

SITUATION ANALYSIS OF CHILDREN IN SOMALIA 2016



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Foreword

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The Situation Analysis of Children in Somalia 2016 aims to provide an objective analysis of the available data and information to create an accurate picture of the current situation in the country.

The study shows how the situation of children in Somalia is improving, with more children surviving, being vaccinated, going to school and being registered, and increasing numbers of families with sustainable water supply systems and access to health care.

However, much more still needs to be done. Somali children and their mothers continue to suffer from multiple nutritional deprivations, which deny them the opportunity to thrive and reach their full developmental potential. Over 300,000 children under the age of five are acutely malnourished and the under-five mortality rate is among the highest in the world, with one out of every seven Somali children dying before their fifth birthday and fewer than half of children estimated to have been vaccinated against measles. In addition, the maternal mortality ratio is extraordinarily high, with 1 in every 12 women dying due to pregnancy-related causes.

Somalia is one of the world's least protective environments for children, with over 2,000 grave violations recorded in 2015. Nearly every girl undergoes Female Genital Mutilation (FGM), and only 4 in 10 go to school.

Children under 18 make up over half of the population and need to be at the centre of the humanitarian and development agenda. The Somali Government is committed to the survival, development and protection of children and demonstrated this by ratifying the Convention on the Rights of the Child in 2015. This provides an important framework for policy and legislation on children's rights.

The children of Somalia represent the future of the country. Investment in them is crucial to ensure there is equitable and sustainable development and this study should help guide all stakeholders in determining how this should happen.



Steven Lauwerier
UNICEF Somalia Representative



Executive Summary

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Somalia is in the process of emerging from the prolonged period of state collapse that followed the civil war of 1988-91. Since 2012, the post-transitional Federal Government of Somalia (FGS) has been internationally recognized, but its capacity as a governing body and the area it controls remains limited. The conflict and destruction wreaked less havoc in the north of the country, where two governing authorities – Somaliland and Puntland – emerged in the 1990s that have at least attained modest levels of governing capacity.

In this context of widespread violence and weak governmental control, children's and women's rights in Somalia have not been sufficiently protected or promoted over recent decades. On 1 October 2015 Somalia became the 196th of the world's nations to ratify the UN Convention on the Rights of the Child (CRC). This report aims to present a comprehensive analysis of the situation of women and children in Somalia that will aid the country in meeting its commitments under the CRC over the next decade. It pays particular attention to five key thematic areas: Health; Nutrition; Water, Sanitation and Hygiene; Education; and Child Protection.

The report is limited by the lack of core data in many areas. The last comprehensive Multiple Indicator Cluster Survey (MICS) was performed as long ago as 2006, although a limited MICS was carried out in Somaliland and Puntland in 2011. The collection of such data has effectively been constrained by the continuing conflict in parts of the country.

The absence of coherent government and security over almost three decades has also meant that Somalia has not made the progress over that period seen in its neighbours or in other countries that started from a similar baseline in human development terms. This has left the country at one extreme of the global rankings on many different indicators. It has, for example, exceptionally high rates of population growth, fertility rates, child mortality and maternal mortality.

The high fertility rate also contributes to the exceptionally large youth bulge. Three-quarter of the population is under 30 years. Such a youth bulge can constitute a 'demographic dividend' in some countries but in Somalia the unfavourable context renders it more of a potential burden. The lack of employment both in rural and urban areas means that young people are unable to find a role, leaving them prone to frustration, insecurity, recruitment by armed groups of all types and, increasingly, desperately seeking opportunities through migration to other countries.

Somalia, then, is a young country in more ways than one, seeking new pathways to stability and social cohesion – and promoting and protecting the rights of its children and women will play a vital part in providing this sense of direction.

Health

Children and women face more health challenges in Somalia than in almost any other of the world's countries. The under-five mortality rate (U5MR) of 137 per 1,000 live births is presently the third worst in the world after Angola and Chad and one in seven Somali children dies before their fifth birthday. Neonatal deaths (those in the first 28 days of life) occur at a higher rate in Somalia than in any other country apart from Angola and Central African Republic.

The maternal mortality ratio (MMR) in Somalia is also, at 732 per 100,000 live births, among the world's highest, exceeded only by Central African Republic, Chad, Nigeria, Sierra Leone and South Sudan. Moreover, there is a higher lifetime risk of maternal death, at 1 in 22, in Somalia than in any other country apart from Chad and Sierra Leone.

Nevertheless, although both child and maternal death rates have declined more slowly than in neighbouring countries – and far more slowly than was envisaged under the Millennium Development Goals – there has at least been consistent progress and that progress has been swifter since 2000 than in the preceding decade.

There are multiple contributory causes to the unacceptably high levels of neonatal, infant and child mortality, the most significant of which are: neonatal issues, acute respiratory illnesses, diarrhoea, vaccine-preventable diseases and malaria.

The high maternal mortality ratio relates to the fertility rate, which is one of the highest in the world, at an average 6.6 children per woman. This is in turn connected to the common incidence of early marriage, low birth spacing, and lack of access to contraception, as well as to cultural expectations. About 1 in 10 marriages occurs before the girl is 15 years old, and about half before she is 18. The 2006 MICS3 found that only 15 per cent of Somali women aged 15 to 49 used any form of contraception.

Other contributors to the unacceptable level of maternal death are the lack of antenatal care (ANC) – only a quarter of women receive this; the low proportion of births attended by skilled medical personnel (only a third); and the inadequate facilities for emergency maternal care.

One area of health in which there has been a positive development is that deaths from malaria have reduced dramatically over recent years. This is due in part to the long periods of drought in 2009-2010 but also to anti-malarial interventions such as encouraging people to sleep under long-lasting insecticide-treated mosquito nets – the rate of usage of these in the southern and central regions, where malaria is endemic, is currently 29 per cent.

In other areas of health, however, there has been insufficient progress. Rates of acute respiratory infection – suspected pneumonia – are high, and the last countrywide survey indicated that only 13 per cent of children suspected of having pneumonia were taken to an appropriate health provider. The incidence of diarrhoea in children under five remains, at 24 per cent, very high, and has changed very little in recent decades, though it is much less common in Somaliland than in the other regions. Overall rates of immunization coverage remain low in Somalia, with an estimated coverage for measles and DPT3 of well under 50 per cent in 2014.

Improving this health situation depends not only on enhancing the coverage and quality of health services but also on changing people's health-seeking behaviour.

Nutrition

Undernutrition is thought to be the underlying cause in over a third of under-five child deaths. The nutritional status of Somali children is among the worst in the world and remains a huge public health concern.

Levels of global acute malnutrition (GAM) for children under five are considered critical if they exceed 15 per cent, at which point emergency action should be triggered. The prevalence of GAM in Somalia is often above this critical level. The causes include: the effects of droughts; underlying vulnerabilities caused by years of conflict; the collapse of basic social services; and an erosion of coping mechanisms and resilience over time.

Stunting is more prevalent in the southern and central regions and Puntland than in Somaliland, and more prevalent in populations of IDPs and those with rural livelihoods.

The prevalence of anaemia amongst children aged 6-59 months is also high, and nearly three quarters of children under the age of two have the condition. Rates of Vitamin A deficiency in all parts of Somalia are over the 20 per cent threshold that the WHO considers severe. About half the women in Somalia are anaemic, whether they are pregnant or not.

Most Somali women do not effectively access appropriate nutritional knowledge, mainly due to their poor use of maternal and child health facilities and their lack of access to community health workers. The overwhelming majority of mothers breastfeed their children for at least some period of time but fewer than 1 in 10 infants are exclusively breastfed up to the age of six months. Children below six months of age are often given tea or sugar water in combination with breast milk, formula or non-human animal milks. Only 1 in 10 Somali children are appropriately fed with the WHO/UNICEF recommended combination of breast milk and complementary solid foods at the age of one.

Somalia is chronically food insecure. Poor rains and seasonal floods affect crop and livestock production, which are the main sources of livelihood for most of the rural population. In the past five years, local cereal production has only catered for an average of about 30 per cent of food needs. In recent years, about a quarter of the population has been moderately food insecure, and about 1 in 10 people have been in acute or emergency food insecurity. At the end of 2015, 71 per cent of those in the latter state were internally displaced persons (IDPs).

Dietary diversity is generally poor in Somalia, reflecting the inadequacy of food access and availability. Consumption of micronutrient-rich foods – including fresh fruits, vegetables rich in Vitamin A, fish, eggs and meat products – is generally low across all parts of the country. This is partly due to lack of availability and to cultural preference but, in addition, such a diet is beyond the economic reach of poor households.

Water, Sanitation and Hygiene (WASH)

The availability of water in Somalia varies between abundance in the regions between the Shabelle and Juba Rivers to the acutely arid regions elsewhere in the country, but overall it is a very scarce resource. The extreme shortage of surface water in parts of the country, especially Puntland and central Somalia, means that groundwater is the only reliable water source and this is at depths of up to 400 metres in some areas. Moreover, up to 40 per cent of the water supplies are non-functional at any one time. Due to the depth of the groundwater, rural water supplies often rely on diesel-powered pumping systems, which require regular maintenance from skilled mechanics, who are only found in urban areas.

Water is usually seen as an economic rather than a social good in Somalia. Businesspeople or clan elders tend to control water supplies for profit or personal interest. Even where government has a presence, there is very little regulation of private water suppliers. This means that operators charge extortionate prices in some areas. Because of high prices, households may fetch water from unimproved sources rather than pay for safe drinking water.

The continuing high incidence of diarrhoea in Somalia is despite the rise in use of improved water, at least in urban areas – overall coverage has risen from 29 per cent in 2006 to 55 per cent in 2015. However, only about one in five Somalis use both improved water and improved sanitation, though almost half of urban dwellers do so compared with just 4 per cent of those in rural areas.

Given the common practice of open defecation and the absence of a system for monitoring and controlling bacteriological water quality, the majority of open wells, berkhads and even some shallow boreholes in Somalia are likely to be contaminated.

In a 2015 survey most respondents claimed to wash their hands but the lack of availability of facilities that include soap indicates that, while there is knowledge and awareness, proper hygiene behaviour is actually not possible. There appears to be relatively little behaviour change being initiated by children in the household, which suggests that WASH programmes in school are not prevalent or effective. There is no system for monitoring water quality.

Budget allocations for sanitation and hygiene are very limited and are considered a low priority by the health professionals responsible for drawing up budgets.

Education

Somalia has one of the world's lowest proportions of primary-age children attending primary school – only about a quarter, according to the last full survey of primary net attendance, which was as long ago as 2006. More than half of children are out of school, and less than 10 per cent of children start school at six years old. Children who do attend primary school tend to start at a later age, which means there is a high proportion of secondary-age children in primary school.

Extremely high rates of poverty in communities across Somalia make it difficult for parents to afford school fees. In many areas, parents are required to pay for their children's education, and poverty remains the main reason they give for not sending their children to school. Somaliland declared free primary public education in 2011 but has had great difficulty in retaining teachers at the salaries the government can afford to pay. With parents and communities no longer paying for public primary education, schools have almost no funds to cover their running costs.

Pastoralist communities make up a quarter of the Somali population, and adapting approaches to ensure that all children living in these settings have access to basic education is critical. Currently, less than a quarter of pastoralist children attend formal schools in Somalia, largely due to the high costs and the lack of an education format that suits their nomadic lifestyle. Pilot models for 'informal education' for pastoralist and other children out of formal education show promise but have yet to be taken to scale.

More children of primary age attend traditional Quranic schools than public schools, especially in the southern and central regions. However, the limited scope of traditional Quranic schools (almost exclusively the Quran and Islamic studies) are no substitute for formal education and only 10 per cent of the students who attend these schools are literate.

Girls' participation in education is consistently lower than that for boys. Fewer than 50 per cent of girls attend primary school, and the last countrywide survey from 2006 showed that only 25 per cent of women aged 15 to 24 were literate. The low availability of sanitation facilities (especially separate latrines for girls), a lack of female teachers (less than 20 per cent of primary-school teachers in Somalia are women), safety concerns and social norms that favour boys' education are cited as factors inhibiting parents from enrolling their daughters in school.

Child Protection

Conflict and political instability over recent decades has weakened governmental authority and the justice system is weak. This means mechanisms for child protection are extremely limited. Displacement can result in separation of children from their families, which exposes them to exploitation, violence and abuse – and the children of IDPs and minorities are particularly vulnerable. In addition, societal acceptance of domestic violence and corporal punishment often stands between child victims and justice. The lack of a framework for law and order allows many children to work in exploitative and abusive environments. In respect of protection and security, girls and women are controlled in every aspect of their lives, including their bodies. Older children are seen as a resource instead of being protected and nurtured for effective growth and development.

Child protection is inadequate from the very start of life: only 3 per cent of children's births are registered in Somalia despite the fundamental importance of such registration to guaranteeing child rights. There is, moreover, no legal or policy framework for birth registration in any of the State entities of Somalia, though UNICEF is supporting the Ministry of Interior in Somaliland to develop a practical system of birth registration and Puntland has expressed interest in a similar approach.

About 1 per cent of Somali children are 'double orphans' but the incidence of children living in households without a biological parent has been rising over recent decades and is higher the older the child is. In Somaliland and Puntland, most children separated from their parents are in kinship care with only a small proportion of these receiving help – and that from relatives. Street children tend to be from IDP families or of Somali ethnicity from Ethiopia, with boys more visible than girls. In the southern and central regions, loss of livelihoods and food insecurity due to conflict or drought result in parents either going away to earn a living elsewhere or sending children away to live with others or for child labour.

About half of Somali children aged between 5 and 14 engage in child labour. The rate is higher for rural than for urban children, and somewhat higher for girls than for boys.

Recruitment or use by armed groups or forces – including Al-Shabaab, the National Army and allied militias, and others – also separates a number of boys and girls from their families. In some areas families feel obliged to send their children to serve in clan militias. Some parents, and even children themselves, consider recruitment as a source of income and a means of

escaping poverty. The armed groups detain, kill, maim, rape and sexually abuse children.

Rape and sexual assault are widespread problems though, because of the strong stigma attached to rape in Somali culture, most incidents go unreported. Prosecutions and convictions for rape and other forms of sexual violence are extremely rare, and there is a climate of impunity. If parents are aware of the rape, customary law is the general means of recourse but girls and women do not have a voice in such forums.

Two other key child protection issues in Somalia are female genital mutilation (FGM) and child marriage.

Some 98 per cent of Somali women aged between 15 and 49 have undergone some form of FGM – the highest rate in the world. Regional authorities are in the process of drawing up legislation on total abandonment of FGM and in Puntland the Ministry of Religious Affairs has issued a fatwa against all forms of FGM.

About 1 in 10 Somali marriages occurs before the girl is 15 years old, and about half before they are 18. Rates of child marriage tend to be high where poverty, birth and death rates are also high; where civil conflict is commonplace; and where there are lower overall levels of development, including schooling, health care and employment. Neither political nor religious leaders see protecting girls from child marriage as a priority.

Social Protection

The need for comprehensive, shock-responsive social protection systems was very apparent during the 2011 famine, which had a devastating impact on Somalia. The famine resulted in the deaths of 258,000 people, half of whom (130,000) were children. Social protection mechanisms have a long history in Somalia, and though generally effective, these mechanisms can come under stress from repeated crises, and may be particularly ineffective in the case of community-wide shocks. They can also lack elements of consistency and predictability that are necessary for households to take informed risks, and may also exclude particularly disadvantaged groups, such as minority clans.

Resilience

Improvements in the situation of Somali women and children as a result of both development and emergency programming have been extremely vulnerable to shocks, including seasonal droughts and floods which routinely affect nutritional and health status of children, limit access to education and have a detrimental effect on progress made in addressing child protection issues. While subsequent cycles of emergency-type

programming have addressed the immediate fall-out of shocks, governments and international partners have to step up efforts to support conflict- and context-sensitive programming achieving sustainable

results for children and breaking the cyclical patterns of conflict and natural disasters that lead to recurrent development reversals.



Country Context

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Contextual factors in Somalia shape both impediments to and opportunities for children's protection, rights and development. This section of the report summarizes the country context in Somalia. Its main findings include the following:

- The current context in Somalia is exceptionally challenging for the protection and advancement of children's well-being. Efforts by Somali civic and political leaders, heads of households and international development agencies to improve the lives of children work on multiple levels in a relatively non-permissive environment.
- Some of the contextual factors that function as constraints are amenable to change, though those changes will take time. Other contextual factors are relatively fixed and must be dealt with as such for the foreseeable future.
- Regional and local variations in context are substantial, offering pockets of new opportunities for improved child well-being in parts of the country.

Geographic and spatial context

Somalia has the longest coastline in Africa. It contains mountains, tropical forests and irrigated farmland, and semi-arid grasslands. But the defining feature of the country is vast expanses of semi-arid or arid, low-lying scrubland, most of which is suitable only for nomadic pastoralism.

Rain falls in two condensed periods of the year – the main gu rains of April-June, and the less reliable deyr rains in October and November. Annual rainfall reaches 600mm in the southern coastal area but the northeastern tip of Puntland receives less than 100mm.¹ Only the inter-riverine areas in the south receive enough to sustain rain-fed farming. Somalia is prone to severe drought and floods: on average, the country suffers from moderate drought every three to

four years, and from severe drought every seven to nine years.²

The single most significant spatial divide in Somalia that affects children's well-being is the urban-rural gap.³ Around 42 per cent of the population is urban, 26 per cent nomadic, 23 per cent rural (mainly agro-pastoral or agricultural) and 9 per cent internally displaced.⁴ Almost all of the IDPs are located in urban settings and half of the Somali people are now in towns or cities. These figures reflect a sea change in the spatial distribution of the population, which was only a few decades ago a mostly rural society.

While the towns and cities feature large slums and deep poverty, they offer better livelihoods and access to basic services than the rural areas, and the persistent urban drift arguably testifies to that. The country's urban economies are less vulnerable to livelihood shocks, and are partially insulated from the crises and geographic constraints in rural areas, thanks to remittances from the large Somali Diaspora, the concentration in cities of foreign aid as well as of government jobs and services, and the availability of imported foodstuffs. The severe drought of 2011, for instance, contributed to the deaths of nearly 260,000 people mostly in rural areas of the south, while people in nearby Mogadishu were less badly affected.

For rural dwellers, Somalia's semi-arid environment is a challenging setting and a major constraint on livelihoods. The rural population is vulnerable to periodic, often severe drought. Even under normal circumstances, annual cycles of rainy and dry seasons produce a 'hungry season' of food shortage prior to the main harvests, exposing some Somali children in rural areas to seasonal undernutrition. Moreover, seasonal pastoral movements create special challenges for access to education and health care. Some evidence suggests that long-term climatic changes, degradation

¹ Jessica Tierney et al, "Past and Future Rainfall in the Horn of Africa," *Science Advances* 1, 9 (9 October 2015), figures and data <http://advances.sciencemag.org/content/1/9/e1500682.full>

² FAO, "Somalia: Geography, Climate, and Population" http://www.fao.org/nr/water/aquastat/countries_regions/som/print1.stm

³ UNDP, *Somalia Human Development Report 2012*, Nairobi, 2012, p. viii. It reports that poverty rates are 61 per cent in urban Somalia, and 94 per cent in rural Somalia.

⁴ UNFPA, 'Population Estimation Survey 2014 for the 18 Pre-War Regions of Somalia', UNFPA, Nairobi, 2014.

of pasture, and deforestation due to charcoal production, are adding new strains to rural livelihoods. While Somali rural dwellers have impressive coping mechanisms to manage this environment, their resilience is under unprecedented strain.

While some opportunities for major increases in productivity exist along the country's two river valleys, Somalia's semi-arid environment places limits on any major expansion of animal husbandry and agriculture. Opportunities to expand livelihoods in the future will mainly be focused on urban-based sectors such as commerce, services and light manufacturing.

Children in rural Somalia have very limited access to basic services and education, and face higher risks of undernutrition or early death. They often begin contributing to family production as herders of goats and sheep, as farm workers, or with household chores and child care at the age of four or five. Children in urban Somalia have a better chance of accessing basic services and education, but their households have to contend with very high levels of unemployment outside the informal sector.

Somaliland and Puntland: For both Somaliland and Puntland, geography is both an opportunity and a constraint. Most of the north is arid to semi-arid, suitable only for seasonal pastoralism. Puntland is the driest region in the eastern Horn. In Somaliland, the rapidly growing metropolitan area of Hargeisa faces future water shortages. Rural livelihoods and development face real constraints in this setting.

But Puntland and Somaliland's geographic location is favourable in other ways. Both are positioned on the coast as entrepôts for trade between the Gulf states and the interior of the Horn of Africa, and enjoy vibrant commercial sectors. Both are also the site of oil exploration, which could in future years yield new sources of revenue. Somaliland and Puntland are both more urbanized than any other regions outside of the Benadir region (Mogadishu), and northern towns enjoy substantial flows of remittances that help to support the urban economy.

Southern and central Somalia: Southern Somalia possesses some of the greatest geographic assets of the country, notably the Jubba and Shabelle river valleys. It receives higher rainfall, enough to sustain rain-fed agriculture in some areas. In addition, it has a long coastline, is the site of the capital, Mogadishu, and abuts the lucrative market of Kenya. But these relative advantages have not translated into gains for development or for child well-being. On the contrary, southern and central regions contains pockets of some of the highest levels of underdevelopment in the country, as measured by infant mortality,

undernutrition and illiteracy. The heaviest concentration of underdevelopment is in the riverine zones, where marginal farming livelihoods, low social status and political weakness contribute to much higher levels of poverty.

Demographic context

Somalia's total population is estimated at 12.3 million. The country has been described as a "demographic outlier" due to exceptionally high rates of population growth, fertility rates, infant mortality and maternal mortality.⁵ Demographic trends in Somalia exhibit few significant regional variations, so this section only addresses the national demographic context.

Somalia's fertility rate of 6.6 per woman is the third highest in the world, though it has declined slightly from a peak of 7.6 in 1998. This exceptionally high fertility rate has many implications for child well-being. It contributes to the country's very high maternal-mortality ratio (732 per 100,000 live births);⁶ it strains the household capacity to invest in basic education, health care and nutrition for all the children in the family; and it contributes to the country's annual population increase, which, at 2.9 per cent, is among the highest in the world.⁷

The high fertility rate also contributes to the exceptionally large youth bulge. Just under half (45.6 per cent) of the population is less than 15 years old, and three-quarters (75 per cent) of the population is under 30 years.⁴ The general literature on the impact of youth bulges is not conclusive, but evidence does point to several concerns. Youth bulges are associated with, among other things: increased risk of armed conflict; spikes in criminal violence; pressures on educational facilities; increased unemployment; and social frustration that can produce political unrest. On the positive side, youth bulges also provide a large labour pool that can attract labour-intensive investment, boost local demand for a variety of goods and services, and expand a country's human capital.

Whether a youth bulge constitutes a 'demographic dividend' or a dangerous burden for a country depends mainly on the local context. In Somalia, the context is far from favourable. Urban employment nationally ranges between 60 per cent and 80 per cent, so the labour market is already saturated with frustrated job-seekers and the current youth bulge is only adding more. Labour-intensive manufacturing is unlikely to be attracted to Somalia in the short to medium term

5 Madsen, Elizabeth, 'In Somalia, Beyond Immediate Crisis, Demography Reveals Long-Term Challenge', *New Security Beat*, Wilson Center, Washington DC, 21 December 2011, <http://nin.tl/Somaliademography>
6 http://www.who.int/gho/maternal_health/countries/som.pdf
7 <http://data.worldbank.org/indicator/SP.POP.GROW>

due to high security risks and political uncertainty, and the rural sector is unlikely to see major expansion in productivity either. The youth bulge in Somalia is more likely to result in: high levels of frustration over limited access to education, jobs and social mobility; easy recruitment of unemployed young men into armed groups of all types; acceleration of urban drift from the countryside, producing ever-larger urban slums; and, perhaps most significantly, increasing numbers of Somali youth seeking out-migration to the Gulf, Europe and North America in search of work and a new life. Recent surveys suggest that the last scenario is already playing out: a majority of young people surveyed identified out-migration as their preferred option for the future.⁸

The continued expansion of the Somali Diaspora as a long-term demographic trend can be seen as a net positive for the country, in that migrants become valuable sources of remittances, the mainstay of the Somali economy and a major source of household revenue to cover the costs of children's education and health care. But it can also cause concern over the 'brain-drain'. Moreover, avenues for out-migration are dangerous, expensive and increasingly restrictive; they are hence a demographic 'safety valve' over which Somalia has little control.⁹ At the same time youth migration can have a negative effect on those left behind – a UNICEF-commissioned survey conducted by the Rift Valley Institute found the families often came under pressure from traffickers to pay for the migrant's passage once he or she had left and was in transit in Ethiopia, Sudan or another African country. The affected families received threatening calls from the trip organizers demanding payment forcing them to use savings, borrow from relatives or sell off assets to ensure the migrant's safe passage.

High population growth guarantees that the country's rates of urbanization will continue to accelerate, transforming what was once a predominantly rural society into one that is increasingly concentrated in towns and cities. Urbanization has the potential to improve net access to education and health care for children, even as it exacerbates problems of unemployment.

Institutional and governmental context

Somalia is emerging from a prolonged period of state collapse. In January 1991, following three years of civil war, the government of President Siyad Barre fell. Rival clan militias then fought among themselves, plunging the country into chaos. Several efforts were made, beginning in 2000, to stand up a central government in Mogadishu, but those transitional governments

never became functional. Since 2012, the post-transitional Federal Government of Somalia (FGS) has been internationally recognized, but its capacity as a governing body and the area it controls remain limited.

However recent efforts for preparation of a National Development Plan 2017-2020 (NDP) remain promising. Focused attention to the social sectors combined with the desire for alignment of the NDP with the Sustainable Development Goals, through a focused and realistic monitoring and evaluation framework, are opening new political space for longer-term sustainable development programming.

An electoral process is expected to take place in August 2016. The process of establishing a federal framework for governing Somalia is also well underway although much work remains to be done to achieve a common vision of how this will work

The north of the country was largely spared the violence and destruction of the war. There, two governing authorities emerged in the 1990s that, in partnership with clan elders and other non-state actors, enjoy at least modest levels of governing capacity. In the northwest, the unrecognized secessionist state of Somaliland has existed since 1991, and, despite daunting challenges and weak government institutionalization, has kept the peace, provided security across most of its claimed territory, and has adopted a political system that has seen multiple transfers of power.¹⁰ The semi-autonomous Puntland authority in the northeast was formed in 1998; its levels of governance and security are also modest but have nonetheless provided a relatively safe environment for service delivery and private-sector activities.

Across Somalia, government capacity falls along a spectrum ranging from modest to non-existent, depending on the location and the issue-area. Throughout the country, civil service expertise in ministries is weak, ministerial turnover high, absenteeism due to very low or irregularly paid salaries endemic, and corruption a major impediment.¹¹ In short, governance is very poorly institutionalized.

Corruption has been a particularly grave impediment to delivery of basic services, and to essential government regulation of for-profit and non-profit service providers. It is fuelled in part by the fact that control of government coffers – and the foreign aid and taxes that flow into those coffers – remain a principal route to private enrichment in Somalia, where accountability remains very poor.

8 UNDP, *Somalia Human Development Report 2012*, Nairobi, 2012.

9 Taxin, Amy, 'Somalis Seeking Asylum Take Back-Door Route to US', *Washington Post*, 4 January 2010, <http://nln.tl/Somalibackdoor>

10 Bradbury, Mark, *Becoming Somaliland*, James Currey Press, London, 2008; Renders, Marleen, *Consider Somaliland: State Building with Traditional Leaders and Institutions*, Brill, Leiden, 2012.

11 Somalia is ranked the second most corrupt country in the world, according to the latest Transparency International ratings. See www.transparency.org/cpi2015

Weak government capacity across most of Somalia is linked to variable but generally high and chronic levels of insecurity (see **Conflict context**, below). In response, Somali households and communities rely on a range of non-state actors and institutions to secure for themselves protection and services that local and national governments are not always in a position to provide. These include: customary law mediated by clan elders; the protection and safety net provided by one's lineage; hybrid governance arrangements involving coalition of municipal authorities, elders, clergy, women's groups and business leaders; local committees assigned to oversee basic services; neighbourhood watch groups; and private security forces.

Many of the most effective forms of government across all of Somalia are located at the municipal and district level.¹²

Somaliland: Formal government capacity is higher in Somaliland than elsewhere in the country, although it varies significantly by ministry and by minister. Somaliland's government has been most effective not so much as a direct provider of core services impacting women and children, but as an enabler of a secure and lawful environment in which other providers have thrived. Ministries overseeing social services have generally been effective and have benefited from partnerships with the UN, aid agencies and local NGOs. Free primary-school education is provided by the Somaliland government. Government effectiveness falls off in more rural and remote areas, especially in disputed territory in parts of the east.

Puntland: Puntland's government has enjoyed more modest success. It has provided generally good security and an environment conducive to private-sector activity and unimpeded access to basic services for the population, though insecurity has periodically flared up in parts of the state. This has the potential to reduce provision of important service delivery to women and children.

Government ministries tasked with social services have worked in tandem with local NGOs, the UN and aid agencies to facilitate modest levels of access to education and basic health care. A number of districts in Puntland now deliver core social services. Lack of regular salaries payments to civil servants and security forces have led to disruption of government operations. As with Somaliland, government capacity and performance tends to fall off away from major urban centres.

Southern and central Somalia: Governance is highly variable across South Central Somalia, but generally much weaker than in the north. Large areas of southern Somalia remain completely beyond the reach of both the Federal Government of Somalia (FGS) and the many nascent federal states claiming jurisdiction over sections of the country. Al-Shabaab operates in an expansive area of the countryside, but engages in minimal governance now that it has lost control of major towns. Even in areas where the FGS is present, its ability to provide basic security and social services is very limited. In some areas the presence of government security forces is associated with declining local security due to poor discipline and control of forces that often act as autonomous clan militia. Much of the population continues to rely on traditional authorities for basic governance and on their clan for protection. Social services are primarily in the hands of local NGOs and local committees, with support from external partners.

The population living in the capital Mogadishu enjoys variable access to governance, security and basic services, with dramatic differences by district and neighbourhood. A combination of government forces, clan paramilitaries, private security and troops of the African Union Mission in Somalia (AMISOM) creates reasonably strong security in some areas, while others are plagued by threats of violence. Government capacity to provide basic regulation is very weak, as evidenced by endemic and serious disputes over high-value urban land.¹³ Most social services are delivered by either the private sector or by NGOs, some fee-based and others free.

Conflict context

Notwithstanding Somalia's conflict-ridden reputation, large parts of the country, especially in the north, are relatively peaceful and secure. The worst instances of armed conflict are concentrated in parts of the South where Al-Shabaab, government forces and African Union peacekeeping forces continue to clash. But many of the incidents of insecurity and violence are unrelated to Al-Shabaab, and are instead linked to communal clashes, political rivalries, revenge killings and struggles over resources. Importantly, both insecurity and state failure create conditions that serve the interests of some constituencies and leaders, some of whom actively seek to perpetuate conditions of chronic disorder and armed violence.

Within the southern and central regions, levels of insecurity vary greatly by location. Even within the capital, Mogadishu, the number and severity of

¹² Menkhaus, Ken, 'If Mayors Ruled Somalia', Nordic Africa Institute Policy Note 2, February 2014, <http://nai.diva-portal.org/smash/get/diva2:714676/FULLTEXT01.pdf>

¹³ Barakat, Sultan, et al, *Beyond Fragility: A Conflict and Education Analysis of the Somali Context*, Post-War Reconstruction and Development Unit, for UNICEF, University of York, 2014, pp. 50-52.

incidents of armed violence vary significantly from one neighbourhood to the next. But armed conflict, in the form of sustained communal violence, political clashes, terrorist attacks and counter-insurgency operations, continues to plague portions of the country, especially the area between the two main rivers, the Jubba and the Shabelle. In some of the hardest-hit areas, movement of agricultural goods and livestock from countryside to towns has been rendered very dangerous, and livelihoods imperilled.

In much of Somalia, conditions of war are not common, but chronic, low-level insecurity is, in the form of criminal violence, militia predation, kidnapping and threat of sexual assault. This has very serious implications for child protection and well-being, affecting everything from the willingness of households to allow girls to attend school to risk-averse farming and business practices that result in lower incomes.

Armed insecurity has both direct and indirect costs to child well-being. It raises risks of direct physical harm; it increases the odds of child recruitment into criminal gangs or armed groups; it drives away business investment and hence employment opportunities; it creates major impediments to access to basic services; and it robs children of the basic freedom to move freely and play in the neighbourhoods where they live. The high and unpredictable levels of insecurity have also rendered large parts of the country inaccessible to local and international development agencies and social service providers, which inevitably has an adverse impact upon the fulfilment of children's basic rights.

For some local actors, chronic insecurity has been good for business and has generated viable livelihoods. Clan militia have been a source of informal employment for young men; private security firms profit from the commoditization of security; and powerful individuals in and out of government derive their power and wealth from control of militias that thrive in an environment of high insecurity. The political economy that has developed around violence means that some have a vested interest in perpetuating conditions of insecurity; this is part of the 'conflict trap' (a cycle of conflict, underdevelopment and failed governance identified by the World Bank in its *World Development Report 2011*) that Somalis are struggling to escape.

Economic context

Somalia is one of the poorest countries in the world, with very low levels of development across the spectrum of indicators used to measure human development.¹⁴ The status and well-being of women and children are inevitably affected by this wider development crisis.

Remittances from the large Somali Diaspora are the main source of hard currency flowing into the country, dwarfing revenues from livestock exports or foreign aid.¹⁵ Households that receive remittances are generally in a much better position to provide adequate nutrition, shelter, education and health care for their children. Though evidence suggests that remittances tend to be redistributed inside Somalia, the system is patchy – children in households that have a relative overseas enjoy significantly better access to food and services than do children in households without a family member abroad.¹⁶ Household economic strategies focus heavily on finding ways to support a family member to travel overseas to work.

The heavy dependence on remittances shapes demand for education. Somali families prefer their children to be taught in either English or Arabic, not Somali, out of a conviction that education is primarily meant to prepare a child to travel overseas for work. In a survey, two thirds of young people expressed their intention to migrate out of the country, despite the mounting costs and dangers attached to doing so.¹⁷

Unemployment levels in urban Somalia are exceptionally high – as much as 54 per cent nationally.¹⁸ The informal sector is the main source of income after remittances, and is especially important for women and children. Much of the informal sector consists of street-vending.

The country's main export continues to be livestock (on the hoof), a sector that provides a sustainable but precarious livelihood for pastoralists. Initiatives to expand chilled meat factories able to export butchered meat by air could increase profits from livestock production in Somalia, but otherwise the livestock sector does not have prospects for dramatic expansion.

