Puntland with expert advice on cultural institution building and developing cultural programmes.
- e. Provide support to civil society organisations, concerned with culture, in organisational development and capacity building.
- f. Provide the necessary support to the local cultural NGOs and the artists still struggling not to give up their creative profession.
- g. Initiate a theatre project reviving the productions of Somali plays discontinued since the outbreak of the civil war over 15 years ago.
- h. Provide support to the organization of an international Somali cultural festival comprising a cultural conference and performing arts among other things, national cultural forum, literary and artistic festival and a nation-wide book fair to encourage writing, reading and creativity.
- i. Rehabilitation of the media and the development of media initiatives for peace-building, reconstruction and development.

Priorities for the next three years

- j. Continue and enhance the preservation initiatives by digitally converting all the materials, establishing an online catalogue creating a rich online archives or database widely accessible to all interested.
- k. Carry out training programmes to prepare skilled people well trained on cultural conservation.
- l. Develop a cultural policy
- m. Provide support to the establishment of information and documentation centres either within institutions such as universities or independently.
- n. Continue providing expert technical consultancy on institution building and programme development to the Governmental cultural departments, civil society and international organisations.

- o. Start reinstating the collapsed cultural institutions, such as the National Theatre, National Library, National Museum, National University and the Academy of Culture.
- p. Sponsor research into various aspects of Somali culture, language and traditional ways of living, with a view to properly advice on the way forward for cultural preservation and development.
- q. Encourage and provide financial support to local authorities (where available) and the civil society to establish public libraries in their localities and to provide them with the necessary books and to create a culture of reading.
- r. Provide printing and publishing facilities and support the publication of books and literary and cultural magazines and periodicals.

Implementation and monitoring arrangements

337. Today the Somali linguistic scene is characterized by confusion and anarchic use of the written language, with widespread abuse and misuse, in the absence of any guidance or point of reference. Currently no cultural policy or national strategy for cultural reconstruction has been developed in South and Central Somalia, Somaliland or Puntland. As urbanization keeps progressively eroding and distorting traditional ways of life in South and Central Somalia, Puntland and Somaliland, it is important to preserve the remaining heritage items that show how people expressed their life in both their language-based forms of cultural expression and in the objects they use in daily life.

338. The plans presented in this document envisage a first phase of 2 years followed by a 3 year phase in which most activities put in place during the first period are scaled up. The plans are for the Education and Training sector in South and Central Somalia, Puntland and Somaliland and include all anticipated resources.

G. FGM

Current status, challenges and opportunities

339. Female Genital Cutting or Female Genital Mutilation is defined as “all procedures, which involve partial or total removal of the external female genitalia and/or injury to the female genital organs whether for cultural or any non-therapeutic reasons” (WHO, 1995). Despite significant interest and action against the practice by the international community and local NGOs for more than two decades, overall, there has been little impact in any region where these activities have been taking place. It is estimated that about 98 percent of young girls have undergone some form of genital mutilation and about 90 percent have been subjected to the most severe type, known as infibulation or ‘Pharaonic’ circumcision³⁶. FGC/FGM has not received sufficient attention from Somali decision makers and politicians. Commitment from government officials has been generally weak.

340. The Islamic perspective of the practice continues to be marred with controversy, inertia, and divergent interpretations. Although there is no reference to circumcision of both male and female in the Koran, there is a well- established tradition of male circumcision in Islam as an act of ‘Sunna’.

341. In the short term, girls who undergo FGC/FGM experience shock, haemorrhage, urine retention, infection, infibulation cysts, obstetric complications and infertility due to chronic pelvic infections which has serious implications on their right to life and has an impact on their reproductive and sexual health. Despite the practice’s harmful effects, the custom is based upon deep-rooted traditions and cultural patterns. It has an important influence on social behaviour, marriage and on family life. The practice is always linked with misconceptions, superstitions, and religious beliefs. The various people who practice FGC/FGM do not conform to any common racial, social or religious pattern.

³⁶ Infibulation, also called ‘Pharaonic’ circumcision, involves removing all or part of the external genitalia and stitching of the raw edges of the vulva together with thorns or catgut sutures, leaving a small opening to allow flow of urine and menstrual fluid. Infibulation is the most commonly practiced type of female genital cutting in Somalia, Somaliland and Puntland.

342. The conventional view that the issue of FGC/FGM is solely a female matter has often excluded potential activist men in the fight against the practice. Without strong involvement from male allies, there is little recognition that the total abandonment of the practice is an important national issue. Many people, especially Somali men, oppose anti-FGC/FGM actions because of a perception that they are generated by external, especially Western, forces. Thus, any active support of its eradication is seen as succumbing to the outside pressure of international groups imposing their views on the Somali people.

343. Several national and international NGOs, women's organizations, relevant government institutions and UN agencies have incorporated the issue in their programmes. While FGM is now a public issue and many people participate in meetings and debates about it, there is little coordination between and among local and international stakeholders regarding FGC/FGM activities; there are limited FGC/FGM education and awareness activities at the community level and hardly any activities undertaken in rural areas.

344. Women themselves may resist the idea of ending FGC/FGM because poverty, ignorance, and their socio-economic dependency on men puts them in a most vulnerable position, denying them the opportunity to make decisions in matters affecting their own lives and those of their daughters. The strong influence of religious leaders in Somali society combined with the reluctance and even resistance of many other leaders and community members poses a serious challenge in the efforts made towards total eradication of FGC/FGM. FGC/FGM prevention and abandonment programmes should be integrated into a wider community development package in literacy, health education, women's reproductive health and rights, child rights, protection from all forms of violence against women and children instead of focusing solely on FGC/FGM.

345. **Gender and Human Rights:** FGC/FGM is rooted in gender inequality and segregation. It is an act of violence against women and young girls and violates the fundamental human rights of women and a number of principles enshrined in international and regional human rights instruments, including the right to life, equality, equal protection under the law and freedom from injury and degrading treatment. The patriarchal system which perpetuates gender inequality is a manifestation of unequal distribution of resources and opportunities for women.

346. **Health:** many Somali women have little or no health education and many infibulated women and girls are suffering in silence. Specific health education needs that have been identified include education on reproductive and sexual health, pregnancy, childbirth, family planning and menopause. Women and adolescents affected by FGC/FGM may suffer from a range of related gynaecological problems, including difficulties with menstruation, difficulties with micturition, recurrent urinary tract infections (UTIs), pelvic infections and infertility.

347. **Education:** plays an important role in the elimination of FGC/FGM. High illiteracy rates, misconceptions, and lack of knowledge among women play a big part in perpetuating the custom. Ironically, cultural values together with economic and social pressure, such as parental preference for the education of boys rather than girls, traditional Islamic/cultural constraints on the movement of young unmarried girls outside the home, and school schedules that conflict with girls' domestic routines and economic activities reduce even further the chances of women and girls benefiting from educational opportunities. UNICEF estimates adult literacy for males at 36 percent and only 14 percent for females (UNICEF, 2003).

348. **HIV/AIDS:** It is possible that FGC/FGM and other bloodletting traditional practices may contribute to the spread of HIV/AIDS. While not proven in the case of South and Central Somalia, Puntland and Somaliland, it is important to study the possible linkage of the FGC/FGM practice with HIV/AIDS, especially within a broader protection framework of research and outreach activities.

349. South and Central Somalia, Puntland and Somaliland should adopt legislation prohibiting FGC/FGM within the framework of the international conventions and declarations - the Convention

on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights and Welfare of the Child (CRC); the Covenant on the Rights of the Child adopted by the Organization of the Islamic Conference (OIC) by the 32 Foreign Ministers from the Member States of the OIC, (Sanaa, Republic of Yemen, 2005) and most importantly the Maputo Protocol (the initiative of the African Union for the abandonment of harmful traditional practices, especially article 5 on FGM) adopted by consensus by all Heads of States of the African Union (OAU) in July 2003, as well as the Cairo Declaration for the elimination of FGM adopted at the Cairo Conference on Legal Tools for the Prevention of Female Genital Mutilation in, 2003. All the above duly recognized that the practice of FGC/FGM is a violation of the rights of women and young girls; a health hazard to their wellbeing and an assault on women's human dignity.

350. In order to ensure the effectiveness of the legislation prohibiting FGC/FGM, appropriate strategies must be implemented, including capacity building of all relevant stakeholders. There should be public information and education through the mass media informing whoever performs FGC/FGM, including health personnel and traditional circumcisers, about the legal implications and sanctions of the law.

Vision and Priority initiatives

351. The overall vision is the total abandonment and eradication of FGC/FGM, primarily through legal institution capacity building, community empowerment, policy development and awareness-raising in the short-term, and attitudinal and behavioural change within practicing communities in South and Central Somalia, Puntland and Somaliland, in the long term.

352. A number of target outcomes have been identified for the five-year period (2007-2011) covering the Somali Reconstruction and Development Plan (RDP). The key target outcomes include the following, from short- to long-term:

- i) Establishment of structures and institutions to carry out and facilitate the implementation of activities relating to FGC/FGM
- ii) Adoption of multi-sectoral (health education, reproductive health, human rights, socio-economic dimensions) community based plans of action for FGC/FGM eradication
- iii) Strengthen capacity of all stakeholders involved in the anti-FGC/FGM campaigns to implement policies, plans of action and programmes towards the elimination of the practice
- iv) Adoption of a unified statement from Somali religious leaders clarifying the stand/position of Islam on the practice of FGC/FGM
- v) Policy guidelines on FGC/FGM eradication
- vi) Adoption of a legal framework that fully supports abandoning the practice of FGC/FGM in Somalia, Puntland and Somaliland and formal support of international human rights laws, conventions and protocols especially related to the rights of women and the girl-child.
- vii) Adoption of a strategic resource mobilization plan for donors and agencies supporting the plan of action for eliminating FGC/FGM
- viii) Establishment of cross-border linkages with Somali populations, Somali Diaspora, refugees and prospective returnees in the effort to eliminate FGC/FGM.

353. Although FGM, like other cultural practices, is viewed as sacrosanct, partly because of the confusion and ignorance about its place in society and the reluctance of religious leaders to publicly explain its role (or lack thereof) in the Muslim faith, many studies suggest that wage employment and educational status have an effect on the individual's attitude towards traditional practices.

354. Literacy, education and empowerment of women are key factors in emancipating women from FGC/FGM and other traditional harmful practices. Strategic approaches should be adopted through

formal and non-formal channels in the promotion of girls' education and training. The reduction of the women's illiteracy rate, provision of health education and improvement in their living conditions through income generation, new skills and supporting material activities is a more comprehensive approach towards FGC/FGM eradication.

