



**Executive Board of the  
United Nations Development  
Programme and of the  
United Nations Population Fund**

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**UNITED NATIONS POPULATION FUND**

**Country programme document for Somalia**

Proposed indicative UNFPA assistance:	\$19 million: \$6 million from regular resources and \$13 million through co-financing modalities and/or other, including regular, resources
Programme period:	Two years (2008-2009)
Cycle of assistance:	First
Category per decision 2005/13:	A

Proposed indicative assistance by core programme area (in millions of \$):

	Regular resources	Other	Total
Reproductive health	3.6	6	9.6
Population and development	1.2	1	2.2
Gender	1.0	6	7.0
Programme coordination and assistance	0.2	-	0.2
<b>Total</b>	<b>6.0</b>	<b>13</b>	<b>19.0</b>

## **I. Situation analysis**

1. Somalia is one of the poorest countries in the world. Nearly half of Somalians live on an income of less than a \$1 a day, while more than half live on less than \$2 a day. Poverty is less pronounced in the northern part of the country, which is more politically stable than other areas of the country. Only 38.5 per cent of urban residents, and 59.3 per cent of those in rural and nomadic areas, are employed. The overall unemployment rate for the country is 47.4 per cent.

2. Somalia is experiencing one of the most challenging humanitarian crises in the world, characterized by protracted conflicts and natural disasters. The environment within the country varies greatly. While the Somaliland and Puntland zones in the North enjoy relative stability, functioning regional institutions and political development, the South-Central zone is in a state of emergency. The three zones require different interventions and approaches.

3. The last census was held in 1974-1975. The population was estimated at 7.7 million in 2005, a figure accepted by the Transitional Federal Government of Somalia and used by the United Nations system. Approximately 39 per cent of the population lives in urban areas; the rest live in villages or are nomads. Ongoing conflicts have altered regional population distribution.

4. Reproductive health is a major challenge. The maternal mortality ratio, which is 1,600 deaths per 100,000 live births, is one of the highest in the world. Malnutrition, haemorrhage, prolonged and obstructed labour, and infections are the major causes of maternal deaths. The high illiteracy rate among women impedes their access to health information. Health facilities are limited. Many of the available health services have been set up by communities or by private medical services. A study of clinics in Northern Somalia found that only one in 10 hospitals functioned adequately.

5. The total fertility rate is estimated at 5.7 children per woman; and the contraceptive prevalence rate is estimated at 15 per cent. Only 1.2 per cent of married women use modern methods of contraception. Lactation amenorrhea, used by 13 per cent of married Somali women, is the most popular contraceptive method. The use of condoms for birth spacing or HIV/AIDS prevention is nearly non-existent. While data on HIV prevalence among the general population are not available, the HIV prevalence rate among blood donors is about 1 per cent. Only 4 per cent of young people aged 15-24 years know how to prevent HIV.

6. Approximately one fifth of the population is literate (19.2 per cent), and access to basic education is limited. The country has one of the lowest primary school enrolment rates in the world (18.8 per cent). Gender-related disparities, especially in education, are a major concern. There are 10 boys for every 8 girls in primary school; in secondary school, the ratio is 10 to 5. Women have limited ability to exercise their rights, due to patriarchal and clan-based systems. The representation of women in parliament is low (12 per cent), despite recent progress to include women in national governance structures.

7. There is little data on violence against women, making it difficult to determine the extent of the problem. However, sexual and gender-based violence (including rape, domestic violence and harmful traditional practices such as female genital cutting), is common. Despite the adverse consequences on women's reproductive health, female genital cutting persists, due to deep-rooted traditions and cultural practices.

## **II. Past cooperation and lessons learned**

8. UNFPA assistance to Somalia began in the 1970s and continued until 1991, when civil war suspended development programming. In 2006,

UNFPA signed a programme of action for 2007 with the Somaliland and Puntland administrations, with a budget of \$4 million. The programme seeks to strengthen the institutional capacity of the Government to respond to population and development issues, specifically in the areas of gender, HIV/AIDS prevention, and access to sexual and reproductive health services and information, especially among youth, internally displaced persons and other vulnerable population groups.