Urban and agricultural land is a highly prized commodity, and real estate development is one of the main sources of local investment. Women have unequal access to inherited land, and title disputes, which are endemic, tend to favour individuals from more powerful clans and families.

Somaliland: Somaliland's economy is the most paradoxical of any part of the eastern Horn. On the one hand, the long peace prevailing there, combined with robust flows of remittances, higher urbanization rates, and strong commercial activity through the

14 UNDP, *Somalia Human Development Report 2012*, Nairobi, 2012, p. xiii.

15 Estimates of total remittances vary, but tend to fall between \$1.0 billion and \$1.5 billion per year. See UNDP, *Cash and Compassion: The Somali Diaspora's Role in Relief, Development and Peacebuilding*, Nairobi, December 2011.

16 Hammond, Laura, Zoltan Tiba and Nimo Ali, *Family Ties: Remittances and Support in Somaliland and Puntland*, School of Oriental and African Studies, London, February 2013.

17 UNDP, "Somalia Human Development Report 2012" (Nairobi: UNDP, 2012), pp. 65-66.

18 UNDP, "Somalia Human Development Report 2012," p. 63.

seaport of Berbera have attracted considerable private-sector investments in real estate, the service sector and retail in the main urban centres. On the other hand, urban unemployment in Somaliland – at 70 per cent – is higher than in any other region of Somalia.¹⁹ The remittance economy has produced distortions in the labour market, in that residents are unwilling to take on low-paying jobs as long as they can secure comparable amounts in remittances. The result is that Somaliland simultaneously has extremely high unemployment rates and yet hosts thousands of migrant labourers from the Ethiopian highlands who are willing to work in menial jobs for \$1-\$2 per day.²⁰

Puntland: Puntland's economy is also very dependent on commercial trade through its seaport, Bosaso, and on remittances from the diaspora. It has the added burden of a large cadre of youth who seek work in the security sector, and who, when unpaid, gravitate towards criminal activity.

Southern and central Somalia: Economic prospects are poorest in South Central Somalia, despite lower overall unemployment and better natural resources. southern and central regions suffer from an incidence of poverty of 89 per cent, compared with 75 per cent in Puntland and 72 per cent in Somaliland.²¹ The most severe concentrations of poverty are in the agricultural, inter-riverine areas, and are linked to a combination of marginal livelihoods, chronic conflict and displacement, as well as to the social marginalization of low-status farming communities. Even though the southern and central regions are currently poorest, they are seen as having the country's greatest economic potential. The seaport cities of Mogadishu and Kismayo could dramatically expand commercial traffic, and the irrigable river valleys have untapped potential for cash cropping.

Identity context

The vast majority of Somalia's inhabitants share a common culture with a strong sense of affiliation to lineage or clan. Somali agnatic kinship is fluid; mobilization of specific clan or sub-clan identity can depend on the situation at hand.

Clannism, and exploitation of clan identity by political leaders, is often seen as a divisive factor in the country. Clannism divides Somalis horizontally, or across communal lines, and the ability of stronger clans to control land, power and access to resources has been a recurring driver of conflict.²² But clannism

also exacerbates vertical stratification in Somali society, by reinforcing inequality of access to protection and resources.

Within each of the four large clan-families – the Dir, Darood, Hawiye and Digil-Mirifle – clans and sub-clans vary considerably in their power, prestige and numbers. Low-status lineages within these major clans, sometimes associated with undesirable occupations, have less access to resources and collective aid, and hence are more likely to suffer in times of scarcity.²³

In addition, Somali society includes a sizeable group of 'minorities' – Somali citizens whose ethnic identity falls outside the Somali clan system, and who are thus considered 'Somali' politically but not ethnically. These groups include the coastal population of the Benadiri, Bajuni and Barawans, whose heritage is more closely linked to the Swahili coast, and the Somali Bantu people, who have historically lived as farmers in riverine areas of southern Somalia. Collectively, the minority groups make up the '.5' in the controversial '4.5 formula' that allocates seats in government proportionately along clan lines. These minority groups, especially the Somali Bantu, have historically faced serious levels of discrimination and abuse in Somalia, enjoy the least protection from armed violence, and are often a difficult group to access with basic social services and humanitarian aid, as aid targeting them can easily be diverted by stronger groups.²⁴

Members of powerful clans and sub-clans are, all things being equal, better able to access protection, shelter and services for their children, thanks to their richer store of 'social capital'.²⁵ Households associated with weak or low-status groups have fewer means of claiming jobs, land and aid, and face a higher risk of losing assets to predatory groups such as criminal gangs, clan paramilitaries and uncontrolled security forces. Households from clans considered 'guests' (including IDPs) in a dominant clan's area also enjoy fewer rights to access resources.²⁶ This was powerfully exposed during the 2011 famine. Children from low-status social groups are at very high risk.²⁷

23 Helander, Bernhard; 'The Hubeer in the Land of Plenty: Land, Labor, and Vulnerability Among a Southern Somali Clan', in *The Struggle for Land in Southern Somalia: The War Behind the War*, edited by Catherine Besteman and Lee Cassanelli, Westview, Boulder, 1996. The Digil-Mirifle clan-family itself has historically been disadvantaged as a mainly agricultural and agropastoral people, though their relative status has improved somewhat in national politics in recent years.

24 UNDP, *Somalia Human Development Report 2012*, UNDP, Nairobi, 2012, pp. 22-23.

25 Mercy Corps, 'What Really Matters for Resilience?' October 2013, p. 4, <http://nin.tl/MercyCorpsSomalia>

26 Human Rights Watch, *Hostages of the Gatekeepers: Abuses Against Internally Displaced in Mogadishu, Somalia*, HRW, New York, 2013.

27 Majid, Nisar, and Steven McDowell, 'Hidden Dimensions of the Somali Famine', *Global Food Security*, vol 1, 2012, p. 37.

19 UNDP, "Somalia Human Development Report 2012" p. 63.

20 Ken Menkhaus, "Somaliland Political Economy Analysis," World Bank, 2013.

21 UNDP, "Somalia Human Development Report 2012" p. 31.

22 UNDP, *Somalia Human Development Report 2012*, UNDP, Nairobi, 2012, p. 37.

Pastoralists

Until recent decades pastoralists constituted the majority of the Somali people. The percentage of Somalis earning a livelihood as pastoralists has steadily declined since the 1960s and today constitutes only about a quarter of the population. They have amongst the lowest access to health and education services and their livelihoods are under stress due to climate and human-made degradation of the land.

Pastoralists have endured dramatic changes in their environment over the past few decades, most of which have made the livelihood harder and less viable. In consequence, many destitute pastoralists have formed part of the rural to urban migration. The chronic insecurity has interrupted access to markets as well as seasonal migrations critical to the survival of herds. Another constraint has been enclosures – the fencing and privatization of valuable rangeland by powerful livestock owners, which began before the civil war but has been expanded. Enclosures prevent the poorest pastoralists from accessing dry-season pasture and limit the mobility of pastoral herds. Water sources have also become privatized – *berkads*, or small dams of seasonal streams and rivers, have been constructed by wealthier community members who charge for access to the water or prevent others from using it altogether.²⁸

Some pastoralists are opting for a shift to agro-pastoralism rather than completely abandoning nomadic pastoralism. Families establish fixed dwellings in settlements, allowing family members greater access to schooling or health care, while adult males take the herds on more limited circuits in search of grazing land and water. This shift does not lead, however, to improvements in household income and food security; in fact, agro-pastoralists are among the poorest sectors of Somali society.

Internally Displaced Persons (IDPs) and Minorities

There are 1.1 million IDPs in Somalia, the majority of whom are in the southern and central regions. Mogadishu has the largest concentration of IDPs, at nearly 370,000.²⁹ According to the latest UN population figures for Somalia (UNPESS), IDPs comprise 9 per cent of the Somali population.

IDPs mainly belong to minorities or minority clans, suffer discrimination, and have fewer informal social protection mechanisms. Most of the IDPs who arrived in Mogadishu as a result of the 2011 famine are from the Digle and Mirifle clans or the Bantu minority³⁰

from the Bay, Bakool and Shabelle regions, and they were fleeing not just drought but also discrimination by majority clans.³¹ Although there are social support ties within these IDP communities, they are less internationalized than the majority clans, and benefit little from remittances.³²

Studies suggest that children of IDPs and minorities are the most vulnerable to violations of child rights. Nearly two thirds of IDP households in Mogadishu are headed by females.³³ IDP female-headed households take in a disproportionate number of unaccompanied children, despite the attendant risk of neglected childcare when the head of household is out of the home working. IDP households depend primarily on irregular and unprotected casual work, humanitarian assistance, petty trading and charitable gifts (*zakat*).³⁴ IDPs are effectively hostages of predatory 'gatekeepers' on whom they depend for the right to settle and for commercially provided services such as water, and to whom they must pay a tax on any humanitarian assistance received.³⁵

Social and cultural context

Some aspects of Somali society and culture have undergone profound and complex transformations since the civil war and collapse of the state in 1991, while other dimensions remain relatively unchanged. This admixture of continuity and change in the socio-cultural context is challenging for both Somalis and foreigners alike.

First, though historically understood to be a fairly egalitarian society, gaps in wealth and power have dramatically increased both before and since the collapse of the state in 1991.³⁶ This has major implications for child well-being. Relatively privileged households – including any household receiving regular remittances from relatives abroad – are much better able to provide for the basic nutritional, health, protection and educational needs of their children.

Second, in the context of protracted state failure, clan and ethnic identity have grown even more important as determinants of rights and access to protection and resources. Members of powerful communal groups are better able to access protection, shelter and services for their children, thanks to their richer store of 'social capital'.³⁷

31 Majid & McDowell, op. cit.

32 Ibid. Only about 5 per cent of IDP households benefit from remittances.

33 FSNAU, Mogadishu & IDP assessment, 2012. The head of household is defined as the one who makes family decisions.

34 Ibid.

35 Human Rights Watch, op. cit.

36 UNDP, Somalia Human Development Report 2012, Nairobi, 2012), pp. 28-30. This study finds that Somalia ranks among the worst in the world in inequality-adjusted Human Development Index.

37 Mercy Corps, 'What Really Matters for Resilience?' October 2013, p 4, <http://nin.tl/MercyCorpsSomalia>

28 USAID, 'Environmental and Natural Resource Management Assessment', : USAID, Nairobi, April 2014, p. 16.

29 UNHCR Population Movement Trends System.

30 Majid & McDowell, op. cit.; Human Rights Watch, 'Hostages of the Gatekeepers: Mogadishu IDPs', 2013.

Another major contextual change is the impact of globalization. Somali society has been 'diasporized' over the past 25 years; an estimated 1.5 million Somalis now live outside the country. They are not only a lifeline for the economy, remitting over US\$1 billion annually, but are also leaders in politics, business and civil society. They are also vectors of new ideas and norms – from the West, the Gulf states and elsewhere – about children's rights, women's rights and family life. The fact that the Diaspora is infusing different values and norms back into Somalia has intensified struggles over cultural and social norms affecting women and children.

The Somali household has gone through considerable strain over the past 25 years of warfare and state failure. Traditional male roles have come under pressure and many men – especially those from marginalized or less powerful groups – are unable to fulfil their traditional role as economic provider. This has contributed to family breakdown, to economic stress on families and to problematic behaviour among some men. Qat consumption – mainly by adult males – is an embedded cultural practice in Somalia, but also a major drain on household revenues, and in many households diverts scarce resources from education, health care and nutrition for children.

Many households are now female-headed, due to a combination of factors – including but not limited to high levels of divorce, polygamy, male death rates and the practice of 'parking' families in one area while the male head of household works. The increased prevalence of female-headed households has a mixed impact on resilience and child well-being. On the one hand, it places considerable strain on the female head of household, and increases the likelihood that female children will be held out of school to help with household duties. There are also concerns that the absence of fathers could increase the risk of behavioural problems among young men. On the other hand, studies have found that greater empowerment of women is a critical factor in household resilience.³⁸

The situation of girls and women in Somalia is largely constrained by social norms on gender that leave them in a subservient position. Somalia is one of only five states in the world not to have signed the Convention Against All Forms of Discrimination Against Women (CEDAW). Girls, especially those from poorer households, face a high risk of child marriage and motherhood.

Female genital mutilation (FGM) remains a near universal cultural practice in Somalia, despite efforts to end the practice by some health professionals, civic groups, clergy and aid agencies.³⁹ For the entire

population of young girls, FGM constitutes a major health risk.

Other cultural practices relating to the treatment of infants and children, including the practice of limiting outside contact with newborns during the first 40 days after birth, and preferential treatment of young boys over young girls, constitute additional impediments to child well-being.

Social Protection/Resilience

The need for comprehensive, shock-responsive social protection systems was very apparent during the 2011 famine, which had a devastating impact in Somalia. The famine resulted in the deaths of 258,000 people, half of whom (130,000) were children.⁴⁰

Social protection efforts help to prevent shocks and stresses at the household or individual level, provide protection during periods of exposure, promote opportunities to overcome vulnerability to shocks and stresses, and transform the societal or household relationships that lead to or exacerbate risk.

Social protection mechanisms have a long history in Somalia, with extensive family and clan-based support providing an important safety net for households. Remittances from the Diaspora were estimated at US\$1.3 billion in 2014⁴¹, and are used for both basic needs (such as household food security, education and medical expenses) and for productive investments. Kinship groups support each other with the practice of wealthier families taking in children from more disadvantaged families, known as *kafala*. There are also informal community solidarity or charity mechanisms. Though generally effective, these mechanisms can come under stress from repeated crises, and may be particularly ineffective in the case of community-wide shocks. They can also lack elements of consistency and predictability that are necessary for households to take informed risks, and may also exclude particularly disadvantaged groups, such as minority clans.

Risks and shocks affecting Somali households are not limited to large-scale disasters. Common shocks at community level include predictable seasonal shocks (lean seasons) and conflict-related trade blockages that impact food prices. Shocks are more common at the household level, and can include things such as the death or disability of a breadwinner, displacement or loss of employment.

40 Detailed analysis of the 2011 famine can be found at <http://www.fsnaa.org/in-focus/technical-release-study-suggests-258000-somalis-died-due-severe-food-insecurity-and-famine>

41 USAID, 'Environmental and Natural Resource Management Assessment', USAID, Nairobi, April 2014, p. 16.

38 *Ibid.*

39 UNICEF, 'Eradication of Female Genital Mutilation in Somalia' http://www.unicef.org/somalia/SOM_FGM_Advocacy_Paper.pdf

Even community-level shocks and stresses have differentiated impacts at the household level, influenced by the strength and diversity of a household's coping mechanisms and their social positioning and networks. The vulnerability of populations in Somalia is influenced by both risk exposure and the capacity to anticipate, cope and overcome these shocks and stresses as well as to change the context (or the 'enabling environment') in such a way that vulnerability to risks decreases. This capacity is what is referred to as "resilience" and building it is termed "programming for resilience". This type of programming aims to maintain a steady improvement of well-being indicators throughout shocks and stresses.

While the concept was initiated after the 2011 famine, programming for resilience is an emerging field in Somalia. Most external development agencies have engaged with it, largely from a concern to avoid the possibility of another such large-scale disaster. Consequently, a lot of programming has focused on improving livelihoods, productive assets and capacities. However, the 2013 study conducted by UNICEF, FAO and WFP shows that the factor of access to basic services in health, nutrition, hygiene, education, and social and child protection is a central determinant of resilience at household and community level.



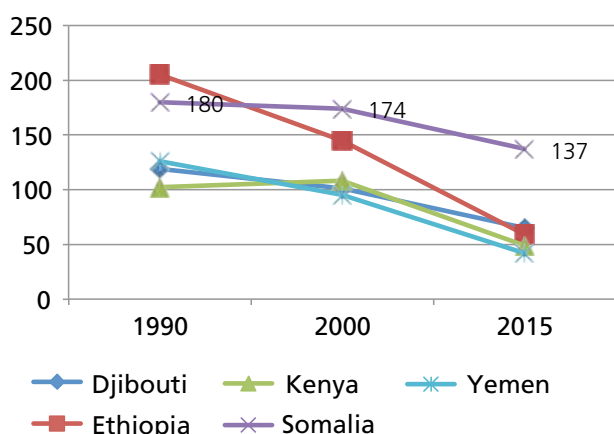
Health

The situation

The under-five mortality rate (U5MR) in Somalia is presently the third worst in the world after Angola and Chad.¹ One in seven Somali children dies before their fifth birthday. Furthermore, child death rates in Somalia have been reduced much more slowly over the whole Millennium Development Goals (MDG) period (1990-2015) than in its neighbouring countries, as the table below shows.

U5MR – Deaths per 1,000 live births

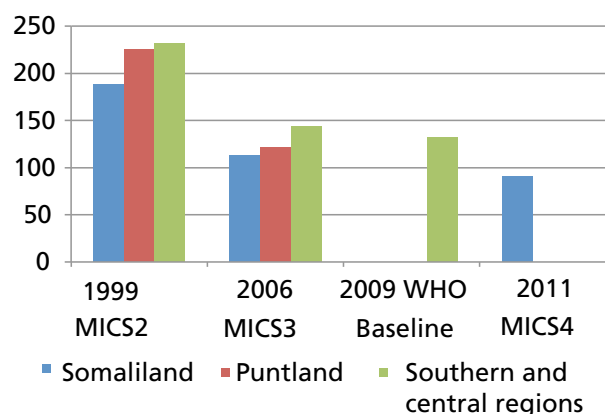
Source: Levels & Trends in Child Mortality, UN Inter-agency Group for Child Mortality Estimates, 2015



While progress has been slower than in other countries in the region, and has fallen far short of the MDG target of a two-thirds reduction, the under-five mortality rate has at least continued to decline, and at a faster pace since 2000 than in the decade preceding that. The reduction in the child-mortality rate has occurred in all regions, as the chart indicates,² though it remains higher in southern and central Somalia than in Puntland and Somaliland. The 2006 MICS3 (third Multiple Indicator Cluster Survey) found there to be no significant difference in U5MR between the urban and rural populations.

1 Two of Somalia's neighbours have met their U5MR MDG 2015 target, and the other two are close.
 2 WHO, Baseline Survey for South Central 2013-14, 2015 estimated U5MR for 2009. The sample was, however, heavily weighted for urban populations and was not representative of the whole population.

U5MR by region of Somalia



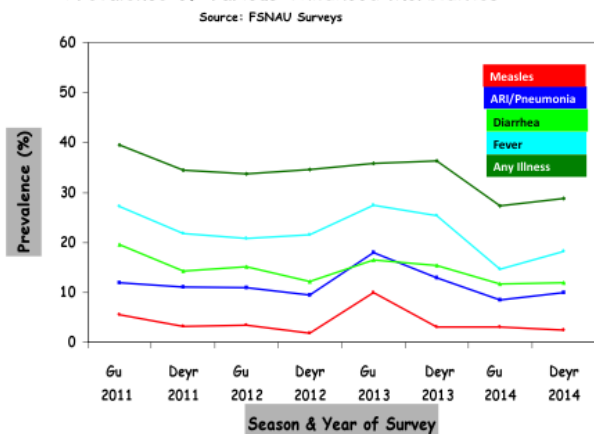
As of 2015, neonatal deaths (those occurring in the first 28 days of life) were estimated at 40 per 1,000 live births and the infant-mortality rate (deaths in the first year of life) at 85 per 1,000 live births.³ These were also among the highest rates in the world: the position on neonatal mortality is only worse in Angola and Central African Republic, and infant-mortality rates are only higher in those two countries plus Sierra Leone. There are multiple contributory causes to these unacceptably high levels of neonatal, infant and child mortality, the most significant of which are: neonatal issues, acute respiratory illnesses, diarrhoea, vaccine-preventable diseases and malaria.⁴

Surveys asking respondents about childhood illnesses in the 'past two weeks' give a consistent picture of major morbidities affecting children under five.

Undernutrition is considered to be the underlying cause of more than a third of child deaths and there is a synergistic relationship between nutrition and health.⁵ The causes of undernutrition and diarrhoea, are explored in the chapters of this report on Nutrition and on Water, Sanitation & Hygiene.

3 UN Inter-agency Group for Child Mortality Estimates, Levels & Trends in Child Mortality, 2015
 4 This conclusion is supported by data from the HMIS (Health Management Information System), which only has data on deaths occurring at reporting health facilities, and is in line with findings from other Sub-Saharan African countries.
 5 The relationship between nutrition and health is summarized in Black, R.E. et al, Maternal & Child Undernutrition, Lancet Series on Nutrition, 2008.

Prevalence of Various Childhood Morbidities



Gu long rains from April – June and Deyr short rains October – December

The incidence of diarrhoea⁶ in children under five has not changed much over recent decades. Rates for urban children do not differ greatly from those for rural children, and they are only somewhat lower for wealthier families and more educated mothers.⁷ While the incidence of diarrhoea is consistently much lower in Somaliland than in the southern and central regions, there are marked differences between the various survey results for Puntland.

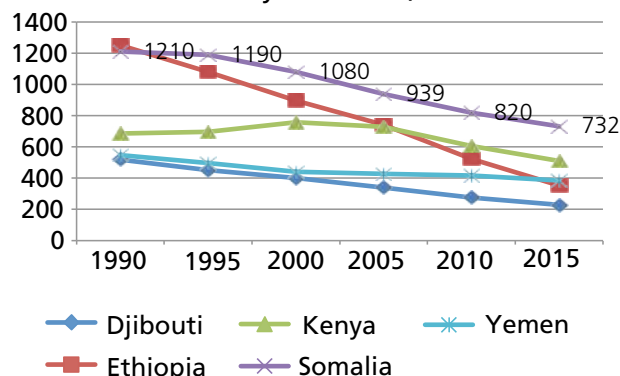
% incidence of under-five diarrhoea	1999	2006	2011	2015
Somaliland	17	13	13	10
Puntland	27	11	10	28
Southern and central regions	25	25		26
Total	23	21		24
Urban	25	17		
Rural	23	24		
Source	MICS2	MICS3	MICS4	WASH KAP

The maternal mortality ratio (MMR) in Somalia is, at 732 per 100,000 live births, also among the world's highest, exceeded only by Central African Republic, Chad, Nigeria, Sierra Leone and South Sudan. Moreover, there is a higher risk of maternal death, at 1 in 22, in Somalia than in any other country apart from Chad and Sierra Leone. Although the maternal mortality ratio was reduced by 40 per cent between 1990 and 2015, Somalia'smmR remains far higher than that of its neighbours, as the chart below demonstrates.

6 Measured by asking whether the child had diarrhoea in the past two weeks.
7 UNICEF, MICS3, 2006 and UNICEF, MICS4, 2011.

MMR – Deaths per 100,000 live births

Source: Level & Trends in Maternal Mortality, UN Inter-agency Group for Maternal Mortality Estimates, 2015



Causal analysis

In analyzing the health situation in Somalia, it is important to consider both the provision of health services, in terms of coverage and quality, and the health-seeking behaviour of the population.

In Somalia, there are broadly three categories of health service providers: the government public sector; the private formal sector using modern medicine; and traditional and complementary medical practitioners (TCMPs).⁸ There is a Health Management Information System (HMIS), supported by international organizations, which collects information about health services provided – but only for the public sector. A high proportion of health services are provided by the private health sector and about these there is limited information. The majority of government health services are actually provided by UNICEF. The analysis below relies mainly on household surveys and respondent information.

Reproductive health

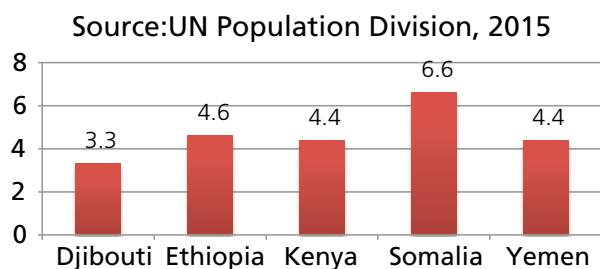
FGM

Women who have undergone FGM (Female Genital Mutilation) are significantly more likely to have long-term health consequences, including menstrual retention and urinary tract infections, than those who have not. In particular, FGM frequently has adverse obstetric outcomes – and the risks increase with the severity of the mutilation.⁹ Amongst Somali women

8 The brief description of these alternatives is drawn from: Buckley, Joanna, Liz O'Neill and Ahmed Mohamed Aden, Assessment of the Private Health Sector in Somaliland, Puntland and South Central, HEART, 2015; and Pavignani, Enrico, The Somali Healthcare Arena, University of Queensland, 2012.

9 WHO, 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries', The Lancet, 367, 2006, pp. 1835–1841. Adverse obstetric outcomes include: caesarean section, post-partum haemorrhage, infant resuscitation, and stillbirth or early neonatal death.

Total Fertility Rate 2010-2015 – average number of children per woman



aged between 15 and 49, 98 per cent have undergone some form of FGM.¹⁰ There is no significant difference in the incidence of FGM between urban and rural populations or between different wealth quintiles and education levels. The vast majority of women have undergone the most extreme form of FGM (infibulation), though there are signs that, at least in Somaliland and Puntland, the proportion undergoing the most extreme form of FGM is dropping.¹¹ Although FGM is performed mainly by traditional practitioners, studies report that nurses or doctors, in clinics or hospitals, are increasingly performing FGM;¹² a process termed 'medicalization of FGM'. This is thought to be favoured by more educated and wealthier families who consider it safer to have the procedure performed by medical professionals. The social norms issues surrounding FGM are further addressed in the chapter of this report on Child Protection.

Fertility rates and early marriage

High fertility is associated with high child and maternal mortality, and Somalia has one of the highest fertility rates in the world.

In recent decades, fertility rates have been dropping in all the world's countries, though Somalia has lagged behind in this trend. Somalia experienced its maximum fertility rate of 7.7 in 1997 and the onset of its transition towards lower fertility is judged to have begun in 2010.¹³ This high but declining fertility will have demographic and socio-economic repercussions. The high fertility rate is related to the common incidence of early marriage, low birth spacing, and lack of access to contraception, as well as to cultural mores and social expectations.¹⁴

The marriage of girls before the age of 18 compromises their development, and may result in early pregnancy, which can have adverse health outcomes for both

mother and child. Globally, complications during pregnancy and childbirth are the second most common cause of death for 15-19 year olds, and babies born to mothers younger than 20 years have a 50 per cent higher risk of being stillborn or of dying in the first few weeks compared with mothers aged between 20 and 29.¹⁵

In Somalia, the fertility rate of girls aged 15 to 19 is higher than in neighbouring countries.¹⁶ About 1 in 10 marriages occurs before the girl is 15 years old, and about half before she is 18.¹⁷ In this respect there is little difference between urban and rural girls and the incidence of early marriage is significantly lower only for the highest wealth quintile.

The 2006 MICS3 found that only 15 per cent of Somali women aged 15 to 49 used any form of contraception. The most common method used, moreover, was breastfeeding, which would only give very limited birth spacing. Contraception use was no different between the urban and rural populations, nor did it differ significantly according to wealth quintiles or levels of education. A quarter of the women surveyed expressed an unmet need for birth spacing.

Antenatal care

According to 2006 MICS3, the last nationally representative survey, only about a quarter of women received professional antenatal care (ANC) and only a third of deliveries were attended by a skilled health practitioner. Only six per cent of Somali women had the recommended four or more ANC visits. All of these proportions were, however, much higher for urban than for rural women and also higher for women who were more educated or from wealthier households. For example, 77 per cent of women in the highest wealth quintile had skilled assisted deliveries compared with only 11 per cent in the lowest quintile.¹⁸ The same general conclusions were borne out by the 2011 MICS4 carried out in Somaliland and Puntland.¹⁹

Pregnant women in areas with a high prevalence of malaria are four times more likely to get malaria and twice as likely to die of the disease. Once infected, pregnant women are at risk of anaemia, premature delivery and stillbirth. Intermittent Preventative Treatment (IPT) is key to addressing pregnancy-related malaria risks, yet only six per cent of Somali women

10 UNICEF, MICS3, 2006.

11 The results derive from a comparison of MICS4 from 2011 with MICS3 from 2006.

12 Somali Aid Foundation, FGM/C Baseline Report, 2013. Rates of FGM medicalization range from 16 to 28 per cent.

13 UN Department of Economic & Social Affairs, World Fertility Report 2013.

14 Early marriage and social-norm issues behind high fertility are addressed in the chapter of this report on Child Protection.

15 WHO website.

16 UN Economic & Social Affairs, World Fertility Report 2013. The 2005 rate was 123 births per 1,000 girls aged 15-19.

17 UNICEF, MICS3, 2006 and UNICEF, MICS4, 2011. The rate of early marriage is much higher in southern and central regions than elsewhere.

18 UNICEF, MICS3, 2006.

19 WHO, Baseline survey for South Central 2015 yielded results very close to the 2006 national average for urban populations; note that the South Central Survey was predominantly sampling urban populations.

% Women 15-49 years who had given birth within prior two years

Services by qualified professionals	Somaliland	Puntland	Southern and central regions	Total	Urban	Rural
ANC	32	26	24	26	46	15
Assisted Delivery	41	37	30	33	65	15

Source: 2006 MICS3

who received ANC also received IPT.²⁰ Only a quarter of pregnant women were immunized to protect them from tetanus.²¹

Several studies help to explain the extent to which health-seeking behaviour contributes to the low rates of professional ANC attendance and skilled assisted delivery.²²

Only a small proportion of women realize the importance of ANC or understand what it comprises. The general perception is that, if they did not have a problem in their previous pregnancy, ANC visits are unnecessary. In rural areas, particularly in the southern and central regions, few health facilities offer ANC.

Skilled birth attendance

Most birth deliveries are at home and are assisted by an elder woman or traditional birth attendant. The decision on where birth will take place is made either by the woman herself or by an elder. Reasons given for favouring home delivery include: there being no perceived necessity to deliver elsewhere; the lack of an available and trusted health facility in the proximity; the belief that the mother will be better cared for at home and can attend to her other children; and financial constraints, including for transport. Often, it is decided to use a health facility for delivery if there is a complication and there is no other option. Many women know the danger signs associated with a complicated pregnancy but the decision to seek skilled medical help is often complicated: women's first recourse may be to prayer or to consultation with local non-professionals; elders, whether female or male, may be involved in the decision-making process; there may not be a health facility nearby; and the costs of involving health-service staff, and of any journey that involves, may have a deterrent effect.

Maternal morbidity and mortality

The most cited maternal morbidities include: obstetric fistula, chronic infection, urinary disorders, chronic

anaemia and post-traumatic psychiatric disorders.²³

The leading causes of maternal deaths are: indirect, by which is meant those conditions not unique to pregnancy or childbirth but exacerbated by them, such as anaemia, malaria and infections (29 per cent); haemorrhage (25 per cent); hypertension (16 per cent); abortion (10 per cent); and sepsis (10 per cent). For Somali women, maternal mortality is second only to infectious diseases as the leading cause of death.²⁴

Reducing the number of maternal deaths depends, as always, both on achieving higher rates of skilled attendance at delivery and on clinical services being available in case of emergency. Studies of Emergency Obstetric & Neonatal Care (EmONC) in each region of Somalia show that not all maternal and child health centres (MCHs) offer delivery services or have qualified midwives, and those that have functioning delivery and EmONC services are usually supported by a UN agency or NGO.²⁵ Few MCHs have both electricity and running water. Although ANC is usually provided free, a normal delivery costs US\$5-10. There is inadequate capacity to respond to emergencies outside MCH open times, which are normally restricted to mornings. Transportation for referrals to an EmONC-equipped facility has to be arranged and paid for by the family of the patient. As a result, these referral EmONC facilities are often equipped and staffed but underutilized.

It is therefore clear that the three delays that classically increase the risk of maternal mortality are all at play in Somalia. These are:

1. Delay in taking the decision to seek care – due to low status of women in decision-making and financial barriers;
2. Delay in reaching care – due to financial barriers including for transportation;
3. Delay in receiving care – due to inadequate facilities and trained staff.

20 IPT is mainly a drug intervention to clear malarial parasite infection from the system and a prophylaxis to prevent new infections.

21 UNICEF, MICS3, 2006.

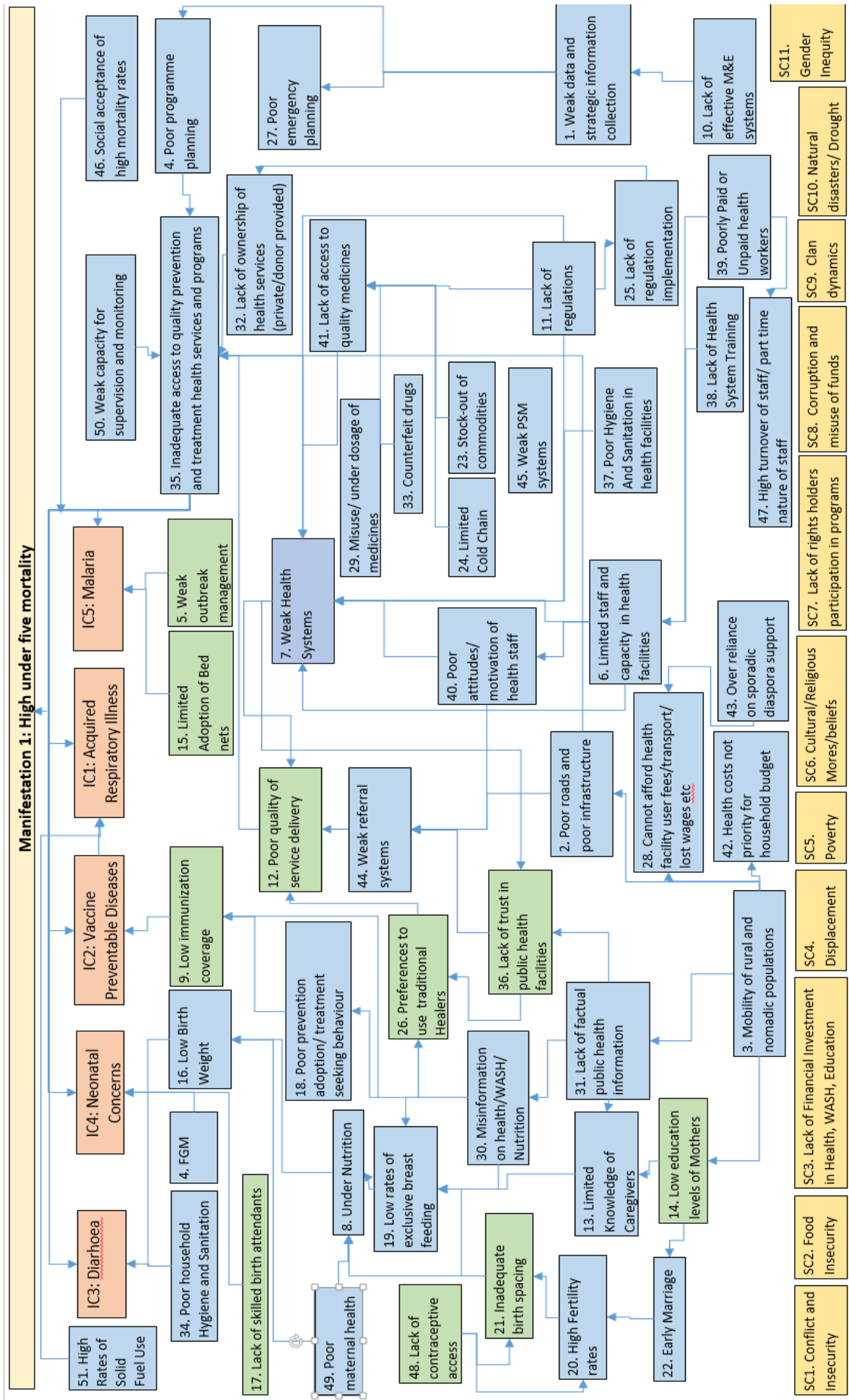
22 Saroj Dhingra, Formative Research Key Behavioral and Communication Barriers in Somalia, UNICEF, 2014; and UNICEF, Health Care Seeking Behaviour in Somalia, 2009.