Phase 2: Next Three Years (2009- 2011)

355. After laying the intensive groundwork during the first two years (2007-2008) that includes comprehensive awareness raising, sensitization, advocacy and lobbying efforts at various levels of Somali society, the next phase covering three years (2009-2011) would mainly consist of sustaining the early efforts and activities and their implementation, as well as monitoring and evaluation. The continued implementation of the key strategies and actions of the FGC/FGM programme should lead to the following concrete results over the three- year period:

- i) Adoption of a national policy on FGM eradication within the broader framework of women's health, safe motherhood and human rights
- ii) Adoption of a clear and unified statement by religious leaders protecting all women and young girls from the practice of FGC/FGM
- iii) Adoption of a law criminalizing the practice of FGC/FGM, including a system to monitor violations of the law and its regulations
- iv) Ratification of all major international human rights conventions (e.g. CRC, CEDAW, etc.), including the African Charter on Human and People's Rights and its Additional Protocol on Women's Rights (Maputo Protocol) of 2003
- v) Improved and strengthened capacity of relevant institutions and structures dealing with FGC/FGM issues
- vi) Strengthened and enhanced collaboration and networking among local and international NGOs and agencies
- vii) Establishment of a pool of funds for FGC/FGM elimination programmes, projects and activities to ensure sustainability, including mechanisms for operating the funds, including distribution and monitoring established
- viii) Continuous and enhanced participation and support from Somali Diaspora in all FGC/FGM-related initiatives and programmes

356. Once a policy and a comprehensive plan of action on FGC/FGM are firmly in place, capacity building efforts can be vigorously pursued that would include the following:

- i) Sensitize/train 3,500 TBAs/health workers in South and Central Somalia, Puntland and Somaliland
- ii) Sensitize 50,000 women and men in 200 towns and villages
- iii) Five hundred (500) Circumcisers to stop performing FGC/FGM
- iv) Twenty percent (20%) of target population to stop practicing FGC/FGM
- v) Curriculum of primary and secondary schools, adult education youth centres, MCH centres and women centres to be modified or developed to include the eradication of FGM in their programmes
- vi) Train 200 activists as change agents
- vii) Train /sensitize 500 advocators in the South and Central Somalia, Puntland and Somaliland, 75% of them started awareness raising activities in 20 regions
- viii) Sensitize 300 university students in South and Central Somalia, Puntland and Somaliland
- ix) Increase girl's primary school enrolment to reach 30% by 2011
- x) Establish 50 literacy classes in 20 towns

- xi) Training/educational materials to be produced/distributed 50,000 booklets, 30,000 pamphlets, 1000 flipcharts, 6,000 posters, 3,000 calendars, 10,000 fliers, 200 training modules and 200 sets of transparencies
- xii) Recruitment of six consultants for policy and legal framework adoption
- xiii) Six meetings/workshops/seminars on policy and legal framework development.
- xiv) Six symposiums/meetings for religious leaders to come up with 'Fadwa' statement on the position of Islam against FGC/FGM.
- xv) 30 training programmes for various stakeholders: state authorities, health workers, change agents, members of women's organizations, NGOs, youth and community-based organization
- xvi) Participation in missions and meetings concerning women's and children's health, FGC/FGM, violence against women and on rights of women and children.

357. **Capacity building and institutional development:** To carry out an effective campaign against FGC/FGM, the organizational and programmatic and technical capacity of all stakeholders, including government bodies and civil society must be strengthened.

358. Governance and rule of law: includes signing on to International Human Rights conventions and protocols, especially related to the rights of women and the girl-child, establishing a legal framework for the eradication of FGC/FGM and capacity building of law enforcement authorities (lawyers, judges, police, etc.) in developing and implementing a plan of action on eradication of the practice.

Implementation and monitoring arrangements

359. Since several stakeholders will be involved in the implementation of the FGC/FGM plan, a comprehensive and cohesive framework for measuring progress in achieving the target outcomes needs to be prepared by the national/regional FGC/FGM commissions.

360. Although it is generally not easy to quantify achievements in FGC/FGM activities, a baseline survey at the start of the programme is necessary to assess and understand the situation and to plan strategic approaches. Regular monitoring and evaluation should be done during the implementation phase (every 6 months) to benefit future programme development and interventions. Considering their critical role in the Somali society, religious leaders and scholars, traditional leaders, youths, other socially influential persons and men in general should be involved and encouraged to take an active role and firm stand against the FGC/FGM practice.

361. The international community can play a crucial role in the fight against FGC/FGM in a culturally appropriate and sensitive manner through the empowerment of voices of change at the local level and supporting the national movement working towards the elimination of this harmful practice. The people they are serving should not perceive that an anti-FGC/FGM campaign is an *attack by outsiders or by insiders in the pockets of outsiders*. The fact that the practice is closely inter-woven in the political, social and cultural fabric of Somali society, the issue should be handled carefully, especially from those outside the community.

362. International actors and NGOs can help government concerned ministries, such as education, health, justice, information, rural development, as well as women's organizations, State FGC/FGM Coordinating Committees, Child Protection Units and maternity hospitals by assisting them with technical and financial resources that can help Somali institutions in many ways through, for example, adopting multi-sectoral approaches involving children's rights, human rights, women's rights, and training programmes, research and financial management; and also to help them carry out qualitative research, surveys and data analysis towards the eradication of FGC/FGM.

363. The most effective way to fight against FGC/FGM is through the empowerment of voices of change at the local and grassroots levels. When communities are empowered they raise the issue themselves to reject the practice and to establish their own preventive strategies. While it is duly acknowledged that traditions and cultural practices that have accumulated over centuries cannot be

changed in a short time, societies are dynamic and can change through education, improving the status of women and empowerment of the entire community. The individuals and institutions that perpetuate the practice and the factors contributing to it must be therefore challenged at the grassroots levels.

H. HIV and AIDS

Current status, challenges and opportunities

364. The results of the WHO 2004 sero-surveillance survey showed a mean HIV prevalence of 0.9% in South and Central Somalia, Puntland and Somaliland. These data indicate that Somalis are approaching a generalized HIV epidemic. HIV prevalence varied between different areas: Central and South Somalia showed average HIV prevalence of 0.6%, Puntland 1% and Somaliland 1.4%. Experience from Sub-Saharan countries shows that when the rate of HIV exceeds 1%, it could be doubled or tripled in two to three years.

365. The WHO 2004 survey also showed that the average rate of HIV infection among patients complaining of sexually transmitted infections in Mogadishu, Bossaso and Hargeisa is 4.3%. Clearly this is higher than the average rate of HIV infection in the general population. STI patients among other sub-populations are one of the well-known bridging groups transmitting the virus to the general population.

366. When examining the burden of curable STIs (Gonorrhoea and Chlamydia) among pregnant women and STI patients in Mogadishu, Bossaso and Hargeisa, the results showed an average rate of 2.5% among pregnant women. Syphilis prevalence was found to be 1.1% among pregnant women in South and Central Somalia, Puntland and Somaliland. Moreover, HIV among TB patients from Mogadishu, Bossaso and Hargeisa showed an average rate of 4.5%

367. In six of the thirteen sentinel sites the HIV prevalence found among the ANC attendants was above 1%³⁷. Various factors, including lack of access to prevention, treatment, care and support services correct knowledge, high mobility and displacement, gender inequality, harmful traditional practices and high prevalence in surrounding countries make South and Central Somalia, Puntland and Somaliland highly vulnerable to an accelerated increase in HIV prevalence in the next few years.

368. UNAIDS estimates that about 44,000 Somali people are living with HIV in 2006.³⁸ There are many misconceptions about HIV and AIDS in South and Central Somalia, Puntland and Somaliland as well as a high degree of stigma directed towards PLWHA. Anecdotal evidence confirms that refugees and IDPs often suffer from HIV-related stigma and discrimination and are very vulnerable to HIV infection. South and Central Somalia, Puntland and Somaliland have 2 million refugees outside the country and approximately 350,000 IDPs; their risk and vulnerability to infection have not been addressed systematically.

369. Displaced people and refugee children for instance, confront completely new social and livelihood scenarios while in settlements and upon return; they are notably vulnerable - a circumstance that facilitates HIV transmission and aggravates AIDS impact. Children in situations of armed conflict, and displaced, migrant and refugee children are also particularly vulnerable to all forms of sexual exploitation.

³⁷ The 2004, First National Sentinel Sero-Surveillance Survey on HIV/AIDS & STIs. WHO Somalia July 2005.

³⁸ UNAIDS 2006 Report on the Global AIDS Epidemic.

370. While 0.9% is considered to be low prevalence, figures from the sero-prevalence study point out that the major source of infection is heterosexual sex; rates are estimated to be higher in urban areas.

371. Based on the HIV prevalence reported above, it is evident that some pregnant women are HIV positive. Niverapine is currently available at Galkayo, Garowe and Bossaso hospitals. In December 2005, 90 AIDS patients were reported to be accessing ART at Hargeisa Group Hospital.

372. The impact of HIV and AIDS has the potential to severely erode many developmental gains anticipated under the reconstruction phase. There is a consensus between local authorities, civil society organizations and international partners on priority interventions regarding prevention, care, support and treatment, as well as on the need to develop the capacity of governmental and non-governmental entities, make management tools available, strengthen and scale up existing programmes and create an enabling environment.

NATIONAL COMMITMENT & ACTION

1. Amount of national funds disbursed by government: **US\$30,000 in Somaliland, US\$10,000 in Puntland (SOLNAC and PAC Report 2004)**
2. Percentage of schools with teachers who taught and have been trained in life-skills-based education during the last academic year: **No data**
3. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes: **No data**

GLOBAL COMMITMENT AND ACTION

4. Amount of bilateral and multilateral financial flow including GFATM, DFID, regular UN agency budget and international NGOs: **US\$12,383,876 for 2004/2005 (UCC Report, 2004, UNICEF Report, 2005, Global Fund, 2005 DFID/UNDP Report).**

373. Many factors fuel the epidemic: While available data is presently too limited to extrapolate with certitude figures for the coming years, common factors known to drive an epidemic or multiple epidemics are: high levels of mobility, dilapidated health systems, gender based violence, high rates of TB and STIs and lack of a coordinated multi-sectoral response among government and civil society actors.

374. Vulnerabilities are usually mainly due to high mobility, high rate of divorce / remarriage, concurrent relationships for economic and cultural reasons, sexual exploitation, widowhood, inheritance, and harmful cultural practices such as FGM, and multiple sexual partners.

