



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

Distr.: General  
9 June 2010

Original: English

**Second regular session 2010**

30 August to 3 September 2010, New York

Item 8 of the provisional agenda

**UNFPA – Country programmes and related matters**

**UNITED NATIONS POPULATION FUND**

**Draft country programme document for Somalia**

Proposed indicative UNFPA assistance:	\$27.2 million: \$12.7 million from regular resources and \$14.5 million through co-financing modalities and/or other, including regular, resources
Programme period:	Five years (2011-2015)
Cycle of assistance:	Second
Category per decision 2007/42:	A

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

	Regular resources	Other	Total
Reproductive health and rights	6.0	8.0	14.0
Population and development	3.5	2.5	6.0
Gender equality	2.5	4.0	6.5
Programme coordination and assistance	0.7	-	0.7
<b>Total</b>	<b>12.7</b>	<b>14.5</b>	<b>27.2</b>



## **I. Situation analysis**

1. Somalia has not had a functional central government since 1991. A civil war has resulted in the deaths of up to one million people in three zones: Somaliland, Puntland and South-Central. This has had a severe impact on the political situation and has led to a breakdown in the delivery of basic social and health services and to a humanitarian crisis.

2. The recent surge in the conflict has resulted in an estimated 3.2 million people (42 per cent of the total population) requiring emergency humanitarian assistance. The number of internally displaced persons is estimated at 1.4 million, 570,000 of whom are living in the South-Central zone. Continued clashes have hindered the Transitional Federal Government from delivering basic social and health services.

3. The protracted security crisis and the political division among the political entities in the three zones have hindered the ability of the United Nations and partner organizations to undertake dialogue with the Government and support programme interventions.

4. Reproductive health is a challenge. The maternal mortality ratio of 1,044 deaths per 100,000 live births is one of the highest in the world. The lack of availability and access to basic and emergency obstetric care is a major cause of the high levels of maternal mortality and morbidity.

5. Early marriage is common. Available data indicates that the age at first marriage is 15.6 years for girls. The age-specific fertility rate for 15- to 19-year-old girls is 123 per 1,000. Early marriage and early childbearing, coupled with the nearly universal practice of female genital mutilation/cutting, is increasing the vulnerability of girls and women and is contributing to the high rates of maternal mortality.

6. The total fertility rate is estimated at 5.7 children per woman, and the contraceptive prevalence rate is 15 per cent. Only 1.2 per cent of married women use modern methods of contraception. The use of condoms for family planning or HIV/AIDS prevention is limited.

7. Youth account for nearly a fifth (18.7 per cent) of the total population. Due to the population momentum built into the current age structure, the percentage of young people will continue to increase. The majority of young Somalis have experienced conflict and hardship throughout their lives; this has resulted in a large number of uneducated, unemployed and marginalized youth.

8. The latest HIV data indicate the existence of multiple HIV epidemics in Somalia. While the epidemic has generalized features in Somaliland, there are concentrated and low-level epidemics in Puntland and South-Central.

9. Escalating violence is increasing the incidence of sexual attacks against women and girls. Prevalence rates for female genital mutilation/cutting are high, at an average of 98 per cent in all zones. Despite the adverse consequences on women's reproductive health, female genital mutilation/cutting persists due to deep-rooted traditions, cultural practices and resistance to legislation that would ban it.

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

10. UNFPA assistance to Somalia began in the 1970s and continued until 1991, when the civil war led to a suspension of development programming. From 2003 to 2006, UNFPA supported comprehensive reproductive health service delivery, focusing on training and the provision of medical supplies for internally displaced persons in Somaliland and Puntland. The first programme of assistance, 2008-2009, was extended through 2010. The programme was based on priorities identified in the United

Nations Transition Plan for Somalia, 2008-2010.

11. Achievements in the area of reproductive health included: (a) the development of a reproductive health strategy for Somaliland and Puntland; (b) strengthened capacity of service providers to increase skilled birth attendance; (c) the provision of family planning services in selected institutions, including health facilities serving internally displaced people in Mogadishu; and (d) the implementation of the fistula management campaign. The programme also supported the establishment of the Youth Peer Education Network (Y-PEER) and youth advisory panels.

12. With regard to population and development, the programme focused on strengthening the institutional capacity of the Government to respond to population and development needs in emergency, recovery and development situations.

13. In the area of gender equality, UNFPA supported and facilitated the work of coordinating bodies to prevent and respond to gender-based violence. UNFPA provided commodities and training support to local partners working with the survivors of gender-based violence.

14. Lessons learned from the first cycle of assistance include: (a) the need for flexible planning that considers the political context and the differing stages of development in the three zones; and (b) the feasibility of delivering essential services through partnerships between non-governmental organizations and governmental organizations in situations where government capacity is weak.