23 WHO/UNFPA, Situation Analysis of Reproductive Health in Somalia, 2009.

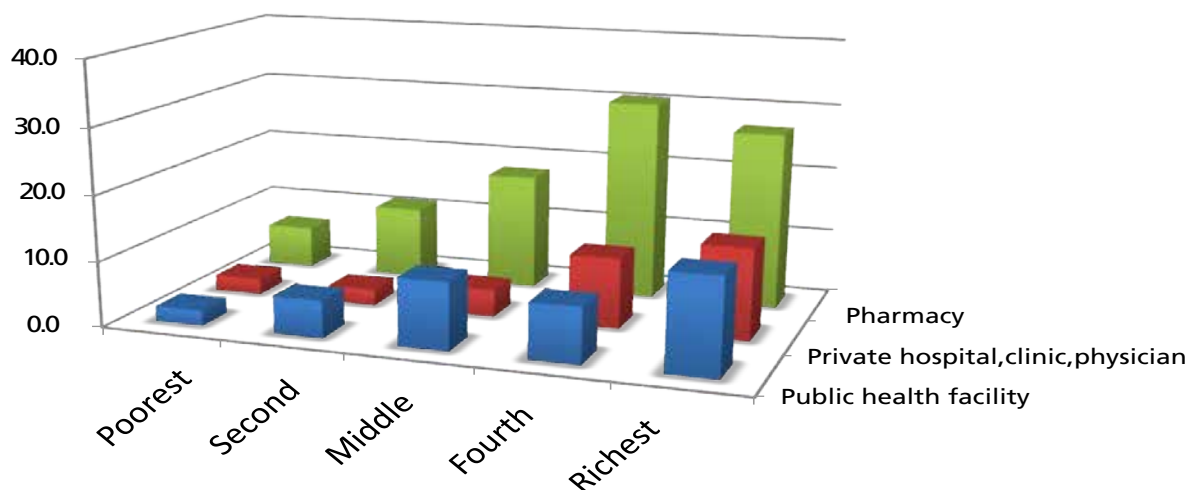
24 WHO, Somalia Statistical Profile, 2014.

25 UNICEF, EmONC Needs Assessment Selected Facilities Somaliland, 2011; UNICEF, EmONC Needs Assessment Selected Facilities Puntland, UNICEF, 2011; SCORE, Facility Assessment Survey South Central Somalia, 2012; WHO/UNFPA, Situation Analysis of Reproductive Health in Somalia, 2009.

Causal Analysis of Under Five Mortality



% U5 suspected pneumonia by health provider & wealth quintile – MICS3



Underlying causes for maternal morbidity and mortality associated with nutrition and with water, sanitation and hygiene are explained in the respective chapters of this report.

Acute respiratory infection (ARI) – Pneumonia

The 2006 MICS3 revealed that 15 per cent of children under five had an Acute Respiratory Infection (ARI) – suspected pneumonia – in the two weeks prior to the survey; the rate was higher for southern and central regions than for other parts of Somalia, but did not show significant disparities based on urban or rural location, the mother’s level of education or household wealth. Of those suspected of having pneumonia, only 13 per cent were taken to an appropriate health provider.²⁶ Many more were taken to a pharmacy than to a public or private health facility. In this respect there was a significant difference in terms of location, as 24 per cent of urban households took a child with suspected pneumonia to an appropriate provider compared with only 8 per cent of rural households. The disparities in seeking appropriate treatment for a child with suspected pneumonia were even more stark in relation to household income, as the chart above shows.

Of those children suspected of having pneumonia who visited a health provider, about a third received antibiotic treatment. About half the children from the wealthiest 40 per cent of households were given antibiotics, but barely a fifth of those from the poorest 40 per cent of households were treated in this way. The same survey found that only 15 per cent of mothers or caregivers could recognize the two signs of pneumonia (rapid and difficult breathing), and there were no

significant differences on this indicator in terms of location or household wealth.²⁷

Use of solid fuel for cooking, without a chimney or other means of disposal of fumes, is widespread and is a significant cause of ARIs/pneumonia, tuberculosis and asthma; it may also contribute to low birth weight.

Immunization against childhood diseases can also protect against Acute Respiratory Infections (ARIs) but coverage is low.

Diarrhoea

There is a high incidence of diarrhoea in Somalia, 28 per cent in Puntland and 26 per cent in southern and central regions as of 2015.

The 2006 MICS3 reveals that only one fifth of children under five with an incidence of diarrhoea in the past two weeks, received appropriate Oral Rehydration Therapy (ORT). This rate was much higher in the northern states than elsewhere, with half the affected children - in Somaliland and a third of those in Puntland benefiting from this treatment. Less than 1 in 10 children under five with diarrhoea had treatment in line with WHO/ UNICEF recommendations for treatment – taking ORT or increasing intake of fluids and continuing feeding. Again the rate was higher in Somaliland and Puntland than in other parts of the country. The 2011 MICS4 suggested that, while the incidence of diarrhoea in Somaliland and Puntland was about the same as in 2006, there were higher rates of ORT and appropriate treatment.

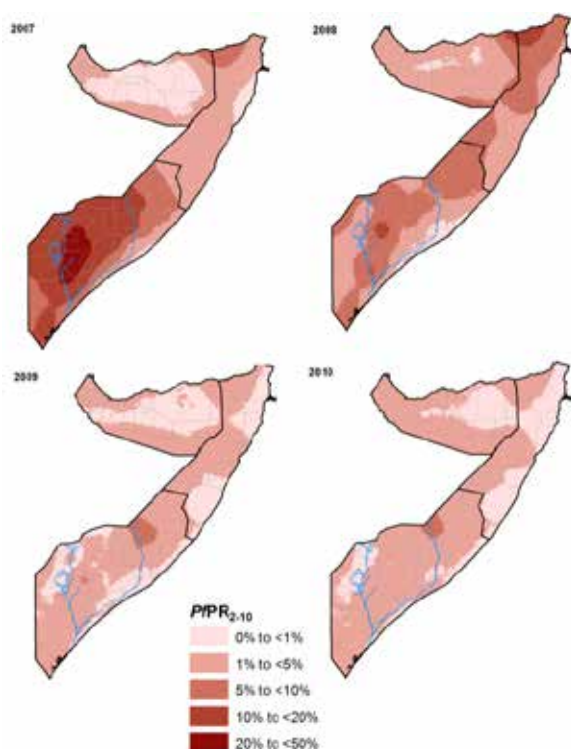
Malaria

The comprehensive 2014 Malaria Indicator Survey for Somalia found malaria parasite prevalence in nearly two per cent of children under five. In southern and

²⁶ UNICEF, MICS3, 2006. MICS considered as appropriate provider: Government Hospital, Government Health Centre, Private Hospital/Clinic or Private physician.

²⁷ Ibid.

Malaria



central areas where the disease is endemic the rate rose to nearly three per cent.

Prevalence of malaria parasite in blood

In fact the proportion of people infected by malaria is on the decline, as the maps indicate. This is due not only to anti-malarial interventions but also to the long periods of drought in 2009-2010.²⁸

Over a third of people surveyed in 2014 in southern and central regions slept under a net, including around 30 per cent of pregnant women. Two thirds of the nets were sourced from 'vertical' anti-malaria campaigns – programmes relying on a single tool.²⁹ The strategy in these regions is to push for universal coverage of long-lasting insecticide-treated nets (LLIN) and the rate of usage in that region is currently 29 per cent.³⁰

Malaria is not endemic in the north of the country, but Puntland and Somaliland are still prone to outbreaks of the disease and, due to lower resistance in the population, there is a risk of higher morbidity rates – fewer than a quarter of people sleep under a net in the north. The priority there is therefore to develop a high-quality surveillance and early monitoring system combined with a highly focused distribution of LLIN to identified hot spots. In the nation as a whole, 20 per cent were sleeping under a LLIN as of 2014.

The anti-malarial efforts have contributed to significantly reduced numbers of deaths caused by malaria in the period since 2010.³¹

According to survey respondents, nationally 10 per cent of children under five had suffered a fever in the previous two weeks – and of these only 27 per cent received treatment. Half of the children for whom treatment was sought received it only after at least a 48-hour delay following the onset of fever. The treatment given was mainly an antipyretic (a fever-reducing drug), with only about one in eight of treated cases given anti-malarial drugs.³² The great majority of respondents had knowledge of malaria symptoms and had been exposed to education about malaria.³³

Immunization coverage

Overall rates of immunization coverage remain low in Somalia. This, coupled with weak health systems, and with inadequate prevention and people's reluctance to seek treatment, increases children's susceptibility to vaccine-preventable diseases such as measles and ARI. Excluding newborn tetanus coverage, all main antigen immunization coverage rates are below 50 per cent of the targeted population.³⁴ The MICS3 in 2006 found that only 12 per cent of children aged 12-23 months had received all the vaccinations required before 12 months, and that 36 per cent had received no vaccinations at all.³⁵ The 2011 MICS4 found that the overall coverage rates for Somaliland and Puntland had not improved. The 2006 MICS3 found that immunization coverage was about four times higher for urban than for rural children, and that rates were much higher for wealthier households and more educated mothers.

Outbreaks of measles remain a problem in Somalia.³⁶ The number of measles cases is much higher in southern and central regions than in elsewhere.

This is at least in part because 18 of its districts are currently inaccessible for immunization campaigns due to security concerns – and many of the districts surrounding them are only partially accessible. In addition, movements of internally displaced people between inaccessible and accessible areas tends to amplify transmission of measles, as does the movement of other mobile populations, such as nomads.

28 Noor et al, Malaria estimates report, 2013.

29 UNICEF, Malaria Indicator Survey, 2014. This data is an improvement over 2006 MICS3 results.

30 Ibid.

31 Ibid. Data for Puntland only in 2012 and 2013.

32 This data, from the 2014 Malaria Indicator Survey, is approximately consistent with the results of the 2011 MICS4 for Somaliland and Puntland. The 2006 MICS3 showed a higher rate of fever, at 20 per cent of children under five, of which only eight per cent received appropriate anti-malarial drugs.

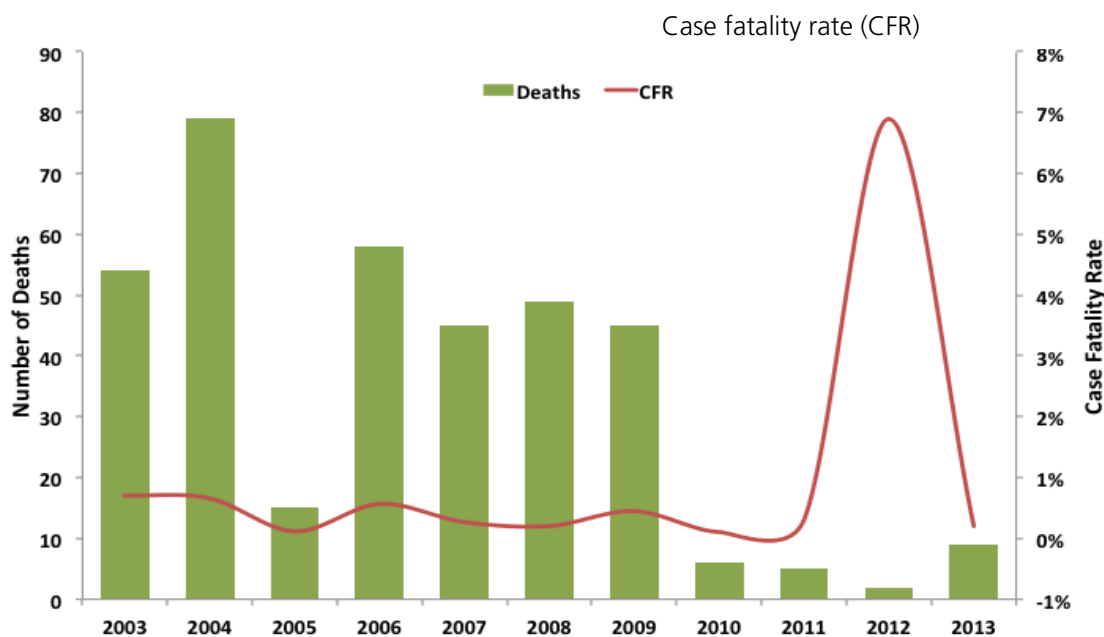
33 Ibid.

34 UNICEF, The State of the World's Children Report, 2015

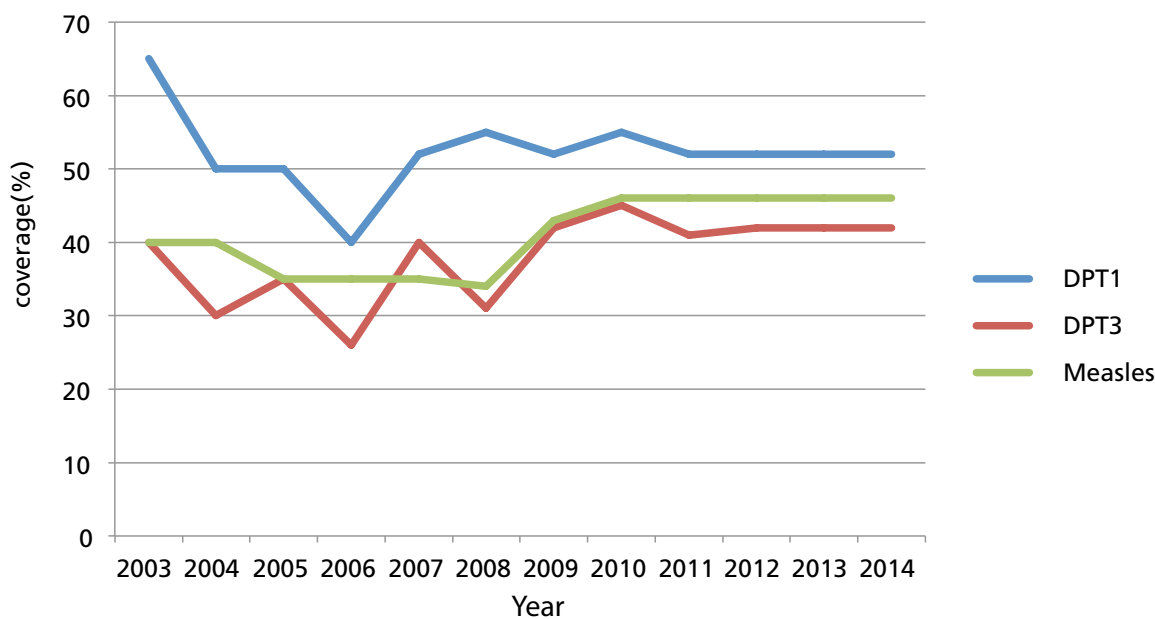
35 Less than 10 per cent of women respondents could show a vaccination card for their children.

36 WHO Surveillance Data.

Deaths caused by malaria



Somalia Immunization coverage 2003-2014



Source: WHO/UNICEF Coverage Estimates, Rev 2015

Among the challenges barring the way to an effective immunization system are inadequate access to essential vaccines, resulting in frequent stock outs, lack of technical expertise, and an absence of national supply managers and tracking systems.³⁷

Surveys asking why caregivers do not bring their children to be immunized against childhood diseases provide mixed results depending on the group surveyed. However, common reasons include: concern that the vaccination will harm the child; cultural and religious concerns; ignorance of the importance of vaccination; the lack of vaccine at the nearest health

facility; the mother being too busy; and the vaccination facility being too far away.³⁸

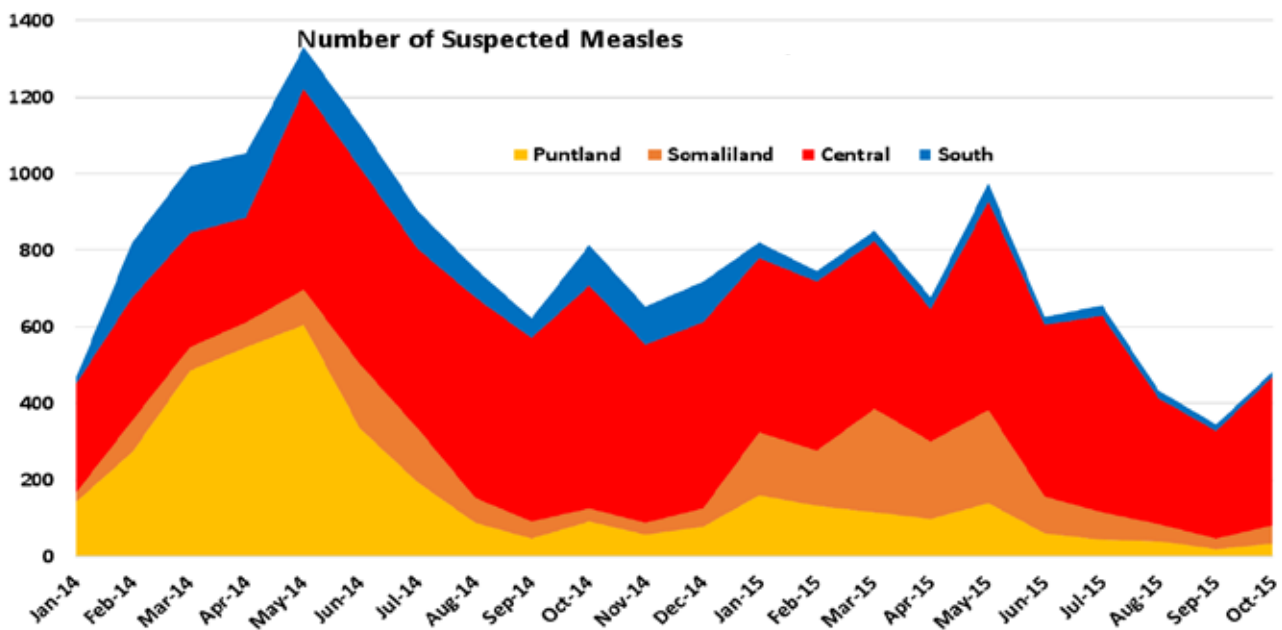
General health-seeking behaviour

Some elements of health-seeking behaviour have already been noted in relation to specific areas of health. This section explores general health-seeking behaviour with findings taken from a number of studies.³⁹

³⁸ UNICEF, Formative Research on Key Behavioural and Communication Barriers in Somalia, 2014.

³⁹ FSNAU, Somali Knowledge Attitudes & Practices Study IYCF and Health Seeking Practices, FSNAU, 2007; UNICEF, Health Seeking Behaviour, UNICEF, 2009; UNICEF, Formative Research on Key Behavioral & Communication Barriers Somalia, UNICEF, 2014; HEART, Assessment of the Private Health Sector Somalia, HEART, 2015

³⁷ WHO, Immunization Systems Report, 2014. RINPS data Puntland.



In general, when a child is sick, caregivers will resort to prayer and home remedies before seeking to purchase medicines or treatment from a facility. The decision to seek care depends both on knowledge of the illness and its consequences, and on the availability, affordability and acceptability of health services. The caregivers match the illness with the services offered by available health facilities and will have their own perceptions about the quality of those services that will include past experience of medical supplies being out of stock and of the quality of staff. The distance to the health facility and the cost of both treatment and transportation are key considerations. The decision makers include mothers, elder women in the household, men of the household and sometimes community leaders. The studies indicate that the decision-making process is complex and convoluted and itself is often a cause of delay in seeking and obtaining treatment.

In about half of cases, caregivers will not seek treatment from a health facility when their children are sick. Less than 10 per cent have recourse to traditional practitioners. There is no concrete information on the degree to which caregivers purchase drugs on the market without a prescription, though surveys indicate that the incidence of this is significant.⁴⁰

When caregivers do seek treatment for their children from a health facility, in about 60 per cent of cases the facility is private rather than public, and pharmacies are by far the most popular of these.⁴¹ The main drivers behind the choice of a private rather than a public facility are:⁴²

- **Availability of facilities.** In urban areas there is

more choice than in rural areas. Private facilities are more established in areas considered profitable, which means places of higher population density like urban areas.

- **Perceived quality of services offered.** There is variation in the quality of services provided at public facilities, with those supported by international UN agencies or NGOs perceived to be of higher quality. With such support, public facilities are perceived to have well-trained staff, but the services offered tend to be narrowly focused on reproductive health services, nutrition services and immunization. Private facilities have a wider range of specialized services.
- **Availability of staff and medicines.** Public facilities are generally only open in the morning or at the latest up to 2pm, and staff are sometimes absent even during open hours. Private facilities have longer opening hours and staff are more likely to be available. Medicines and vaccines from public-supported facilities are believed to be of better quality than those in private facilities but there is a higher likelihood that medical supplies will be out of stock in public facilities.
- **Cost.** Supported public facilities will generally offer basic primary health services free of charge or at nominal cost, though there is a charge for medicines. However, the general practice is for patients to pay a 'voluntary' fee of about US\$2 per consultation to ensure prompt service. Although private facilities charge higher costs, in rural areas, where there is lower willingness to pay amongst poorer populations and there is competition with public facilities, costs may be reduced. Private health costs are cited as ranging from US\$10 to US\$100 depending on the type of service. Though

⁴⁰ Ibid.

⁴¹ UNICEF, Health Seeking Behaviour, 2009; HEART, Assessment of the Private Health Sector Somalia, 2015; UNICEF, Scoping Study Public-Private-Partnership Health Sector, 2015

⁴² Ibid.

poverty is rife in Somalia, there are occasions when even poor people seek and receive private health care; sometimes this is when clan leaders and relatives raise the necessary funds – a practice known as Qaadhaan – and at other times it is paid for through the sale of livestock or assets that have negative consequences on their resilience.

General functioning of the health sector

Public health facilities include hospitals, maternal and child health centres and Health Posts. Those not supported by donors are likely to be dysfunctional – to offer limited facilities, unresponsive staff or to be frequently closed.⁴³ However, those public facilities supported by donors implement their Reproductive, Maternal, Newborn and Child Health (RMNCH) and nutrition services mainly under the umbrella of the Joint Health and Nutrition Programme (JHNP). Thus they have standards covering the quality of medicines and the training of staff as well as providing public health messaging and communication. In rural areas, public health facilities have more geographic coverage, and cost less, than private facilities. Therefore public facilities tend to be favoured by the poor in both rural and urban areas, including pastoralists and IDPs.⁴⁴ Studies report that public health facilities are often underutilized.⁴⁵

Private health facilities can include hospitals, clinics and pharmacies. Other than having to obtain a business licence, they are not regulated and therefore do not adhere to any health ministry standards. Private facilities are most concentrated in urban areas and the cost of services is determined by market and profit-margin considerations. Private facilities are sometimes supported with investments from the Diaspora and from Islamic NGOs, which may stipulate that a service is provided at an affordable price to at least to certain segments of the population.⁴⁶

There are informal inter-relationships between the public and private segments of the health sector. Patients may be referred from one to the other depending on availability of services and the disease burden. Staff in the public sector often also work in the private sector and this practice, coupled with weak oversight, could lead to quality medicines being diverted from the public to the private sector.⁴⁷ There is also concern that health facility staff trained under the JHNP will opt to work in the private sector where remuneration is better and more reliable.⁴⁸

Weak supply chain management is a critical bottleneck to the maintenance of key health services in the public health sector.⁴⁹ This has been attributed to the following factors: insecurity in certain areas; ongoing reliance on a push system from suppliers rather than a pull system from facilities; lack of availability from suppliers; human resource shortages and weak capacity; limited monitoring and supervision of supply-chain sites; and non-existent logistical management information systems.⁵⁰ This has the following consequences: poor data management and reporting; weak forecasting and quantification of commodities; undersupply of the commodities required; and some oversupply of commodities, resulting in drugs running beyond their expiry date.⁵¹

Counterfeit drugs kill an estimated one million per year worldwide.⁵² There is some evidence of counterfeit drugs in Somalia, though there is little documentation regarding their availability and distribution. It has been asserted that, since the collapse of the State in 1991, Somalia has become a hub for counterfeit drugs due to its lack of border controls.⁵³ The lack of regulation of the sector and the high incidence of unregulated private pharmacies are risk factors exposing Somalia to the large-scale circulation and use of counterfeit drugs.

Due to the insecurity, especially in the southern and central regions, along with the poor road and transport infrastructure, there is limited regular supervision and monitoring to manage and oversee the quality of the public health system. Donor-supported health programmes have become reliant on third-party monitoring to ensure the supervision of hard-to-reach areas.

Poor hygiene and sanitation in public health facilities are mentioned in surveys but there has been no comprehensive assessment.

Structural factors and enabling environment

Health-sector legislative, strategic and planning framework:

There has been significant recent progress in the legislative, strategic and planning framework for the public health sector in Somalia, largely through the support of the JHNP.⁵⁴ Health sector strategic plans (HSSPs) and related annual work plans (AWPs) were completed for all regions in 2013. A National Somali Health Policy was approved by the health ministers in

43 UNICEF, Scoping Study Public-Private-Partnership Health Sector, 2015

44 UNICEF, Health Seeking Behaviour, 2009

45 Ibid.

46 Enrico Pavignini University Queensland, Somalia Healthcare arena, 2012; HEART, Assessment of the Private Health Sector Somalia, 2015; UNICEF, Scoping Study Public-Private-Partnership Health Sector, 2015

47 Ibid.

48 JHNP, MTR, 2015

49 Ibid.

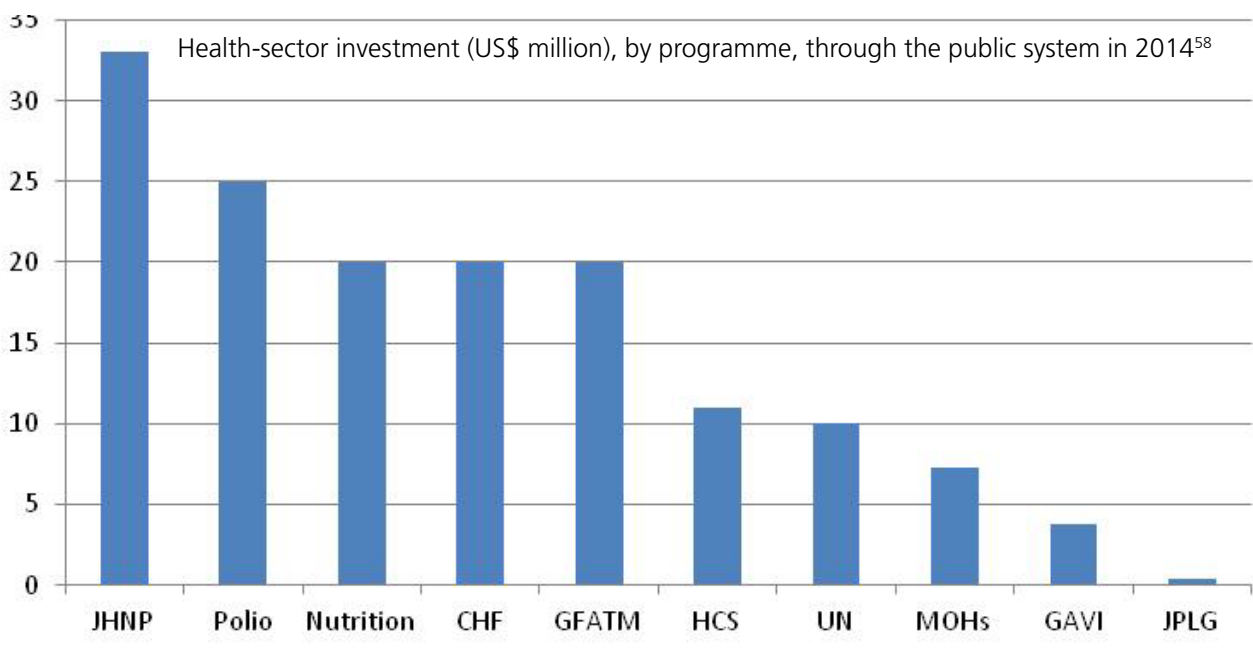
50 Ibid. Mawse for UNICEF, Report on Medical Logistics, 2015

51 UNICEF, EPHS Supply Chain Management Workshop Report – Baidoa, 2015.

52 Interpol website

53 Somali Current, April 2015, 'Somalia Government to take firm action against counterfeit drug sellers'. - <http://www.somalicurrent.com/2015/04/10/somalia-government-to-take-firm-action-against-counterfeit-drug-sellers/>

54 Joint Health & Nutrition Programme (JHNP), Mid Term Review (MTR), 2015



Mogadishu, Garowe and Hargeisa in 2014. Policies and plans covering human resources in health were finalized in 2014. A community-based health care strategy was approved in 2015. A National Health Professions Commission has started to certify and register health professionals after enabling legislation in 2013 but this only applies to the public sector. The private sector is also not included in the HSSPs so the private sector is practically unregulated.

Health-sector finances: Overall, there is significant funding to Somalia's health sector that amounts to about US\$30 per capita per annum.⁵⁵ For 2014, the total investment in the public health sector is estimated to be US\$150 million spread across the different programmes shown in the chart above.⁵⁶ The Government's share is very small and the public sector is too dependent on international aid donors and UN agencies. Government health budgets are too meagre to support government policy making and oversight of health activities in the country. Thus there is limited government influence on health-care provision and the private health sector is dominant.⁵⁷ The great majority of Somalis experience deep poverty and have great difficulty meeting health user fees. Remittances from the Diaspora are an important contributor to health-care costs for the families that receive them.

Public health facility coverage: There is an uneven distribution of health facilities, which are concentrated in urban areas, and long distances between health facilities in rural areas impede access. The planned assessment of health facilities urgently needs to be completed. The JHNP is covering a substantial portion of the population of the country with the Essential Package of Health Services (EPHS)⁵⁹. However, as noted earlier, utilization of services remains low.

Health Management Information System (HMIS): HMIS has been introduced with the help of the JHNP but does not include the private sector and there remain issues in relation to its lack of completeness, quality and consistency.⁶⁰

Public health system management: Staff in public health facilities lack adequate training and supervision. Despite significant investments in capacity building of Ministry of Health staff, there is need for more capacity building and supervisory functions are weak.⁶¹ There is no proper national system for logistics management, there remains a lack of warehouses and staff skills on supplies and procurement are poor. There is inadequate capacity in data analysis and operational research. There is a lack of co-ordination between public health programmes. Health facilities have limited hours of operation, no continuity in service delivery and an inconsistent approach to service-delivery standards.

Accessibility and transportation: The continuing conflict in Somalia impedes access to some areas and in others there are roadblocks. This insecurity, along with the poor transportation infrastructure, interferes

55 Enrico Pavignani, University of Queensland, The Somali Health Care arena, 2014

56 JHNP, MTR, 2015

57 Enrico Pavignani, The Somali Health Care Arena, University of Queensland, 2014

58 JHNP, MTR, 2015. CHF=Common Humanitarian Fund, GFTAM=Global Fund for Tuberculosis, AIDS & Malaria, HCS=Health Consortium Somalia, GAVI=Global Alliance Vaccines & Immunization, JPLG=Joint Programme on Local Governance.

59 Ibid.

60 Ibid.

61 Ibid.

with health support activities, including the delivery of essential supplies and drugs.

Community participation: In general, there is a lack of community participation in planning, in implementation and in monitoring and evaluation.

Social norms and cultural practices: The low status of women in Somali society has multiple effects on child

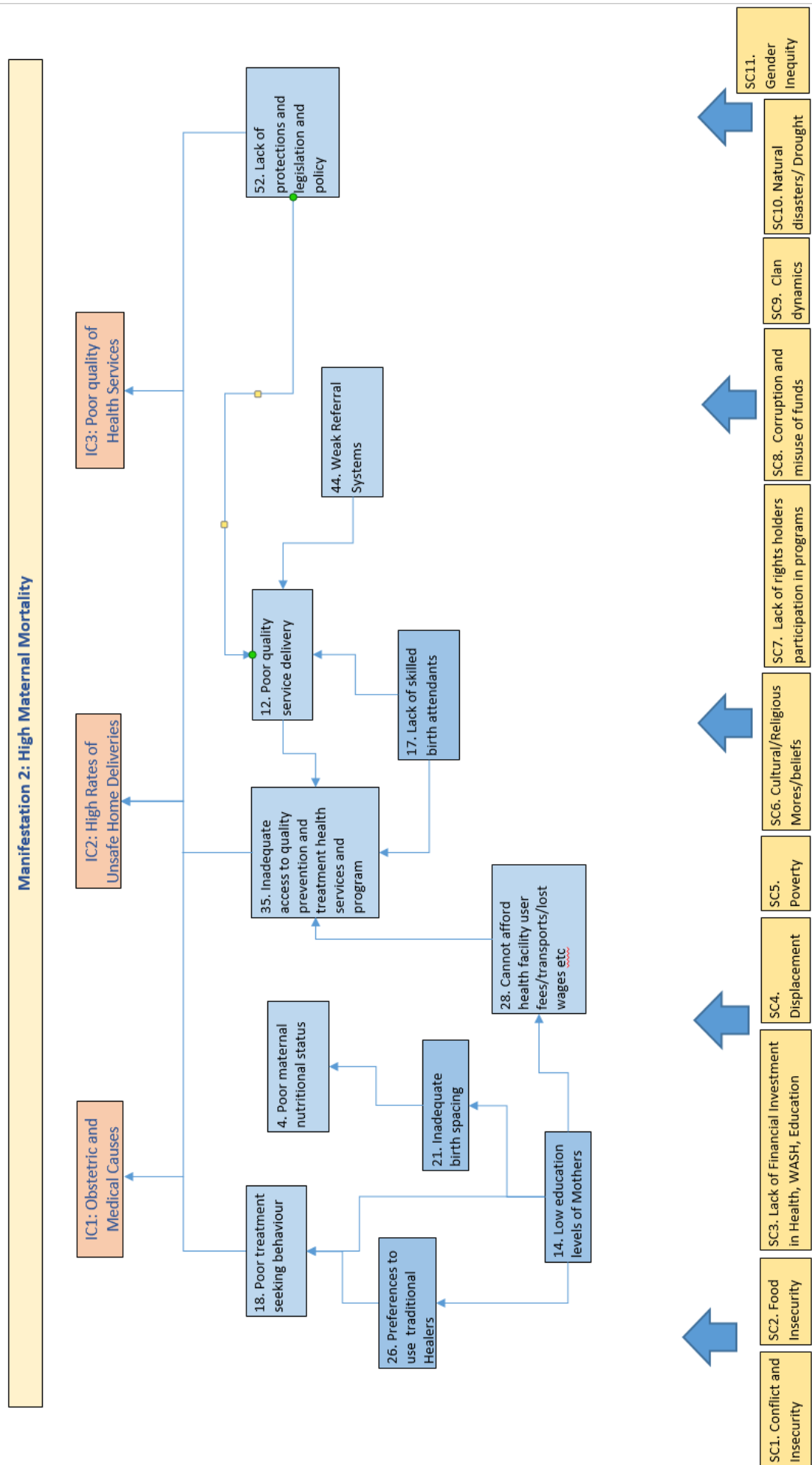
health care. In particular, the low education of women is associated with poor knowledge and health-seeking behaviours relating to child health and maternal care. Cultural practices and perceptions may be detrimental to maternal and child health. More research is needed on family decision making regarding health-seeking behaviours especially related to the allocation of family resources.