375. Other vulnerability factors relate to militia, urban transit centres (ports, highway villages and towns), truckers and transporters. Mobile and most at risk populations include truck drivers, policemen and militia, dock workers and sailors, and those living away from their family social bonds. If not addressed, these vulnerabilities could fuel the epidemic in the years to come.

376. UNAIDS is currently supporting the conduct of a situational analysis of vulnerabilities among Somali populations in Puntland and Somaliland, which should provide a baseline for implementation of the 5 year period 2007 - 2011. UNICEF is conducting a behaviour surveillance survey in South and Central Somalia, Puntland and Somaliland, which will provide much needed behaviour-related information.

Table I8: Knowledge and behaviour table for Somalia

Knowledge and Behaviour

1. Percentage of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention: **Males –12.5%, Females –7.9% (KABP Survey, UNICEF, 2004)**
 2. Percentage of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner: **(No data)**
 3. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: **No data**
 4. Percentage of female and male sex workers reporting the use of a condom with their most recent client: **No data**
 5. Percentage of men reporting use of a condom the last time they had anal sex with a male partner: **No data**
 6. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who avoid using non-sterile injecting equipment and use condoms, in the last 12 months: **No data**
 7. Percentage of the population who have ever heard of HIV: **Males – 67.1%, Females – 57.1% (KABP Survey, UNICEF, 2004)**
 8. Percentage of the population who have ever heard of AIDS: **Males – 79.6%, Females – 71.3% (KABP Survey, UNICEF, 2004)**
 9. Percentage of the population who mention use of condoms as a prevention tool (out of those who had ever heard of AIDS): **Males - 24.1%, Females – 11.4% (KABP Survey, UNICEF, 2004)**
 10. Percentage of the population who have ever used condoms (out of those who have ever heard of condoms): **Males – 16.2%, Females – 8.7% (KABP Survey, UNICEF, 2004)**
 11. Percentage of the population who have ever taken an HIV test (out of those who had ever heard of AIDS): **Males – 4.8%, Females – 2.5% (KABP Survey, UNICEF, 2004)**
 12. Number of people (Voluntary persons for VCT and STD patients) who have received HIV testing and know their results from 2004-2005): **500 (VCT programme monitoring report, 2004)**
- #### **Treatment, Care and Support**
13. Percentage of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled: **No data**
 14. Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission: **3.33% (Puntland Situation Analysis Report)**
 15. Number of people enrolled in treatment, care and support programme with access to ARV: **86 patients (ART Programme Monitoring Report, 2005)**
 16. Number of people with advanced HIV infection receiving ARV combination therapy: **45 patients (ART Programme Monitoring Report, 2005)**
 17. Number of adults and children with HIV still alive and known to be on treatment 6 months after initiation of antiretroviral therapy: **43 (ART Programme Monitoring Report, 2005)**
 18. Number of health facilities with the capacity to deliver appropriate care to PLHIV – **1 centre (ART Programme Monitoring Report, 2005)**
 19. Percentage of transfused blood units screened for HIV: **No data**
- #### **Impact Alleviation**
20. Percentage of infected infants born to HIV infected mothers: **No data**
- #### **Impact**
21. HIV prevalence among pregnant women 15-49 years- **0.9% (WHO HIV surveillance Report, 2004)**
HIV prevalence among 15-24 years pregnant women- **0.9% (WHO HIV surveillance Report, 2004)**

Table source: Somali UNGASS Report 2004-5³⁹

377. **AIDS Commissions:** It is necessary to build institutional and human capacity to play a greater management role in the use of current resources and to develop resource mobilization strategies. Nevertheless, developing capacities cannot be seen as simply conducting training, workshops and developing / providing guidelines and tools. Systems need to be strengthened and organizational management capacities have to be developed. This is very much needed to bring partners together for coordinated implementation, surveillance, monitoring and evaluation purposes.

378. The position of the National AIDS Commissions - outside the Ministries of Health, under the President's office - provides the authority and access to other government departments to initiate and co-ordinate a comprehensive multi-sectoral response to the epidemic. However, the institutional capacity of the National AIDS Commissions is still very weak. More attention will be required on strengthening systems, including creating strong partnerships with civil society organizations and private sector partners, leveraging and managing funding, as well as responding more effectively to social contextual factors such as gender and harmful cultural factors which influence sexual norms and behaviours.

³⁹ Somali UNGASS Report 2004-2005

379. Rural populations: experience from other sub-Saharan countries shows that a hidden epidemic can develop in this unknown chasm. It took 10 to 15 years in the Southern Africa context to document and to acknowledge the adverse impact of the HIV/AIDS epidemic on the rural populations.

380. In South and Central Somalia, Puntland and Somaliland there is a common absence of a surveillance system to monitor HIV sero-prevalence. Public clinical and laboratory services are limited and most of the privately operated ones are inadequately equipped. While Somaliland has nascent information system section in the Ministry of Health and trained staff for analyzing available data, data collection and analysis has to become more regular and systematic. Significant work remains to be done in accurately assessing prevalence and information related to risk and vulnerability to HIV infection in South and Central Somalia, Puntland and Somaliland.

381. South and Central Somalia, Puntland and Somaliland have many of the conditions that facilitate the spread of HIV in a post-conflict setting. These conditions include but are not limited to:

- i) traditions and norms that increase the vulnerability of individuals to infection such as multiple sexual partners, low condoms usage and high rates of gender based violence which affect women disproportionately;
- ii) widespread impoverishment that often leads women and girls with few alternatives but to exchange sex for survival in other countries;
- iii) curtailed usage of and limited access to condoms and treatment of sexually transmitted infections;
- iv) mass displacement, IDPs, refugees and Diaspora which lead to the break up of families and relocation into crowded refugee and internally displaced settlements where the traditional social values are tested by others. There is also the added risk of SBGV in refugee camps;
- v) dysfunctional education, training, health and communication systems normally used to advocate programmes against HIV transmission.

382. Existing policies and plans include the 2003-2008 Strategic Framework for the Prevention and Control of HIV/AIDS and STIs, under the auspices of the Somalia Aid Coordination Body (SACB); the UN Joint Strategic Review and the Contingency planning process sponsored HIV/AIDS Implementation Support Plan. There are three existing action plans (Central and South Somalia, Puntland and Somaliland Action Plans) however clear definition of sectoral responsibilities is required, to clarify the roles of coordination and support bodies (national AIDS Commissions and partners).

383. In South and Central, there is no national blood transfusion service and there is no policy on the selection and retention of blood. A summary of challenges to be overcome include:

- i) Continued disagreement among stakeholders and actors in the sector over whether South and Central Somalia, Puntland and Somaliland are highly vulnerable to an accelerated increase of HIV/AIDS prevalence.
- ii) Collapse of the healthcare infrastructure.
- iii) Lack of knowledge on Somali contextual vulnerabilities (who exactly are the vulnerable groups? What are the specific vulnerabilities of women and girls, youth, IDPs, refugees and other returnees?)
- iv) Lack of information on high risk groups, as well as behavioural data.
- v) Continued denial and stigma surrounding HIV/AIDS discourse.
- vi) Capacities of service providers extremely limited.

384. While infection rates among children above the age of five are not known, the governments would be well advised to develop plans to respond to paediatric AIDS in South and Central Somalia, Puntland and Somaliland.

385. The current efforts to make ARVs more widely available e.g. Universal Access and GFATM mean an opportunity for increased PMTCT programmes, expanded capacities and skills in the health sector on HIV/AIDS and strengthened infrastructure and health delivery systems. Effective implementation of PMTCT services in industrialized countries has resulted in near elimination (less than 2% transmission of paediatric AIDS). The challenge is to use these opportunities to respond to paediatric AIDS as well.

Vision and Priority initiatives

386. The shared Vision of South and Central Somalia, Puntland and Somaliland has three thrusts:

- Improve the provision and delivery of prevention, treatment, care and support services targeting Universal Access by 2011.
- Prevent HIV transmission, with emphasis on reducing sexual transmission and reduce further HIV prevalence;
- Strengthen the multi-sectoral institutional framework to monitor the trends of the epidemic, the coverage and impact of interventions.

Target Outcomes

387. By 2008, a community-based model of home-based care and counselling has been adopted and programmes operational.

388. State Health policies on HIV testing and facilities for standard testing of blood for HIV before blood transfusions instituted.

389. By 2009, there are policy guidelines on orphan care, HIV/AIDS policy and technical guidelines revised and distributed, including: prevention of HIV transmission through promotion of universal precautions, safe needles/instruments, blood safety; HIV second generation surveillance; PMTCT; Care of PLWHA, STI case management and VCT.

The First two years

390. This first two years should see the strengthening of AIDS Commissions' capacities in South and Central Somalia, Puntland and Somaliland, the revision of the Strategic Plans and adaptation to regional peculiarities, addressing specific constraints and needs of South and Central Somalia, Puntland and Somaliland, and the establishment of a common information sharing system.

391. Key policies to ensure equal access to and demand for services, with equal access for women and young people, non-discrimination etc., preparing the way for all Somalis to access HIV/AIDS comprehensive services should be developed. Capacities will be built; a human resource development plan will address the need for recruitment and HIV/AIDS training in all sectors.

392. Provision of anti-retroviral treatment will increase in the context of scaling up the response towards universal access for all Somalis who need treatment and care by 2010. Awareness raising strategies will be implemented and religious leaders will play a crucial role supporting the authorities to fight against stigma and discrimination. Culturally sensitive strategies to make condoms available in main towns and borders, and creative ways to have them distributed in rural areas should be piloted. With the expansion of the health system, HIV/AIDS services (VCCT, PMTCT, Care and support) will be available in all main towns by the end of the period. With the roll-out of the transport and other infrastructure reconstruction activities, this service should scale-up to rural and coastal populations.

393. Strengthening of civil society partners to respond to HIV and AIDS effectively should also be a priority in the first two years. This is particularly important to reach the most vulnerable groups, women and children.

The next three years

394. The monitoring and evaluation system will be fine-tuned and adapted to the various needs of partners, ensuring that the data collected and analyzed is shared across South and Central Somalia, Puntland and Somaliland. Ministries will report on their own sector / cluster and the HIV/AIDS Commissions secretariats will confirm and synthesize an overall yearly report. This report will be part of the RDP yearly report.

395. The Strategic plan will be updated in 2009 and 2010 according to the results obtained in the first two years period. Lessons will be learned and shared yearly through a Joint National Review.