9. UNFPA supported comprehensive reproductive health projects in Somaliland and Puntland from 2004-2006, providing support for: (a) training; (b) the provision of medical supplies; (c) services for internally displaced persons and refugees in Ethiopia and Kenya; and (d) peer education to raise awareness about HIV/AIDS. In the South-Central zone, assistance focused on: (a) training; (b) reproductive health services; and (c) the treatment, in health facilities and mobile clinics and through outreach services, of victims of sexual and gender-based violence. The programme provided reproductive health kits, supplies and post-rape treatment kits to health facilities and personal hygiene kits to internally displaced women.

10. To address the lack of reliable population data, UNFPA and other United Nations organizations trained local authorities and the staff of educational institutions to strengthen institutional capacity for data collection, analysis, reporting and management. A joint project with the United Nations Development Fund for Women and UNDP supported the development of a national gender policy framework and advocacy for gender mainstreaming in the administrations of all three zones. UNFPA mobilized support among Somali experts and religious leaders to campaign against female genital cutting and supported initiatives for national journalists to raise awareness of and prevent sexual and gender-based violence.

11. Lessons learned include: (a) the need for flexible planning that considers the political context and differing stages of development in the three zones; (b) recognition of the weak capacity of local institutions as a result of the migration of qualified workers; (c) the need to ensure that projects meet the needs of clients and are culturally appropriate; and (d) the importance of a UNFPA operational presence in the regions as well as the presence of national staff, to ensure that programme activities take political, religious and cultural sensitivities into account.

### **III. Proposed programme**

12. The programme is based on priorities identified in the United Nations transition plan for Somalia for 2008-2009, which focuses on the transition from conflict to peace, from crisis to recovery, and on longer-term development. The programme is also based on the Somalia reconstruction and development programme for 2008-2012. The United Nations country team and national authorities developed the documents through intensive, broad-based consultations with non-governmental organizations (NGOs) and international donors. The programme takes into account the development priorities outlined in the Millennium Development Goals and in humanitarian frameworks.

13. The goal of the programme is to contribute to the fourth outcome of the United Nations transition plan for Somalia: children, youth and vulnerable groups have increased and equitable access to high-quality education and health services.

#### *Reproductive health component*

14. The outcomes of this component will be: (a) selected communities, government authorities and the private sector are able to manage high-quality health services; and (b) more women of reproductive age benefit from improved access to high-quality reproductive

health services. Three outputs will contribute to these outcomes.

15. Output 1: Enhanced national capacity to plan, formulate, manage, implement, monitor and evaluate policies that promote increased access to reproductive health and HIV-prevention services. This will be achieved by: (a) building the capacity of health service providers to deliver high-quality reproductive health and HIV services; (b) developing policies and strategies on reproductive health commodity security, adolescent sexual and reproductive health, and HIV prevention; (c) supporting research on emerging reproductive health issues for policies, strategies and service delivery; (d) building the capacity of service-delivery points to provide high-quality reproductive health services, including emergency obstetric care and fistula treatment; and (e) building the capacity of local authorities and civil society organizations to deliver high-quality reproductive health services in order to restore confidence among the public in health services.

16. Output 2: Increased availability of a minimum initial service package for high-quality, gender-sensitive reproductive health services, with special consideration for humanitarian needs. This will be achieved by: (a) providing in-service training in clinical skills, counselling and interpersonal communication; (b) supporting the reproductive health commodity logistics management system; (c) supporting behaviour change communication efforts targeting vulnerable groups; (d) strengthening referral systems for emergency obstetric care and fistula repair services; (e) expanding access to reproductive health information and services; (f) expanding partnerships to ensure the provision of a minimum package of essential reproductive health services at all levels; (g) advocating greater involvement of local organizations in fistula treatment campaigns; and (h) supporting youth-friendly services.

17. Output 3: Promotion of effective behaviour change across sectors at the community level, aimed at groups that are most at risk. This will be achieved through: (a) outreach services through media campaigns and counselling; (b) the production and dissemination of educational materials and programmes in the formal and informal education sectors; and (c) supporting community-level interventions with ministries and the national AIDS commissions.