Role and Capacity Analysis for Duty Bearers in Health

Level	MAIN ACTORS	ROLES	CAPACITY GAP
International community	Donor community International NGOs/UN agencies International banks International government partners	Advocacy as part of global agendas. Fundraising. Technical assistance and capacity development. Service delivery.	A clearer picture is needed of health-sector financing and allocations to different programmes. There is a plethora of inconsistent data available, and international partners should agree on strategic information that needs collecting, sharing and clarifying.
Federal state governments	The Somali Ministry of Health	Policy development, monitoring and evaluation, co-ordination, regulation, planning and strategic objectives, leadership, public campaigns, fund allocation and accountability, promoting collaboration, technical skills development, budget allocation.	Laws and policies relating to the health sector need to be reviewed and completed. A priority is the need for a national drug policy. There is limited government influence on provision of health services. Ministries of Health need more authority and capacity to regulate the sector, including private as well as public provision. The capacity to exercise oversight and monitoring of the health sector is generally weak. The Government sees health as a low priority and the budgets provided are meagre. There is inadequate capacity for data analysis and operational research. Co-ordination between national health programmes is poor. There is also a lack of a national logistics management system.
Local government	District and local health officers.	Supervision, co-ordination, data collection, advocacy for child right issues, implementation of government policies and protocols on the ground. Management of any other decentralized responsibilities.	Public health facility staff lack adequate training and supervision. Payment of staff salaries by the Ministry of Health is often delayed, and staff often also work in the private sector. In general there is weak staff supervision and capacity building.
Civil society	Diaspora, local NGOs, religious organizations and universities.	Fundraising, advocacy, and mobilizing communities. Also, health-service provision.	
Private sector	Employers and health providers.	Co-operate in public-private partnerships for the common good.	There is a need to conduct more studies on the capacities of the private sector and public-private partnerships need to be explored.

Level	MAIN ACTORS	ROLES	CAPACITY GAP
Communities	Community-based organizations, elders, gatekeepers, clan leaders, women's groups, community health workers and committees, religious leaders, self-help groups, youth groups, volunteers.	Awareness creation and advocacy on health issues; mobilization on particular campaigns; holding health officials accountable to deliver services.	In general, there is a lack of community participation in planning, in implementation and in monitoring and evaluation. There is no co-ordination of community mobilizers.
Family	Fathers, mothers, step-parents, older siblings, grandparents.	Ensure appropriate child health care.	There is a lack of knowledge about child and maternal health issues and appropriate health-seeking behaviours. Some cultural practices are harmful to maternal and child health. Pervasive family poverty is a major impediment to maternal and child health.

Maternal Mortality Causal Analysis



Strategic Recommendations

The Government's legislative framework needs strengthening. This should include:

- Drug policy;
- Regulation of the private sector;
- Authority for the Ministry of Health to oversee and supervise the health sector.

Public-private partnerships in health should be actively explored.

Further research is required into:

- Financing of the health care sector;
- Utilization of health facilities;
- Assessments of health facilities, including their provision and practice related to water, sanitation and hygiene, need to be completed.
- There needs to be further investigation into health-seeking behaviours, including barriers to accessing quality services, so as clearly to build the evidence for programming.

Somalia's health programme needs strengthening in the following ways:

- The Integrated Management of Childhood Illnesses (IMCI) should be adopted and implemented;
- The rate of weighing of newborns needs to be increased;
- UNICEF should use its C4D (Communication for Development) capacities to address the barriers of misinformation regarding health services, raise awareness and mobilize communities.
- Resources need to be devoted to empowering communities so as to build community resilience, with a particular focus on women and young people.
- There is a special need for holistic support services and programmes for women of reproductive age, including to build up their resilience.

Cross-sectoral co-ordination and planning must be improved.



Nutrition

Nutrition

The situation

Undernutrition is thought to be the underlying cause in over a third of under-five child deaths.¹

For the last three decades, the nutritional status of Somali children has been among the worst in the world. Child undernutrition remains a huge public health concern. In addition to the existing chronic food insecurity, there is poor access to facilities and services for health and for water, sanitation and hygiene (WASH) – and all these problems are exacerbated by a continuously insecure environment.

Child undernutrition manifests itself differently from maternal undernutrition, and involves somewhat different health risks. Although all types of undernutrition have the same broad causal factors, there are diverse and complex combinations of causal

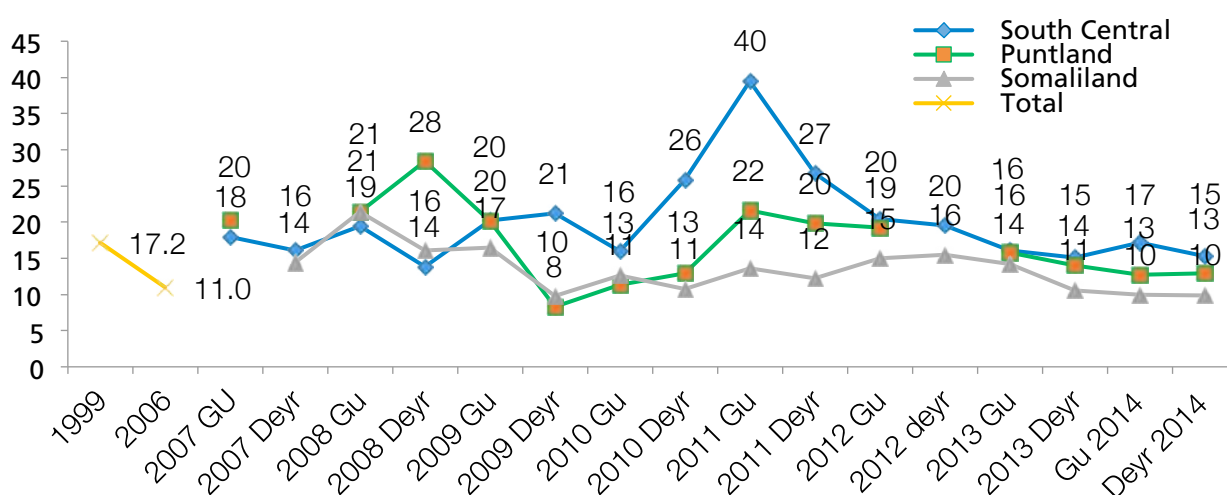
pathways, all varying according to geography, the season and people's means of livelihood.

A child suffers from acute malnutrition if their weight for height is less than two standard deviations below the norm.² Levels of global acute malnutrition (GAM) for a population of children under five are deemed critical if they exceed 15 per cent, at which point emergency action should be triggered.³ Somali children experience high levels of acute malnutrition and the prevalence of GAM is often above this critical level.

Trends in GAM reflect: the effects of droughts; underlying vulnerabilities caused by years of conflict; collapse of basic social services; and an erosion of coping mechanisms and resilience over time. Droughts explain the peaks in the chart: 2011 most severely in southern and central regions, and 2008 mainly in Puntland. Note that the level of GAM for southern and

Global acute malnutrition (GAM) - Weight for Height - trends in different regions of Somalia -

Global acute malnutrition (GAM) - Weight for Height - trends in different regions of Somalia -



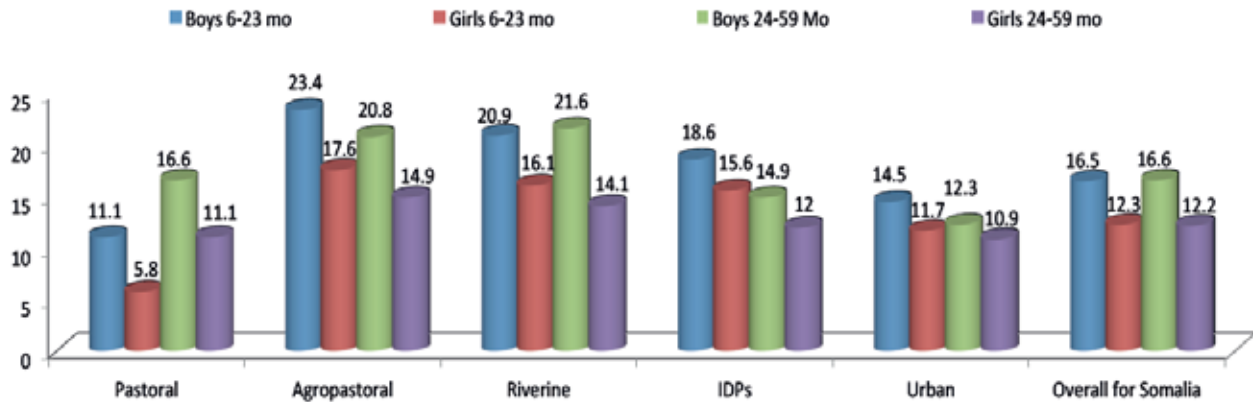
Source: FSNAU⁴ data except ... 1999MICS2 & 2006MICS3. Gu & Deyr are rainy seasons.

1 Lancet Maternal and Child Undernutrition Series, 2013. "Undernutrition (fetal growth restriction, suboptimum breastfeeding, stunting, wasting, and deficiencies of vitamin A and zinc) causes 45% of all deaths of children younger than 5 years".

2 Standard deviation (SD) is a statistical measure of the spread of a distribution around the mean.

3 www.who.int/en/

GAM – Deyr 2014 FSNAU, southern and central regions



central regions has been consistently above the 15 per cent critical level that signals a nutritional emergency. Analysis of the FSNAU survey data on which the graph draws shows that the epicentre of the nutritional crisis in southern and central Somalia lies with the rural populations of the regions of Bakool, Bay and North Gedo. While urban populations generally have better nutritional status than rural ones, internally displaced people (IDPs) in urban or peri-urban areas experience relatively high levels of GAM. Levels of GAM are consistently higher for boys than for girls, though the reasons for this are as yet unclear but could be linked to boys not being given certain foods due to traditional beliefs connected with them.

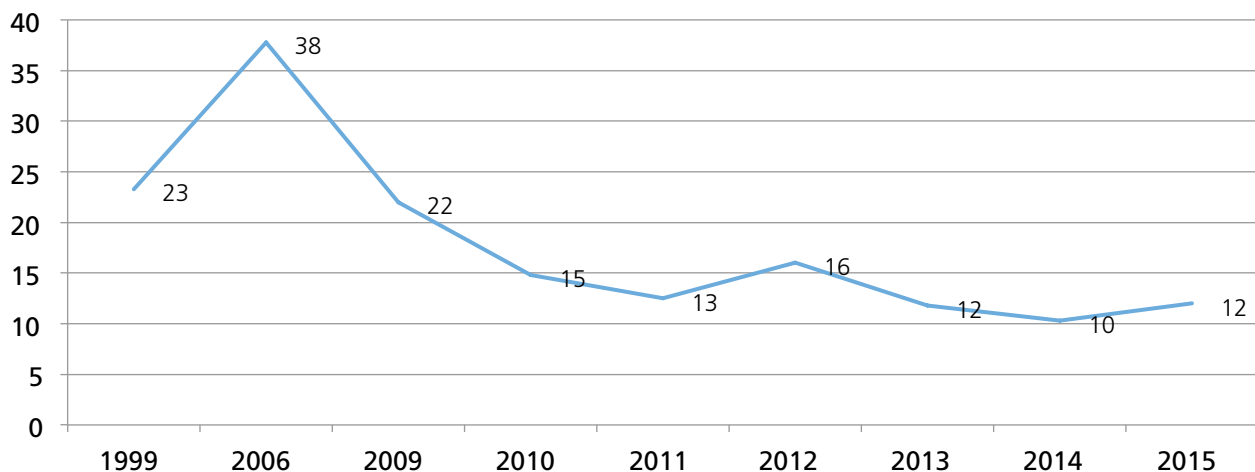
A child suffers from stunting if their 'height for age' is two standard deviations below the median height for age of the relevant population. Stunting generally occurs if a child suffers consistent malnutrition and/or suffers

many episodes of infection, maternal malnutrition, poor feeding practices, poor food quality, and not having access to safe water and sanitation. Because stunting is measured over the long term, it is often referred to as chronic malnutrition. Acute malnutrition often interacts with chronic malnutrition to exacerbate it, especially at an early age. Stunting in children results over the long term in diminished cognitive and physical development, reduced productive capacity and poor health.⁵

Stunting is more prevalent in southern and central Somalia and Puntland than in Somaliland, and more prevalent in populations of IDPs and those with rural livelihoods.⁶

Iron, iodine and Vitamin A are termed micronutrients because they are needed only in minuscule amounts to enable the body to produce enzymes, hormones and other substances essential for proper growth

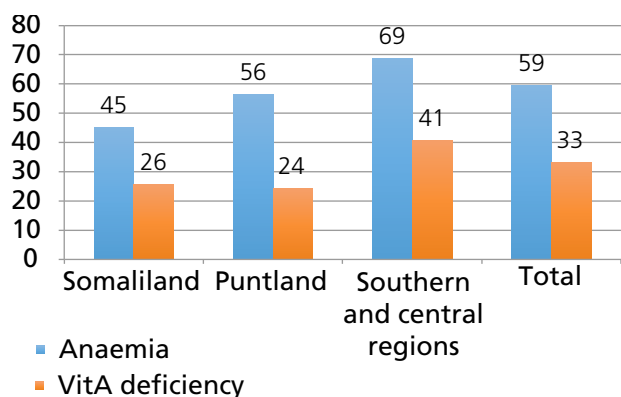
Height for age (stunting) – % of children under five in Somalia



Source: FSNAU⁴ data except 1999MICS2 & 2006MICS3.

4 Food Security Nutrition Analysis Unit that surveys and studies this subject on a regular basis in Somalia.
 5 World Health Assembly (WHA), Stunting Policy Brief, 2014.
 6 FSNAU, Food Security and Nutrition Survey, Deyr 2014.

% of children aged 6-59 months suffering from micronutrient deficiency



Source: National Micronutrient & Anthropometric Nutrition Survey, FSNAU, 2009

and development. Deficiency in these micronutrients, especially in children and pregnant women, has severe consequences. Iron deficiency causes anaemia, iodine deficiency causes goitre and cretinism, and Vitamin A deficiency causes blindness in children as well as increasing the risk of disease and death due to infections.⁷

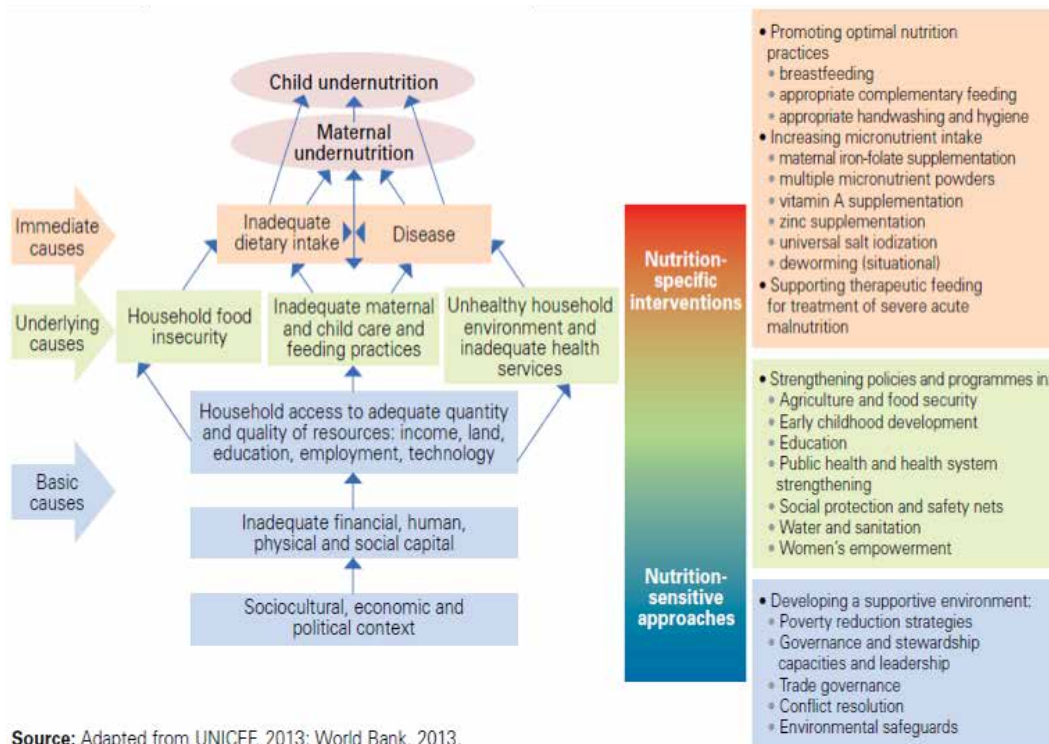
The prevalence of anaemia amongst children aged 6-59 months is high in Somalia, though it is higher in southern and central regions than in Puntland and Somaliland. Nearly two thirds of rural children have

anaemia, a significantly higher incidence than for urban children. Furthermore, nearly three quarters of children under the age of two have anaemia – a higher rate than for children over two.⁸ Rates of Vitamin A deficiency in all parts of Somalia are over the 20 per cent threshold that the WHO considers severe; there is no significant difference in prevalence between urban and rural areas.

The prevalence of goitre in Somalia is very low and there is generally excessive intake of iodine associated with the sources of household drinking water.⁹

Maternal nutritional status not only affects the healthy development of the foetus and the birth weight, but also impacts upon the mother's ability to sustain breastfeeding and to care for children as they develop.¹⁰ This means that all women of childbearing age (15-49 years) are the subject of concern in relation to undernutrition. Adolescent girls, and pregnant and lactating women are particularly vulnerable.¹¹ Given the prevalence of early marriage and high fertility rates, half of Somali women aged between 15 and 49 are either pregnant or lactating.

As measured by Body Mass Index (BMI),¹² about one in five women aged 15 to 49 are underweight (indicated by a BMI of under 18.5), and among rural women the rate rises to one in four. About half the women



Source: Adapted from UNICEF, 2013; World Bank, 2013.

7 WHO website.
 8 FSNAU, National Micronutrient & Anthropometric Nutrition Survey, 2009.
 9 Kassim et al, Journal of Nutrition, Iodine Intake in Somalia, 2014 – this study makes use of FSNAU, National Micronutrient & Anthropometric Nutrition Survey, 2009. See also the WASH Chapter of this report.

10 Black et al, Lancet Series on Nutrition, Maternal & Child Undernutrition, 2008.
 11 Kramer MS, Determinants of low birth weight: methodological assessments, Bull WHO, 1987; 65: 663-737.
 12 Body Mass Index (BMI) is the ratio kg weight to meters height squared
 13 FSNAU, National Micronutrient & Anthropometric Nutrition Survey, 2009

in Somalia are anaemic, whether they are pregnant or not.¹³

Causal analysis of maternal and child undernutrition

The two-way causal relationships between undernutrition and disease, and the influence of maternal undernutrition on child malnutrition, are explained in the Lancet 2008 Series on Nutrition. The immediate causes of maternal and child undernutrition are inadequate dietary intake and illness or disease. This could be the result of consuming few nutrients or of an infection. Infection can result in loss of appetite, can increase the amount of nutrients required and can prevent absorption of them from the foods consumed. In general, poor dietary intake can result in reduced immunity to infection. This can increase the likelihood of infection or increase its duration and/or severity. This triggers further weight loss and reduced resistance to further infection.^{14,15}

The major immediate and underlying causes that most particularly bear on child and maternal undernutrition are:

- Only about a quarter of women received professional antenatal care (ANC).
- Only six per cent of Somali women who receive ANC also received Intermittent Preventative Treatment (IPT) against malaria.
- Only a quarter of pregnant women have had immunization protecting them from tetanus.
- There is a high incidence of childhood illnesses and a lack of appropriate and timely treatment. This is due to relatively low immunization coverage, poor family knowledge about diseases and delay in seeking treatment.
- Poor health-seeking behaviours also apply to women of child-bearing age and this has consequences for undernutrition.
- There is a high incidence of diarrhoea and open defecation and hand washing is uncommon.
- There is limited understanding of the risks attached to contaminated water and poor sanitation and thus limited understanding of the reasons for improved practices.

- Women's household burdens include fetching water and firewood.

Care practices

Most Somali women do not effectively access appropriate nutritional knowledge. This is mainly due to their poor use of maternal and child health facilities and their lack of access to community health workers (CHW). Some populations have traditional prohibitions regarding food given to pregnant women, mainly with the goal of limiting the size of the baby at birth. Liver and kidney, for example, are only given to women as a curative measure.¹⁶

The traditional norm for most Somalis has been for the maternal grandmother of the newborn to care for her daughter for a period of up to 40 days following delivery (*Umo Bah*), to encourage the new mother to eat and nurse. This practice is in decline due to breakdowns in family norms and lack of resources.¹⁷ The high Somali fertility rate¹⁸ strains family resources in terms of time, attention and family economy. This makes it difficult for women to access nutritious foods or prioritize their food choices, and the additional burden of work falls largely on the mother. In general, women have a large burden of household and often economic work that is in addition to the drain on their health and nutritional status of carrying children through pregnancy and nursing them. This is further exacerbated in situations of family poverty and family breakdown that may lead to female-headed households and siblings caring for infants; in such circumstances some neglect of childcare may result.¹⁹

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process, with important implications for the health of mothers.²⁰ Inadequate breastfeeding practices contribute to child malnutrition either directly or via disease. WHO/UNICEF guidelines call for:

- i) initiation of breastfeeding within one hour of birth, providing the infant with the benefits of colostrum and ensuring there is no delay that may inhibit the reflex allowing milk to flow and lead to lactation failure;
- ii) exclusive breastfeeding, with no other fluids added except for medical purposes, from birth up to six months; and

14 Black R.E, L.H. Allen, Z.A. Bhutta et al, Maternal and Child Undernutrition: Global and regional exposures and health consequences, 2008.

15 Lancet Maternal and Child Undernutrition Series, 2013.

16 FNSAU, Somali KAP Study on offal consumption in certain towns, 2010.

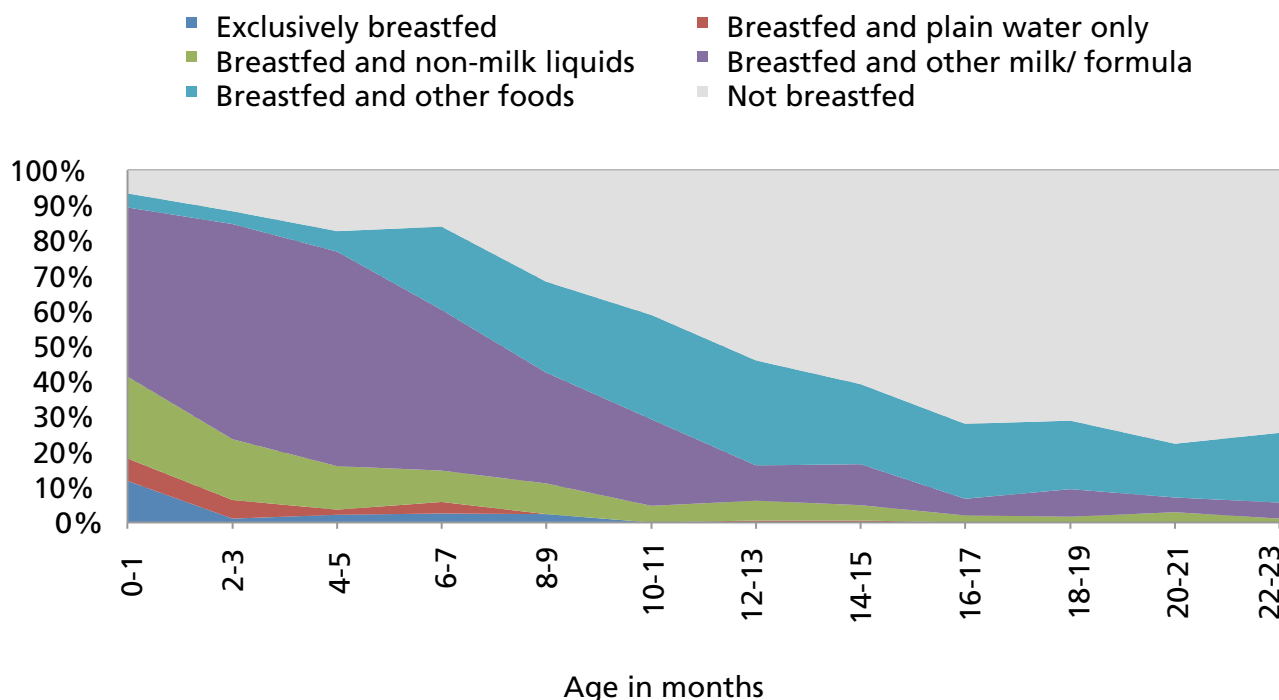
17 FNSAU, Somali Knowledge Attitudes and Practices Study Infant & Young Child Feeding and Health Seeking Behaviours, 2007.

18 UNICEF, MICS3, 2006.

19 FNSAU, National Micronutrient Anthropometric Nutrition Survey, 2009; FNSAU, Somali KAP IYCF Study, 2007; SAGE, North Gedu Nutritional Causality Analysis, 2014.

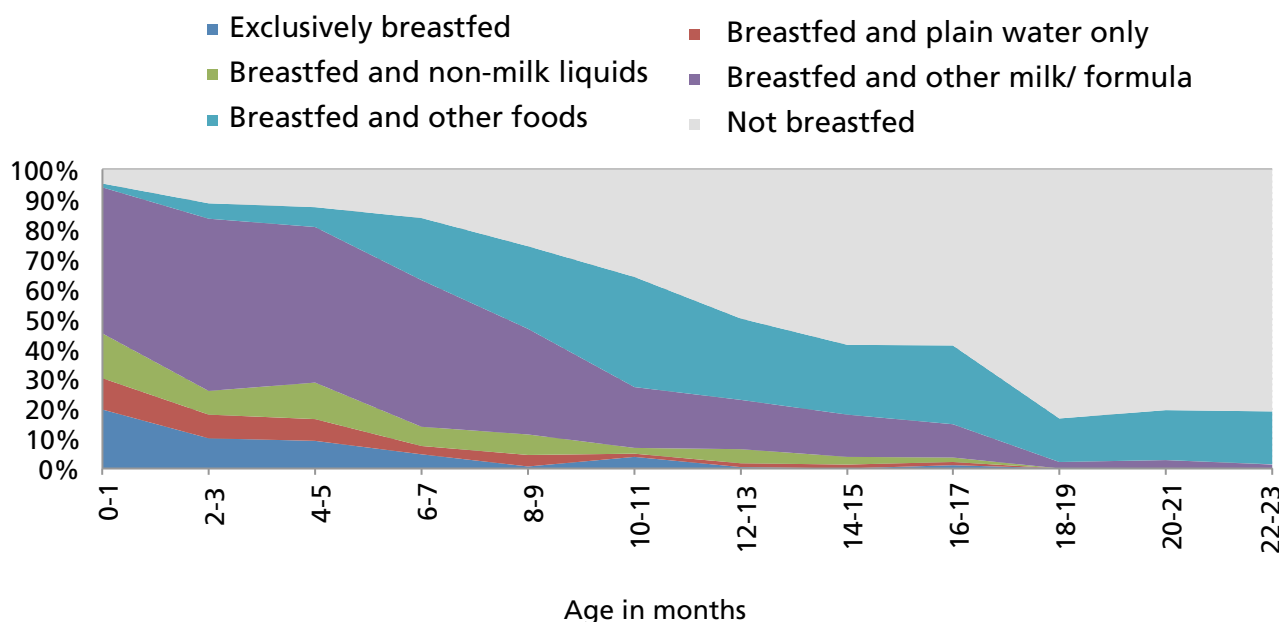
20 UNICEF & WHO, Global Strategy for Infant and Young Child Feeding, 2003. Black et al, Lancet Series on Nutrition, Maternal & Child Undernutrition, 2008.

Figure 1. Children under the age of two by feeding pattern and by age group, Puntland, Somalia 2011



Sources: MICS 2011 Puntland

Figure 2. Children under the age of two by feeding pattern and by age group, Somaliland, 2011



Source: MICS 2011 Somaliland

iii) continued breastfeeding together with appropriate complementary foods up to the age of two and beyond.

In Somalia, the majority of mothers breastfeed their children for at least some period of time.²¹ Only about

a quarter of mothers initiate breastfeeding within the first hour following birth but about two thirds do so by the end of the first day.²² The practice of feeding newborns with sugar and water before the initiation of lactation is common.²³ Fewer than 1 in 10 infants are exclusively breastfed up to the age of six months.²⁴

21 FSNAU, National Micronutrient and Anthropometric Nutrition Survey, 2009; MICS3 and MICS4.

22 Ibid.

23 FSNAU, Somali KAP Study on Infant & Young Child Feeding and Health Seeking Practices, 2007; UNICEF, MICS4, 2011

24 UNICEF, MICS3, 2006; FSNAU, National Micronutrient and Anthropometric Nutrition Survey, 2009.

Exclusive breastfeeding rates are significantly lower in southern and central regions than in the rest of the country and notably lower in wealthier households.

Children below six months of age are often given tea or sugar water in combination with breast milk, formula or non-human animal milks. The non-human animal milk, whether given full strength or diluted, cannot be readily digested by infants. When formula is used, as it is by both rich and poor, the quality of water used is often low, putting the child's health at risk from water-borne disease. According to 2006 MICS3, only about half of Somali infants are still being given breast milk at the age of one and about a third at the age of two – these proportions are significantly higher for rural children than for urban children, are lower in southern and central regions than in the rest of the country. Only 1 in 10 Somali children are appropriately fed with the WHO/UNICEF recommended combination of breast milk and complementary solid foods at the age of one.²⁵

Social norms, passed down by maternal grandmothers, do not match up well with the WHO/UNICEF guidelines, and there is a lack of knowledge on appropriate breastfeeding and weaning practices. Lack of space between births, typically less than two years, is also a major obstacle – if a mother has not recovered her nutritional and health status after the previous birth, it can contribute to preterm birth and low birth weight.²⁶

Generally, micronutrient deficiencies are caused by inadequate diet or, in the case of infants, by poor complementary feeding practices, which are not compensated by supplementation. Micronutrient deficiencies are also caused by infections and disease, as well as by poor water, sanitation and hygiene practices, with worm infestation a problem in some regions. These factors are explored further in the health and WASH chapters of this report.

The majority of pregnant and lactating women do not attend an antenatal care (ANC) facility where nutritional advice and maternal micronutrient supplementation are offered.

2006 MICS3 shows that, in the six months preceding the survey, only about a quarter of children aged between 6 and 59 months received high-dose Vitamin

A supplements. The same survey showed that fewer than 1 in 10 post-partum women received high-dose Vitamin A supplements within eight weeks of the birth of their babies. Iron-deficiency anaemia for women is primarily caused by poor birth spacing and diets that are low in essential micronutrients (not only iron but also other nutrients that support iron absorption). In addition, absorption of iron can be inhibited by tea drinking, and about three quarters of women drink more than one cup of tea a day.²⁷

Household food security

Somalia is chronically food insecure. Over half of Somali households rely on natural resource-dependent activities for their livelihood, making them highly vulnerable to environmental factors and shocks. Successive seasons of poor rains and seasonal floods affect crop and livestock production, which are the two main livelihood sources for the majority of the rural population. In the last five years, local cereal production has only catered for an average of about 30 per cent of food needs.²⁸ The reasons for low cereal production include: low agricultural productivity due to insufficient use of modern materials and methods; land degradation; and abandonment of agricultural land due to conflict and displacement.²⁹ Somalia therefore depends on imports of both commercial and food aid. With the demographic trend towards urbanization, Somalis are increasingly dependent on commercial imports and therefore on international markets. Food security varies widely according to area, season, livelihood, climate, and political and economic factors.³⁰ In recent years, about a quarter of the population has been moderately or borderline food insecure,³¹ and about 1 in 10 people have been in acute/emergency food insecurity.³² At the end of 2015, 71 per cent of those in acute/emergency food insecurity were IDPs, with the remainder divided between the urban poor (6 per cent) and pastoralists, agro-pastoralists and riverine agriculturalists (23 per cent) mainly in the centre and south of the country.³³

When communities are not food self-sufficient and depend on food deliveries, whether commercial or humanitarian, physical access can be impeded by conflict or the high cost of transportation.³⁴

At household level, food security, as measured by the number of meals eaten per day, is poorer in southern and central regions, where three quarters of households consume only two meals a day. This compares with Somaliland, where two thirds consume three meals a day, and with Puntland, where half have two meals a day and the other half have three.³⁵

25 UNICEF, MICS 2006.

26 Ibid.

27 FSNAU, National Micronutrient and Anthropometric Nutrition Survey, 2009.

28 WFP website

29 WFP, Trend analysis of food & nutrition insecurity in Somalia 2007-2012, 2012

30 wice yearly FSNAU surveys provide a rich analysis of both nutrition and food security.

31 WFP website and recent FSNAU surveys.

31 This according to the Integrated Food Security Phase Classification (IPC) – Phase 2 moderately/borderline, Phase 3 Critical and Phase 4 Emergency.