396. Access and demand for HIV related services will gradually be expanded to all areas, with the goal to reach all vulnerable groups and communities by 2011. Antiretroviral Treatment will be available through all main towns and systems put in place to have OI, STI and ARV drugs reaching rural areas, through delivery systems working in connection with the health sector. More NGOs will have reach remote / rural communities developing with them adapted ways to identify risks and needs and how to cater for them in a human rights approach.

397. Capacity building & institutional development: Three HIV/AIDS Coordination Authorities fully functional. These should be built on the three AIDS Commissions currently operational. South and Central, Puntland and Somaliland should setup Regional monitoring and evaluation mechanisms and structures to oversee the geographical response, facilitate evidence-based planning and implementation. The line Ministries of Health, Education, Labour and Women and Family Planning should have the capacity to plan, implement and monitor sectoral HIV/AIDS action plans and link them to their respective sector plans.

398. Human Resources: There should be sufficient numbers of clinical staff, trained for HIV related health services (i.e. physicians, nurses, clinical officers, counsellors, lab technicians, pharmacists, doctors etc.), across South and Central Somalia, Puntland and Somaliland. Sector surveys of skilled staff available and the type of skills needed should be conducted in the first half of the implementation stage and thereafter a sufficient number of skilled staff for planning and management of HIV programmes (i.e. planners, managers, epidemiologist, social science, data processing, etc.); community-based workers for (multi-sectoral) outreach (information, care and support), accordingly trained. Three State human resource management and training plans should be developed and implemented.

Priority initiatives

399. When planning an intervention, cultural sensitivities of the beneficiaries should be considered. Inappropriate services are more likely to cause negative reaction from the community rather than achieve the desired impact, as such this report advocates for community based intervention development for socially sensitive interventions: for instance on FGM, condom use, Khat chewing by children, schooling for girl children and HIV/AIDS.

400. Integrating HIV into all aspects of national development, particularly in relation to cross-cutting issues such as gender, human rights and governance, sustainable livelihoods and poverty alleviation will help strengthen national institutions within and outside the government.

401. An immediate priority in the HIV response is acceleration of prevention among 'primary duty bearers', in particular expansion of PMTCT programmes and prevention of infection in young people

and support to the Somali context community-based orphan care programme which may serve as a replicable model.

402. Building partnerships between communities and health systems to improve access to care/drugs for people living with HIV/AIDS. Consideration should be given to surveys that include statistics such as how many teachers, lecturers and other skilled personnel are infected and whose productivity is affected by HIV/AIDS. South and Central Somalia, Puntland and Somaliland, should pass and develop legal frameworks in South and Central Somalia, Puntland and Somaliland, protecting the rights of people infected and affected by the virus; they should be developed and reviewed using a human rights based approach.

403. Training of trainers in gender, human rights and HIV/AIDS should be provided to ensure that gender focal points in Government Ministries and NGO partners' capacity is strengthened to mainstream gender and human rights into HIV/AIDS policies and projects. To facilitate sustainable implementation, prevention strategies of transmission of HIV and other STDs should be integrated into IDP, refugee protection, education and reproductive health programmes.

404. Policies: The development and implementation of policies are required to address the following issues: behaviour change communication, using a mix of communication strategies to shape and maintain protective behaviours; health education and other preventive health interventions for most-at-risk populations; Comprehensive HIV care and support with attention to removing barriers for women, children and most-at-risk populations; Non-discrimination laws and regulations for PLWHAs, specifying protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination.

405. Policy development will with all probability be implemented first in Somaliland and Puntland. Somaliland has a stronger and more functional Parliamentary system than Puntland and the line Ministries are already involved in policy development via the Ministry of Planning. South and Central Somalia will need considerably more capacity building to equip the responsible line ministries.

406. This approach recommends the consolidation and synthesis of existing HIV/AIDS plans and programs, addressing gaps and weaknesses identified through the process, (as multiple vulnerabilities of women and girls, especially in IDP settings, refugees, returnees, high risk groups and others, to build a more strategic focus) supporting a greater involvement of religious groups, developing a comprehensive prevention, care, support and treatment approach, addressing stigma and discrimination, and expansion and universal access to ART. Linkages between short term / humanitarian interventions, contingency planning and longer term objectives, ensuring sustainability through renewable resources will be established, harmonizing HIV/AIDS policies, strategies, implementation and monitoring of interventions for a greater impact with one coordination structure, national strategic plan and monitoring and evaluation system.

Implementation and monitoring arrangements

407. In South and Central Somalia, Puntland and Somaliland, the AIDS Commissions have already been formed and will need capacity building, both institutional and in terms of human resources, to provide positive indicators on their ability for innovative and socially inclusive action. South and Central Somalia, Puntland and Somaliland will need further capacity to implement key national policies for social development, alleviation of poverty and fighting the spread of HIV.

408. However, key obstacles identified include a collapsed health system (existing health structures inaccessible to vulnerable populations), limited human resources and capacities, limited VCT sites, high political insecurity and uneven humanitarian access. There are vertical M&E structures, multiple coordination structures to harmonise; poor incentives and demotivated programme staff all working

within a collapsed public service system⁴⁰. Somaliland is consistently more advanced than Puntland and there is very little to build upon in South and Central Somalia.

I. KHAT

Current status, challenges and opportunities

409. Khat affects all walks of Somali life. There is hardly any aspect of society that remains unaffected by it. It touches upon issues of culture, economy, infrastructure, private business, politics, livelihoods, household economies, health, religion, sexuality, gender and security. The khat consumed by Somalis is grown in Kenya and Ethiopia where it is a major income-generating crop.

410. With the civil war and dispersal of Somalis the trade in and consumption of khat has increased to unprecedented heights. Before the civil war the consumption of khat was restricted and controlled by specific socio-cultural norms and practices. It is now a major strain on the Somali economy and presents many problems felt within families and households. As many men spend a big proportion of the daily household budget on khat, there are fewer resources to care for the basic needs of the household (i.e. food, medicine, education, etc.), causing women and children to suffer further deprivations.

411. As khat is mainly consumed by Somali men this has left many Somali women as the sole breadwinners for their families. On the other hand, selling khat has become an important employment opportunity to a considerable number of women. In the eyes of many Somalis however, it is a violation of cultural values and gender roles for women to be engaged in the selling of khat. Women in the Khat business find themselves subject to gender based violence and unfavourable working conditions. Harsh working conditions coupled with long hours away from home directly affects the family where children and spouses become the recipients of the negativity experienced in hostile work environments by women. The prevalence of the many female breadwinners and female-headed households has to be understood within the larger gender transformations caused by the civil war and the dispersal of Somalis. Excessive khat chewing can also be linked to the break-up of Somali families (i.e. divorce or separation).

412. Besides economic and social consequences, the large-scale consumption of khat may also have serious negative health effects on the individual user such as gastritis, increased blood pressure, constipation, anorexia, insomnia, migraine, depressions, psychiatric disorders and decreased sexual potency in men. It has to be stressed however, that there is very little qualified knowledge on khat's possible long-term negative health effects. The consumption of khat is often accompanied by smoking, which will potentially lead to additional negative health effects. Today, there is increased discussion but no substantive knowledge on the links between sexually transmitted diseases (i.e. other STDs and HIV/AIDS) and the consumption of khat.

413. Many consumers of khat do not see it as a real problem. Khat is so ingrained in how people live their lives that it has come to represent something natural and taken for granted. Many chewers see khat as having many positive social (i.e. making them more social and talkative) and pharmacological effects (i.e. making them stronger and able to endure a harsh life) and are unaware or negligent of the negative effects of excessive consumption of khat. Based on assessment the present level of consumption of khat has the following negative socio-economic, socio-cultural and health related effects:

- i) Khat is a major hard currency drain estimated at around US\$ 250 million yearly.
- ii) Khat has a negative effect on entrepreneurship and economic development.
- iii) Khat lowers productivity and work moral.

40 Scaling-up HIV Services Towards Universal Access. Somalia, February 2006.

- iv) Khat is a severe drain on household budgets and is thereby a major contributor to poverty.
- v) Khat challenges food security and contributes to malnutrition.
- vi) Khat consumption may lead to family problems (e.g. divorce).
- vii) Khat consumption transforms Somali values and traditions (e.g. changes what is considered acceptable and normal).
- viii) Khat has a particular negative effect on women and children.
- ix) Khat leads to increased insecurity.
- x) Khat consumption leads to health problems like sleeping difficulties, loss of appetite, spermatorrhoea (involuntary loss of semen), changed libido, impotence, poor nutrition, dental problems, risk of ingesting pesticides, depression, bronchitis and respiratory problems (due to smoking).
- xi) Khat increases the risk of mental illness in predisposed consumers (e.g. war veterans).
- xii) The littering of "khat plastic bags" creates environmental problems

414. Khat represents somewhat of an anomaly in the international legislation on drugs, as the most active chemical ingredients in khat, cathinone and cathine, are classified as controlled substances according to the 1971 Convention on Psychotropic Substances. The khat plant is not regulated by any of the international drug conventions that normally regulate the production of and trade in drugs. The United Nations Office for Drugs and Crime (UNDOC) has left it up to national governments to decide what legal status they wish to ascribe to khat. The ambiguous status of khat is well reflected in the fact that khat is categorized differently around the world by different nation-states. In East Africa, khat is legal in Ethiopia, Kenya, Djibouti, Madagascar, Congo, South and Central Somalia, Puntland and Somaliland and illegal in Tanzania and Eritrea. Khat has been banned throughout Europe, The Middle East and North America. In the United Kingdom and Holland khat is not regulated and is imported legally from Ethiopia and Kenya.

Vision and Priority initiatives

415. The vision for the next five years is to reduce the number of daily khat consumers and to reduce consumption in South and Central Somalia, Puntland and Somaliland, through youth-driven and youth-centred reduction programmes. The eventual aim is to ban the drug entirely. The key to a long-term reduction of khat consumption lies with the youth and coming generations. Somali youth should be incorporated actively into the development and implementation of demand reduction programmes.

416. A combination of (increased and formalized) taxation, public awareness campaigning and the creation of alternatives to khat will be the primary policies established to decrease its widespread consumption. These moves should lead eventually to khat's total prohibition. The key actions that should be taken are to:

- i) Establish Khat Commissions in South and Central Somalia, Puntland and Somaliland
- ii) Formulate and implement a policy enforcing public institutions (e.g. schools and ministries) to be open in the afternoons
- iii) Increase access to socio-cultural alternatives to khat chewing
- iv) Increase access to sports activities as an alternative to khat chewing
- v) Increase awareness about the socio-economic and health related effects of khat abuse
- vi) Establish counselling and support facilities
- vii) Establish better access to credit-schemes for female khat vendors and vulnerable women (e.g. widows with children)
- viii) Secure funding and sustainability through the Somali Diaspora and tagging of khat revenues for khat programmes.

