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' circumcision[36]. 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 frame work 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, widowing, 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 18: 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 2004-5[39]

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 system[40]. 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 SECURITY[41] 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 berkeds (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 household[42]. 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 dietry 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.

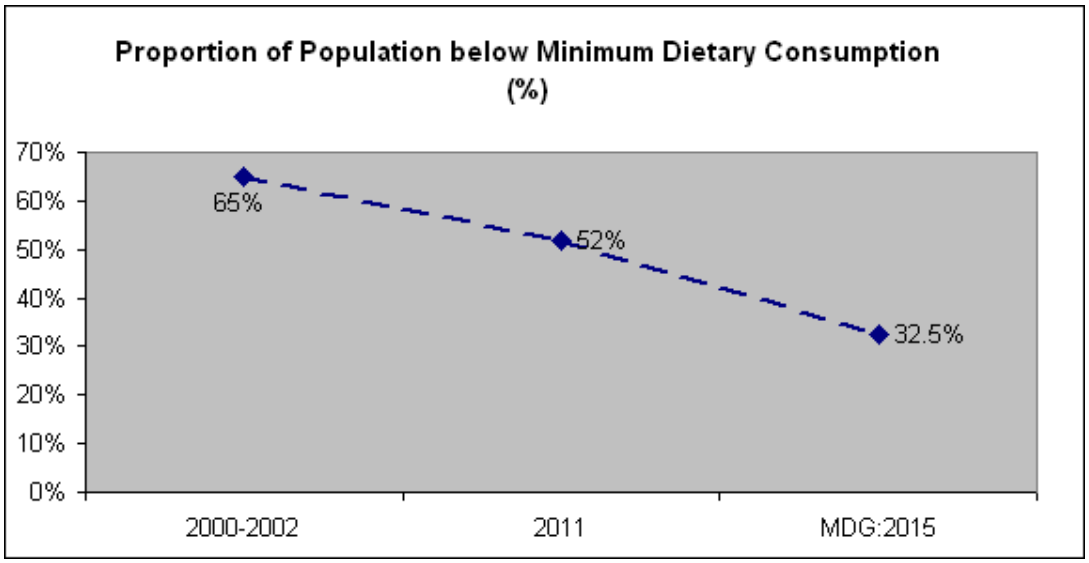
447. Provision of food processing and storage should be encouraged in rural areas together with some marketing skills courses. This type of training initiatives could be linked to more general education programmes and/or to food for training (FFT). Veterinary services should also improve in order to increase the quality of the livestock and therefore strengthen its economic value[44]. 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.

2000-2002 2011 MDG:2015

65% 52% 32.5%



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, tryponosomiasis, 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 communities[45].

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

A. BIBLIOGRAPHY

ADEA (Association for the Development of Education in Africa). *What Works and What's New in Education: Africa Speaks!* Paris: Association for the Development of African Education (ADEA). 2001. http://www.adeanet.org/downloadcenter/publications/arusha%20papier_eng_web.pdf

Appleton, P. & Blondet G. 2004. *Support to employment Promotion in Somalia: Feasibility Study Report.* European Commission, Kenya Delegation, Somalia Operations. une 2004

Bel Buono, M. 2002. *Basic and Vocational education for the Demobilization of Youth in Somalia: An Evaluation Report.* UNESCO PEER: Nairobi and Mogadishu, March 2002.

Bunyi, G. W. & Munyui, W. 2005. The Provision of Primary Alternative Education to Vulnerable Groups of Children in Somalia. UNICEF.

Bennaars, G. A., Seif, H. A., Mwangi, D. 1996. *Mid-Decade Review of Progress Towards Education for All: The Somalia Country Case Study*. Nairobi: UNDP, UNICEF & UNESCO.

CfBT (Centre for British Teachers). 2004. Institutional Support to Secondary Education in Somalia: Final Report.

Cummings, W. K. & Rost van Tonnigen, L. 2003. *Somalia Education Sector Assessment: With special attention to the Northwest Zone*. USAID & Creative Associates International.

European Commission — Somalia Operations. 2006. EC Intervention Strategy and Policy Considerations for Education and Training Sector. A document in support of the EC Strategy for the Implementation of Special Aid to Somalia. January 2006.

FAO, *The Right to Food in Theory and Practice, Rom*e, 1998.

Jonsson, Urban, *Human Rights Approach to Development Programming*. Nairobi: UNICEF, 2003.

Le Sage, A., 2004. "The Rise of Islamic Charities in Somalia: An assessment of impact and agendas." Paper presented to the 45th Annual International Studies Association Convention, Montreal, 17-20 March 2004.

Lindley, A., 2005. "Influence of Remittances and Diaspora Donations on Education." Paper for Conference on Somali Remittances, Washington, DC, December 1-2, 2005

NGO Consortium Somalia (2005): NGOs in Somalia. Handbook 2005. Nairobi: The NGO Consortium.

NOVIB & World Association of Muslim Youth. 2004. *Arab Donor Policies and Practices on Education in Somalia/Land.* Supported by the EC Somalia Operations. September 2004.

Pfaffe, J. F., & Smith, I. 2004. *Feasibility Study on a Program for Strengthening Capacity of Teacher Training (SCOTT) for Puntland and Somaliland*. Draft Final Report, July 2004. European Commission, Kenya Delegation, Somalia Operations.

Sesnan, B. & Milas, S. 1995. *Evaluation of UNICEF Assistance to Basic Education in Somalia.* Mogadishu, Sosasso, Hargeisa, Nairobi: December 1995.

Sinclair, M. 2002. *Planning education in and after emergencies*. Paris UNESCO/IIEP.

Smart A. 2004. *A policy study on textbook provision for Somalia (grades 1-8).* International Book Development Ltd. (done for Unicef), June-July 2004.

Transitional Federal Government of Somalia. *Somali Transitional Charter: Transitional Federal charter for the Somali Republic.*

UNDP. 2006. *Millennium Development Goals Report for Somalia (Draft)*

UNESCO PEER. 2002. Basic and vocational education for demobilisation of youth in Somalia: Project document. December 2002.

UNICEF. 2004. *Survey of Primary Education in Somalia 2003/4.*

UNICEF. 2005. *Survey of Primary Education in Somalia 2004/5.*

World Bank. 2005. Expanding Opportunities and Building Competencies for Young People: A New Agenda for Secondary Education. Washington, DC: World Bank.

World Bank. 2006. Somalia: From Resilience Towards, Recovery and Development: A Country Economic Memorandum for Somali