33 FNSAU, Somali Food Security & Nutrition Analysis post Deyr 2015/16.

34 WFP, Trend analysis of food & nutrition insecurity in Somalia 2007-2012, 2012

35 FSNAU, National Micronutrient and Anthropometric Nutrition Survey, 2009

Dietary diversity aims to increase the variety of foods across and within food groups to ensure adequate intake of essential nutrients and to promote good health. A minimum diet should contain at least four or more food groups from a total of seven food groups, including grains, roots and tubers, legumes and nuts, dairy products (milk, yogurt, cheese), flesh foods (meat, fish, poultry and liver/organ meats), eggs, Vitamin-A rich fruits and vegetables, and other fruits and vegetables.³⁶ Dietary diversity, which is linked to nutritional status, is generally poor in Somalia, reflecting the inadequacy of food access and availability.³⁷

Somali diets consist mainly of cereal (maize or rice), oil, and sugar, with seasonally variable access to milk and occasional access to meat; vegetables and fruit are rarely consumed. Cereals are preferred to locally available nutritious foods. About one in five households across all parts of Somalia reported consuming less than four food groups a day. This proportion was significantly higher for rural than for urban households, with the exception of IDPs.

Consumption of micronutrient rich foods – including fresh fruits, vegetables rich in Vitamin A, fish, eggs and meat products – is generally low across all parts of Somalia. This is partly due to lack of availability and to cultural preference but, in addition, micronutrient-rich diets are beyond the economic reach of poor households. When faced with economic or environmental shocks, these often resort to negative coping mechanisms, including reduction of food intake, taking children out of school, and sale of assets that reduce the household's capacity to recover.³⁸

Nutritional requirements during lactation and pregnancy are high and the consumption of nutritious foods is particularly important. Food distribution within households is often inequitable, with women – especially those who are pregnant or lactating – unable to access their fair share when food is prepared at home. This factor exacerbates the risks of maternal undernutrition as compared with the population at large.

Structural Factors and Enabling Environment

The conflict and continuing insecurity in parts of Somalia is a basic cause of poor governance, displacement and economic underdevelopment. It directly limits physical access to parts of the country and hinders both the inflow of food into the regions concerned and the outflows of agricultural and livestock produce to markets.

The semi-arid geography of Somalia has moulded traditional pastoral lifestyles and social norms. Recurrent droughts and floods directly affect agricultural and livestock production, and generally impact livelihoods. The trend towards urbanization increases the dependence on imported foodstuffs, but also increases the access to food of urban populations provided that markets and household income allow their purchase.

The displacement of certain populations due to conflict and drought has rendered most IDPs destitute, including inevitably poor nutritional outcomes. Most of the displaced from the 2011 drought, and from the 1991/92 famine, were drawn from the historically marginalized minority communities – Bantu and Reewin people.³⁹ Their plight needs further research and understanding.

Traditional social norms affect knowledge and care practices for infants as well as for pregnant and lactating women. The decades of conflict have led to an increase in family breakdown and poverty with consequences for the nutritional status of women and children; this is elaborated on in the chapters of this report on Country Context and child protection. The high Somali fertility rate puts strains on family, and especially on women, that has a deleterious effect on nutritional status. At community and family level, especially in rural areas, men and older family members primarily make the decisions regarding health and nutrition with the interests of women considered as secondary.⁴⁰ Only a quarter of Somali women aged 15-25 years have basic literacy; this is a serious barrier to their acquisition and understanding of new knowledge to improve care practices.⁴¹

There is a strong and effective humanitarian response to the food security and nutrition crises in Somalia, driven by international organizations, led by FAO, WFP and UNICEF. However, the longer-term developmental national programme on nutrition is very weak.

The Somali Nutrition Strategy 2011–2013 recognized the multisectoral nature of the nutrition problem and sought to focus interventions to achieve priority outcomes. These were:

- i. improved provision of quality services for the management of acute malnutrition;
- ii. sustained quality nutritional surveillance and analysis of nutrition information to inform appropriate and rapid responses;

36 WHO criteria for assessing infant and young child feeding

37 FSNAU, National Micronutrient and Anthropometric Nutrition Survey, 2009

38 WFP, Trend analysis Food & Nutrition Security Somalia 2007-2012, 2012; WFP, Household Food Security South Central Somalia, 2014.

39 Majid, Nisar, & Stephen McDowell, 'Hidden Dimensions of the Somali Famine', Global Food Security, , 2012, <http://nin.tl/HiddenDimensions>

40 UNDP, Human Development Report, 2012.

41 UNICEF, MICS3, 2006 - the respondents were judged literate if they could read all or part of a sentence in the Somali language.

- iii. improved knowledge, attitudes and practices regarding infant, young child and maternal nutrition;
- iv. improved availability, accessibility and coverage of micronutrients and de-worming;
- v. increased redress of underlying negative practices through awareness and commitment to effective action across other sectors; and
- vi. improved in-country capacity and means to make effective responses in the area of nutrition.

However, the intent expressed in the strategy document has not been well realized as a result of: the weak institutional framework for nutrition in the country; the lack of a clear joint framework of action; the famine response in 2011, which diverted attention and resources towards an emergency-oriented response; continued weak capacity; conflict-related access constraints; and other competing national agendas related to state building.

The nutrition-related capacity of the Ministries of Health (MoH) is weak in terms both of budget and of adequately trained personnel with the right mix of technical nutrition and managerial skills. MoH structures beyond the central level are either non-existent or very weak. However, the Joint Health and Nutrition Programme (JHNP), which brings together key actors and government partners, has provided leadership for planning and co-ordination of nutrition programme activities; it has also furnished enhanced support for MoH nutrition unit structures at central and regional levels.

Poor human resource capacity at all levels, including communities, civil society and at facilities, continues to restrict the scale, quality and impact of community-based programming, especially any that involve behavioural change. Capacity development has been limited to in-service training of health workers on nutrition, immunization and management of childhood illnesses. Systems strengthening has not received equal attention, largely because of the life-saving nature of humanitarian interventions and the need to show

Role and capacity analysis for duty bearers in nutrition

Level	MAIN ACTORS	ROLES	CAPACITY GAP
International Community	Donor community International NGOs/UN agencies International banks International government partners	Advocacy as part of global agendas. Fundraising. Technical assistance and capacity development. Service delivery.	Motivation is constrained by the general confusion in directives and policies, and the lack of effective systems. They have the authority to support nutrition but resources are limited and not sustainable.
State governments	The Somali Government Ministries of Health (MoH) Ministries of Agriculture (MoA)	Policy development, monitoring and evaluation, co-ordination, regulation, planning and strategic objectives, leadership, public campaigns, fund allocation and accountability, co-ordination and promoting collaboration, technical skills development, budget allocation.	They have limited motivation, as there is a high rate of staff rotation, poor enumeration and lack of effective systems. Federal ministers have limited legitimate authority over all state entities to develop and implement policies and strategies. Resources are limited and are not sustainable and there are capacity gaps in technical and human resources. At the level of state entities, they have full legitimate authority to develop and implement policies and strategies but resources are limited.
Local government	District and local health officers responsible for nutrition	Supervision, co-ordination, data collection, advocacy for recruitment, and implementation of government policies and protocols on the ground. Managing any other decentralized responsibilities.	The motivation is limited as there is widespread corruption, poor enumeration and lack of effective systems. The state entities have full legitimate authority to develop and implement policies and strategies but resources are limited.

Level	MAIN ACTORS	ROLES	CAPACITY GAP
Civil society	Diaspora Local NGOs Religious organizations	Fundraising, advocacy and championing for education rights, especially for marginalized groups, and mobilizing communities to enrol children in school. Also, service provision and capacity building of education-sector staff.	These groups' capacity gaps range from low resources, weak political connections, low data for advocacy and long distances to be covered in the region's vast geographic area. Civil-society organizations are also affected by weak co-ordination mechanisms with each other and with key government ministries.
Private sector	Private health providers – hospitals, clinics and pharmacies	Service delivery	
Communities	Community-based organizations, elders, gatekeepers, clan leaders, women's groups, religious leaders, self-help groups, youth groups, community health workers and committees	Creating awareness of the importance of good nutritional practices; knowledge transfers (especially those returning from the Diaspora); and holding service providers accountable, including for resources.	They have the motivation to improve nutrition, as generally they have effective systems and are open to accountability. They have the authority to support this process but their resources are limited and are not sustainable.
Parents	Father, mother, grandmother	Support and implement appropriate infant and young child feeding practices. Support appropriate maternal feeding and care within the family, including reducing work burdens.	Generally parents have limited motivation because they have low awareness of the dangers of undernutrition as well as limited participation in programme planning and implementation. They do have the authority to support the improvement of key household practices and have local resources and coping mechanisms that could make positive changes. Women do not have the authority or resources but could be motivated.

immediate results. A strategy to develop the capacity of national nutrition staff is needed to ensure an appropriate level of technical expertise at all levels.

The Health Sector Strategic Plan 2013-2016 provided for a 2014 nutrition-related budget that was 2 per cent of the total health budget for that year but only 0.6 per cent was actually utilized on nutrition-related services.⁴² Since there is such a meagre budget allocated for government nutrition-related activities, nutrition programmes are financed through humanitarian funding and other development-oriented donor funding such as the JHNP

Government policies that do exist to support and promote maternal and child nutrition are barely implemented and monitored. Generally there is low community involvement in planning, monitoring and implementing programmes throughout the country.⁴³

Weak capacities at the community level are a hindrance to the promotion and adoption of appropriate and positive nutritional behaviour. Similarly, inadequate and insufficiently diverse communication channels limit the coverage of messages targeted at promoting appropriate patterns of behaviour.

42 Federal Ministry of Health Somalia, Annual Report, 2014

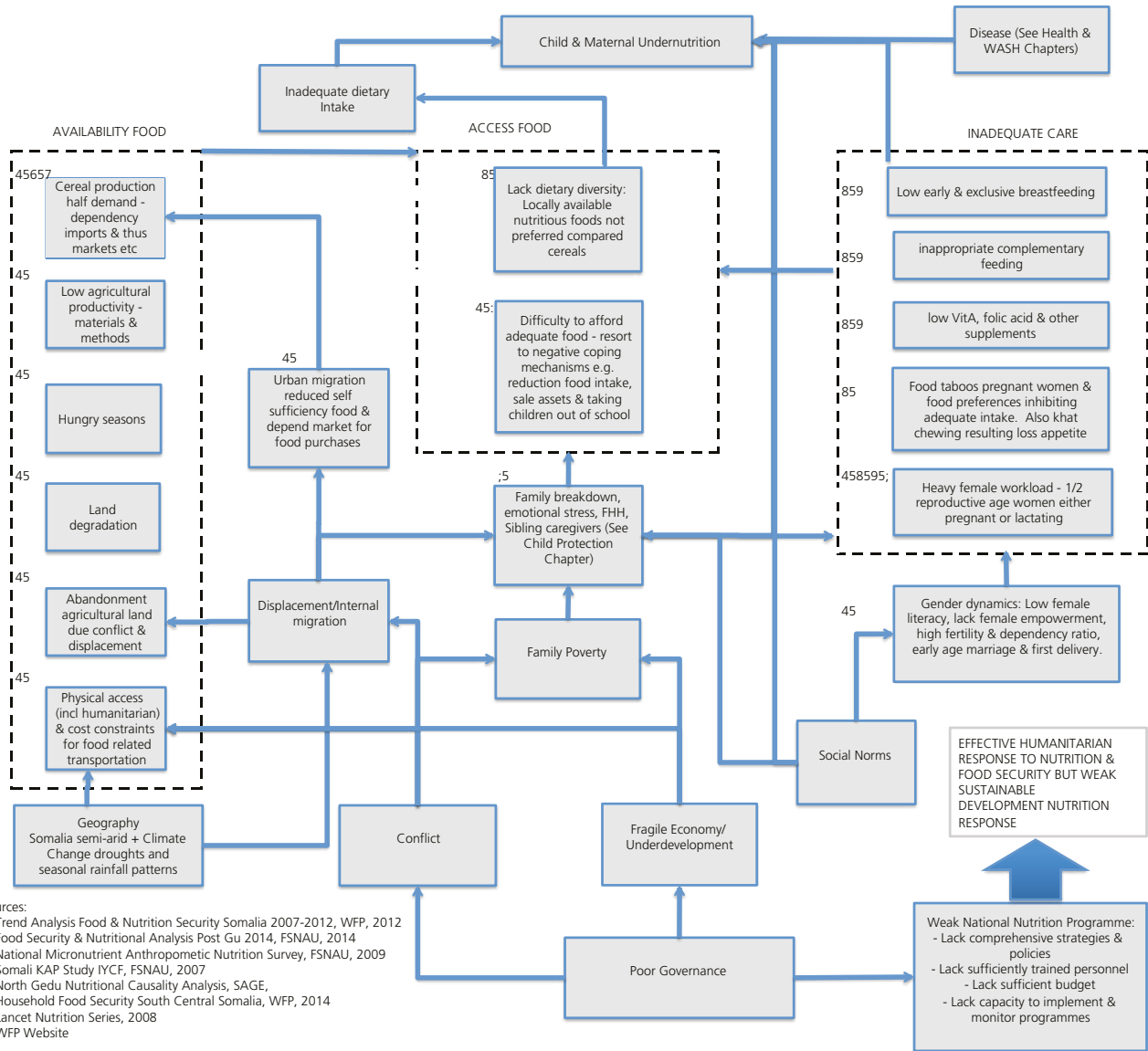
43 UNDP, Human Development Report, 2012

Overview of causal pathways

The situation of each household is different and the causes of their ability or inability to realize nutrition

rights will vary. However, the analysis reveals general causal pathways that are depicted in the figure below.

SOMALIA NUTRITION CAUSAL PATHWAYS



Somali children share their hopes and fears

- Food Security -

Children were asked how often they went to sleep at night hungry because there was not enough food. Among those children who reported that they had gone to sleep hungry, the majority said that it happened “sometimes” or “about once a week”.

Children gave several reasons why it was a struggle for families in their communities to have enough food every day, including:

- Lack of job opportunities
- Lack of money
- Lack of enough working personnel
- Inadequate livestock
- “Most of us are casual labourers, hence we have a low income”
- Lack of transportation
- Insufficient firewood to prepare food
- Inadequate water

Percentage of each group reporting going to sleep hungry in the last 4 weeks due to a lack of food



Strategic recommendations

Strengthen the national nutrition programme

- Review and update strategy and policies on nutrition
- Invest in human resources development for nutrition
- Strengthen and operationalize the multi-sector platform for nutrition co-ordination
- Support the government in establishing and strengthening an information management system for nutrition and in using data for research and decision making
- Explore sustainable long-term financial resources for nutrition
- Generate evidence by conducting more studies, surveys and research

Establish an effective communication programme for nutrition

- Develop a comprehensive social mobilization and advocacy strategy for addressing undernutrition in Somalia as part of the multi-sectoral approach through the Scaling Up Nutrition (SUN) movement

- Explain the importance of nutrition to children’s physical and mental development
- Inform parents and communities of appropriate feeding and care practices
- Develop tailored messages and information materials for behaviour change

Build resilience and promote social transfers

- The goal would be to ensure that families have sufficient resources to sustain household nutrition and food security

Conduct a detailed analysis of the long-term livelihood options of the IDP populations so that appropriately targeted programs can be developed

Strengthen integrated service delivery of nutrition interventions at facility and community level, focusing on disparities and hot spots

- Ensure community participation in the programme design

Public-private partnerships

- Involve private health providers in observance of the International Code of Marketing of Breast-Milk Substitutes so as to support the promotion and protection of breastfeeding
- Strengthen social marketing approaches.



Water, sanitation & hygiene (Wash)

Water, Sanitation & Hygiene (WASH)

The Situation

Use of contaminated drinking water and ineffective sanitation facilities, as well as lack of proper hygiene, are the major causes of diseases related to water and sanitation, especially diarrhoea. Diarrhoea is a major cause of child morbidity and mortality and is strongly correlated with child malnutrition, leading to both

wasting and stunting.¹ Since malnourished children are more susceptible to disease, there is a feedback causal loop from undernutrition to WASH-related diseases. The consequences of issues related to health and nutrition are covered in the respective chapters of this report.

% incidence of diarrhoea in children under five	1999	2006	2011	2015
Somaliland	17	13	13	10
Puntland	27	11	10	28
Southern and central regions	25	25		26
Total	23	21		24
Urban	25	17		
Rural	23	24		
Source	MICS2	MICS3	MICS4	WASH KAP

%	1993	1999	2006	2011	2015
Use of improved Water	21	23	29		55
Urban	24	31	58		77
Rural	20	19	11		18
Nomad		12			
Use of improved sanitation	21	49	37		
Urban	42	83	78		
Rural	12	26	13		
Use of both improved water & sanitation					
Somaliland			24	29	
Puntland			16	37	
Southern and central regions			20		
Total			20		
Urban			47		
Rural			4		
Data Source:	MDG db	MICS2	MICS3	MICS4	KAP

¹ FSNAU, Meta-analysis of WASH related data, 2009-2010.

The incidence of diarrhoea in children under five² has not changed much over the last decades in Somalia; it is similar for urban and rural children, and only somewhat lower for wealthier families and more educated mothers.³ It is, however, lower in Somaliland and Puntland than in the southern and central regions. The continuing high incidence of diarrhoea is despite the rise in use of improved water, at least in urban areas of Somalia. However, only about one in five Somalis use both improved water and improved sanitation, though almost half of urban dwellers do so compared with just four per cent of those in rural areas.

Availability of water

There is high variability in water resources in Somalia, ranging from the abundance in the regions between the Shabelle and Juba Rivers to the acutely arid regions elsewhere in the country. The availability of water in Somalia varies, but overall it is a very scarce resource. In the regions in the south of the country, between the Shabelle and Juba Rivers the rainfall can be as high as 600mm per annum. However, in the north of the country, where there are no perennial surface water sources, some areas receive less than 50mm of rain in a year. The average for the country is less than 250mm.

Coverage of water sources for the population is within an acceptable range in some regions.⁴ In rural areas this is a result of regular investment in new boreholes. However, water points are often unevenly distributed, leaving many households with a long distance to travel to permanent water supplies in the dry season, or needing to rely on water trucking. The extreme shortage of surface water in parts of the country, especially Puntland and central Somalia, means that groundwater is the only reliable water source and this is at depths of up to 400 metres in some areas. In drought-prone and conflict-affected regions in the South, such as Gedo and Hiran, the coverage is as low as 30-50 per cent.⁵ In urban areas, private water utilities often provide a reliable service, but at a high cost, especially to the poorest and most vulnerable.

Although the coverage is adequate in some areas, up to 40 per cent of the water supplies are non-functional at any one time.⁶ Due to the depth of groundwater, many rural water supplies rely on diesel-powered pumping systems, which require regular maintenance from skilled mechanics. Breakdowns are common, the spare-parts supply chain is weak or non-existent, and

skilled mechanics are only found in urban areas. Poor operation and maintenance is also common where local governance of the water supply is weak. Water infrastructure constructed by aid agencies is usually handed over to community committees, who lack the knowledge, skills and resources to maintain it.

Water is usually seen as an economic rather than a social good in Somalia. Businesspeople or clan elders mostly run water supplies. Profit or personal interests dominate the operation of these water supplies and there is little reinvestment in expanding the systems. Repairs are ad-hoc and dependent on available cash. Even where government has a presence, there is very little regulation of private water supply operators; as such, tariffs are not controlled and monopolies allow operators to charge extortionate prices in some areas. However, in communities where the local governance of water services is established and functioning effectively, and with the inclusion of clan elders for public oversight, the private water operators are extremely successful in maintaining services even where external actors have no access.⁷ Another challenge is the unreliability of the water sources, especially due to seasonality. Up to a quarter of the rural population, and 50 per cent of nomad pastoralists, rely on rainwater, usually from underground collection tanks or *berkhads*.⁸ This water is not permanent and users have to move to find alternative sources or revert to filling the *berkhads* from water tankers at high cost during the dry season.

Access to water

Family life in Somalia is mainly based upon the societal structure of patrilineal clan and sub-clan, which serves as a source of solidarity as well as conflict. Clans combine forces for protection, access to water and good land, and political power. Clan dynamics and scarcity of water result in water being a major source of power and hence conflict between different clans and sub-clans. Water supplies that are near and safe may be controlled by a rival clan, requiring households to fetch water from a further, less safe source.

Water supplies in Somalia have very high operation and maintenance costs due to a number of factors, including: poor design and construction; over-reliance on inappropriate technology (diesel-powered pumping systems); lack of routine maintenance and the poor technical skills of operators; and the high cost of fuel, spare parts and skilled labour.

2 Measured by asking whether the child had had diarrhoea in the past two weeks (p2w).

3 UNICEF, MICS3, 2006 and UNICEF, MICS4, 2011.

4 FAO/SWALIM, SWIMS Database, 2015. The standard acceptable range is 70-90%.

5 Ibid.

6 Ibid.

7 Case study on Johar and Merka water supplies during period of Al-Shabaab control.

8 UNICEF, WASH KAP, 2015.

In many parts of Somalia the Government has little or no involvement in the provision of water services. Private operators and small entrepreneurs can generally charge what they like for water,⁹ and people will pay because they have no option.¹⁰ This situation is particularly acute in rural areas during the dry season where many settlements rely on water trucked by tankers after their *berkhads* dry up. In some urban areas private utilities operate under a lease agreement but these are written for the benefit of the operator and there is no requirement for public oversight, for a pro-poor tariff, for ensuring water quality, or for reinvesting in capital expansion to unserved areas. In other urban areas, such as Galkayo, the cost of water production is so high that there is no available profit to invest in expansion or services. In areas with no piped water supply, including most of Mogadishu and Kismayo, many households rely on water vendors who collect water of unknown quality from private wells and sell it from donkey carts and kiosks.

As a result of the lack of any standard tariffs, there is high variability in the price of water throughout the country. A 20-litre jerry can of drinking water can cost up to \$0.50 and an average family requires at least two jerry cans to meet their bare minimal daily requirements for potable water.¹¹ Because of high prices, households may fetch water from unimproved sources rather than pay for safe drinking water.

The quality of water used for domestic purposes is also reduced by cultural preferences for surface water including ponds, rivers and surface run-offs (i.e. rainwater that is considered 'sweet'). This is primarily as a result of the salinity of the groundwater, as described below. There is limited understanding of the risks surrounding contaminated drinking water.

About a half of households require more than 30 minutes to make a round trip to collect water and the proportion rises to about two thirds for rural households,¹² with three to four such trips usually required daily, depending on the size of the water-collection container. Almost no rural households have water provided to their dwellings, and women usually have the burden of fetching water. A full 20-litre jerry can weighs 20 kg and this is frequently carried on the heads of women and girls. Carrying filled jerry cans of water significant distances represents a physical strain for women who are already overburdened with other domestic, and often economic, work.

Innovative designs for reducing the burden of carrying water, such as rolling jerry cans, have been introduced in other arid and semi-arid areas in the Horn of Africa but they are rare in Somalia. The logistical difficulty of transporting bulky jerry cans mean that the majority of humanitarian relief distributions provide collapsible jerry cans that cannot be rolled. Additionally, for women and girls¹³, fetching water in distant locations subjects them to the risk of sexual abuse. As a result of all the above factors, the quantity of water fetched by a household is usually well below the recommended volume per person. WHO recommends a minimum of 7.5 litres per capita per day to meet the requirements of most people under most conditions.¹⁴ This limits hygiene practices and results in further disease risk. In contexts where high levels of diarrhoea are closely related to hygiene and sanitation behaviour, there is evidence that an adequate quantity of water is even more important for disease prevention than water quality.¹⁵

The urban poor and internally displaced people (IDPs) have to rely on poor quality water from small-scale water providers. More than 60 per cent of IDPs in southern and central regions report that it takes more than 30 minutes to collect water, suggesting that they are having to queue or go some distance to find affordable supplies.¹⁶

Only a third of primary schools in Somaliland and Puntland have potable water for the students to drink.¹⁷

Water quality

Groundwater quality in Somalia is relatively poor, with much of the water considered 'brackish' due to high levels of salinity and minerals. There is growing evidence of high levels of iodine and fluoride, which are detrimental to child development. Levels of other harmful chemicals are unknown. In Somaliland and Puntland, few actors in the water sector make use of recent surveys on groundwater potential.¹⁸ Poor drilling techniques also result in boreholes that produce water from a number of different aquifers, not all of which have safe water. Saline intrusion in shallow wells in coastal areas is also a major problem and a growing concern in cities like Mogadishu and Kismayo, where mounting demand is leading to excessive extraction of groundwater.

9 Water prices are on average 5-10 times higher than in neighbouring Kenya.

10 Geopolicity, JPLG Water Sector Study, 2010.

11 The WHO minimum standard for an average family of six people is 40 litres per day.

12 UNICEF, MICS3, 2006; UNICEF, MICS4, 2011; and UNICEF, WASH KAP, 2015.

13 In about 1 in 10 rural households girls usually collect water – UNICEF, WASH KAP, 2015.

14 Howard, Guy, and Jamie Bartram, Domestic Water Quantity, Service Level and Health, WHO, 2003.

15 Cairncross, Sandy, and Richard Feachem, Environmental health engineering in the tropics, Wiley, 1993.

16 UNICEF, WASH KAP, 2015.

17 Somaliland & Puntland School Yearbooks 2013/2014. The figure for southern and central regions is likely to be much lower.

18 FAO/SWALIM, Hydrogeological Survey and Assessment of Selected Areas in Somaliland and Puntland, 2013.

Given the common practice of open defecation and the absence of a system for monitoring and controlling bacteriological water quality, the majority of open wells, *berkhads* and even some shallow boreholes in Somalia are likely to be contaminated. In many urban areas, including Mogadishu, water is frequently supplied from privately owned shallow wells. These are usually not protected and the shallow groundwater means the contamination from latrines and open defecation is very high.¹⁹ Some disinfection of water supplies is carried out in Mogadishu but this is not reliable enough to control contamination. More than half the water points in Mogadishu are considered to pose a high risk of disease transmission based on the sanitary conditions around the water point.²⁰

Diarrhoeal disease is highly seasonal, with peaks occurring during or immediately after the rainy seasons. Similarly, outbreaks of acute watery diarrhoea (AWD) are most common in the coastal towns during the rains that fall along the coastal strip during July and August. The high level of diarrhoeal disease at these times is related to the common practice of using surface water whenever it is available. There is a cultural preference as well as an economic incentive for women to use this water, but localized flooding, particularly in urban areas contaminated by faeces, makes this water highly unsafe.

There is no system for monitoring water quality in Somalia, despite multiple attempts to build capacity at national and sub-national level. Although borehole-drilling standards exist, there is no enforcement and very few contractors test the water quality before sealing and equipping boreholes for use. Regular monitoring and chlorination is only carried out in high-risk areas, such as Mogadishu. Furthermore, even where there is a public health department, they do not take responsibility for ensuring that water supplies are safe for consumption. The Somalia Water and Land

Information System (SWALIM) recent assessment of groundwater potential in Somaliland and Puntland did produce maps of groundwater quality but there has been limited dissemination of this information and there is no capacity within government to take action on water supplies that do not meet drinking-water standards.

Appropriate household water treatment

Contamination of water during collection and storage is a common problem, indicated by low levels of hygiene at the water points and in the home.

Four out of five households do not treat water appropriately to make it safe to drink.²¹ Eighty per cent of drinking water consumed by rural households is not from an improved source and not treated.²² There is a high level of awareness of the need to treat water for drinking but few do so.²³ In areas where free distribution of chlorine tablets is widespread under humanitarian programmes, more households practise water treatment. There is, however, a strong dislike of the taste of chlorine.

Only about half of households have an appropriate means of storing and handling drinking water in the home to ensure it is not contaminated; this figure differs little between urban and rural homes.²⁴

Use of improved sanitation facilities and disposal of excreta

Extremely poor sanitation and hygiene practices and cultural preferences for open defecation in Somalia result in many children – and adults – ingesting faeces from both humans and animals on a regular basis.

Besides the implications for household hygiene, the high incidence of open defecation also carries with it a risk that women and girls will suffer sexual abuse

% practising open defecation	1999	2006	2011	2015
Somaliland	49	44	35	20
Puntland	57	49	17	7
Southern and central regions	52	58		39
Total	52	54		29
Urban	17	8		11
Rural	73	82		44
Nomads	95			59
Source	MICS2	MICS3	MICS4	KAP

19 IOM, IDP KAP Survey, 2012; and UNICEF/SOPPHA, Shallow well survey, 2012.

20 UNICEF, Mogadishu sanitary survey, 2013.

21 UNICEF, MICS3, 2006; and UNICEF, WASH KAP, 2015. Appropriate treatment includes: boiling; adding bleach/chlorine; using a water filter; or solar disinfection.

22 UNICEF, MICS3, 2006.

23 UNICEF, WASH KAP, 2015.

24 UNICEF, MICS, 2006 and UNICEF, WASH KAP, 2015.

% of households with a facility for hand washing	Somaliland	Puntland	Southern and central regions	Total
Near food preparation	18	12	18	17
... with water & soap	2	1	10	7
Near toilet	19	6	11	12
... with water & soap	3	0	5	3

when out of the house at night for the purpose of defecation. The need for privacy and requirements for cleansing often force people to defecate in places that are particularly risky in terms of contaminating water supplies.

The poor design of latrines in urban areas, particularly in IDP camps, has resulted both in high rates of collapse during the rains and in latrines that fill up rapidly, forcing users to empty them manually to be able to continue using them. Lack of systems for cleaning, maintaining and emptying public latrines has resulted in low levels of usage and widespread reversion to open defecation. The 2015 WASH KAP found that 39 per cent of respondents said they would empty their latrines if full, but only 11 per cent of the respondents said they had ever done so. Only a third of households safely dispose of child faeces, though there is a wide disparity in this respect between urban households (three in four) and rural households (only one in eight).²⁵ In rural areas the main barrier to latrine construction is the lack of technical skills to construct a durable and affordable latrine in soils that are either collapsing due to the high water table or too rocky to dig through.

Household sanitation in Somalia has been a subsidized intervention for many decades. Aid agencies have relied on the dual premise that hygiene promotion and communication encouraging behavioural change would lead to a higher demand for latrine use, and that an injection of a targeted subsidy would result in the construction and use of sanitation facilities. This has proven not to be the case, however – as in most other developing countries.

There is no data on school sanitation facilities. Surveys indicate in passing that lack of sanitation facilities in schools inhibits school attendance, at least for girls. This is particularly because of the lack of WASH facilities in schools that would allow the proper management of menstrual hygiene.

Hand washing

Surveys on appropriate hand washing ask different questions. Households usually report frequent hand washing but evidence suggests that this does not take

place at critical times. The 2011 MICS4 for Somaliland and Puntland observed a place for hand washing in 22 per cent and 33 per cent of households respectively. The 2015 WASH KAP asked the questions shown in the table above, with results that are not encouraging. Although most respondents claimed to wash their hands, the lack of availability of facilities that include soap indicates that, while there is knowledge and awareness, proper hygiene behaviour is in fact not possible.

The 2015 WASH KAP study found that knowledge of good hygiene practice is high and many households receive education on hygiene from radio, TV and community health workers.

There appears to be relatively little behaviour change being initiated by children in the household,²⁶ which suggests that WASH programmes in school are not prevalent or effective. This may also be due to the very low school enrolment rates in many areas, so children do not have exposure to hygiene and sanitation education.

Structural factors and enabling environment

The climate of Somalia is mainly arid or semi-arid, with a few pockets of semi-humid areas.²⁷ Somalia also has a high rate of evapotranspiration.²⁸ Local water shortages are common as climate change makes rainfall less predictable and there have been three serious droughts in the last 15 years. Many of the drier areas of Puntland and Galmadug rely on ground water that is between 100 to 300 metres deep and therefore difficult to extract, and there are signs of unsustainable exploitation of some aquifers. Water is therefore a scarce and prized commodity throughout the country.

There are considerable gaps in the information about existing water resources, particularly in the south of Somalia. While SWALIM has tried to fill some of these gaps with monitoring of climate, groundwater and river flow and hydrogeological assessments in Somaliland

²⁶ In the UNICEF, WASH KAP survey, 2015 only 9 per cent of respondents said they got hygiene information from relatives compared to 57 per cent from the radio.

²⁷ SWALIM, Atlas of Somali Water and Land Resources, 2009.

²⁸ SWAMIL/FAO, Technical Report No. W-01, Somalia Water and Land Information Management, October 2007. Evapotranspiration is the sum of evaporation and plant transpiration into the atmosphere.

²⁵ UNICEF, MICS3, 2006.

and Puntland, the network is limited and the capacity to interpret and use the data is minimal.

Drought, floods and over two decades of conflict in Somalia, resulting in disease outbreaks and displacement, have led to a WASH sector dominated by interventions of a short duration intended to save lives and relieve the suffering of the people affected. WASH services remain extremely poor across the country with a consequent devastating effect on the health of Somali people, especially children.

While communities frequently state water as the highest priority need,²⁹ WASH development has fallen between the pillars of the New Deal and there has been very little allocation to the sector under the Multi-Donor Trust Fund (MDTF) and other funding mechanisms. Yet water is a high priority for the majority of Somalis and particularly for the clans whose livelihood base is pastoralism. Considerable peace dividends could be gained from strategically planned water development.

Budget allocations for sanitation and hygiene are very limited and are considered a low priority by the health professionals responsible for drawing up budgets – for example under the Joint Health and Nutrition Programme (JHNP). Issues such as antenatal care, immunization and nutrition are prioritized and WASH is not considered to be a health issue by decision makers. In order to have a sustainable impact on WASH-related diseases, actions to improve hygiene and sanitation need to be integrated with actions to improve sustained access to safe water. This requires close co-ordination and collaboration between various ministries and departments in government. The Inter-Ministerial WASH Steering Committee (IWSC), established in Mogadishu in 2013, is a good starting point for this, but co-ordination between non-government stakeholders is also required.

After 2004, international support was given to both Somaliland and Puntland to draft Water Acts and to enter them into force. These drew on established/traditional law and custom and have reinstated at least some vital government oversight over a scarce resource.³⁰

Even where government has been relatively stable, the technical ministry has had limited engagement in the provision of water and has not been able to effectively co-ordinate water infrastructure development by multiple actors. The Somaliland and Puntland water policies have not been widely disseminated and there is

little capacity to enforce them. Investment by external actors has therefore been allowed to go ahead without adherence to technical standards or following any defined priorities or plan. Without clear policy guidance, many water actors continue to provide unsustainable, diesel pumping systems rather than investing in renewable-energy technology, although there have been positive results from solar pumping systems in the last eight years. In the conflict-affected south there has been limited investment in water infrastructure and support to operation and maintenance has mostly focused on short-term rehabilitation and repair. As a result, private owners and operators have been left to provide water services with minimal guidance, regulation or capacity building. Efforts are now under way to develop a new WASH Policy under the FGS but enforcement will be difficult in a sector that has had no regulation or control for over 20 years.