417. Only a few measures are taken to control the level of consumption of khat and counter the negative socio-economic and health related affects. In Somaliland the only regulatory policy is the

taxation of khat imports (estimated at 18%). Taxation of khat imports is less substantial in Puntland and not within government control in South and Central Somalia.

418. The economic and commercial interests in khat challenge implementation of regulatory khat policies. The goal of a comprehensive, effective and sustainable khat policy can only be attained by ensuring the active and committed involvement of all relevant stakeholders.

419. The key to a long term reduction of khat consumption lies with the youth and coming generations. Somali youth should be incorporated actively into the development and implementation of demand reduction programmes. The vision is to make demand reduction programmes youth-driven and youth-centred.

Intervention strategies

420. Increase and formalize the taxation of khat imports (which is the responsibility of the macro-economic cluster). From the sub-cluster of khat it is recommended that political authorities work with khat importers in constant dialogue and negotiation on the matter of khat taxation. With an increase in tax (and price) the consumption will be lowered (particularly among the poor) and the increase in new consumers will be lowered, for the market group where consumption is related to price and affordability of product.

421. As the legitimacy and strength of political institutions in Puntland increases a similar process of tax increase should be promoted as in Somaliland. For South and Central Somalia, there is need to establish a viable and legitimate political authority that will be able to start negotiations with the warlords/khat importers to South/Central Somalia about increasing/formalizing the taxation on khat imports. It is recommended that khat revenues are used/tagged for khat prevention programmes.

422. Expand Working/Opening Hours in all Government Institutions including academic facilities. Formulate and implement a policy that expands the office hours of public institutions (e.g. in ministries, schools and universities) to also include (parts of) the afternoons when most khat is chewed. This would lower the consumption of khat considerably and send a message that there is a political will to confront the khat issue.

423. Establish Khat Commission(s) (KC) for Somaliland, Puntland and Somalia with the responsibility of advocating, monitoring and evaluating khat programmes.

424. Create Socio-Cultural Alternatives to Khat: Demand for khat can be reduced by creating alternatives to khat chewing. Besides the creation of more jobs and better education the goal is to create social alternatives to khat so people have something meaningful to engage in during the afternoons. There is a need to improve sports facilities (e.g. football, basketball and volleyball grounds); improve sports organizations (e.g. the establishment of football associations with the ability to establish a formal football league) and to establish and improve the capacity of sports clubs (e.g. better training of coaches and instructors). Gender sensitive sports opportunities like volleyball and basketball should be established for Somali girls and young women.

425. Establish Youth and Cultural Centres in all Major Towns: Establish recreational facilities like libraries, cinemas, theatres and youth clubs. Youth centres could be important venues for socio-cultural alternatives to chewing sessions. The cultural and recreational opportunities have largely been neglected by the ongoing humanitarian interventions. The Youth Centres should be:

- i) Offering social alternatives to khat chewing (e.g. theatre, music, literature, poetry, sport and Internet).
- ii) Staffed by volunteers and (partly) funded by local contributions (e.g. from the Mosques and private sector) and by khat revenues to secure sustainability beyond the five year development perspective.

- iii) Established in close dialogue with Somali stakeholders (including religious institutions) in order to secure approval and support from the larger community.
- iv) Venues for dissemination about khat.
- v) Providing free access to the Internet.

426. Raise Awareness about Khat: An important element in the strategy of demand reduction will be to raise awareness of the socio-economic and health related problems of excessive khat chewing. Awareness campaigns should be done using the mass media (TV, radio and newspapers). The issue of khat should also be addressed in Mosques (e.g. during Friday prayer). Information (e.g. flyers) on khat should also be distributed at all health facilities (private and public hospitals and clinics) as well as dentists.

427. Approach Khat regionally: As khat is a regional (and global) phenomenon that includes Ethiopia and Kenya as producers on one side, and South and Central Somalia, Puntland and Somaliland, as consumers on the other, khat should be explored further as an inter-regional issue. A regulation of supply (and production) would most fruitfully be targeted at producer country level. This should be addressed by advocacy in regional gatherings such as the International Conference on the Great Lakes Region where such subjects are currently being discussed, within the African Union and in bilateral talks with the producing countries.

Implementation and monitoring arrangements

428. The Khat Commissions should be advisory and coordinating bodies with relevant ministries (e.g. finance, health, education, youth and family) NGOs, the business community, youth organizations, religious groups, and people employed in the khat business, women's groups (minimum 12% women), etc. The overall responsibility of the Khat Commissions of Somaliland, Puntland and South/Central should be to:

- i) Lobby for political support for the reduction of khat consumption (e.g. securing presidential and ministerial support) and the introduction of khat policies in public institutions (e.g. introduction of longer working hours as is seen in the private sector).
- ii) Secure and coordinate the support for the reduction of khat consumption among other groups in society (e.g. religious community, elders, universities, primary and secondary schools, teachers training colleges, etc.).
- iii) Ensure that demand reduction programmes are sensitive to Somali culture, gender and human rights issues.
- iv) Coordinate and monitor information and awareness programmes about the hazards of khat-chewing.
- v) Coordinate and monitor the programmes designed to provide recreational facilities that will serve as alternatives to khat chewing sessions.
- vi) Establish and monitor the activities of sub-commissions working under the KC (these sub-commissions could be established to serve regional, thematic or research demand).

429. Currently interventions are by NGOs and UN Agencies targeting certain aspects of Khat consumption. These activities and future interventions should be coordinated by the Khat Commission.

J. FOOD SECURITY⁴¹ AND NUTRITION

Current status, challenges and opportunities

⁴¹ Food security is currently defined as access by all people at all times to the food needed for a healthy and active life; FAO, "The Right to Food in Theory and Practice", Rome, 1998, p. 32

430. The FSAU classification by livelihoods was adopted at the sub-cluster level. To aid analysis, it split Somalis into the following broad groupings: pastoralists, agro-pastoralists, riverine, urban dwellers, IDPs and coastal/fishermen community. The common feature in all the groupings is that the lack of a secure source of food through out the year food affects women and children the most. When food is limited it is usually the men first and then the male children who get preference within the family in terms of food distribution. This discriminatory practice compromises the health of women and female children leaving them susceptible to malnutrition and other diseases. The lack of access to a permanent source of clean water and effective sanitation, which affects a large number of the Somali population, has a negative impact on nutrition, more so when it comes to infants and mothers. Therefore water and food security have obvious impacts on health which directly affects maternal health and child mortality.

431. For Pastoralists, drought is a recurrent phenomenon with devastating effects. Rainwater harvesting and groundwater provide temporary essential water during the dry season. Large waars (earth dug water catchment ponds) and berkedes (a small pond, average 300 m³, with cemented floor and walls) capture rainwater and provide relief for the first two or three dry months.

432. Agro-pastoralists practise subsistence rain-fed agriculture but mainly rely on livestock not agriculture as their main source of food and income. In some respects they are more vulnerable to drought than pastoralists since they cannot move to areas too distant from their cropland and shelters. However agro-pastoralists families are known to separate during harsh dry seasons, some move with the animals in search of water and some stay in the settlements or villages. The range of movement depends on the animals they own and, of course, on the severity of the drought affecting water and pasture availability in surrounding districts. Agro-pastoralists run up more debts because of water purchased in situ (water trucking is a good business in Somalia). During severe drought a final option is to abandon their homes and relocate their entire families. However, having a permanent base allows better access to education and health services – an advantage over pure pastoralists,

433. For both pastoralists and agro-pastoralists, diet consists chiefly of cereals (wheat, rice, maize and sorghum). Tea with sugar is taken by adults and children above one year old. Milk is available mainly during the wet season (Deyr and Gu Season) and added to tea or drunk on its own. Infants are usually breastfed for one year. Drinking water is not boiled. Diarrhoea among children is prevalent especially during the dry season: malaria comes with the wet season. Coupled with poor water and sanitary conditions populations face illnesses, such as diarrhoea, respiratory infections, worm infestation, skin infections, eye and ear infections, and anaemia; adults complain of malnourishment and anaemia. Outbreaks of other diseases, such as measles and whooping cough have also been reported in the assessed villages. High levels of malnutrition and disease are consistently found among displaced populations and marginalized groups who face discrimination in access to food, health and water.

South and Central Somalia

434. The riverine community lives along the fertile banks of the Juba and Shabelle rivers in South and Central Somalia. This group of about 400,000 is unique in its requirements since water and grazing land is fairly abundant. Irrigation canals divert water from the rivers and irrigate crops of maize, beans and rice, but, once the breadbasket of Somali, the riverine region now produces a fraction of pre-1991 harvests, as most of the canals and irrigation systems are in disrepair.

435. During the time of writing this report, South and Central Somalia is facing one of the most severe drought situations in 15 years. 800,000 children are deemed highly vulnerable facing an acute food and livelihood crisis and humanitarian emergency. The following are instances of the impact the failure of two consecutive rainy seasons (Gu and Deyr 2005) has resulted in:

- i) Many shallow wells drying up (Bay and Bakool Nov. 2005 – Jan. 2006)
- ii) A large number of livestock has died;

- iii) Traditional food stocks have run out;
- iv) Mass displacement of people within Bay and Bakool (drought displacement in Wajid and Dinsor estimated at 2000 households and 500 households respectively);
- v) Increased cases of diarrhoea, respiratory infections, poor child feeding and care practices, especially in IDP camps;
- vi) An estimated 680,000 people in Bay and Bakool regions are currently in need for food aid;
- vii) Community resource based conflict is on the increase;
- viii) School age children (7 – 15 years) and their parents have been displaced (in Bay region, the drought affected the education of about 8625 children who left their villages during the last 3 months).

436. An estimated total number of 680,000 people in the entire Bay and Bakool regions (Bay – 529,000, and Bakool- 151,000) are currently in pressing need of food aid. The total number of people in need of food aid in the assessed area in Bay and Bakool is 120,000 people (32,160 in Bakool and 88, 200 in Bay region). Increasing cases of diarrhoea and respiratory infections; poor child feeding and care practices especially in the IDP camps are factors that reflect malnutrition levels.