### III. Proposed programme

15. The proposed programme is based on national priorities identified in the Somalia Reconstruction and Development Programme, 2008-2012, and the United Nations Somalia Assistance Strategy, 2011-

2015, which focuses on: (a) emergency response; (b) the transition from conflict to peace and from crisis to recovery; and (c) longer-term development.

16. The country programme seeks to improve the overall quality of life of the Somali people. The programme will contribute to the three outcomes of the United Nations Somalia Assistance Strategy: (a) Somali people have equitable access to basic services in health, education, shelter, water and sanitation; (b) Somali people benefit from poverty reduction through equitable economic development and decent work; and (c) Somali people live in a stable environment, where the rule of law is respected and rights-based and gender-sensitive development is pursued.

17. The overall strategy of the proposed country programme seeks to: (a) promote and strengthen partnerships with government, non-governmental and community-based organizations, and strengthen capacity and advocacy efforts to deliver humanitarian assistance aimed at reducing maternal mortality and morbidity, especially in the South-Central zone; and (b) strengthen partner institutions and increase the availability of data to guide and monitor sustainable programme interventions in the areas of reproductive health and rights, gender equality, and population and development that contribute to the reduction of maternal mortality and morbidity. This strategy will apply to Somaliland and Puntland in particular. A comprehensive approach to delivering humanitarian assistance will complement implementation of these strategies.

#### *Reproductive health and rights component*

18. The outcome of this component is: the demand for, access to and utilization of equitable and improved reproductive health services are increased in all three zones, including in settlements for internally displaced people.

19. Output 1: Improved health-care delivery to reduce maternal and neonatal mortality and related morbidity. Strategies include: (a) developing, monitoring and coordinating the implementation of the road map for reducing maternal mortality; (b) building the capacity of skilled birth attendants; (c) strengthening community midwifery to improve maternal health; (d) strengthening the capacity of selected health facilities to provide basic and comprehensive emergency obstetric care as well as obstetric fistula repair; (e) strengthening referral systems for emergency obstetric care; (f) strengthening reproductive health commodity security, including the provision of emergency delivery kits; (g) increasing and consolidating partnerships to address reproductive health needs within the context of humanitarian crises and emergency situations, as per the minimum initial services package; and (h) supporting the production and implementation of, and training on, standard reproductive health service protocols.

20. Output 2: Increased capacity of government, community-based and non-governmental organizations to offer high-quality, comprehensive sexual and reproductive health services, education and information for young people, with a focus on those who are most at risk. Strategies include: (a) advocating the inclusion of adolescent sexual and reproductive health and HIV prevention in the national youth strategy; (b) increasing the access to and use of integrated HIV/AIDS and reproductive health services; (c) supporting community-based interventions with selected line ministries and the National AIDS Commissions; (d) building the capacity of youth groups and networks to disseminate knowledge and information on reproductive health, including HIV/AIDS; (e) helping line ministries and civil society organizations to design and establish youth-friendly health facilities; (f) supporting the development of behaviour change communication interventions to reduce high-risk behaviour; and (g) strengthening partnerships with organizations, groups and

networks that address the needs of those populations who are most at risk, including young people affected by the conflict.

#### *Population and development component*

21. The outcome for this component is: the availability of reliable demographic and related data is ensured, along with institutional capacity and systems for planning, delivering and monitoring humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal levels. Two outputs will contribute to this outcome.

22. Output 1: Improved systems for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of maternal health at zonal and sub-zonal levels in order to inform interventions in this area. Strategies include: (a) supporting the establishment, strengthening and periodic updating of an integrated population database on selected issues at zonal and sub-zonal levels; (b) developing a framework and support for evidence-informed advocacy to improve maternal health; (c) supporting the collection, analysis and use of data on maternal mortality and morbidity; (d) strengthening the capacity to monitor and report on International Conference on Population and Development (ICPD) and Millennium Development Goal targets; and (e) building the capacity of government and other partners to integrate maternal mortality and morbidity into emergency preparedness and response efforts.

23. Output 2: Strengthened capacity of selected sectoral ministries and partner organizations to collect, analyse, disseminate and utilize disaggregated population data for planning and delivering humanitarian, recovery and development assistance. Strategies include: (a) improving the capacity of selected sectoral ministries and partner organizations in data collection and analysis; (b) providing technical support to improve the planning and monitoring of humanitarian assistance and recovery efforts; and (c) operationalizing

interlinkages between humanitarian, recovery and development assistance.

#### *Gender equality component*

24. The outcome of this component is: the sociocultural environment to advance gender equality, reproductive health and women's empowerment is improved. There are two outputs within this component.