Difficulties in co-ordinating and regulating water services are mostly due to the low capacity of authorities at the national and sub-national levels. Human resource capacity in government has been boosted in the last five years by the return of skilled engineers and managers from the Diaspora but there is rapid turnover and consequently little consistency in strategy or planning. Vocational training to create skilled workers for the water sector (plumbers, electricians and mechanics) does not exist inside Somalia and the engineering schools at the universities do not have the resources to teach students effectively. Both the public and the private sector suffer from a lack of skilled workers with the result that water supplies are badly constructed and maintained.

Local governance of water supplies is generally weak. Tools for effective regulation and oversight of private water services are under development in Somaliland³¹ but there is limited understanding or political will at local level to enforce them. Users are not empowered to demand better services from providers and there is a lack of collective responsibility for providing affordable water supplies to the population. Where private water operators are providing water, roles and responsibilities are not clearly defined so public-private partnerships are effectively only private businesses with no public oversight.

The delivery of aid has been heavily dominated by humanitarian approaches aimed at delivering quick, life-saving relief. This is compounded by the difficulties in accessing some of the most vulnerable communities due to insecurity and the banning of some organizations by non-state entities. In some areas, however, local NGOs have been operating in the

29 Centre for Humanitarian Change, Scoping Study for Improvement of Water and Sanitation in Somalia, October 2014.

30 Although no official WASH policies are available for southern and central Somalia, UNICEF and Panafcom Ltd supported the drafting of a Water Policy Framework in 2009.

31 As part of the EU-funded urban water infrastructure and governance project.

same communities for many years, if without adopting approaches that allow for more community, and specifically youth, participation. Indeed there has been limited engagement of communities in the planning, implementation and monitoring of projects as well as limited incentive for community committees to operate and maintain water supplies effectively. Inputs are not seen to be demand driven and frequently do not meet the needs of the beneficiaries. Many water projects result in water supplies that break down soon after completion and these are not repaired by the community due to the lack of a sense of ownership.³² As a consequence, WASH interventions in Somalia have so far not translated into sustainable behaviour change.³³ There is growing recognition that aid programmes in Somalia need to be based on an approach that builds resilience at a community and household level.

UNICEF introduced the Open Defecation Free (ODF) concept using the Community Led Total Sanitation (CLTS) approach into Somalia in 2011, but it has not progressed well so far due to access constraints and continued emergency conditions. The CLTS is a more demand-driven approach and should result in more sustained behaviour change. Central to the CLTS approach is the requirement that there are zero household subsidies for latrine construction and in the Somali aid-dependent environment this concept contradicts all approaches of the past 30 years. So far Somalia remains the only country that has not managed to create an ODF community more than three years after the introduction of CLTS. The health authorities in Somaliland, Puntland and the FGS in Mogadishu have all issued circulars insisting that the CLTS zero subsidy approach be used for promoting household sanitation. It remains the challenge of the implementing agencies to create and sustain ODF communities.

Poverty is a major factor limiting access to expensive, privatized drinking water and forces poor families to use unsafe water, who also can not afford treatment to render the water safe. Water's lack of affordability also limits the quantity of water that households can use for hygienic purposes. Diarrhoeal disease requiring medical treatment further strains the family economy.

Social norms and cultural practices support the expectation that women and girls engage in the time-consuming and onerous task of fetching water, presumably because their time is considered less valuable than that of men. That women and girls are at risk of sexual abuse when away from the home fetching water or defecating is a fact that requires communities to question underlying social norms.

Cultural beliefs, negative social norms and common practice are all considerable barriers to changing behaviour, especially where the key agents of change are women with very low education levels. Changing sanitation behaviour is difficult in Somalia because of the cultural practice of open defecation. Hand-washing behaviour is focused on religious rituals rather than on effective hygiene to reduce disease transmission. Evidence from neighbouring countries suggests that the involvement and leadership of religious leaders and clan elders can be highly effective in changing social norms. Conflict and clan dynamics often create barriers to the access of safe water.

³² UNICEF, Informal study of completed water supply projects in Somaliland, 2012.

³³ UNICEF, WASH KAP Study, 2015.

Role and capacity analysis for duty bearers and rights holders in WASH

Level	MAIN ACTORS	ROLES	CAPACITY GAP
International Community	Donor community International NGOs/UN agencies International banks International government partners	Advocacy; global agenda i.e. MDG/SDG; service delivery (International government – Organization of Islamic Co-operation (OIC), Turkey); disaster preparedness and response; technical assistance; fundraising, research.	The international NGOs, UN and donor community have the motivation, authority and resources to carry out their role but fatigue and global de-prioritization of Somalia is reducing capacity to advocate for and support the WASH sector. In UNICEF's case this capacity is further reduced by limited human resource capacity for advocacy at national and global levels. International partners such as the Turkish Government and the OIC appear to have the motivation and resources but need to act in a more co-ordinated manner with a water development forum.
National Government	Ministry of Health; Ministry of Energy and Water Resources; Ministry of Education; Ministry of Planning; Disaster management agencies; Ministry of Interior; Inter-ministerial WASH Steering Committee (IMWSC); WASH Cluster.	Policy development; monitoring and evaluation; co-ordination; regulation; planning and strategic objectives; leadership; public campaigns; fund allocation and accountability; co-ordination and promoting collaboration; technical skills development; budget allocation.	Ministries of Health have some motivation and authority to guide and co-ordinate public health-related activities but their capacity is undermined by prioritization and resource allocation to curative health services over preventative actions such as sanitation and hygiene. The leadership of the FGS MoH in WASH has been weakened by frequent changes of staff but it has taken positive action to support the eradication of open defecation. Ministry of Energy and Water Resources has the authority and some human and financial resources but its motivation to take on the full range of roles required to expand WASH services is weak. Attention is frequently focused on more beneficial activities such as drilling new water supplies. The capacity to act of the FGS MoE and WR is limited to Benadir (Mogadishu) Region. The WASH Cluster has the full capacity to co-ordinate humanitarian action and some ability to develop capacities within the local WASH NGOs. IMWSC (Inter-ministerial WASH steering committee), led by the Ministry of Planning and International Co-operation has demonstrated strong commitment to its role in co-ordinating WASH activities across the different parts of government. Despite strong human resources, its capacity is weakened by lack of authority and limited finances. Other ministries and departments have some involvement in WASH (e.g. through IMWSC) but their motivation is weak.

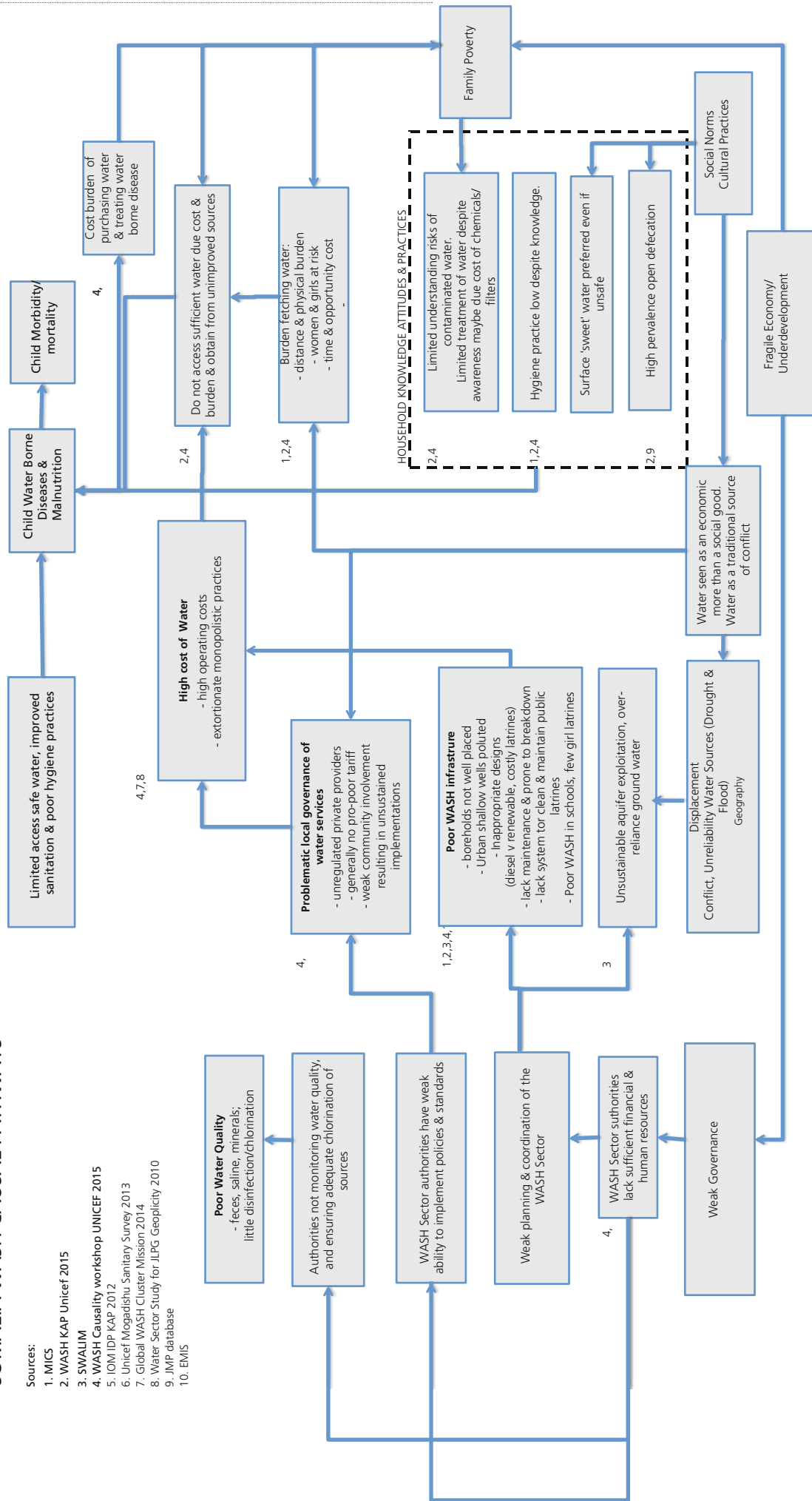
Level	MAIN ACTORS	ROLES	CAPACITY GAP
Regional Governments/ States	PSAWEN, State Ministry of Health, State Ministry of Water, State Ministry of Education, State Ministry of Interior	Co-ordination; service delivery; quality control; monitoring & evaluation; oversight of technical standards; protocols and enforcement of policies; advocacy and public information on WASH issues.	PSAWEN (Puntland State Agency for Water, Energy & Natural Resources) is the strongest state body and takes full responsibility for water service delivery. Its capacity is weakened by limited human and financial resources but its motivation is strong. The Ministry of Health in Puntland is keen to be active on the ground to implement CLTS programmes, but has yet to grasp the need to be in a more leading role to ensure successful scale-up of WASH interventions in Puntland. The Ministry of Water in Somaliland has a reasonably effective management structure, which has been one reason why Somaliland has the largest increase in access to improved water sources over the past five years. Its primary challenge is understanding that WASH is not only water and that co-ordination with other line ministries is essential. Other Federal State Ministries are either yet to be established or are still trying to understand their responsibilities. In future they are expected to have motivation and authority and possibly resources.
Local Government	Water agencies, local authority (Mayor's office, regional governors, municipalities), non-state agencies	Service delivery; prioritization; tariff setting and collection; inspecting and enforcing a healthy environment.	Local authorities (and state water agencies in Somaliland) have considerable authority and some financial resources. Their interest in taking responsibility for water service delivery tends to be based on potential revenue rather than equitable services for the population. There is therefore a conflict of interest in their role of tariff setting and enforcing regulation. It is difficult to get local authorities to take responsibility for ensuring/enforcing a health environment and this is a serious capacity gap in urban areas. Non-state entities (NSEs) have shown some responsibility for water service delivery in the areas they control (usually to gain popular support) and have been less obstructive in this sector than in some others. However, there are examples of NSEs blocking deliveries of hygiene items, water spare parts and even deliberately destroying water infrastructure, so their overall motivation is questionable. Their authority comes from the population in the areas they control rather than from the state and they have considerable resources if/when they choose to apply them to the WASH sector.

Level	MAIN ACTORS	ROLES	CAPACITY GAP
Civil Society	Diaspora, local NGOs, religious organizations	Fund raising; awareness and hygiene sanitation promotion; assessment and surveys; advocacy and championing rights; community capacity building and empowerment.	Local NGOs (LNGOs) have strong motivation for WASH and in Somaliland and Puntland they also have authority and some resources. Experience has shown that the human resources within WASH LNGOS may not be adequate for effective Community Led Total Sanitation (CLTS) triggering and follow up. LNGOs in South and Central Somalia have high motivation driven by a business incentive but also, in some cases, by a genuine desire to serve their community. However LNGOs who implement health and nutrition programmes may be better positioned to implement WASH behaviour-change programmes. The LNGOs based in the south have little authority under the FGS and there is suspicion between the two. Resources have reduced in recent years due to funding cuts and perceived lack of accountability. Diaspora and religious organizations have the motivation and resources to contribute to and advocate for WASH services
Private Sector	Utility companies, water bottling companies, private telecom companies, remittance companies, hygiene items distribution companies, transport companies, construction companies, private businesses (water service providers, waste collection disposal)	Service delivery; investment; tariff setting; cash flow; sector support as part of CSR.	In most cases the private sector is highly motivated to engage in water systems and WASH facility construction. This is partly due to the profit motive but also due to potential gains from being perceived to support the community (especially their clan). The financial incentive from selling products and services at high prices means there is no motivation to adopt pro-poor tariffs. All private businesses have <i>de facto</i> authority in the absence of public WASH services. The capacity of private businesses in the water sector is constrained by: the lack of access to skilled workers; the lack of a supply chain for spare parts; the lack of experienced managers; and the lack of broader exposure to the benefits of business planning and efficient service delivery. The motivation of traders to engage in supply of sanitation and hygiene items is constrained by poor market demand.
Communities	Community-based organizations, elders, community health workers, gate keepers, clan leaders, women's groups, religious leaders, self-help groups, youth groups.	Hygiene promotion participation; articulating the needs; holding service providers accountable.	The motivation of local leaders and community groups to engage in WASH service delivery is limited in the absence of clear incentives. Some leaders have shown commitment to taking up the Open Defecation Free campaign and there are examples of clan elders playing a leading role in enforcing local rules around water supply and water collection. However, the absence of clearly defined roles and responsibilities and the frequent lack of involvement of communities in water-supply projects tends to leave actors at this level with limited authority, resources or motivation.
Family - Household (duty bearers & rights holders)		Family hygiene; water provision; reducing the water-collection burden on women and children	Parents have increasing motivation to provide sanitation and hygiene services for their households under CLTS. This is, however, still being undermined by subsidized latrine programmes. As rights holders, parents should hold water and sanitation service providers accountable for delivering affordable and reliable services but in many cases users are not empowered and do not have the tools to do this.

SOMALIA WASH CAUSAL PATHWAYS

Sources:

1. MICS
2. WASH KAP Unicef 2015
3. SWALIM
4. WASH Causality workshop UNICEF 2015
5. IOM IDP KAP 2012
6. Unicef Mogadishu Sanitary Survey 2013
7. Global WASH Cluster Mission 2014
8. Water Sector Study for JLPG Geoplicity 2010
9. JMP database
10. EMIS



Strategic recommendations

Strengthen WASH institutional co-ordination, planning and implementation of policies and standards – at federal, regional and district levels:

UNICEF should continue its support role in the WASH Humanitarian Cluster and Inter-Ministerial WASH Steering Committee (IMWSC)

Establish water quality surveillance and response system

Collaboration with SWALIM, Ministry of Health and local authorities is needed to establish more effective surveillance and response to frequent disease outbreak and identify other, longer-term health risks related to poor-quality ground water.

Strengthen local water supply governance

UNICEF should work especially in collaboration with UNDP (through JPLG) and HABITAT (for urban water supply). The potential for water-resource development to be a catalyst for peace building has been examined through a number of case studies in Somalia and should be pursued through this activity. This will *inter alia* require research into the economics of water in Somalia and exploration of options for public-private partnerships.

Strengthening local sanitation and hygiene governance

Specifically this means reinforcing the inter-ministerial co-ordination mechanism for CLTS led by the Ministry of Health.

Technical capacity building at all levels

Limited human and financial resources are a considerable constraint for WASH sector development and are responsible for the poor sustainability of WASH initiatives. UNICEF has the potential to support capacity building more systematically than it has in the past but the task is huge and UNICEF should collaborate with other actors to develop a comprehensive capacity-development action plan.³⁴

Stopping open defecation

UNICEF can lead the advocacy on eliminating open defecation and facilitate government and other actors to work towards targets using CLTS approaches. Using this objective as an entry point, UNICEF can also play a role in empowering schoolchildren, youth, teachers, religious leaders and clan elders to change hygiene and sanitation behaviour within their communities.

Reducing the number of non-functional water supply systems

Given the relatively high rate of failure of rural and urban water supplies, the investment in improving existing water-supply functionality will have a higher impact on safe water access for women and children than investment in the construction of new water supplies. UNICEF has the experience and credibility to support the considerable advocacy and technical support required to address the multiple institutional, technical, social and financial issues associated with this.

Improving WASH in schools, maternal and child health centres and outpatient therapeutic centres (WASH in institutions)

When the school toilet situation is identified as a major culprit in low attendance and high dropouts among girls, the community, government as well as UNICEF and partners have to join forces to build facilities and a support system that reverse the trend. Safe drinking water and a safe place to use the bathroom are as important as teachers, classrooms and books. With WASH facilities, girls will learn to observe, communicate, co-operate, listen and carry out decisions about hygienic conditions and practices for themselves. Their friends and younger siblings, whose hygiene they may care for, become beneficiaries from the empowerment of these girls. They will also learn about menstrual hygiene and physical and emotional changes during puberty.

New water-supply construction in rural areas

UNICEF is the largest supporter of new and rehabilitated rural water supplies in Somalia and there is a need to continue to focus on underserved areas to reduce the inequities demonstrated by the recent KAP survey. This will particularly involve reducing the distance to water for nomadic pastoralists and reducing the reliance on surface water of many communities in southern Somalia. Continued development of the water supply in Somalia is vital given the ageing and destroyed infrastructure.

Support for development and enforcement of drilling standards

Concern over poorly developed boreholes and the risk of over-exploitation of ground water have led UNICEF to engage in a debate over drilling standards. UNICEF could play a role in advocating and providing technical support to ensure that drilling standards are enforced and the risks of proving poor-quality or even hazardous water are reduced. Unless other actors take on this role it will continue to be vital. It is very likely that the issues of chemical contamination would be solved by proper drilling practices.

³⁴ The capacity gap assessment and subsequent development of training tools for WASH NGOs, which was commissioned by the WASH Cluster, is a good starting point.



Education

Education

The situation

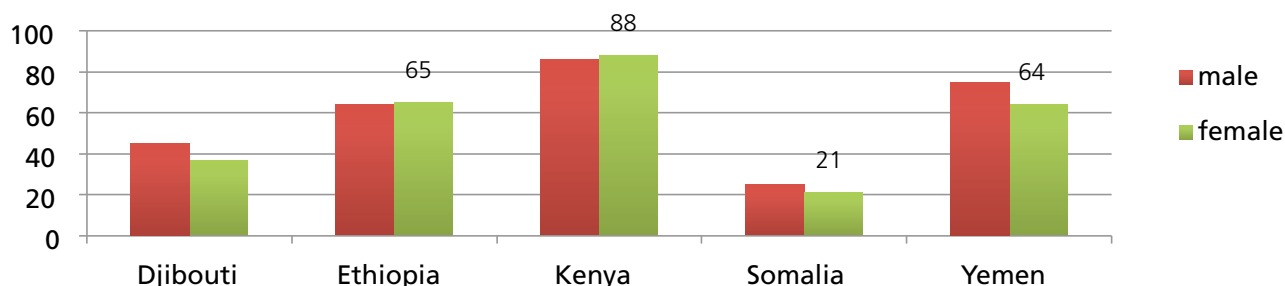
Enrolment and attendance rates

The State of the World's Children 2015 (SOWC) shows Somalia to have the world's lowest proportion of primary-age children attending school. With a primary net attendance ratio of just 25 per cent for boys and 21 per cent for girls, Somalia stands not only well below its near neighbours (as shown in the chart below) but

also at only a third the average level in sub-Saharan Africa (71 per cent and 68 per cent) and in the Least Developed Countries (74 per cent and 72 per cent).¹

There has been no reliable assessment of school enrolment and attendance in the whole of Somalia since 2006, though there have been more recent surveys in Somaliland and Puntland, as the table below indicates. The rates for Somalia as a whole are very low, and lower for girls than for boys. The primary net

Primary net attendance ratio - SOWC 2015
(Somalia figures come from 2006 MICS3)

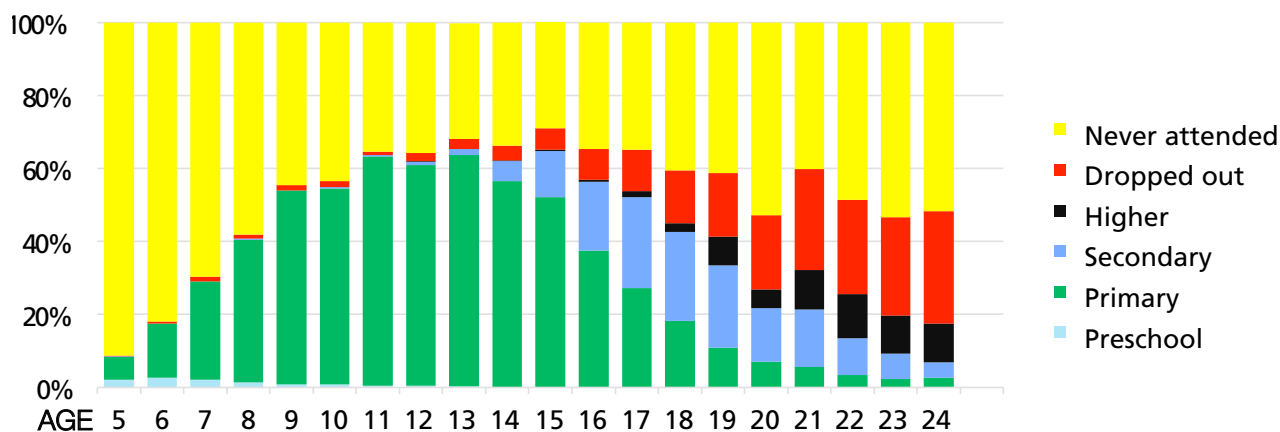


	Last available % PNAR for all Somalia MICS3 2006	% Primary net attendance ratio (PNAR) MICS4 2011		% Gross Enrolment Rate (GER) 2013/14 MoE EMIS	
	All Somalia	Somaliland	Puntland	Somaliland	Puntland
Urban	41	59	50	70	57
Rural	12	43	31	30	43
Male	25	55	46	48.2	62
Female	21	47	40	39.1	49
Total	23	51	43	43.6	55.6

	Last available % SNAR for all Somalia MICS3 2006	% Secondary net attendance ratio (SNAR) MICS4 2011		% GER Secondary school 2013/14 MoE EMIS	
	All Somalia	Somaliland	Puntland	Somaliland	Puntland
Urban	14	30	21	85	83
Rural	1	7	3	15	17
Male	10	24	18	24.9	16.3
Female	5	16	11	15.7	8.8
Total	7	21	15	20.5	12.9

¹ This indicator was selected for world and regional comparison since it was the only one for which SOWC showed education data for Somalia.

School Participation – Source: MICS4 Somaliland



attendance ratio (PNAR) for urban children in 2006 was 41 per cent compared to 12 per cent for rural children. The rate in 2006 for all Somalia was 11 per cent for the two lowest wealth quintiles, compared to 87 per cent for the two upper wealth quintiles.²

The southern and central areas (where half the population live) are estimated to have significantly lower enrolment and attendance than other regions, although due to the security situation no full school census or household survey has been completed since 2006. The 2011 MICS4³ in Somaliland and Puntland gave a dramatically different picture from that in the 2006 MICS3 for the whole of Somalia. The survey showed much higher rates of school enrolment and attendance in Somaliland and Puntland, though disparities favouring urban and wealthier households still remained.

Over-age primary schoolchildren

Primary net attendance ratios are low in Somalia partly because many children attending primary school are older than the typical 'primary age' student (6-14 years). As is demonstrated by the charts on this page and on page 65 analysing school attendance in Somaliland and Puntland, there are significant numbers of 'secondary age' children (14-17 years) attending primary school. In addition, it can be seen that the dropout rate starts to increase after the age of 15, and further analysis of the data indicates that this is from all grades of primary. Therefore the earlier children start school, the greater chance they have of completing their basic education. Over 30 per cent of children in Somaliland and more than 40 per cent of children in Puntland never attend school.

Quranic schools and their effect on formal and early childhood education

Quranic schools provide religious education for children focusing on the Quran and related material. The schools, which are widespread in both rural and urban areas, are run and supported by communities and are not part of Somalia's formal education system. They come under the mandate of the Ministries of Religion (Ministry of Justice in Puntland). The formal education system has a number of Integrated Quranic Schools (IQS), which include secular subjects in the curriculum, but they serve relatively few children. 2006 MICS3 revealed that, for all of Somalia, 42 per cent of boys and 28 per cent of girls enrol in traditional Quranic schools; these rates are much higher in the southern and central regions and much lower in Somaliland. In southern and central regions only 3 per cent of nomadic children were enrolled in formal school although 42 per cent were enrolled in Quranic school. In all parts of Somalia, girls' participation in formal or Quranic schools is significantly lower than that of boys.⁴

Early Childhood Education (ECE) prepares children for successful primary education,⁵ but provision of this is at a negligible level throughout Somalia. Many children attend Quranic schools from an early age but these cannot be considered a preparation or replacement for ECE or primary school since what is taught is primarily the Quran in Arabic. Participation in Quranic school extends well beyond primary-school age.

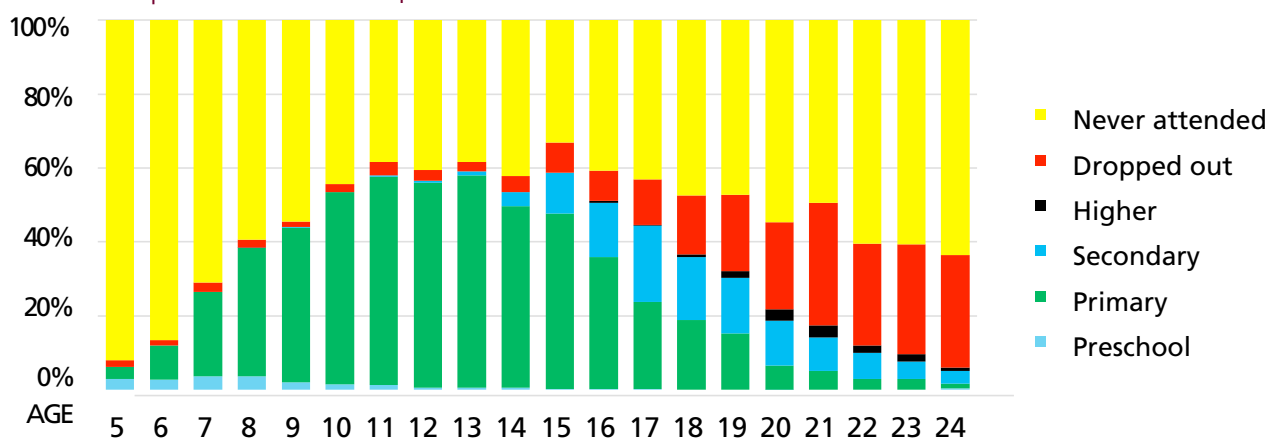
² UNICEF, MICS3, 2006

³ This chapter uses a mix of MICS 3 (2006) and MICS 4 (2011) data to evaluate the situation in Somalia, as MICS 4 does not include data from the South and Central areas of the country.

⁴ Peter Moyi, 'School Attendance in South Central Somalia', SAGE Open 2012. An analysis performed using 2006 MICS3 data but on a larger data set than appeared in the actual MICS3 report.

⁵ UNICEF website cites multiple studies on this, but a good summary is Woodhouse & Moss, Early Childhood & Primary Education, 2007

School Participation – Source: MICS4 Puntland



Quranic school may be seen as an alternative to primary school due to various possible factors, including: the desire of parents to give their children a religious education; non-availability of a formal school nearby; and the lower cost of Quranic school.⁶ However, the 2006 MICS3 reported only a 10 per cent literacy rate among those who had attended Quranic school as their highest education level, indicating that traditional Quranic school cannot be considered an alternative to formal schooling in terms of achieving satisfactory educational outcomes.

Service provision

The education system in Somalia has seen improvements over the last five years, thanks in part to UNICEF support, but significant challenges remain that impede much growth in the sector.

Information on school provision is available from the Education Management Information System (EMIS) Yearbooks for Somaliland, Puntland and the Banadir region. The EMIS Yearbook for Somalia outside Somaliland and Puntland does not include regions other than Banadir, but some education data about those missing regions was included in the 2015 Joint Review of the Education Sector (JRES).

Formal basic education

Even with low enrolment rates, the ratio of pupils per classroom is high, indicating the shortage of school infrastructure and facilities.⁷ In all parts of Somalia there is a shortage of teachers; there are high rates of teacher attrition and teacher remuneration is low in relation to living costs.⁸ In primary schools the majority of teachers do not have a teaching certificate.⁹ In-service teacher training takes place but JRES reports that these are too

short and insufficient. There is a stark lack of female teachers.¹⁰ Teaching and learning supplies are also insufficient.¹¹ In Somaliland and Puntland, less than half of primary schools have drinking-water facilities.¹² Various studies mention inadequate school sanitation facilities,¹³ and if these exist there are likely to be no separate latrines for girls. Some studies comment on the use of corporal punishment by teachers as a common form of discipline that may deter some pupils from attending school.¹⁴

Somaliland, where a majority of schools are owned by the Government, introduced free primary education (FPE) in 2011, but that has not led to much (if any) increase in enrolment in government schools. Since FPE was introduced, teachers' salaries have decreased, their morale is low and headteachers complain of having less control over their staff, who are mostly paid directly by the Ministry of Education.¹⁵ Families understand the free education policy to mean they should not pay money to schools, and there is no alternative income stream established, so schools are left with no or insufficient funds to cover running costs.

Puntland runs a mainly government schooling system, usually supported with fees from families. In the southern and central regions of the country at least two thirds of schools are owned by private school associations known as 'umbrella schools', and parents must pay for the cost of their children's education.¹⁶ In all parts of Somalia, overt or hidden costs (such as the cost of learning materials) negatively affect educational access for children from poor households – and poverty is widespread.

7 Somaliland, Puntland & Banadir: 2013/14 School Yearbooks. For primary schools, the pupil-classroom ratio was 53 for Somaliland, 40 for Puntland and 26 for Banadir.
8 JRES Reports 2015, and Heritage Institute, 'Educational Challenges in Post-Transitional Somalia', 2015.
9 Somaliland, Puntland & Banadir: EMIS School Yearbooks 2013/14.

10 Ibid. The proportion of female primary teachers in the three areas is 19.5 per cent, 13 per cent and 14.7 per cent respectively.
11 Ibid.
12 Ibid.
13 For example, Caritas, Education Assessment Somaliland, 2013
14 Colombia Group for Children in Adversity, Ethnographic Study on Child Protection, 2013
15 JRES, Somaliland, 2015.
16 JRES, southern and central Somalia, 2015

An estimated US\$1.3 billion is remitted annually to Somalia by Somalis living abroad. This remittance flow accounts for around 50 per cent of Somalia's gross national income and for 80 per cent of investment in the country. This being so, remittances play a very significant role in Somali family finances. A high proportion of families, at least in Somaliland and Puntland, receive significant remittances, which are partly used for education costs, though remittances is said to be at a lower level in the rest of Somalia. One of the major uses of such remittances are to pay for education costs, and a third of survey respondents said that if remittances ceased they would not be able to pay for basic costs, including education. The survey also found that 72 per cent of urban recipients of remittances were caring for children other than their own. In a sub-survey of the same study, half of rural respondents said they sent their children to urban relatives if there was no local school available or they could not afford to support their children properly. However, for the majority of Somali families, poverty is the prime reason not to enrol their children in school.

Alternative basic education

Pastoralist communities make up over a quarter of the Somali population, and finding ways to ensure that all children living in these settings have access to basic education is critical. Currently, less than a quarter of pastoralist children attend formal schools in Somalia, largely due to high costs and the lack of an education format that suits their nomadic lifestyle.¹⁷ Studies find that even if they attend school, the average grade attained is Class 3, the average time to school is 57 minutes (although this varies by region), and total school-related costs amount to an average of US\$121 per annum.¹⁸

Barriers to education for nomadic children include factors common to all rural children but in a more extreme form: fewer schools are available within a reasonable distance; families are less able to afford the high costs; and there is scepticism that education will benefit the pastoralist livelihood. In addition, there are particular considerations related to the nomadic life. Conventional school timetables do not correspond to livestock herding schedules. Nomadic families draw their labour primarily from their families, including their children.

In the Pastoral Assessment Study, the reasons given by parents for not enrolling their children in formal school are shown in the table at the top of the page.

Pastoralists: Reason not to enrol children in formal school % Source: Pastoral Assessment Study, Horn Relief, 2011	Boys	Girls
Not available	45	51
Lack of money	35	38
Constant migration	17	18
Lack of perceived benefit	13	11

Alternative Basic Education (ABE) informal education programmes are identified as an option to formal schooling especially for pastoralists' children and for out-of-school adolescents, particularly girls. Despite the great potential of ABE programmes, there is a lack of consistent, well-funded policies and strategies that ensure good-quality services are in place.

Non-formal learning programmes designed to accommodate pastoralist lifestyles are being piloted in Somalia, but so far have not gained enough traction to be taken to scale.¹⁹ When the Pastoral Assessment Study asked parents which type of non-formal education they preferred for their children, 70 per cent cited Quranic School, 3 per cent Integrated Quranic School (which combines secular with religious instruction) and 18 per cent mobile school. More research is needed on parental decision-making regarding schooling for their children when faced with limited options.

Studies comment that children in Internally Displaced Persons (IDP) communities have disproportionately low participation in education but there is weak data to support that. There are no specific data on the educational participation of minority clans and non-clan minorities (such as the Rahanweyn and Bantu), but these groups are disproportionately represented amongst IDP populations, and are thought to have particularly low access to education.²⁰

Youth education and skill development (children out of school)

Young people make up nearly 70 per cent of Somalia's population, yet often suffer due to limited education and employment opportunities. Furthermore, of the nearly 1.7 million children of primary-school age in the country, only 710,000 are enrolled in school. Somalia's pastoralist populations face further impediments to education as communities move with their children and livestock in search of water and pasture, making education in normal, static schools impractical and often impossible. Because of this deficit, youth miss out

17 Horn Relief, Pastoral Situation Assessment, December 2011

18 Registration US\$9, Annual School fees US\$60, Educational Materials US\$28 and Meals US\$24.

19 2 per cent of children are in mobile schools or ABE (Alternative Basic Education); 4 per cent of children are in Integrated Quranic School. Ibid.