437. Civil insecurity continues to present enormous challenges to nutrition surveillance activities but nevertheless, FSAU continues to conduct interagency nutrition assessments in areas of concern. In an interagency nutrition and mortality assessment conducted in Gedo region, excluding Bardera town, by FSAU, Gedo Health Consortium, UNICEF, WFP, CARE, NCA, FEWS-NET and COSV, between 22nd and 29th March 2006, it was found that the global acute malnutrition (GAM) rate (weight for height <-2 Z score or oedema) was 23.8% and severe acute malnutrition (weight for height <-3 or oedema) was 3.7% (95%CI 2.6 – 5.2). The GAM rate indicates a critical malnutrition situation in the entire Gedo region. Access to a sufficient and diverse diet and prevalence of common childhood illnesses appear to have been the major factors contributing to high levels of malnutrition.

438. Throughout the South, population movement continues and levels of malnutrition remain generally high and subject to fluctuations. There can be little doubt that early humanitarian and social assistance which responded to food security early warnings (issued in November 2005) have prevented a large scale humanitarian disaster in this area. Unfortunately, devastation of livelihoods has occurred for tens of thousands of households who will require substantial assistance to recover and will be unable to maintain household food security for some time.

Puntland

439. Livestock rearing and fishing are the main food production activities. Puntland is the area of the country that has suffered the most from the long drought cycle of 2001-2004, compounded by the effects of the tsunami in late December 2004. Moreover, because of the extent and duration of the disaster, normal coping mechanisms have been overwhelmed: assistance from other clan members for restocking has been much reduced; and many pastoralists have thus been unable to regain productive and sustainable livelihoods. Puntland shows the same terms of trade livestock vs imported cereals like Somaliland and also in this case food insecurity is mainly caused by food access problems.

Somaliland

440. With fewer conflicts and stability, food insecurity in the northern regions has become increasingly a matter of access to food rather than availability. There are pockets of high food insecurity and vulnerability that require special vigilance however, where livelihoods have been shattered by the past four years of drought. This is especially so in eastern Somaliland and the remote areas of Puntland as well as in the areas of concentration of IDPs and returnees in and around the main towns in both Somaliland and Puntland. The cumulative impact of recurring natural disasters (especially droughts), the upsurge of fuel prices, unfavourable terms of trade for livestock and the livestock export ban as well as the related vulnerability to prices of imported food have continued to

limit severely Somaliland and Puntland communities' ability to protect, secure and improve livelihoods and food security.

441. Pastoral livelihood is by far the most predominant livelihood in Somaliland with few areas where agro-pastoralist communities can be found. As a result, imported cereals (rice, pasta and wheat flour) are considered the food staple for the large majority of the communities urban and rural alike. Livestock and dairy products selling prices are the most important factors in guaranteeing access to cereals. Any shock affecting livestock prices can disrupt the terms of trade of livestock vs. cereals and therefore cause a food access problem for many pastoralists. Droughts, and more generally, lack of water in dry seasons are the cause of major livestock prices fall. Sool and Sanaag regions have suffered the most from the past four years of severe drought (2001 – 2004) that has damaged the natural resource base and reduced the herds, which are the main source of livelihood. This has disrupted the traditional nomadic lifestyle and caused the displacement of thousands of nomadic families to villages and towns where they have become dependent on other clan members or kinsfolk.

442. Food access seasonality patterns affect food stability and food utilization. Poor or non-existent health care facilities coupled with lack of education are also negatively affecting food utilization, especially among children.

Table 19: Severe and Moderate Malnutrition Levels in Children under 5 Years Old

	Weight for Age		Height for Age		Weight for Height	
	%<-2 SD	%<-3 SD	%<-2 SD	%<-3 SD	%<-2 SD	%<-3 SD
Per Livelihood Zone						
Pastoralist	27.8	6.1	20.8	11.6	17.1	3.8
Agro-Pastoralist	29.7	8.4	26.9	13.6	16.4	3.5
Urban	22.8	4.2	16.7	12.5	16.7	0
Female	25.2	7.7	22.8	10.9	16.3	2.8
Male	26.3	6.3	23.9	13.3	18.0	4.2
Per state						
Somaliland	26.8	4.8	17.7	10.5	14.8	2.4
Puntland	21.0	2.8	22.6	12.5	10.1	2.0
South/Central	27.5	9.5	25.7	12.5	21.2	4.6
Total	25.8	6.9	23.3	12.1	17.2	3.5

Source: UNICEF, Multi-Indicator Cluster Survey 2000

443. Years of conflict and economic decline, coupled with increasing exposure to natural disasters and environmental degradation, are the primary causes of malnutrition in South and Central Somalia, Puntland and Somaliland. Food insecurity and malnutrition have been exacerbated by lack of healthcare, poor infant-feeding practices and inadequate sanitation and public hygiene. Diet, food source, hazards that may affect source, coping mechanisms and potential initiatives to achieve food security, all are linked, with varying degrees, to the adopted livelihood of a particular household⁴². Field visit focus group meetings, discussions, direct observation and collected data and its extrapolation led to the following broad conclusions:

- i) Food production has progressively deteriorated with the continued insecurity
- ii) Malnutrition is wide spread in Somalia
- iii) Large tracts of irrigation and road infrastructure are in disrepair
- iv) Water harvesting structures could retain rainwater for the benefit of livestock
- v) Poor knowledge and society norms result in avoidable diseases and loss of life
- vi) Water quality and sanitation is poor in most rural areas

42 For a tabulation of diet, food sources, hazards and coping mechanisms in Somaliland, Puntland and South and Central see Food Security Data Sheets in Annex 4.

- vii) Diarrhoea and ARI are prevalent in children under five years old
- viii) Schools and health service in rural areas are poor or non-existent
- ix) There is an acute shortage of farm to market roads
- x) Drought is a recurring phenomenon with devastating effects

444. The development of the food sub-sector is hampered by difficulties of access to water, and inputs, notably seeds, low productivity of local varieties used, damage caused by drought, insects and diseases and post-harvest losses.

Vision and Priority initiatives

445. The sub-cluster vision is to ensure that all households have access to adequate and safe food at all times of the year needed for active healthy life, with a focus on vulnerable households, and to contribute towards the availability of adequate, safe and nutritious food for active life for all. Adequate nutrition is a human right, especially when considering the best interest of children.⁴³ it is important to remember that poverty and instability directly impacts the ability of the heads of families to provide for themselves and their children. Therefore parents as duty-bearers can not be held responsible for not fulfilling their obligation to provide the sufficient dietary intake for their children. Families, communities and local administration need to be empowered so as to have the capacity to provide adequate nutrition for one and all especially in times of drought and instability. Recommendations account for political boundaries and institutional capacities of South and Central Somalia, Puntland and Somaliland governments.

Table 20: A summary of issues and intervention

Livelihood Group	Issues	Policies Strategies	Priority Interventions
Pastoralist/ Agro-Pastoralist	Water Pastureland	Sustainable use of natural resources	Land use planning: Rainwater harvesting Boreholes, Rangeland management, fodder banks
Riverine	Siltation, Tse-tse fly, Damp earth-dug granaries	Irrigation management system	Desilting, Aircraft spray Concrete village granaries Regional warehouses
Urban	Skills Credit Employment	Livelihood diversification	Training Micro-credit Income generation schemes
IDPs	Ownership, Credit Employment	Land tenure	Land titles, Micro-credit, Income generation schemes
Coastal/Fishermen	Skills, Fishing gear, Credit	Technology transfer	Training Credit
All groups	Malnutrition	Awareness raising	Nutrition education Food aid, Supplementary/ Therapeutic feeding
Food Insecure Areas	Access	Market integration	Rural roads, Markets Regional warehouses

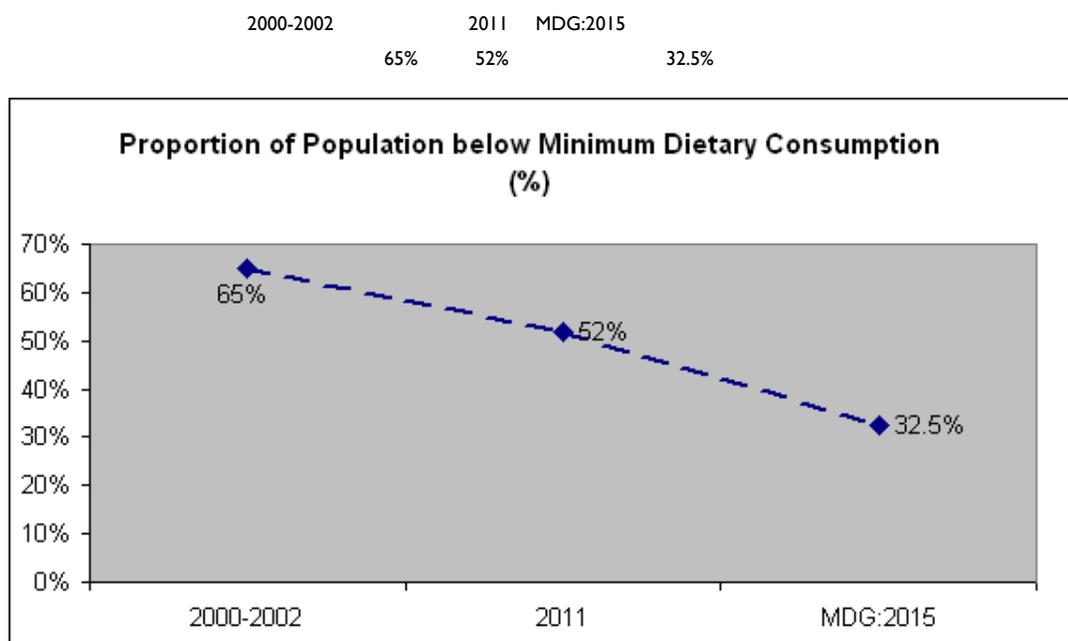
Somaliland and Puntland

446. Increase food availability at local level in order to diversify the options for household/community food access. Local food availability can be improved through local agricultural production, gardening and food processing and marketing skills. Water availability lies at the base of these types of intervention, therefore water harvesting projects, dams and bunds, and oasis agriculture should be recommended, through cash for work or food for assets (FFA) intervention.

⁴³ Convention on the Rights of the Child.

447. Provision of food processing and storage should be encouraged in rural areas together with some marketing skills courses. This type of training initiatives could be linked to more general education programmes and/or to food for training (FFT). Veterinary services should also improve in order to increase the quality of the livestock and therefore strengthen its economic value⁴⁴. Nutrition education through *ad hoc* campaigns, e.g. drama, radio, should also be fostered.

Figure 9: Proportion of the Population below Minimum Dietary Consumption
Target: Halve by 2015.



South and Central Somalia

448. Stable water availability is an issue of primary concern for food security together with livelihood diversification and health care and nutrition practices at household and community level. Water supply and irrigation infrastructure offer huge opportunities for improvement of the water quality and availability throughout the year in a period of crisis (e.g. drought).