25. Output 1: Increased advocacy and community engagement to promote the reproductive health and rights of women and adolescent girls and to eliminate harmful practices affecting maternal health. Strategies include: (a) raising awareness of the effects of female genital mutilation/cutting and early marriage on maternal mortality and morbidity; (b) advocating the implementation of laws prohibiting female genital mutilation/cutting; (c) enhancing community-based efforts to address the harmful effects of early marriage and female genital mutilation/cutting; (d) strengthening community-based initiatives to increase the retention of girls in formal and non-formal education; and (e) targeting community and religious leaders, young men and boys with awareness campaigns on early marriage and female genital mutilation/cutting.

26. Output 2: Enhanced systems and mechanisms to prevent and protect against all forms of gender-based violence, using a human rights perspective, including in emergency and post-conflict situations. Strategies include: (a) strengthening the capacity of selected non-governmental and community-based organizations to provide health and psychosocial support to survivors of sexual and gender-based violence, including support to address the complications of female genital mutilation/cutting; (b) supporting the institutionalization of modules to prevent sexual and gender-based violence in a training-of-trainers curriculum for health-care providers; (c) strengthening community-level 'safety nets' for survivors of sexual and gender-based

violence; (d) promoting the involvement of men, boys and community leaders in preventing sexual and gender-based violence; and (e) addressing sexual and gender-based violence as part of humanitarian response efforts and as per the minimum initial services package.

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

27. UNFPA and the Government will implement the programme in partnership with government institutions, other United Nations organizations and civil society organizations. Partners will include the Ministries of: (a) Planning and International Cooperation; (b) National Planning and Cooperation; (c) Health; (d) Women's Development and Family Affairs; (e) Information; (f) Education; and (g) Sports and Youth; as well as the National AIDS Commissions. The country office will promote and support the national execution modality where appropriate.

28. Given the security situation, the country office will develop a resource mobilization plan along with a contingency plan for alternative approaches to programme delivery. UNFPA will develop a monitoring and evaluation plan aligned with that of the United Nations Somalia Assistance Strategy. The office will conduct a midterm evaluation of the programme and adjust approaches, if necessary.

29. The UNFPA country office for Somalia is temporarily located in Nairobi, Kenya, and includes a representative, a deputy representative, an international operations manager, international programme specialists, national programme officers and administrative support staff. There are three sub-offices (in Puntland, Somaliland and the South-Central zone), with programme and support staff funded from programme funds. National and international experts and institutions and the Arab States regional office will provide additional support.

## RESULTS AND RESOURCES FRAMEWORK FOR SOMALIA

<b>National priority:</b> (a) investing in people through improved social services; (b) establishing a sustainable, enabling environment for rapid, poverty-reducing development; and (c) strengthening peace, improving security and establishing good governance <b>United Nations Somalia Assistance Strategy outcome:</b> the Somali people have equitable access to basic services, including health, education, shelter, water and sanitation				
Programme component	Country programme outcomes, indicators, baselines and targets	Country programme outputs, indicators, baselines and targets	Partners	Indicative resources by programme component
Reproductive health and rights	<p><b>Outcome:</b> The demand for, access to and utilization of equitable and improved reproductive health services are increased in all three zones, including in settlements for internally displaced people</p> <p><b>Outcome indicators:</b></p> <ul style="list-style-type: none"> <li>• Modern contraceptives prevalence rate Baseline: 1.2 per cent; Target: 10 per cent</li> <li>• Percentage of births attended by skilled health personnel Baseline: 9 per cent; Target: 20 per cent</li> <li>• Percentage of populations most at risk are reached with HIV prevention programmes Baseline: 0 per cent; Target: 15 per cent</li> </ul>	<p><b>Output 1:</b> Improved health-care delivery to reduce maternal and neonatal mortality and related morbidity</p> <p><b>Output indicators:</b></p> <ul style="list-style-type: none"> <li>• Number of obstetric fistula cases successfully repaired at supported sites. Target: 300 cases</li> <li>• Number of graduated midwives. Target: 200 graduated</li> <li>• Number of service delivery points at target sites providing at least three modern family planning methods</li> </ul> <p><b>Output 2:</b> Increased capacity of government, community-based and non-governmental organizations to offer high-quality, comprehensive sexual and reproductive health services, education and information for young people, with a focus on young people who are most at risk</p> <p><b>Output indicators:</b></p> <ul style="list-style-type: none"> <li>• Number of outlets providing youth-friendly services Baseline: 0; Target: 5</li> <li>• Percentage of young women and men aged 15 to 24 who correctly identify ways of preventing the sexual transmission of HIV and other sexually transmitted infections Baseline: 4 per cent; Target: 15 per cent</li> </ul>	<p>Ministry of Health; Ministry of Sports and Youth; Ministry of Women's Development and Family Affairs</p> <p>National AIDS commissions</p> <p>Community-based organizations; local and international non-governmental organizations; training institutes; universities</p> <p>United Nations organizations; World Bank</p>	\$14 million (\$6 million from regular resources and \$8 million from other resources)
<b>National priority:</b> (a) investing in people through improved social services; (b) establishing a sustainable, enabling environment for rapid poverty-reducing development; and (c) strengthening peace, improving security and establishing good governance <b>United Nations Somalia Assistance Strategy outcome:</b> the Somali people benefit from poverty reduction through equitable economic development and decent work				
Population and development	<p><b>Outcome:</b> The availability of reliable demographic and related data is ensured, along with institutional capacity and systems for planning, delivering and monitoring humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal levels</p> <p><b>Outcome indicator:</b></p> <ul style="list-style-type: none"> <li>• Maternal mortality and morbidity monitoring system is developed at selected sites</li> </ul>	<p><b>Output 1:</b> Improved systems for generating, analysing and disseminating disaggregated population and related data, with a focus on improving the monitoring of maternal health at zonal and sub-zonal levels in order to inform interventions in this area</p> <p><b>Output indicators:</b></p> <ul style="list-style-type: none"> <li>• Number of up-to-date databases on humanitarian, recovery and development variables to guide achievement of the country programme outputs and monitoring of maternal mortality and morbidity</li> <li>• Number of high-quality reports on utilizing data to measure the attainment of country programme outputs and to monitor maternal mortality and morbidity</li> </ul>	<p>Ministry of Planning and International Cooperation</p> <p>Community-based organizations; local and international non-governmental organizations; training institutes; universities</p> <p>United Nations organizations; World Bank</p>	\$6 million (\$3.5 million from regular resources and \$2.5 million from other resources)