18. Output 4: Increased coverage and utilization of high-quality, gender-sensitive and youth-friendly HIV-prevention services. This will be achieved by: (a) advocating increased coverage of reproductive health services; (b) closing gaps in delivering HIV-prevention services that target youth; and (c) supporting dialogue on HIV-prevention service delivery, including male and female condom programming, family planning, voluntary counselling and testing, prevention of mother-to-child transmission, and post-testing services.

#### *Population and development component*

19. The outcome of this component will be: key social, demographic and economic data are available for planning and policy development. The outcome will be achieved through two outputs.

20. Output 1: Strengthened national and local capacity to collect, analyse, interpret, disseminate and utilize disaggregated population and poverty data for decentralized planning, monitoring and policymaking. This will be achieved through: (a) training programmes for Somali universities, including distance learning, in partnership with regional institutions; (b) training in electronic data collection and management; (c) technical support to statistical departments and planning ministries; and (d) support for a nationwide, comprehensive household survey.

21. Output 2: Increased advocacy for population and development issues and

improved understanding of international and national policies and agreements on population, including the Programme of Action of the International Conference on Population and Development (ICPD). This will be achieved by: (a) providing technical support for policy formulation and implementation; (b) involving civil society organizations in policy formulation and implementation; and (c) raising the awareness of the Government and civil society of international issues and standards outlined in the Millennium Development Goals, the ICPD Programme of Action and the Convention on the Elimination of All Forms of Discrimination against Women.

#### *Gender component*

22. The outcome of this component will be: Somalis, especially vulnerable groups, have better protection under the law, including legal redress for previous conflict-related human rights violations, and improved access to justice. It will be achieved through two outputs.

23. Output 1: HIV/AIDS, gender and human rights principles are articulated in key government policies and plans. This output will be achieved by: (a) providing technical support to mainstream gender in the planning and programming processes; (b) helping ministries formulate gender policies and action plans; and (c) sensitizing policymakers, community leaders and religious leaders on gender, HIV/AIDS and human rights issues.

24. Output 2: Enhanced capacity of the Government and women's institutions to advocate the prevention of, and the response to, gender-based violence and other harmful practices. This output will be achieved by: (a) establishing a multisectoral mechanism to coordinate partnerships to combat sexual and gender-based violence; (b) providing technical support for an in-depth situational analysis on sexual and gender-based violence; (c) promoting women's participation in decision-making and the electoral process through civil society; and (d)

developing national and subnational strategies, work plans and monitoring mechanisms to address sexual and gender-based violence.

#### **IV. Programme management, monitoring and evaluation**

25. UNFPA will execute the programme in cooperation with the Government and national NGOs. The Ministry of Planning and International Cooperation will coordinate the programme. Key implementing partners include the Ministries of Health; Women's Development and Family Affairs; Planning and International Cooperation; Sports and Youth; and Education, as well as the national AIDS commissions in all three zones.

26. UNFPA will mobilize resources for the humanitarian response, in collaboration with Office for the Coordination of Humanitarian Affairs. Potential donors include the Governments of Belgium, Finland, and the United Kingdom; the Humanitarian Response Fund for Somalia; the Central Emergency Response Fund of the United Nations; and the UNFPA Humanitarian Response Unit, among others. UNFPA will give priority to developing joint programmes with United Nations organizations, in accordance with the United Nations transition plan for Somalia.

27. The UNFPA country office for Somalia is temporarily located in Nairobi, Kenya. It consists of a UNFPA representative, an assistant representative, national programme officers and administrative support staff. There are three sub-offices (in Puntland, Somaliland and South-Central) with professional and support staff funded from programme funds. In South-Central, UNFPA will focus efforts on humanitarian and early-recovery interventions, particularly the provision of minimum initial service package interventions on reproductive health, strengthening emergency obstetric care services, and building the capacity of health-care workers and local institutions.