449. Given the importance of food production, feeder roads should also be rehabilitated and, in some cases, built. Opportunities for assets creation (irrigation canals, feeder roads, boreholes, river banks, sand dunes control and reforestation) are huge and cash for work and food for assets (FFA) projects should be planned in a sustainable manner (see report for details on boreholes and water points). Veterinary services for livestock should also be provided. Also for the South and Central Somalia provision of food processing and storage should be encouraged in rural areas together with some marketing skills courses. This type of training initiatives could be linked to more general education programmes and/or to food for training (FFT). Nutrition education through *ad-hoc* campaigns, e.g. drama, radio, should also be fostered.

⁴⁴ Investing in quality rather than quantity should be a strategic priority for livestock export and environmental sustainability of the pastoral sector in a fragile ecosystem like the Somali inhabited areas.

Disaster mitigation capacity building

450. Due to the recurrent drought, it is proposed that South and Central Somalia, Puntland and Somaliland initiate disaster mitigation initiatives to address the transitional food shortage caused by seasonal shocks associated with droughts, flash floods, pest infestation, and/or economic adjustment programmes (e.g. livestock export bans etc) that disproportionately affect physical and economic access to food among the poorest population groups.

451. Since the national early warning system is weak, a National Disaster Management Plan should be put in operation and be mainstreamed at the district level. District-level capacity development will need further support.

452. This will improve availability and access to food for the most vulnerable households in acute food deficit areas and stabilize the nutritional status of malnourished families/children residing in the most food insecure areas of the country during periods of acute food shortage. The targeting of safety net operations is based on food production and nutrition indicators using FEWSNET and FSAU Vulnerability Assessment and Mapping data. This will help Regional Units coordinate responses to drought relief in drought-stricken districts.

Vulnerability Assessment and Mapping (VAM)

453. VAM has been used to direct food aid effectively to the poorest and most vulnerable groups, through vulnerability analysis related to food insecurity, mapping of the underlying causes and patterns of how food insecurity occurs or persists in any given country and thereby locating areas that suffer from recurrent food shortages.

454. VAM institutionalisation in Regional Monitoring Units and related capacity building will help in targeting limited resources to well-defined food insecure areas and enhance the effective prevention and preparedness strategies for districts at risk of drought or other disasters. VAM can also assist the Regional Monitoring Units to assess the impact of food aid by providing increased knowledge and database of the targeted beneficiary communities.

455. VAM analysis could help in Nutritional Surveillance and targeted feeding programmes in rural areas, or for targeting particularly vulnerable groups such as patients treated for pellagra, TB, leprosy, trypanosomiasis, individuals at risk of malnutrition in rural food insecure areas including returning refugees and IDPs in centres. The most vulnerable are the displaced people who have lost all their assets and are living in settlements. They do not enjoy protection through clan affiliation thus leaving them subject to multiple human rights violations including inadequate food and nutrition.

456. Nutrition Rehabilitation - development of South and Central Somalia, Puntland and Somaliland Plans of Action for Nutrition by providing supplementary feeding to vulnerable groups and support to diversification of food production and education in nutrition to promote household food diversification. This should be part of a comprehensive programme including, micronutrient supplementation for pregnant/lactating women and children under-five and rehabilitation programmes for severely malnourished children through targeted feeding in Nutrition Rehabilitation Units in Maternal Child Health (MCH) clinics.

457. Training health staff in primary health care services, caring for at-risk expectant women or lactating mothers and children under five years of age attending Maternal Child Health (MCH) clinics; and improve skills of volunteers and beneficiaries through health and nutrition training and education under the community-based supplementary feeding programme. For South and Central Somalia, Puntland and Somaliland, the development of frameworks to address food insecurity and promote participatory methods for developing interventions (including livelihoods and employment creation) at the community and district levels to broaden the household income base for vulnerable groups remains an overarching priority.

Implementation and monitoring arrangements

South and Central Somalia, Puntland and Somaliland

458. A Land-use planning Department within the Planning Ministries of South and Central Somalia, Puntland and Somaliland should be established with the following mandate:

- i) Advise and inform the government on land use issues and priorities
- ii) Seek inputs from ministries of Agriculture; Rural Development, Environment and Wildlife, Water department, NERAD (Somaliland) and HADMA (Puntland)
- iii) Prepare land use plans for each district taking into account regional and inter-district priorities, current demands and potential land uses
- iv) Ensure plans account for water resources and grazing lands including drought and seasonal reserves
- v) Establish guidelines on land use priorities
- vi) Maintain and update land use information
- vii) Establish and train district level land use planning committees
- viii) Provide managerial and technical supervision to district land use planning and enforcement authorities
- ix) Train district land use committees, pastoralist and village committees in participatory land use planning
- x) District land use committees would make land use recommendations to the Ministry. These recommendations will be based on guidelines from the Ministry, land potential and input from pastoralist committees and village committees.

459. The Ministry of Agriculture/Rural Development should establish a Department of Rural Water Harvest to identify locations suitable for rainwater harvesting structures, and then it should mobilize and train communities to build and maintain the structures.

460. The Ministry of Rural Development should establish a Roads Department to construct and maintain rural roads, train local people in low cost road construction and maintenance, and collect minimal toll/tax to cover costs of maintenance.

461. The Ministry of Health should establish a Nutrition/Sanitation Education department with the mandate to prepare nutrition education programmes, prepare sanitation education programmes, arrange for the regular broadcast of these programmes and broadcast early warning information generated from early warning systems such as FEWSNET and LEWIS.

462. The Ministry of Health should support programmes of supplementary and therapeutic centres to establish malnutrition data recording procedures, train district level staff on nutrition practices and programme monitoring, monitor data recording and periodically collect, analyze and submit findings to government.

463. The Ministry of Family Welfare and Social Development should establish a Vulnerable Children's Department to organize local teams (elders or community groups) to identify vulnerable children maintain information on vulnerable children and disseminate information to aid agencies, the Diaspora and other funding sources.

South and Central Somalia

464. The Ministry of Agriculture would organize water user associations to plan and execute de-silting activities twice a year on both the Juba and Shabelle rivers. Each association would be responsible for a particular segment of the canal/river, periodic de-silting and collection of tax from farmers to reduce costs by the Ministry for aerial sprays along the riverbanks to eradicate pests

VI. General Conclusion

465. The proposed role and functions of the three government line ministries in each state and the local governance structures in the RDP's first two years are to develop, enact and enforce the law, policies and regulations and to oversee ongoing service delivery and provision by the private sector, NGOs and CBOs. Central and local government – which nowhere is well-developed - will need capacity to advocate, support and oversee the active empowerment and participation of the poor and disadvantaged groups. The aim is to encourage and foster public accountability through a participatory process which is part of sustainable human development.

466. After 15 years of private sector domination of service delivery, monitored only by the self-regulatory role of a market economy, many people remain vulnerable. The aim is to strengthen government and community capacity in order to achieve sustainable results in service provision so that human rights can be realised.

467. **Local Implementation Capacity.** Capacity constraints will be acute and expatriate staffing in core posts will need further donor support to facilitate implementation of the initial two-year programme.

468. **Legislative bottleneck.** In South and Central Somalia in particular, an ambitious legislative agenda for the first two years of the RDP is envisaged. But given the new Parliament's limited technical capacity, this may constitute a constraint in programme implementation, especially in initiatives where legislation is a prerequisite for full implementation.

469. **Private sector participation:** Any increased role for the private sector must be properly regulated and monitored in order to bring basic social services to *all* levels of Somali society wherever they are needed.

470. **Services financing and cost recovery** will need to be addressed from year three. Current commitments and availability of resources will need to be identified for future implementation of all on-going and proposed activities. Benefits and the levels of institutional income generation from user fees and funding sources have to be analysed separately. It is assumed that an appropriate combination of sources and funding types - including public-private partnerships - will be adopted.

471. **Formulae driven resource allocation for financing Service Delivery:** From the central government, the financing of service delivery scale-up under the RDP could be formulae driven. This, as a departure from the usual approach that deliveries at the rural area level should be financed based on needs, often estimated somewhat arbitrarily by “experts” from the local government or central levels. The formulae approach seeks to ensure equity and provide the necessary transparency where all the stakeholders are aware why a particular district or community was allocated a given amount of money for a particular intervention. This approach aims to pilot the devolution of discretionary development and humanitarian budget support to different levels through local government in the rural areas.

472. However, in South and Central Somalia, Puntland and Somaliland, it is difficult to arrive at formulae which are applicable to all the districts given the regional diversity and differences in terms of resource endowments, level of development and capacity of involvement of the communities and private sector. Taking into consideration this diversity, through a consultative process, it has to be accepted that the formulae to be used for sharing the grants should be based on, for instance, child mortality rate, school age going population, youth population and land areas. Activities for implementation should therefore be split initially, in the ratio of 65%: 35% between the direct private and community sector and the public sector. The higher ratio for private sector is based on current capacity for implementation and absorption levels of the private sector as opposed to public sector in service delivery, and at district level on population and land areas on pro-rata weights respectively.

This is because it is still difficult to get data on child mortality and school age going population at these levels.

473. It is estimated that there are close to two million Somalis in the Diaspora. This large community is a huge resource of finance, skills, expertise and investment potential. It remains largely untapped by local governance structures in South and Central Somalia, Puntland and Somaliland. The local community has a history of effective coping mechanisms that are linked with the growth of Diaspora numbers, Islam's charitable traditions and clan loyalties. Traditionally young Somalis have been sent off for scholarships or to work as an assurance of returns, via remittances, to the wider community. The Diaspora is believed to be educated and the return programmes that have been set-up in the past by UNDP (Quest) and IOM (Return of Qualified Nationals) have attracted highly educated Somalis. There is unfortunately no current data or up-to-date profiling available but this resource should be researched and further utilised as it has great potential for reflecting locally owned development.

474. Progressive Government engagement in South and Central Somalia, Puntland and Somaliland should encourage public institutions to:

- i) Take charge of public services delivery that will initially be largely private sector and community demand driven until sufficient data has been collected to identify the gaps in service access at the local level; this will highlight the pros and cons of the public-private partnership.
- ii) Increase the use of the private sector, community based organizations and NGOs as partners of Government.

475. Democratic values in Somaliland are progressively taking root - free elections were held in November 2005 with universal adult suffrage. The government combines democratic principles and customary values, retaining considerable influence for male elders, a good template which South and Central Somalia and Puntland could follow. Policy formulation and decision-making are relatively open and involve widespread consultation. The overall quality of public administration has improved in recent years but the government has identified the following weaknesses: inadequate budgeting and budget control systems including data collection and analysis; deficient sectoral planning and monitoring; and a lack of focus and capacity by ministries on their core functions and responsibilities.