20 Majid, Nisar, and Steven McDowell, 'Hidden Dimensions of the Somali Famine', Global Food Security, vol 1, 2012; Human Rights Watch, 'Hostages of the Gatekeepers: Mogadishu IDPs', 2013.

on critical services, face limited economic opportunities, and become increasingly vulnerable to recruitment by extremists and/or criminal elements.

The EMIS School Yearbooks do not have information about absenteeism, which could give insights as to reasons for poor educational outcomes and students dropping out. However, the 2013/2014 School Census does show the proportion of children who survive to Grade 5. In Somaliland, 85.6 per cent make it to Grade 5 (including 84 per cent of girls). In Puntland, rates are much worse: only 54.6 per cent of students (52.6 per cent of girls) complete Grade 5. The yearbooks also contain figures showing high dropout rates at least for Grade 1, with girls faring worse than boys. Further research is needed.

Surveys indicate that there is a generally high demand for primary education. However, many Somali families face widespread poverty and contend with very high levels of unemployment. One of the most serious implications of family poverty is the inability of many poor parents to afford to sustain schooling for their children and the need for children to work to help support the family, or, in the case of girls, to look after siblings at home. This is cited as the primary reason for parents not enrolling their children in school, and particularly applies to IDP families. Children out of school are at heightened risk of joining gangs, being recruited into armed groups and engaging in other forms of dangerous behaviour.

Education authorities and school management

Decades of conflict have destroyed much of the country's education infrastructure and services. The migration or displacement of much of Somalia's skilled human capital has severely damaged the education system's human resource base for delivery of good quality education services. The conflict has also reduced state revenue and so has impacted negatively on the sustained flow of finances towards the education system in all parts of Somalia. The negative effects have been felt by all key education-sector areas, including: teacher training colleges; curriculum development and review systems; and alternative flexible learning programmes for the most excluded children.

Each of the Somali regions has a Ministry of Education. In Somaliland, policies guiding education include the Somali National Education Policy (2005), the Somaliland Education Act, the Teacher Education Policy and the Free Primary Education Policy. Implementation of existing policies is ongoing, including the Somaliland Sector Education Strategic Plan (2012-2016), and the National Education Act (2006). The education sector in Puntland is guided by the Puntland Education Sector Strategic

Plan 2012-2016, which references the Puntland Education Policy Paper. The southern and central regions have an Interim Education Sector Strategic Plan, 2013/2014-2015/2016. The Federal Government of Somalia (FGS) cabinet agreed a proposed Education Policy that is yet to be approved in law. Therefore, as of now, most of Somalia lacks the education policies and regulatory frameworks to guide education from early childhood through to tertiary education. Since most schools are private umbrella schools, the lack of a regulatory framework is a serious gap.

At present, the education sector lacks the requisite data to effectively plan, manage and implement learning programmes for children in schools. This deficiency creates difficulties in the prioritization, financing and monitoring of the quality of education services provided by the Government and by other agencies. The want of an Education Management Information System (EMIS) is linked to weak government capacity in data collection, collation and analysis throughout the education system. Somaliland, Puntland and Banadir (a region of the south) have produced yearbooks for the past three years. In future years, the data quality of these yearbooks needs to be improved and other regions included. However, with more years of EMIS school data, a better appreciation of education provision will be possible, guiding future priority action.

There is only scattered information on the financing of the education sector and more research is needed to understand it better. International agencies are a very important source of funding but the total money available still falls far short of what is required. Although government education budgets have increased, actual expenditures fall short of these and government funding is inadequate to achieve the planned results. The share of primary teachers' salaries borne by the Ministries of Education is 54 per cent in Somaliland, 22 per cent in Puntland and 4 per cent in Banadir.²¹ Teacher salaries are inadequate, especially in view of the ambition to strive for high enrolment and much greater numbers of qualified teachers.

The Go-to-School initiative is an initiative led by the Ministries of Education and, as such, planning and implementation will be conducted at the central level in collaboration with regional education officers and in consultation with education partners who will assist the Ministries in implementation. UNICEF supports all the relevant Ministries of Education through technical inputs and co-ordination.

Although the role, reach and capacity of the Ministries of Education in overseeing the delivery of education have increased at central, regional and district levels,

²¹ EMIS School Yearbooks 2013/14.

lack of financial, institutional and human capacity hinders the development of the sector. At local levels, community education committees play a key role in school administration and in building community resilience. Regular monthly meetings of the Education Sector Committee will be supported, as well as the technical working group (on, for example, gender or EMIS), in order to strengthen the co-ordination of education-sector programmes.

Quality-assurance mechanisms within the Ministries of Education to assess curriculum delivery, monitor system delivery and manage education services are weak. This is due to a lack of qualified personnel and to the meagre financial resources allocated by the government in question. For example, Somaliland has a language policy favouring the Somali language as the medium of instruction for teachers and learners in primary schools. However, the language of instruction in secondary school is Arabic or English, which makes it difficult for pupils to transition from primary to secondary school.²²

A Measuring Learning Achievement (MLA) assessment of Grade 7 and Grade 4 students was undertaken for Somaliland and Puntland in 2012/13.²³ The assessments found some reasonable results in reading comprehension. Competence in writing and numeracy was low, however. There were no significant gender disparities in learning achievements. There has been no equivalent assessment of students in the rest of the country.

Gender disparities

As noted above, girls' participation in education is consistently lower than that of boys. Somali social norms favour boys over girls for educational opportunities and,

as described above, there are other barriers to girls' participation in education. Somali social norms are very sensitive about the protection of girls before marriage. Parents need to feel secure in allowing their daughters out of the home and attending school. Where schools are distant, girls are at risk of sexual abuse on their way to and from school. The low availability of sanitation facilities, especially separate latrines for girls, is also cited in surveys as a factor inhibiting parents from enrolling their daughters in school.

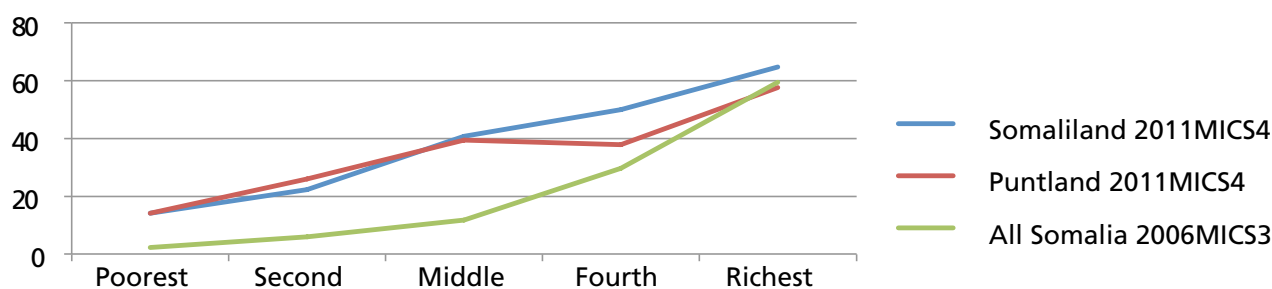
The perception is that girls are safer with female teachers but there are very few of these in schools – less than 20 per cent of primary-school teachers in Somalia are women. When there are fewer female teachers, there are typically fewer female students in school.

The last countrywide survey on literacy of 15-24 year old women was the 2006 MICS3, which showed that only 25 per cent of women in that age group were literate.²⁴ This presents major challenges, as girls and women who are uneducated face higher risks of becoming marginalized socially, economically and politically. Furthermore, this is the next generation of mothers, and evidence shows that uneducated mothers are less likely to send their daughters to school. Uneducated mothers are also less informed on appropriate child care, health and nutrition practices and suffer higher rates of maternal and infant mortality. The 2011 MICS4 survey, performed for Somaliland and Puntland only, showed a level of improvement on this indicator that was encouraging.

In all MICS surveys, the literacy of young women aged 15 to 24 is strongly correlated with poverty.

% Literacy Women 15-25 yrs	Somaliland	Puntland	Southern and central regions	Total
2006 MICS3	36	32	19	25
2011 MICS4	44	37	Data not available	Data not available

% Literacy of women (15-24 year old) by wealth quintile



22 Caritas, Education Assessment Somaliland, 2013.

23 Somaliland and Puntland: Report on Measuring Learning Achievements in Grade Seven (MLA 7), June 2013.

24 For MICS, the respondents were judged literate if they could read all or part of a sentence in the Somali language.

Role and capacity analysis for duty bearers in education

In all parts of Somalia there are Education Sector actors providing services in collaboration with governments and local communities. Despite the presence of non-governmental (NGO) partners, there are still gaps in reaching the most excluded children. Given the significant presence of NGOs in all parts of Somalia there is need for more collaborative work. Currently, different partners support different levels and thematic

areas such as: construction and rehabilitation of schools; strengthening of teacher capacity (training, provision of salaries, learning resources and skill development); and the school feeding programme, for which the World Food Programme (WFP) is the main partner. The Joint Review missions have emphasized the importance of strengthening the co-ordination of developmental and humanitarian programmes for all parts of Somalia.

Level	MAIN ACTORS	ROLES	CAPACITY GAP
International Community	Donor community International NGOs/UN agencies International banks International government partners	Advocacy as part of global agendas, e.g. MDG/SDG/EFA; fundraising; technical assistance and capacity development; co-ordination; and service delivery.	Monthly education co-ordination meetings occur in all three established Ministries of Education in Somalia. The Ministries also hold annual joint sector reviews in each area with the development partners, assessing progress against their respective Education Sector Strategic Plans. However, financing of the Education Sector operates outside of the New Deal mechanism, meaning that good donor and education partner co-ordination is essential. Further work is required to strengthen co-ordination, including the linkages between the Humanitarian Education Cluster and the Education Sector committees, and the decentralization of the co-ordination groups. The role of education in peace building and state building needs to be better articulated to other donors outside of the Education Sector to leverage further funds-especially for the essential recurrent costs of teacher salaries.
Federal State Governments	The Somali Government Ministries of Education (MoEHE/ MoE)	Policy development; monitoring and evaluation; co-ordination; regulation; planning and strategic objectives; leadership; public campaigns; fund allocation and accountability; co-ordination and promoting collaboration; technical skills development; budget allocation.	There are a number of draft policies, plans and strategies in place for conventional learning programmes. However, there is weak capacity in the timely drafting, review, implementation, financing and monitoring of the existing institutional frameworks. Whereas broad education frameworks exist across the board, there is a serious gap with regard to specific laws and policies targeting special groups such as girls, nomadic children and children with special needs. Moreover, policies that specifically target nomadic education or IDP children are non-existent across the three regions. While these ministries have relatively low budgets, the actual allocations of funds are sporadic and far lower than the indicative budgets, which in turn reduces the realization of equal access to basic education of good quality for all children. The main capacity gaps identified include lack of skilled human resources, low participation of communities and low financing due to limited government revenues. At times the lack of political will and low staff motivation to pursue services for the sector affects financing, prioritization, access and delivery of good-quality education services, particularly for most excluded children such as nomads.

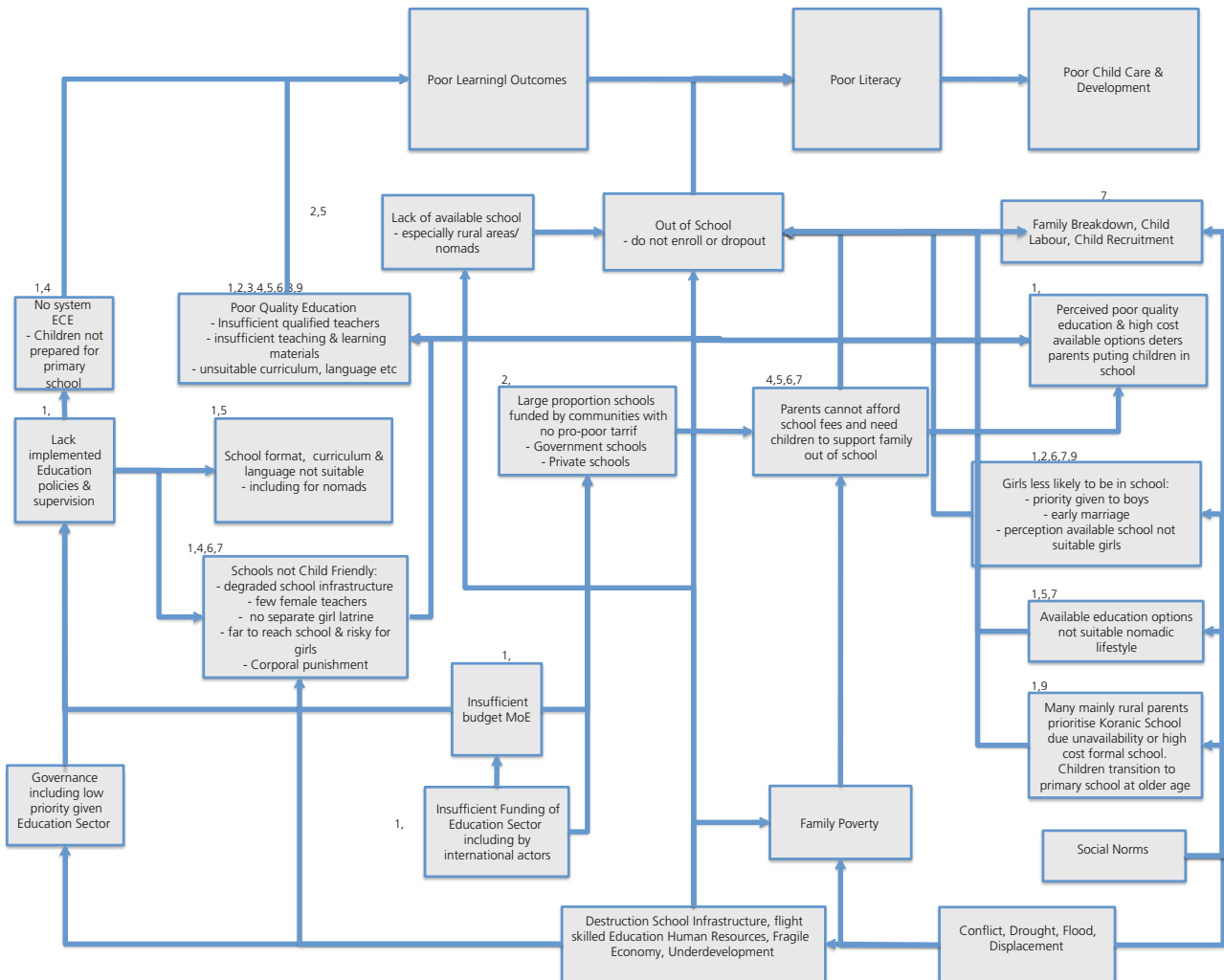
Level	MAIN ACTORS	ROLES	CAPACITY GAP
Local Government	District and local education officers	Supervision; co-ordination; data collection; advocacy for recruitment; provision of school security; and implementation of government policies and protocols on the ground. Manage any other decentralized responsibilities.	At this level the main capacity gaps identified include low motivation, weak skills – and inadequate financing, which reduces the ability for local and district-level staff to undertake their roles and responsibilities effectively. This group requires strengthened training programmes and capacity-building programmes. For southern and central regions, regional-level education officers were appointed by the MOE only in early 2014. These officers do not have their own offices and need training to strengthen their capacity in order to meet their roles and responsibilities. There are no district-level officers in these areas, with the result that regional supervisors are expected to supplement this gap and take on these roles.
Civil Society	Diaspora, local NGOs, religious organizations	Fundraising; advocacy for and championing education rights, especially for marginalized groups; and mobilizing communities to enrol children in school. Also, service provision and capacity building of Education Sector staff.	These groups' capacity gaps range from low resources, weak political connection, low data for advocacy and long distances to be covered in the region's vast geographic area. Civil-society organizations are also affected by weak co-ordination mechanisms – amongst themselves and with key government ministries.
Private-Sector	Private-school umbrella organizations	Service delivery; leveraging public and ODA resources to improve the quality of education.	Private schooling has proliferated across Somalia since the collapse in public education provision resulting from the conflict. These schools became part of umbrella organizations and many are funded by the Diaspora. Private schools are still the main provider of education outside Somaliland and Puntland. While they are working with government on a harmonized curriculum and centralized examinations, government needs to establish standards and quality assurance for private providers of education. Pro-poor policies for the provision of education need to be explored with the private providers.

Level	MAIN ACTORS	ROLES	CAPACITY GAP
Communities	Community-based organizations, elders, community education committees, gatekeepers, clan leaders, women's groups, religious leaders, self-help groups, youth groups.	Creating awareness of the importance of education; mobilization of out-of-school children through enrolment drives; advocacy; contribution to schools in cash or in kind; knowledge transfers (especially the Diaspora returnees); monitoring school security; supporting the teaching and learning process; and holding service providers accountable, including for resources.	Key capacity gaps affecting communities are: low motivation due to the costs of education infrastructure when set against low levels of community income; lack of authority (political and legal) in relation to education managers, such as school heads; and weak organizational structures. Other gaps include the lack of skilled person power at school level, especially teachers, and frequent insecurity in rural areas Community education committees (CECs) represent parents and larger communities in the management of school resources and act as liaison with local government offices. This group is meant to collaborate with headteachers and school staff. However, CECs have numerous capacity gaps, including limited awareness of the wider issues affecting the Education Sector, minimal government support, lack of a clear mandate regarding their roles and responsibilities, non-existent legal/formal agreements with MoEs and NGOs. CECs could benefit from improved capacity and skills, including all key school stakeholders and a clear mandate or agreement with schools, the MoE and NGOs to empower them to exercise their mandate.
Parents		Enrol children in school; pay for school fees; and participate in management of schools.	While a mother might want to send her children to school, she might not have sufficient control over the household budget to meet the related costs. Sometimes fathers, who hold the primary family authority, prioritize non-education items without consulting mothers. This might also affect girls' education given the parental preference for boys' schooling. Parents in rural areas and low-income households also face the challenges of high illiteracy, low awareness of their roles, as well as competing demands for meagre household income; the result is the low priority attached to education.

Overview of Causal Pathways

The situation of each household is different and the causes of their ability or inability to realize education rights will vary. However, the above analysis reveals general causal pathways that are depicted in the Figure below.

SOMALIA EDUCATION CAUSAL PATHWAYS



Sources:

1. Education Causal Analysis Workshop Jul 2015
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Somali children share their hopes and fears

- Education -

Children universally agreed that it was important for them to go to school. Children identified that education would help them achieve personal success, but more often, they discussed the impact that they could have on developing their communities.

“Education is the light... it is the weapon for life... it helps our future... it brings development to the society... it develops us out of darkness” – boys, 13-18, Baidoa.

“When you get educated, you are a very important person in your community. You will participate in the development of your village, district and even country” – boy, 17, Dangarayo.

“When a child is educated, he or she spreads the knowledge to their community” – out-of-school girl, 15, Garowe

“I had some problems with the school teacher and I decided to stop education from that time. I was beaten with a big stick by my teacher” – boy, 7-12.

“I live with my grandmother, I look after the livestock and I don't have time to study.”

“There was a prolonged drought that happened in this village. I migrated with my family during that time and I had no time or opportunity to stay in school” – boy, 7-12, Odweyne.

Strategic recommendations

Expanding access for the most excluded groups of children

- Enrolment at the right age. To give children a better chance of completing their basic education, action is required to ensure children enrol in school at the age of six.
- Nomadic children. Given the fact that this group constitutes the largest number of out-of-school children, it is important to focus on: specific government policies and institutional frameworks; resource allocation; harnessing of partnerships for effective programming; establishment of alternative/flexible learning strategies and curriculum; intensive community-level awareness creation and advocacy; provision of supplies such as mobile schools; recruitment of teachers for nomadic communities.
- ECDE (pre-school) children. There is a general lack of data and consistent programmes and therefore a need to focus on data collection, integrated programmes of comprehensive quality, cross-sector interventions (including on health, nutrition and birth registration), policy frameworks and quality assurance.
- Other excluded children. These are mainly children from IDP families, coastal and riverine areas, girls and children with special needs. Strategies to reach them include: increasing the provision

of Alternative Basic Education programmes; supporting the transition to formal schooling; harnessing partnerships; offering incentives and bursaries; and providing equipment to special learning institutions.

- Education planning based on data collection and analysis to ensure equitable provision of resources across Somalia.

Intervening to improve learning outcomes for children in schools

The essential systems required to deliver education services of the requisite quality are weak, inadequate and poorly financed. Key areas that could benefit from strengthened capacity and partnerships aimed at improving the quality of education outcomes include:

- Development of curriculum, examination and accreditation systems for flexible learning programmes targeting out-of-school children. The target group for this alternative curriculum would be nomadic children, adolescents, and children who cannot come to conventional formal schooling programmes. The curriculum would be accompanied by key strategies that would ensure flexible delivery approaches, the ability to re-enter the mainstream system, certification/accreditation systems, as well as the delivery of age-appropriate content relevant to the community's lifestyle.

- Teacher development. A professional development scheme is needed, including an emphasis on improved teacher training institutions, teacher recruitment, remuneration, motivation, retention and management across all the three regions. Investment in female teachers is also vital, which will involve attention to recruitment, motivation and policies aimed at fast-tracking community confidence in female educational institutions, in addition to offering girls a head start with school-based female role models.
- Learning assessments. This will involve: support to improve early-grade reading and numeracy; development of assessment tools; standardized learning assessment; and the training of personnel for continuous assessment so as to ensure the improved monitoring of learning outcomes in the sector.
- Quality assurance. This will entail focusing on the capacity of personnel, technical support, infrastructure, and quality-assurance systems to improve education services.
- Capacity building for Ministry of Education personnel. Such capacity building needs to take place at all levels to increase the delivery of good-quality education services, with particular emphasis on those in the areas of planning, financing, monitoring and quality assurance.
- Establishing school development/improvement plans. These would be aimed at individual schools accommodating those children who are most vulnerable to missing out on schooling programmes.

Enhancing gender equality in both access and improved learning outcomes

- Increasing girls' participation in formal schooling at all levels, for example through: providing bursaries as well as teaching and learning materials; delivering WASH/health services at school level and within a Child Friendly School framework; and encouraging role modelling by teachers and women professionals.

- Increasing the impact of programming through the networking of gender-focused groups.

Increasing the participation of children who are missing or dropping out of school

- A key strategy is to provide cash or other packaged incentives such as food rations and dignity kits to motivate families. The target categories include IDP children, pastoralists, children in coastal and riverine areas, girls and those from the poorest households.

Developing a comprehensive EMIS

- This will involve supporting government capacity on data collection, collation and analysis; it will also entail evidence-based research for quality assurance and programme monitoring/evaluation.

Aiming to enhance the funding of the Somali Education Sector

Education in Somalia needs quantum, not incremental, improvement and a major barrier is lack of funds to the sector. Strategies to be pursued include:

- Researching the economics of the Education Sector, including the barriers to education for poor families who cannot afford high education costs.
- Making the case for the large investments that the sector needs.
- Promoting social protection programmes either directly or indirectly to help families afford education.
- Harnessing the private education sector into the national education framework, including through private-public schemes for pro-poor education tariffs.



Child Protection

Child Protection

The situation

Birth registration

Apart from being the first legal acknowledgement of a child's existence, the registration of births is fundamental to the realization of a number of rights and practical needs of children including:

- Providing access to health care and immunization;
- Ensuring that children enrol in school at the right age;
- Enforcing laws relating to minimum age for employment to prevent child labour;
- Countering the problem of girls being forced into marriage before they are legally eligible;
- Ensuring that children in conflict with the law are given special protection;
- Protecting young people from under-age military service or conscription;
- Securing the child's right to a nationality, at the time of birth or at a later stage;
- Protecting children abducted or trafficked, and facilitating their family reunification;

- Protecting children recruited by armed forces/armed groups
- Obtaining a passport, voting or finding employment.

Only a small fraction of children's births are registered in Somalia.

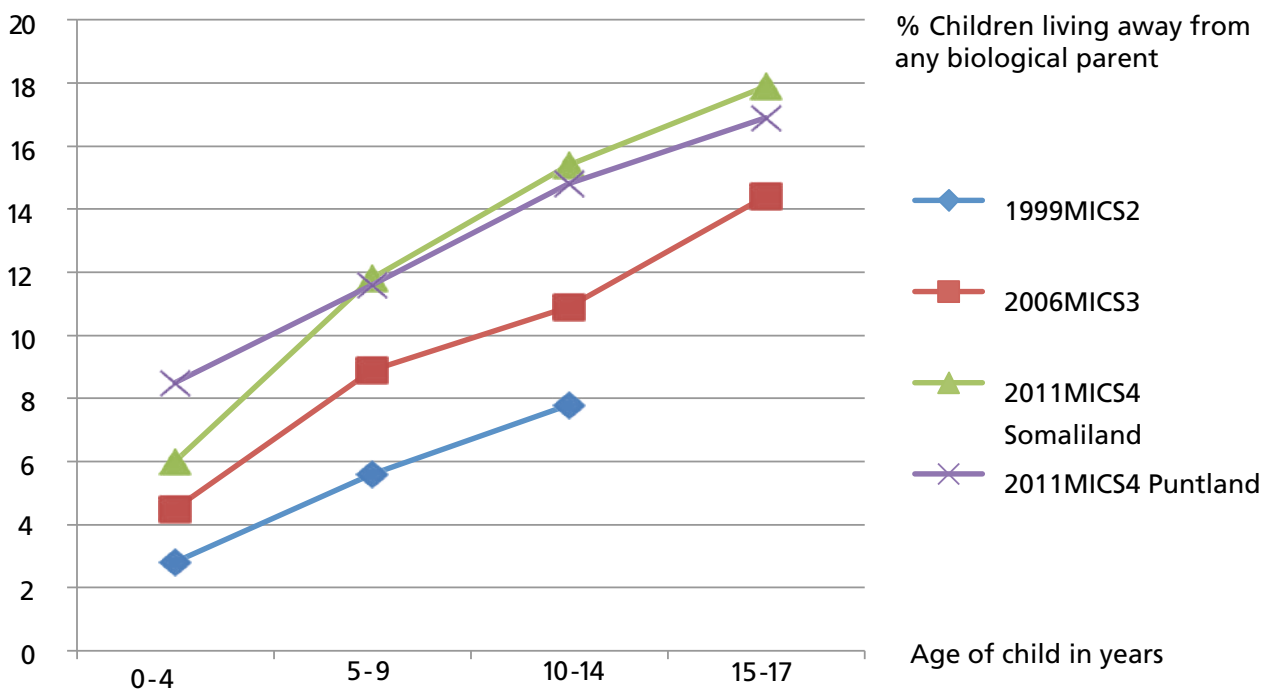
The fact of birth registration may not mean that the family has possession of an actual birth certificate.² Interestingly, cost or 'distance to travel' are not cited as main reasons for failing to register births.

There is no legal or policy framework for birth registration in any of the State entities of Somalia. Some local municipalities and hospitals issue birth certificates but there is no proper linkage with national systems. In Somaliland, a legal and policy framework is under development and meanwhile UNICEF is supporting the Ministry of Interior to develop a practical system of birth registration. Puntland has expressed interest in UNICEF pursuing a similar approach to the one being undertaken in Somaliland. The issue of birth registration has been a low priority for the Federal Government of Somalia (FGS) in Mogadishu due to other competing priorities.

% 2006 MICS3	Somaliland	Puntland	Southern and central regions	Total
Birth registered	7	3	2	3
Reasons not to register ¹				
Cost	4	4	1	2
Distance to travel	17	18	7	10
Don't know should	25	24	29	27
Don't know where	25	30	36	33
Don't see need	19	19	23	22

¹ Columns do not add up to 100 per cent – the missing number is 'don't know' or 'other'.

² Adesco, Assessment, Education Livelihoods Somali Pastoralists, 2011, reports that only 2 per cent of those surveyed registered births with civil authorities. Of this very small proportion, only 11 per cent said they had a birth certificate.



Child orphans and children separated from their families

The various MICS have data on this subject but only related to children in the households surveyed.³ Children in institutions, 'living in the street', abducted or with armed groups would not be captured in MICS.

About 1 per cent of Somali children living in rural or urban households are 'double orphans' (i.e. both of their biological parents are dead).⁴ In the wealthiest households with the means to support them, 2-3 per cent of children are orphans.

In households 9 per cent of the children are 'single orphans' (i.e. one biological parent dead) with the rate a few percentage points higher for Somaliland and Puntland.⁵ This figure is broken down as 7 per cent 'father dead' and 2 per cent 'mother dead'. When the father dies, the child tends to continue living with the mother.

The incidence of children living in households without a biological parent has been rising over recent decades and is higher the older the child is – as shown in the chart above. In the older bracket of children '15-17 years', there are more girls than boys by about two percentage points. The high proportion of girls marrying before their 18th birthday⁶ is one explanation of this phenomenon but more quantified research is needed since there are also reasons for boys to leave home at that age.

A study across a wide variety of sub-Saharan African countries reported common forms of maltreatment among orphaned children and youth living with extended families: intra-household discrimination; material and educational neglect; excessive child labour; exploitation by family members and psychological, sexual and physical abuse.⁷ Research on orphaned children living with extended families and in kinship care is needed to understand the positive and negative impact of such care arrangements on children.

In Somaliland and Puntland, most children separated from their parents are in kinship care with only a small proportion of these receiving help – and that from relatives.⁸ Orphans are enrolled in school at a slightly higher rate than non-orphans, presumably because they are being cared for by relatives who are wealthier than the average. Street children tend to be from IDP families or of Somali ethnicity from Ethiopia, with boys more visible than girls. The main reasons given by street children for separation from their families were the loss of the primary family breadwinner, especially the mother, and general poverty. When the family arrangement changes and there is a new stepmother or stepfather, boys are more likely to leave than girls who tend to stay with their mothers or go to their mother's kin. In IDP camps and communities, it is predominantly female-headed households that take in non-biological children. Since the female head of household must earn a living outside the home, there is a likelihood of childcare being neglected. In southern and central

3 UNICEF, MICS2, 1999; UNICEF, MICS3, 2006; and UNICEF, MICS42011 for Somaliland & Puntland only

4 Ibid.

5 Ibid.

6 46 per cent for all in MICS3.

7 Gillian Morantz et al, 'Child abuse and neglect among orphaned children and youth living in extended families', *Vulnerable Children & Youth Studies*, 2013.

8 UNICEF, *Situational Assessments of Alternative Care of Children Somaliland & Puntland*, 2015

Somalia, loss of livelihoods and food insecurity due to conflict or drought results in parents either going away to earn a living elsewhere or sending children away to live with others or for child labour.⁹ Some families also send their children to live in IDP camps to improve their access to basic services. Some of these children live on their own or with other children as 'child-headed households'.

Recruitment or use by armed groups also separates a number of boys and girls from their families. Some parents feel obliged to send their boys to work with the clan militia.¹⁰ Children are among those Somalis migrating to other countries, rendering them especially vulnerable to the risk of violence, abuse, trafficking and exploitation.

There are no adequate mechanisms in the country to monitor the situation of children, and to offer them protection if they are being exploited or abused. In particular, there are inadequate mechanisms for tracing and re-unification of children separated from their families, and there are no formal mechanisms for arranging alternative care for orphans.¹¹

Child labour

About half of Somali children aged between 5 and 14 engage in child labour.¹² The rate is higher for rural than for urban children, and higher for older than for younger children within that age group. The rate is also lower for children of educated mothers and wealthier households. The incidence of child labour is somewhat higher for girls than for boys.

Many studies reference the hard working lives of children in Somalia.¹³ In pastoralist families, typically children aged between five and nine take care of small animals around the house. After the age of 10, boys take on herding duties, sometimes with grazing areas far from home, while girls are given domestic chores including fetching water and firewood. In agro-pastoralist families, children of a similar age have farm duties. Child labour is increasing in areas facing water scarcity, and where stock is switching to smaller animals. Children in IDP settlements are usually out of school and working as domestic labourers, farm workers, and some are recruited to armed groups. In large cities like Mogadishu it is the norm for children to contribute to household income, with girls mainly working as house-helpers or in markets and often being exploited by their

employers. Especially in female-headed households, girls are expected to take on homemaker duties while mothers are working.

As confirmed in the ILO study, the main driver of child labour is the poverty paradigm common to many other developing countries, though the phenomenon is also linked to strong social ties between children and families coupled with strong patterns of economic migration. Although some children work while remaining in school,¹⁴ most child labourers are deprived of the opportunity of completing their education. Being out of school exposes children to a variety of protection risks.

Children associated with armed conflict

The results of the UN Monitoring and Reporting Mechanism on grave violations of child rights,¹⁵ mainly related to conflict, are reflected in annual reports.¹⁶ The numbers cited in the reports, totalling about 5,000 violations per annum, are acknowledged to be seriously under-reported due to difficulties of access and verification.¹⁷

Children are recruited or used by Al-Shabaab, the National Army and allied militias, and other armed groups. According to the Human Rights Watch report, the National Army does not have a practice of recruiting of children but may accept children who volunteer. In some areas families feel obliged to send their children to serve in clan militias. Some parents, and even children themselves, consider recruitment as a source of income and a means of escaping poverty. Al-Shabaab has recruiting campaigns, involving either persuasion or abduction, in places where children congregate, including mosques, schools or other public places. Quranic schools in some areas may indoctrinate children, making them more receptive to joining armed groups with the same ideological persuasion. Children are offered small amounts of money, mobile phones or food as incentives to join the armed groups. Children living alone in IDP camps become easy targets for recruitment by armed groups. Although most of the

9 Child Protection Working Group, Inter-agency Child Protection Rapid Assessment, 2014.

10 UNICEF, Child Protection Causality Analysis Workshop, 2015.

11 Alternative Care for Orphans and Vulnerable Children Policies for Somaliland and Puntland are awaiting approval by Cabinet.

12 UNICEF, MICS3, 2006. This defined as work per week: 5-11yrs >1hr economic or >= 28 hr household; 12-14 yrs >=14 hr economic or >=42 hr household.

13 ILO, Child Labour in Somaliland: A rapid assessment in Hargeisa, Burao and Borama, 2011; Somalia Child Protection Working Group, Interagency Child Protection Rapid Assessment South Central Somalia, 2014; Save the Children, Child Protection Mogadishu, 2013; UNICEF, Designing Social Protection Frameworks for Three Zones of Somalia, 2015; Columbia Group for Children in Adversity, Rapid Ethnographic Study of Community Based Child Protection Mechanisms Puntland & Somaliland, 2013; Adesco, Assessment of the Education, Livelihoods & Living Conditions of Pastoralists in Somalia, 2011

14 UNICEF, MICS3, 2006 shows a substantial proportion, though less than half, of child labourers also being school pupils.