## RESULTS AND RESOURCES FRAMEWORK FOR SOMALIA

<p><b>National priority:</b> (a) securing peace, improving security and establishing good governance; (b) investing in people through improved social services; and (c) creating an enabling environment for private sector-led growth to expand employment and reduce poverty</p> <p><b>United Nations transition plan for Somalia outcome:</b> by the end of 2008: (a) key federal, Somaliland and Puntland institutions administer and manage core government functions effectively; (b) local governance contributes to peace and to equitable priority service delivery in selected locations; (c) improved security and protection under the law for all Somalis; (d) children, youth and vulnerable groups have increased and equitable access to high-quality education and health services; and (e) vulnerable and marginalized groups have improved, sustainable food security and economic opportunities</p>				
Programme component	Country programme outcomes, indicators, baselines and targets	Country programme outputs, indicators, baselines and targets	Partners	Indicative resources by programme component
Reproductive health	<p><b>Outcome 1:</b> Selected communities, government authorities and the private sector are able to manage high-quality health services</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> <li>• National and subnational policies on reproductive health are in place and effectively implemented</li> <li>• Proportion of contraceptives in health budget</li> <li>• Proportion of contraceptives in family planning budget</li> <li>• Laws on health, population and the family are revised</li> </ul> <p><u>Baseline:</u> Reproductive health policies not in place; United Nations transition plan for Somalia; Somalia reconstruction and development programme</p> <p><b>Outcome 2:</b> More women of reproductive age benefit from improved access to high-quality reproductive health services</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> <li>• Proportion of births attended by skilled health personnel</li> <li>• Contraceptive prevalence rate</li> <li>• Skilled birth attendance</li> <li>• Condom use at last high-risk sex</li> <li>• Proportion of youth using condoms</li> <li>• Proportion of rural women benefiting from high-quality reproductive health services</li> </ul> <p><u>Baseline:</u> Research data; multiple indicator cluster survey; family health survey; Ministry of Health reports</p>	<p><b>Output 1:</b> Enhanced national capacity to plan, formulate, manage, implement, monitor and evaluate policies that promote increased access to reproductive health and HIV-prevention services</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Proportion of reproductive health policies, guidelines and protocols developed and implemented</li> <li>• At least 20 to 30 per cent of all health managers in the Government and NGOs trained in management, planning, monitoring and evaluation, and in the use of protocols</li> <li>• Reproductive health commodity strategy document developed, published and endorsed in at least two regions</li> </ul> <p><b>Output 2:</b> Increased availability of a minimum initial service package for high-quality, gender-sensitive reproductive health services, with special consideration for humanitarian needs</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Percentage of service delivery points providing integrated reproductive health information and services</li> <li>• Percentage increase in number of satisfied users</li> <li>• Percentage of women with obstetric complications identified and referred</li> <li>• Percentage of women with obstetric complications treated in emergency obstetric care facilities</li> <li>• Percentage increase in number of service delivery points offering a minimum package of high-quality reproductive health services</li> <li>• Percentage of service delivery points with a regular and appropriate mix of contraceptives</li> <li>• <b>Number of local organizations involved in fistula treatment campaigns.</b></li> </ul> <p><b>Output 3:</b> Promotion of effective behaviour change across sectors at the community level, targeting groups that are most at risk</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Increased number of men, women and youth who have knowledge of sexual and reproductive health</li> <li>• Increased percentage of men supporting their partners in the use of sexual and reproductive health services</li> <li>• Increased number of adults who discuss sexual and reproductive health issues with youth</li> <li>• Increase in number of media programmes on HIV and reproductive health</li> <li>• Number of NGOs and community-based organizations implementing a minimum behavioural change package</li> </ul> <p><b>Output 4:</b> Increased coverage and utilization of high-quality, gender-sensitive and youth-friendly HIV-prevention services</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Percentage reduction in vulnerability factors in HIV infection</li> <li>• Number of HIV voluntary counselling and testing sites established</li> <li>• Percentage increase in number of outlets providing youth-friendly information and services</li> <li>• Percentage increase in number of youth using youth-friendly outlets</li> </ul>	<p>Ministry of Health; Ministry of Women's Development and Family Affairs; Ministry of Sports and Youth; national AIDS commissions</p> <p>NGOs</p> <p>United Nations organizations; World Bank</p>	<p>\$9.6 million (\$3.6 million from regular resources and \$6 million from other resources)</p>