476. Puntland and in particular South and Central Somalia should study the lessons already learned by Somaliland so as not to repeat mistakes already made in a similar situation. Small-scale provision as an interim solution to service delivery to remote pastoral and rural communities will need to be supported by interventions directed towards private providers as well as government institutions. Quality of service by small-scale providers may not initially meet international standards. For instance, small-scale water providers are unlikely to follow World Health Organization (WHO) or local regulatory bodies' standards for pollutants, dissolved solids, microbiological presence and other measurements of quality. They are rather, as in Somaliland and Puntland, generally unlicensed, unregulated, untaxed and increasingly targeted as impediments to the development of public services by public institutions that are trying to reinstate their rights in service provision. Facilitating the enjoyment of human rights involves the attainment of human development goals such as set out in the MDGs. For example the goal to reduce child mortality rates is linked to the right to safe drinking water. Therefore if the provision of services such as water goes unregulated it is a disservice rather than an improvement.

477. **Policy and service delivery standards:** To date there are no laws that require line ministries – where extant - to issue national service delivery standards and still no capacity to enforce such guidelines. There is also the problem of agreeing on the operational definition of service delivery standards between the public institutions and private sector providers. There is confusion between design specification and service delivery in terms of quality, quantity and accessibility of services by the population.

478. “Provision activities involve decisions generally associated with “governing.” These include decisions regarding (a) what services to provide and to whom, (b) the quantity and quality of services to be provided, (c) how to finance those services, (d) how to ensure that the services are produced. Production, on the other hand, is the process of converting inputs into outputs. (L. Schroeder et al, 2001).

479. Line ministries need to develop design specifications and provide guidelines on service delivery parameters. The private sector has been collaborating in service delivery as contractors and as private providers. Provision of services by the private sector has been limited to those sectors that attract user charges such as water, education and health services.

480. Other sector ministries should build on the experiences of, for instance, Kenya and Uganda in the education, health and water sectors and start to develop appropriate service delivery standards in their sectors.

481. In rural/pastoral areas there is a lack of both private sector implementation and absorptive capacity. Rural local governments in most countries therefore usually have difficulty attracting and retaining qualified private providers. The trend in Somaliland and Puntland suggests that even Diaspora investments have been concentrated in urban centres (Hargesia, Bossaso and Garowe).

482. Social accountability: It is important to take note of lessons learned about the critical success factors and steps for implementing social accountability in local settings over the last 10 years. Interventions should begin by identification of potential strategies where social accountability might enhance citizen voice and service delivery at the local level. Social accountability has the potential to improve the responsiveness of governments and other power and duty-holders to the needs of local people and especially those with ‘less voice’. But social accountability mechanisms arise from specific needs, power imbalances and a desire to improve services. The success of one mechanism elsewhere in a local context in no way guarantees success in another.

483. Price variance in services provided is driven by factors such as the delivery mechanism, the availability of alternative sources (in the case of water for example), the number of competitive service providers, and to a lesser degree, the existence of a licensing, regulatory or contractual framework.

484. **Private providers play an important role** but need to be regulated in order to ensure the protection of marginalised groups. It is essential to recognize the importance of small-scale providers, and the local administration should encourage their spread to more remote communities. **The role that the government plays** in welcoming and encouraging these providers may prove crucial to semi-urban, rural and other poor and isolated communities⁴⁵.

485. The absorptive capacity of the social services sector in South and Central Somalia, Puntland and Somaliland could be constrained, especially considering the complex operational context – particularly in South and Central Somalia, but also in the contested Sool and Sanaag regions, where there have been minimal humanitarian emergency projects. Interventions envisaged aim for two year and three year approaches, to reach both the conflict affected vulnerable groups and also set-up a sustainable structure for social services delivery to an expanded post-conflict market.

45 The first act of government in this area would be to refrain from shutting down small-scale private service providers, however exorbitant their tariffs seem at first. Other initiatives by the government or from non-governmental organizations and the donor community might include: financial and technical support to micro-finance and small banking institutions with outreach for private and community infrastructure provision; assistance in the development of basic licenses and other contractual arrangements that legitimize these businesses without regulating them into bankruptcy; training to providers or potential providers (i.e., construction firms) of basic infrastructure in business planning, public-private contracting, the identification of collateral, and association building; and support for the design and implementation of community-based users' groups to provide a minimal level of regulation.

486. In South and Central Somalia clients have adopted an air of apathy towards the future and current role of government. The RDP is therefore in a position to bolster Government status and capacity to implement visibly for its citizens. This is an essential part of the future RDP's mandate and should be reflected in all sectors.

487. A focused effort of local area/district coordination must have a rapid and visible impact on local environmental conditions - increasing local access, social accountability, anti-poverty market responsive strategies and direct savings in the public institution structure. The degree to which a local area coordination strategy offers the means to community management will be influenced by the accountability structures, broader performance measures and the relationship between area initiatives and mainstream departments/ministries' policies and their capacity for effective participation.

488. In Puntland and Somaliland, there is increased interest and participation by local government structures in water and health services delivery. Current local area coordination in practice includes accountability structures and forms of governance such as area committees and community forums, which have increasingly become mainstream fund raising and management structures. They already demonstrate a variety of possible functioning approaches to area coordination or neighbourhood/locality management in service delivery.

489. There are political obstacles too, because area structures may require changes not only to public service departments but to the political and local governance structures that are bound up with them. Often, moves towards greater localisation of service delivery are found alongside decentralisation of political structures to community level area committees.

490. The limited access to and thereby limited coverage of community services infrastructure and their poor condition in rural areas constitute constraints for the development of entire areas and for improving the living conditions of the vulnerable population groups.

491. Community Driven Development (CDD) is one mechanism by which South and Central Somalia, Puntland and Somaliland can empower local communities to monitor and discipline providers at any level. Initiatives towards poverty reduction will require local level, community-based planning, as well as an alignment of public expenditure patterns towards pro-poor service delivery. Possible programmes to benefit communities include:

- Education: Schools, kindergartens, orphanages, environmental schools, training centres and multi-purpose social centres;
- Health and Nutrition: Community Health posts and centres, Village hygiene posts and maternity posts;
- Water and Sanitation: Family latrines, separate public toilets, school sanitation blocks, water points, wells, boreholes, water tanks, public water standpipes, etc;
- Small-scale community and municipal based environmental upgrading (e.g. water and waste management, reforestation, etc.).
- HIV/AIDS: the wider community will benefit from all HIV interventions which – if fast-tracked – immediately could avert the looming nation-wide epidemic that has so far been avoided.
- FGM, Khat: Education and discussion of FGM, Khat and the resultant empowerment of women will have knock-on effects in education, health and the general economy.

Using a CDD approach, the Community-based recovery rehabilitation programmes will finance local initiatives to build and restore social and economic infrastructure based on communities' participation in the identification, prioritisation, implementation and maintenance of small-scale interventions, giving increasing control over decisions and resources to community groups and local authority level institutions, including local government. This will build organisational capacity and develop social accountability mechanisms between communities and formal support institutions, and lay the foundation for activities envisaged from year four. Results can imply a positive change in the condition

of vulnerable groups and especially for women and children. For example an increase in educational facilities will improve child development, and increased participation of parents and communities in school management will be a positive change in the development process. Human rights based approach to programming entails that the process by which outcomes and impact for women and children are achieved are important. Participation, local ownership, capacity development and sustainability are essential characteristics of a high quality process.

492.

493. **Services scale-up:** Unlike most project-oriented programmes, interventions under the five-year RDP will focus more on understanding institutional service delivery at community, private sector and public sector levels. During the process a number of guidelines and manuals need to be developed and what will therefore be scaled up are the systems piloted during this period with lessons learned incorporated.

494. There should be an elaborate monitoring and evaluation framework through which lessons learned can be used to perfect service delivery systems. It is therefore crucial that for national scale-up more emphasis should be placed on system development as opposed to scale-up in terms of money or geographical coverage. Scaling-up through expanded institutional and human resources capacity building has a high possibility of success and sustainability as opposed to merely increasing the amount of money or the number of local governments to be covered. How to provide access to the most marginalised groups to quality basic services can only be attained through analysing and generating lessons from experience. It is therefore necessary to evaluate and document all efforts to improve access to services by women, children and their families.

495. Services in South and Central Somalia, Puntland and Somaliland should be delivered within a broader recovery and development community-based human rights-driven strategy. Such a strategy should include long-term capacity building for state institutions involved in the broader social services sector. This will have a knock-on effect of increasing national confidence in the nascent administrations and their institutions. The views of marginalised groups should be periodically sought in order to establish the adequacy of services provided in relation to their needs.

496. There are so many needs that there is currently no obvious structure or strategy in the choice of rehabilitation or reconstruction of one particular school, water tank or hospital in one district or another in a different location. It has often been quoted in evaluation reports that there is a need for coordination of funding requests and implementation among aid agencies and donors to contribute towards sustainable interventions in post-conflict areas. There is a clear need to scale up responses (where possible) and strengthen the coordination of interventions to ensure effective and quality interventions. Most strategies to provide services especially to vulnerable groups, including women and children require affirmative action and/or an extra-ordinary action on the part of legislators, local and national planners, policy decision makers, service providers and communities. These efforts need to be monitored to maintain quality service provision. Each strategy must have an inbuilt system for monitoring compliance to policy provisions, commitments, service standards and new behaviours – at least until access to services by these groups have been become routine.⁴⁶

497. Service delivery should eventually be based on current contextual and physical mapping of established policies and strengthened institutions, all of which are - in the Somali context - activities in flux. Analysis and updating of the socio-political environment in the transition period before implementation will be particularly important, as increased contest over resources is inevitable, but also because situational gap analyses will yield data and statistics necessary for streamlining interventions to suit evolving conditions.

⁴⁶ Programme Policy and Procedure Manual, UNICEF (2005)

498. Most importantly of all, a human rights led approach is essential, one that does not always take the easy option of concentrating on easily achievable goals in safe and accessible areas. In adopting Integrating Human Rights with Sustainable Human Development promotes international standards established to protect the human rights of every individual. Human rights bring to the development discussion a unifying set of standards-a common reference for setting objectives and assessing the value of action. The rights approach will enhance the human dimension of strategies that, among others, focus on eliminating poverty, helping groups that require special protection, and strengthening institutions of governance and democracy.⁴⁷

⁴⁷ Mary Robinson, former United Nations High Commissioner for Human Rights

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