	<ul style="list-style-type: none"> <li>• Availability of high-quality data for each programme sector and for assessing the impact of the programme on reducing maternal and neonatal mortality and morbidity</li> <li>• Number of institutions with strengthened systems in applying data for humanitarian, recovery and development interventions</li> </ul>	<p><u>Output 2:</u> Strengthened capacity of selected sectoral ministries and partner organizations to collect, analyse, disseminate and utilize disaggregated population data for planning and delivering humanitarian, recovery and development assistance</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Number of trained personnel with expertise in collecting, analysing, disseminating and using demographic and related data for humanitarian, recovery and development interventions</li> <li>• Number of high-quality reports on the progress that has been made in integrating ICPD and Millennium Development Goal concerns into humanitarian, recovery and development programmes</li> </ul>		
<p><b>National priority:</b> (a) investing in people through improved social services; (b) establishing a sustainable, enabling environment for rapid, poverty-reducing development; and (c) strengthening peace, improving security and establishing good governance</p> <p><b>United Nations Somalia Assistance Strategy outcome:</b> the Somali people live in a stable environment where the rule of law is respected, and rights-based and gender-sensitive development is pursued</p>				
Gender equality	<p><u>Outcome:</u> The sociocultural environment to advance gender equality, reproductive health and women's empowerment is improved</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> <li>• Number of young girls between the ages of 5 and 15 who have undergone female genital mutilation/cutting</li> <li>• Prevalence rate for female genital mutilation/cutting Baseline: 98 per cent; Target: 85 per cent</li> <li>• Laws, policies and strategies incorporate gender equality and the human rights of women and girls</li> <li>• Net enrolment rates for girls Baseline: 20 per cent; Target: 30 per cent</li> </ul>	<p><u>Output 1:</u> Increased advocacy and community engagement to promote the reproductive health and rights of women and adolescent girls and to eliminate harmful practices affecting maternal health</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Number of religious leaders trained to address the negative impact of female genital mutilation/cutting Baseline: 0</li> <li>• Number of initiatives conducted to address female genital mutilation/cutting and early marriage Baseline: 0</li> </ul> <p><u>Output 2:</u> Enhanced systems and mechanisms to prevent and protect against all forms of gender-based violence, using a human rights perspective, including in emergency and post-conflict situations</p> <p><u>Output indicators:</u></p> <ul style="list-style-type: none"> <li>• Number of community-based initiatives combating gender-based violence, especially those targeting young men and boys</li> <li>• Number of institutions providing services to survivors of gender-based violence</li> </ul>	<p>Ministry of Planning and International Cooperation; Ministry of Women's Development and Family Affairs; regional and district authorities</p> <p>Community-based organizations; non-governmental organizations; training institutes; universities</p> <p>United Nations organizations</p>	<p>\$6.5 million (\$2.5 million from regular resources and \$4 million from other resources)</p> <hr/> <p>Total for programme coordination and assistance: \$0.7 million from regular resources</p>