Programme component	Country programme outcomes, indicators, baselines and targets	Country programme outputs, indicators, baselines and targets	Partners	Indicative resources by programme component
Population and development	<p><b>Outcome:</b> Key social, demographic and economic data are available for planning and policy development</p> <p><b>Outcome indicators:</b></p> <ul style="list-style-type: none"> <li>Population, reproductive health, gender, poverty and development linkages are reflected in national and subnational strategic plans</li> <li>Disaggregated data are available and used to monitor programmes and progress towards the Millennium Development Goals</li> <li>Data are utilized in developing the Millennium Development Goals report and planning documents</li> </ul>	<p><b>Output 1:</b> Strengthened national and local capacity to collect, analyse, interpret, disseminate and utilize disaggregated population and poverty data for decentralized planning, monitoring and policymaking</p> <p><b>Output indicators:</b></p> <ul style="list-style-type: none"> <li>Statistical departments strengthened in the Ministry of Planning and International Cooperation</li> <li>Statistical units in other ministries established</li> <li>All statistical units have increased staff capacity to collect and use population data for development plans and programmes</li> <li>Focal points in planning and implementing agencies are trained on the use of data</li> <li>Number of large and small-scale surveys and studies conducted in regions and districts using social-sector, disaggregated indicators on population, reproductive health and gender issues</li> <li>In-depth analyses carried out using existing data sources for policy formulation and planning</li> </ul> <p><b>Output 2:</b> Increased advocacy for population and development issues and improved understanding of international and national policies and agreements on population, including the ICPD Programme of Action</p> <p><b>Output indicators:</b></p> <ul style="list-style-type: none"> <li>Web-based <i>SomInfo</i> (database of development indicators) is rolled out, a maintenance system is set up, and the staff of government statistical units are trained in its use</li> <li>Population database integrating results of major surveys and continuous record systems (school statistics, health facility statistics) is available</li> <li>Number of events organized to promote population and development issues</li> </ul>	<p>Ministry of Planning and International Cooperation; Ministry of Health; Ministry of Women's Development and Family Affairs</p> <p>Universities; NGOs</p> <p>United Nations organizations</p>	<p>\$2.2 million (\$1.2 million from regular resources and \$1 million from other resources)</p>
Gender	<p><b>Outcome:</b> Somalis, especially vulnerable groups, have better protection under the law, including legal redress for previous conflict-related human rights violations, and improved access to justice</p> <p><b>Outcome indicator:</b></p> <ul style="list-style-type: none"> <li>Number of policies in place and implemented in key areas</li> <li>Parliamentary reviews of key policies</li> <li>Mechanisms in place to monitor and reduce gender-based violence</li> <li>Discriminatory provisions against women and girls are removed from national and subnational legislation</li> <li>Civil-society partnerships actively promote gender equality, women's and girls' empowerment, and reproductive rights</li> </ul>	<p><b>Output 1:</b> HIV/AIDS, gender and human rights principles are articulated in key government policies and plans</p> <p><b>Output indicator:</b></p> <ul style="list-style-type: none"> <li>Percentage of budget of local plans dedicated to HIV/AIDS, gender and human rights</li> </ul> <p><b>Output 2:</b> Enhanced capacity of the Government and women's institutions to advocate the prevention of, and the response to, gender-based violence and other harmful practices</p> <p><b>Output indicators:</b></p> <ul style="list-style-type: none"> <li>Number of national and local strategies on sexual and gender-based violence</li> <li>Number of awareness-raising interventions among communities with the most vulnerable population groups</li> <li>Gender-related policies and programmes formulated</li> <li>Gender frameworks integrated into local development plans</li> <li>Gender dimensions strengthened in population and reproductive health modules and protocols</li> </ul>	<p>Ministry of Women's Development and Family Affairs; Ministry of Planning and International Cooperation; National AIDS commissions; Regional and district authorities</p> <p>NGOs</p> <p>United Nations agencies</p>	<p>\$7 million (\$1 million from regular resources and \$6 million from other resources)</p> <hr/> <p>Total for programme coordination and assistance: \$0.2 million from regular resources</p>