15 Killing or maiming, recruitment, attacks on schools or hospitals, rape or other sexual violence, abduction of children, and denial of humanitarian access to children.

16 UN Secretary General's Report on Children and Armed Conflict

17 Somalia Child Protection Working Group, Inter-Agency Rapid Assessment Child Protection South Central Somalia, 2014; and Human Rights Watch, No Place for Children, 2012

recruits are boys, girls are also used by armed groups for domestic duties and may be raped and forced to marry fighters. The National Army and the African Union Mission in Somalia (AMISOM) takes children who escape Al-Shabaab, or are captured on the battlefield, into custody for interrogation, often without formal protection mechanisms.

Living in a state of insecurity attracts some children to join an armed force that will protect their community. Minority groups, who suffer discrimination from dominant clans, may be attracted to join armed groups that defend their communities. When children or their families have suffered from violence and abuse at the hands of other people, they may also be attracted to the idea of joining an armed group to exact revenge. The same armed groups detain, kill, maim, rape and sexually abuse children. Rape and sexual abuse of girls is under-reported due to the stigma attached. Girls in IDP camps are particularly vulnerable to both sexual violence and forced marriages.

The Optional Protocol of the Convention on the Rights of the Child on the involvement of Children in Armed Conflict has not yet been ratified by the FGS. Even when it is ratified and laws and policies have been produced, the FGS will only be able to implement these in the areas over which it has control.

Children are also often recruited by clan militias that are maintained for the protection of communities. Other armed groups also attack and kill innocent people with impunity.

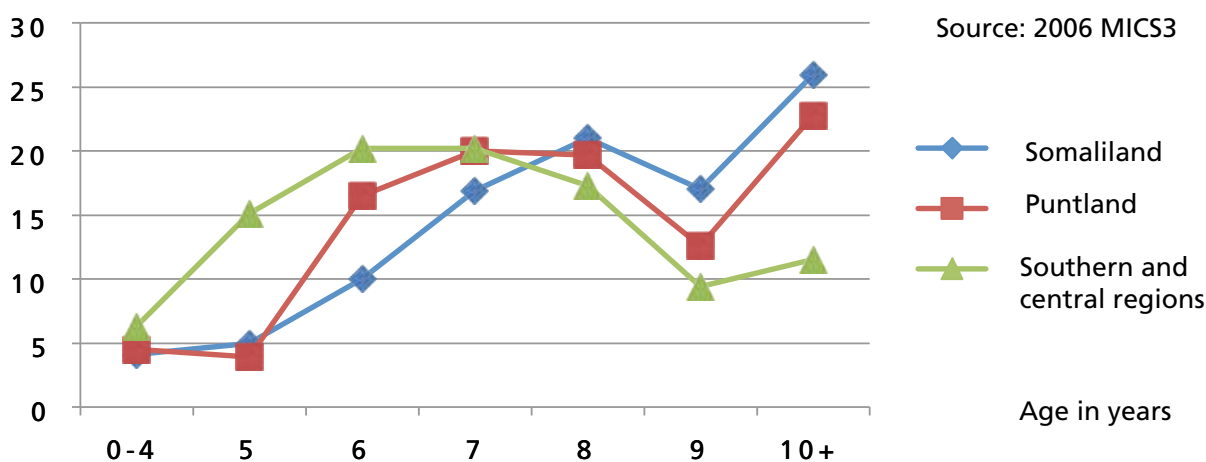
Female Genital Mutilation (FGM)

WHO classifies the different practices of FGM as follows: FGM I – excision of the prepuce, with or without excision of part or all of the clitoris; FGM II – excision of the clitoris with partial or total removal of the labia minora; FGM III – excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation).

The practice of FGM has serious negative health and psycho-social effects. The health effects are described in the chapter of this report on health. The psychosocial effects include: fear of sex and lack of sexual satisfaction; consequent difficulties in relations with the husband; and depression.

Amongst Somali women aged between 15 and 49, 98 per cent have undergone some form of FGM.¹⁸ There is no significant difference between urban and rural populations or between different wealth quintiles and education levels. In the past, the vast majority of women underwent the most extreme form of FGM (infibulation) but, at least for Somaliland and Puntland, the proportion undergoing this most extreme form of the practice appears to be dropping.¹⁹ Although FGM is performed mainly by traditional circumcisers, studies report that nurses or doctors, in clinics or hospitals, are increasingly performing FGM – a process known as medicalization of FGM.²⁰ This is thought to be particularly favoured amongst more educated and wealthier families who consider it safer to have the procedure performed by medical professionals.

% Age at which girls undergo FGM

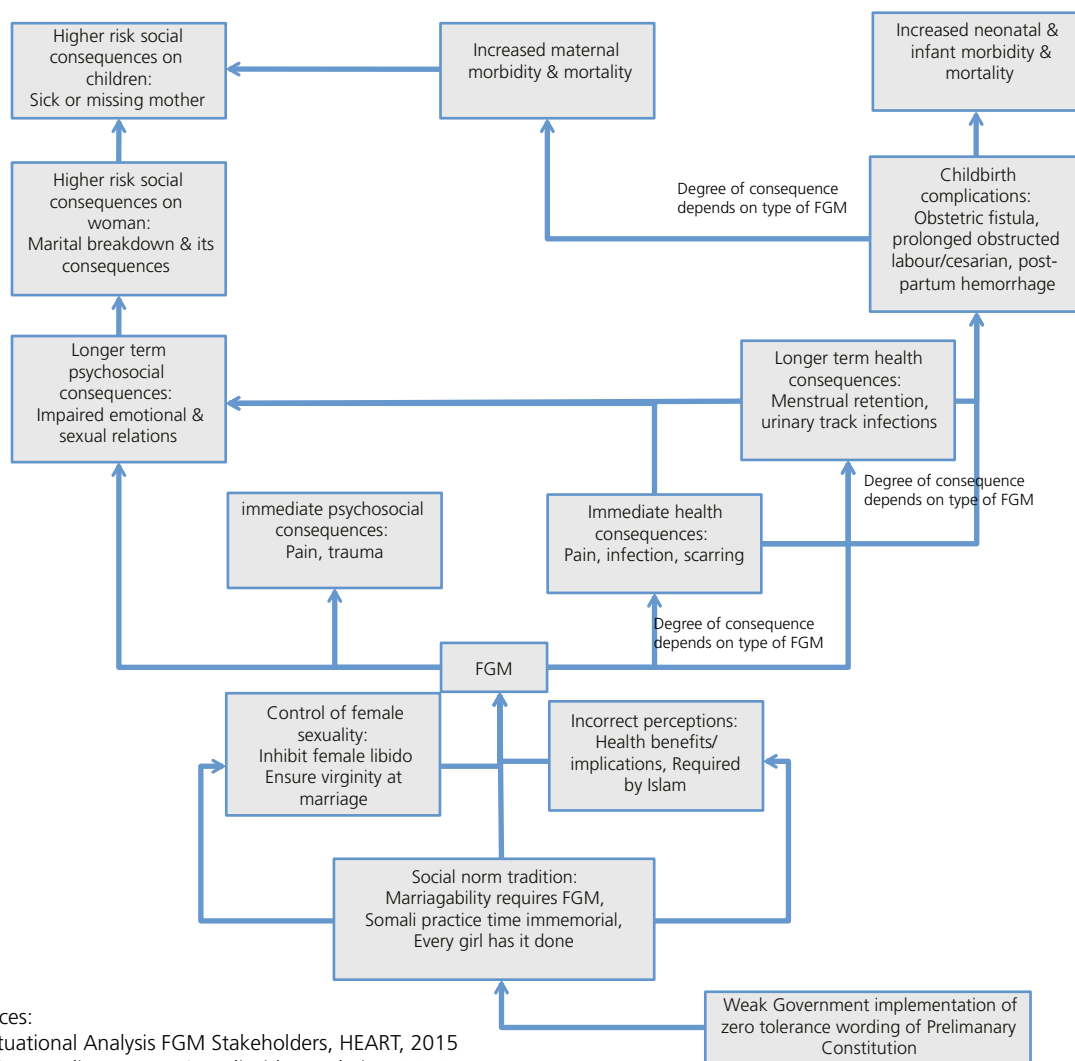


¹⁸ UNICEF, MICS3, 2006.

¹⁹ The comparison is between 2011 MICS4 and 2006 MICS3.

²⁰ Ibid. Somali Aid Foundation, FGM/C Baseline Report, 2013. Rates of FGM medicalization are in the range 16-28 per cent according to these studies.

FGM CAUSAL PATHWAYS



Sources:

1. Situational Analysis FGM Stakeholders, HEART, 2015
2. FGM Baseline Report, Somali Aid Foundation, 2013
3. FGM Obstetric Outcomes, WHO, 2006

In Somaliland about two thirds of women aged 15 to 49 believe FGM should be discontinued, though somewhat less than half express that view in Puntland and less than one fifth in the southern and central regions.²¹ This belief is higher among urbanites, better-educated women and those in the highest wealth quintiles. One study explains that there are different understandings in Somalia as to what FGM means, with some considering only the most extreme form (infibulation) as constituting FGM.²² There may therefore be a trend away from infibulation but not away from the other forms of FGM.

Studies explain the underlying causes of the FGM practice.²³ Many Somalis believe that this practice is preferred or even obligatory under Islam, though Islamic scholars have made statements against the practice. Some Christians in the Middle East and Africa

also practise FGM. There is a perception that 'cut causes cleanness'. There is a belief that FGM controls a girl's sexual urges and ensures that her virtue remains intact up to the time of marriage; indeed FGM is seen as a prerequisite for marriage.

A basic cause of FGM is that girls and women face gender-based discrimination throughout their life cycle. They are socialized to accept a subservient position in the family and patriarchal norms give control over women and children to the male head of the family.

The Provisional Constitution of the Somali Federal Republic states that: "Circumcision of girls is a cruel and degrading customary practice, and is tantamount to torture". The circumcision of girls is prohibited by 'Article 15, [4] Liberty and Security of the Person'. Across all state entities of Somalia, the governments have declared a position of 'zero tolerance' for FGM. In each state entity, legislation to prohibit FGM either has been or is in the process of being finalized, though so far it has not been enacted. In Puntland the Ministry of Religious Affairs has issued a fatwa against all forms of FGM.

21 UNICEF, MICS.

22 HEART, Situational Analysis of FGM/C Stakeholders and Interventions in Somalia, 2015.

23 Ibid; and Somali Aid Foundation, FGM Baseline Report, 2013.

Child/early/forced marriage

Marriage of girls before the age of 18 compromises their development, may result in early pregnancy with adverse health outcomes for both mother and child, and limits their opportunities to complete their education and acquire vocational skills. Globally, complications during pregnancy and childbirth are the second highest cause of death for women aged 15 to 19, and babies born to mothers younger than 20 years have a 50 per cent higher risk of being stillborn or dying in the first few weeks compared with those born to mothers aged between 20 and 29.²⁴

In Somalia, about 1 in 10 marriages occur before the girl is 15 years old, and about half before they are 18.²⁵ There is little difference between urban and rural girls in this respect and the incidence of early marriage is significantly lower only for the highest wealth quintile. About 30 per cent of girls aged 15 to 24 marry husbands who are 10 or more years older.

Rates of early marriage tend to be high where poverty, birth and death rates are high; where civil conflict is commonplace; and where there are lower overall levels of development, including schooling, healthcare and employment.²⁶ Major drivers of early marriage are: poverty; weak legislative frameworks and enforcement; traditional attitudes, including ensuring the virtue of girls before marriage; gender discrimination; and lack of alternative opportunities for girls, especially education.²⁷

About one in five women aged between 15 and 49 are in polygynous marriages (where the husband takes more than one wife), with little difference in incidence based on urban/rural location, education or wealth.²⁸ Women in polygynous households experience numerous challenges, including difficulties in accessing sufficient resources, intra-household conflict over resources and abandonment, usually of the older wife.²⁹ An interesting trend reported almost everywhere is that the extent of polygyny is decreasing. There may be a correlation to increasing poverty, as fewer households are reported as being able to afford to keep multiple wives. In cases where polygyny is continuing, divorce of the first wife is common. In southern and central regions it is common for the first wife, or sometimes all wives, to work.

The Provisional Somali Constitution Article 28 on Family Care states that “no marriage shall be legal if one or both have not reached the age of maturity”. While age is not specifically mentioned, in Article 29 Section 8 a

child is defined as being less than 18 years old. There is an absence of laws and policies to implement this provision. Religious leaders do not speak out against early or forced marriages, nor do they issue religious *fatwas* against these practices.

Gender-based violence (GBV)

About three quarters of Somali women between the ages of 15 and 49 surveyed considered their husbands justified in beating them for any of five specific reasons.³⁰ The proportion of women believing this was significantly lower if they were formerly married rather than currently married, lived in an urban rather than rural area, or were from a wealthier household.

The Somalia Protection Cluster has a Gender Based Violence Information Management System (GBVIMS), but the reported figures are thought grossly to underestimate the incidence of such violence. Various reports and studies shed light on the problem and indicate that it is widespread.³¹ Boys can be raped or sexually assaulted but the overwhelming majority of attacks reported are on girls. Girls are typically raped or assaulted in the following contexts: returning home from market in the evening; fetching water or firewood; engaging in open defecation after dark; in the workplace. Assaults can, however, also occur at home. Girls from female-headed IDP households are particularly prone to rape and sexual assault. Incidents of sexual violence are reported to have increased in recent years in areas of the country affected by drought and conflict. Besides the physical damage sustained in attacks, survivors of rape suffer profound psychosocial impacts.

There is a strong stigma attached to rape in Somali culture. The victims feel fear, shame and loss of dignity. If they report the incident, they risk abuse, stigmatization, isolation and retaliation and most attacks therefore go unreported. The main sources of support for victims of sexual violence are health workers and mothers. Prosecutions and convictions for rape and other forms of sexual violence are extremely rare, and there is a climate of impunity. If parents are aware of the rape, customary law is the general means of recourse but girls and women do not have a voice in such forums. The rapist’s family gives compensation to the survivor’s family and/or the girl may be forced to marry her rapist.

28 World Vision, *Untying the Knot – Exploring Early Marriage in Fragile States*, 2013.

29 UNICEF, MICS3 & MICS4.

30 UNICEF, *Study on Designing Social Protection Frameworks for Somalia*, 2015.

31 UNICEF, MICS3, 2006. Specific reasons cited were: going out without telling; neglecting children; arguing; refusing sex; and burning food. Refusing sex ranked highest at 64 per cent, while burning food was lowest at 29 per cent.

24 WHO website.[more specific citation surely needed]

25 UNICEF, MICS3 & MICS4. The rate of marriage of girls under 15 is much lower in Somaliland and Puntland than in the rest of the country.

26 UNFPA, 2005.

Somali children share their hopes and fears

- Physical Violence -

In total, more than a third of children reported that they did not feel safe in their neighbourhood. They felt most threatened by their parents or other relatives in situations of domestic violence, by other children, teachers and the police. As many as 34 per cent of children said that they'd been beaten up or physically hurt in the last 12 months by someone from their family; 23 per cent by another adult they did not know; 29 per cent by friends or another young person they knew; and, 16 per cent by someone they did not know .

- "We are beaten by our teachers, parents and friends" – girls, 7-12, Baidoa.
- "Because my father does not live in the house, so anyone can hurt me otherwise they would have fear from my father" – boy, 7-12, Baidoa.
- "One day, I met a police who blocked me and slapped me" – boys, 7-12, Dolo.
- "We fear insecurity and conflict and bandits" – boys, 13-18, Dolo.
- "I was beaten by one of my relatives, and I can't see well now" – boy, 13-18, Baki.
- "My big sister always beats me with a big cane whenever I do something wrong, it made me form a habit of having nightmares about being beaten up by her" – girl, 10, Dangarayo.
- "Big children in my neighbourhood beat small children like me when they don't see their parents or my big siblings" – girl, 11, Garowe.

Children also spoke about the reasons that they might not report abuse:

- "In the case of abuse, elders prevent us from reporting the problem" – girls, 13-18, Baidoa.
- "Sometimes we just leave it in the hands of Allah" – girls, 13-18, Baidoa.
- "My parents cannot be reported because they are my parents" – boys, 13-18, Baidoa.
- "Sometimes I fear from parents, if they hurt me and I report them, they will punish me" – girl, 13-18, Baidoa.
- "I report to my (football) team so that we can revenge" – boy, 7-12, Dolo.
- "Feeling afraid that they can beat me again badly or kill me" – boy, 7-12, Dolo.
- "Fear of the police if we go to the police station to report them" – boys, 13-18, Dolo.
- "We do not know where the offices of the NGO are" – boys, 13-18, Dolo.
- "Children are not allowed to go directly to the police station" – boys, 7-12, Odweyne.
- "I do not report anything to anyone, I just keep silent" – girl, 10, Dangarayo.
- "I fear to be beaten by the accused person" – boy, 7-12, Dangarayo.
- "We cannot go directly to the police station unless we report to an elderly person first" – all girls in Garowe 13-18.

The current context in Somalia, with weak rule of law and lack of legislation and mechanisms for addressing GBV, allow such abuses to continue with total impunity. Security challenges affect legal services across Somalia, but particularly in southern and central regions, where survivors, lawyers, witnesses, journalists and family members have been threatened, harassed and arrested for reporting GBV offences. Legal-aid providers taking on such cases regularly receive death threats towards their staff. Fear of reprisals against staff, survivors, witnesses and medical personnel rise if the perpetrators are from the security forces. It is not surprising that survivors are hesitant to report cases of GBV. The lack of women in the justice sector is also detrimental to survivors reporting cases or pursuing

prosecution. In Somalia there is a clear link between the number of women in senior positions in the Criminal Investigation Department (CID) of the police as well as the Attorney General's office and the increase in reporting, investigations, prosecutions and convictions of perpetrators. Many negative practices have developed within the legal systems of each region that adversely affect the ability of survivors of GBV to access the formal legal system. In many cases, these negative practices have become accepted as policy, though in reality these practices are not in line with existing policy. These practices and a lack of understanding amongst legal-aid providers and other justice actors about what law and policy provides represents major challenges in all regions.

There are also enormous social, cultural and religious barriers in reporting GBV cases. Survivors are often reluctant to pursue prosecution or civil cases against the perpetrator due to the social stigma associated with rape. In rural and remote areas across Somalia the customary law (*xeer*) is used to resolve the majority of disputes. In GBV cases, the decisions reached are rarely survivor-centred.

The FSG is in the process of finalizing a 'Sexual Offences Bill'.

Juvenile justice and children in conflict with the law

In Somalia, there are many situations in which children come into conflict with the law. Family poverty, and subsequent neglect of childcare, drive children into risky and dangerous behaviour, including with criminal elements. Some children from marginalized groups and minority clans can also get into conflict with the law due to discrimination, violence and abuse. Ongoing armed conflict also creates a number of situations where children might be at risk of committing crimes. Presently there is only one prison in Somalia (Mandera Prison in Somaliland) that separates children from adults. All other children in custody in Somalia are currently held with adults. Placing children in jail with adults is highly detrimental to their physical and emotional well-being and could have lifelong negative impacts.

There are no statistics for children in conflict with the law. However, the special protections for children in conflict with the law would not be possible unless a juvenile justice system were created to respond to the specific needs of children. Somaliland has had a Juvenile Justice Law in effect since 2008, though it is not yet fully operational, and efforts are ongoing to establish a juvenile justice system. A child rights bill is in draft stage in Somaliland. Puntland has a Juvenile Justice Bill at the draft stage.

Children are exploited and abused with impunity since they have limited opportunities to receive justice, and there is limited accountability of violators due to weak law enforcement. Families do not trust the justice system due to low capacity and weak enforcement of laws. There are also a number of conflicting justice systems, which run parallel to one another – state, religious and traditional. As there are no special provisions in the legal system for protection of children, the best interests of the child are seen as secondary to the best interests of other stakeholders. Lack of birth registration makes it difficult to prove the age of the child, which can take away the system might offer to children. A number of laws have different ages for protection of children,

which creates confusion and prevents children from benefiting from any available protections. If children are in conflict with the law, parents and families may not have the time and resources to seek any available protections.

Structural factors and enabling environment

Challenges for the Somali family in protecting children

A number of studies shed light on the effect of the past decades of conflict and state collapse on the dynamics of Somali families.³² Fathers and husbands may become dependent on wives and children for family livelihood. Family breakdown can occur if a husband is not contributing to family livelihood and instead squander family income on qhat consumption, leading to loss of respect from his wife and children.³³ In difficult economic circumstances, husband and wife tend to blame each other for family problems, which may lead to an increased incidence of physical violence and verbal abuse. This can result in husbands divorcing their wives or departing or deserting the family and they may marry other wives to obtain additional economic support. In addition, husbands may be absent from the family due to death or the 'parking' of families in one place, including IDP or refugee sites, while they seek work elsewhere. The above factors have led to a substantial absence of fathers and husbands from the family and a rise in female-headed households in Somalia. Family breakdown impacts the protective environment of children in many ways, including the following:³⁴

- Poverty where the father has no livelihood and the mother cannot compensate, with consequences for health, education and meaning child labour becomes necessary.

32 Somalia Child Protection Cluster, GBVIMS Consolidated Data Report Jan-Jun 2015, 2015; Columbia Group Children in Adversity, Rapid Ethnographic Study of Community based Protection Mechanisms Somaliland & Puntland, 2013; Save Children, Somaliland Child Rights Situation Analysis, 2010; Amnesty International, Briefing Note on Rape & Sexual Violence in Somalia, 2013; Inter-Agency Child Protection Rapid Assessment South Central Somalia, 2014.

33 Gardner, Judith, and Judy El-Bushra, The impact of war on Somali men and its effects on the family, women and children, Rift Valley Institute, August 2015; Cabdi, Sucaad Ibraahim, 'The Impact of the War on the Family', Academy for Peace and Development, Hargeisa, , July 2002; Mohamed Ingiriis and Markus Hoehne, 'The Impact of Civil War and State Collapse on the roles of Somali Women: A Blessing in Disguise', Journal of East African Studies, , May 2013; Gardner, Judith, and Judy El Bushra, Somalia: The Untold Story – The war through the eyes of Somali women., Pluto Press, 2004.

Colombia Group for Children in Adversity, Rapid Ethnographic Study Somaliland & Puntland, 2013. The Impact of Civil War on State Collapse, Somalia the Untold Story.

34 Sources include: Cabdi, op cit; Gardner and El-Bushra, The impact of war on Somali men, op cit; Rapid Ethnographic Study; Save the Children, Research to Support Learning Child Protection in Emergencies, 2013; Adesco/UNICEF, Pastoral Situation Assessment, 2012; Save the Children, National Study Street Children Somaliland, 2013.

- Neglect of the children if the mother is occupied gaining family livelihood, and care of younger children being entrusted to older siblings, especially girls.
- The marriage of girls at an early age for economic reasons becomes necessary, which often involves a polygynous arrangement with an older wealthier husband.
- When older boys migrate from a rural area to a town they do not work for relatives but look for other opportunities, thereby increasing their exposure to protection risks. This is especially the case for pastoralist boys, who herd livestock often at the expense of educational opportunities.
- Older boys may engage in risky behaviour in trying to adapt to social economic pressures such as illegal migration (*Tahrib*) and recruitment into gangs or armed groups.
- Decades of ongoing conflict and frequent droughts have resulted in internal displacement, lack of shelter and access to basic services and also emigration. Displacement can result in separation of children from their families, which exposes them to exploitation, violence and abuse.
- Many studies and surveys consider the children of IDPs and minorities to be the most vulnerable to child rights violations. Most of those displaced by the 2011 drought are from minorities, at least in Mogadishu, and they were fleeing not just drought but also discrimination by majority clans.³⁶ More research is needed on this issue.
- At the community and family level, the concept of childhood, and special protections needed for it, do not form part of the cultural norms. In respect of protection and security, girls and women are controlled in every aspect of their lives, including their bodies. Older children are seen as a source of augmenting family income instead of being protected and nurtured for effective growth and development.

Other factors

- Overall, the relevant articles of the Provisional Constitution of the Federal Republic of Somalia are in line with the Convention on the Rights of the Child (CRC), which was ratified by the FGS.³⁵ The child is clearly defined in Section 8 as any person below 18 years of age. However, there is a need to follow up with corresponding domestic legislation. Once the laws are in place there is a need for new policies and the mechanisms and capacities to implement them. Even where laws and policies do exist, enforcement will be weak until the Government has full control over all the area in its jurisdiction.
- Conflict and political instability over recent decades has weakened governmental authority and the justice system is also weak. In this situation, the chances of justice for children, or of children in conflict with the law receiving special protection, are remote. The absence of paralegals and lawyers in rural areas is also a barrier for children seeking justice. Poor parents intent on survival may not have the time or resources to help their children seek justice following exploitation or abuse. Many children live away from their biological parents, and this may limit their right to justice violence or abuse occur. Societal acceptance of domestic violence and corporal punishment stands between child victims and justice. The lack of a framework for law and order allows many children to work in exploitative and abusive environments.

³⁵ Contained in chapter 2 of the Constitution 'The fundamental Rights and duties of Citizens'

³⁶ Majid, Nisar, & Stephen McDowell, 'Hidden Dimensions of the Somali Famine', Global Food Security, , 2012, <http://nin.tl/HiddenDimensions>

Role and capacity analysis for duty bearers in child protection

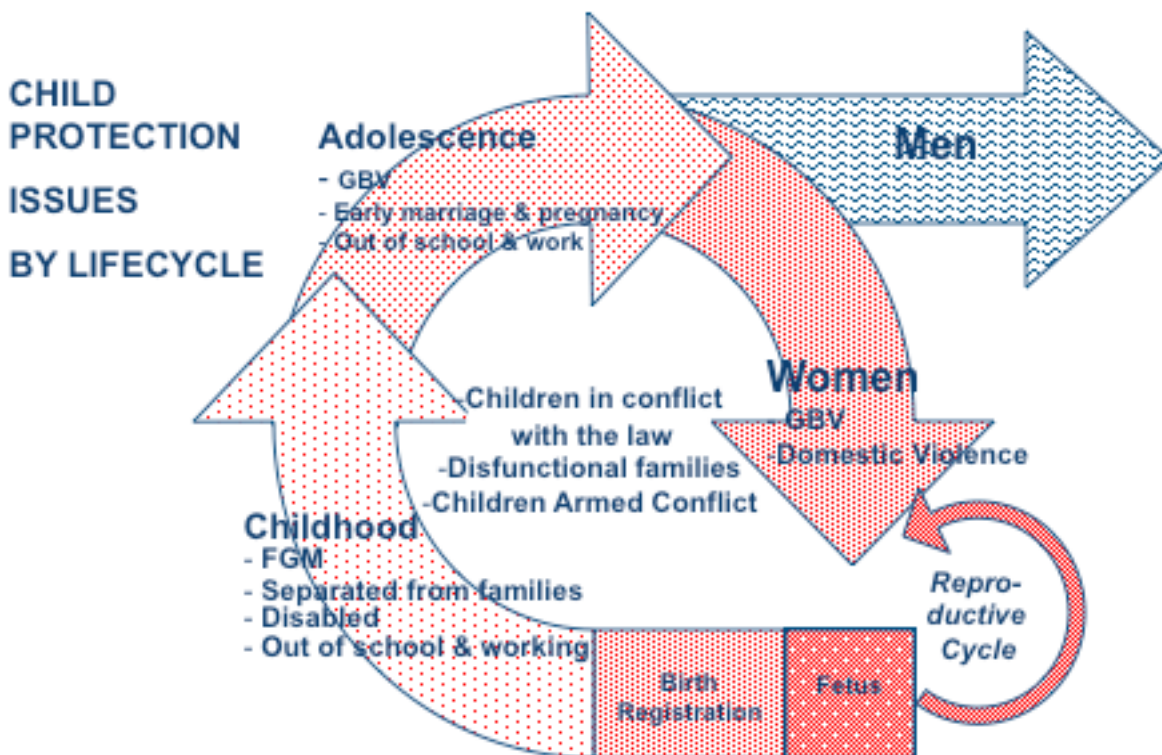
Level	MAIN ACTORS	ROLES	CAPACITY GAP
International Community	Donor community International NGOs/UN agencies International banks International government partners	Advocacy as part of global agendas. Fundraising. Technical assistance and capacity development. Service delivery.	The international community is large, with the donor and UN community remaining fairly constant while the INGO community tends to be more dynamic, with many INGOs coming in during a specific crisis and then leaving when funding is no longer available or when their priorities change. While most have a fairly robust capacity to deliver programmes, some INGOs take on a particular task or theme – such as GBV – because there appears to be donor interest in it and funding is available. Co-ordination of the child protection sector needs further strengthening. Donor interest in child protection has gradually increased.
State governments	The Somali government ministries related to child protection: <ul style="list-style-type: none"> Ministry of Labour and Social Welfare Ministry of Religion Ministry of Women's Affairs Ministry of Justice Ministry of Health Ministry of Education Ministries of National Security and Defence Ministry of Information 	Policy development, monitoring and evaluation, co-ordination, regulation, planning and strategic objectives, leadership, public campaigns, fund allocation and accountability, co-ordination and promoting collaboration, technical skills development, budget allocation.	<p>All ministries: Each ministry needs to assess the gaps in existing laws and policies related to the articles of the CRC. Based on the gaps identified, there is a need to develop new or improved laws and policies (gender sensitive and equity focused), prepare rules and guidelines and monitor implementation. Although there may be motivation to work on these issues, the ministries need knowledge about CRC commitments, reporting mechanisms to the CRC Committee and processes for aligning the country's laws to the CRC. They also need technical and financial resources for legislation and policy development as well as the establishment of co-ordination mechanisms amongst different ministries.</p> <p>In general, there is low priority given by government to child protection issues as compared with other sectors such as security.</p> <p>Ministry of Social Welfare: A cadre of social workers is needed to support implementation of child protection policies. There is some motivation but the main gaps are in technical and financial capacity.</p> <p>Ministries of Justice, Information and Health: These should take the lead in drafting legislation for birth registration and then construct and implement the system for it. The ministries lack the motivation, human and financial resources, and the technical capacity for this task.</p> <p>Ministry of Justice: This should take the lead in establishing a juvenile justice system. Traditional leaders should be engaged in a dialogue at community level for protection of girls, boys and women from violence and abuse as well as discontinuation of FGM. Laws should be amended to ensure that rapists are held accountable for their crimes and do not escape accountability by marrying the victim. Legal actors, including the judiciary, should be trained in the non-discriminatory and correct interpretation and enforcement of the harmonized laws (especially in relation to females and minority ethnic groups). In terms of capacity gaps, the Ministry needs to be motivated to lead this initiative. It has the necessary authority to take action, but needs technical support and financial resources.</p> <p>Ministry of Religion: This should lead a national discourse on rights of children from an Islamic perspective and should also issue a religious fatwa on particular violations of child rights. Motivation needs to be enhanced to take up this campaign. They would also require evidence and technical support for this initiative.</p> <p>Ministries of National Security and Defence: An action plan should be developed to prevent the recruitment or use of children in armed conflict, for example through screening exercises during recruitment. The plan should also cover the processes for re-integration of children who withdraw from armed groups. These ministries have the authority and motivation to undertake this task, but they lack the requisite technical and financial resources.</p> <p>Ministry of Information: This should work with the media to develop a sensitization campaign discouraging young people from joining armed forces/groups. The campaign should promote education, skills training, self-employment and community-building initiatives as constructive alternatives for girls and boys. The Ministry needs to enhance its motivation to take action, and should obtain authority for this campaign from the Cabinet. It also needs financial and technical support.</p>

Level	MAIN ACTORS	ROLES	CAPACITY GAP
Local Government	District and local social welfare officers	Supervision, co-ordination, data collection, advocacy for child-rights issues, implementation of government policies and protocols on the ground. Manage any other decentralized responsibilities.	Support implementation of child-protection-related policies. At this level the social workers' structure would have to be put in place as per national policy. The regional authorities would also need to establish a monitoring system to ensure effective implementation of the policies and structures. There are general capacity gaps related to technical and financial resources.
Civil Society	Diaspora, local NGOs, religious organizations and universities	Fundraising, advocacy and championing for child rights, especially for marginalized groups, and mobilizing communities. Also, social child welfare service provision.	<p>Local NGOs: Should work with communities to create awareness at the family level to prevent separation of children as far as possible and find alternative care as necessary. Community volunteers should be trained to monitor the situation of vulnerable children in the community and refer their cases to social workers. Local NGOs should also support the roll-out of a campaign to promote alternative care for children. Authority needs to be delegated by the Government to NGOs to undertake this task.</p> <p>Religious organizations: Should use their religious authority and established channels of communication to raise their voice and advocate for child protection issues at community and national levels. Their motivation needs to be enhanced to undertake this role, but once they get on-board, they can make a critical difference in the protection of children.</p> <p>Universities: Should create a quality curriculum and deliver social-work courses for the social workers cadre. The courses should include a gender-sensitization and equity focus in social-work interventions. Universities currently lack resources for developing and rolling out courses for this cadre.</p>
Private sector	Employers, health providers	Co-operate in public-private partnerships for the common good.	<p>Employers: Should initiate internships for young girls and boys to prepare them for entering the job market with adequate knowledge and skills. Child labour in all its forms should be discouraged. They have the necessary authority and resources but they need to be motivated to get involved in this initiative.</p> <p>Health providers: Should discourage FGM and cease any involvement in the medicalization of this.</p>
Communities	Community-based organizations (CBOs), elders, gatekeepers, clan leaders, women's groups, child protection committees, religious leaders, self-help groups, youth groups, volunteers	Awareness creation and advocacy on child rights; mobilization on particular campaigns; holding social-welfare officials accountable to deliver services.	<p>Communities should work with social workers and child protection committees to identify children who may be vulnerable to separation or already separated from their families. Communities can also provide local volunteers (male and female) to work with social workers in arranging referrals of vulnerable children for support and protection. Raise awareness at the family level to prevent separation of girls and boys and promote protective practices. Provide support for community-based alternative care and practice of <i>Kafala</i> (traditional community-based alternative child care). There is a lack of motivation to undertake these tasks because of inadequate information or other competing priorities. Communities may also lack resources.</p> <p>CBOs need to work with local authorities, clan leaders and families to establish community dialogue mechanisms to raise awareness on the dangers of recruitment of boys and girls to armed groups or community militias. CBOs are not sufficiently aware or motivated to undertake this initiative. They also have no authority to work on this issue. They will need technical support and financial resources.</p>

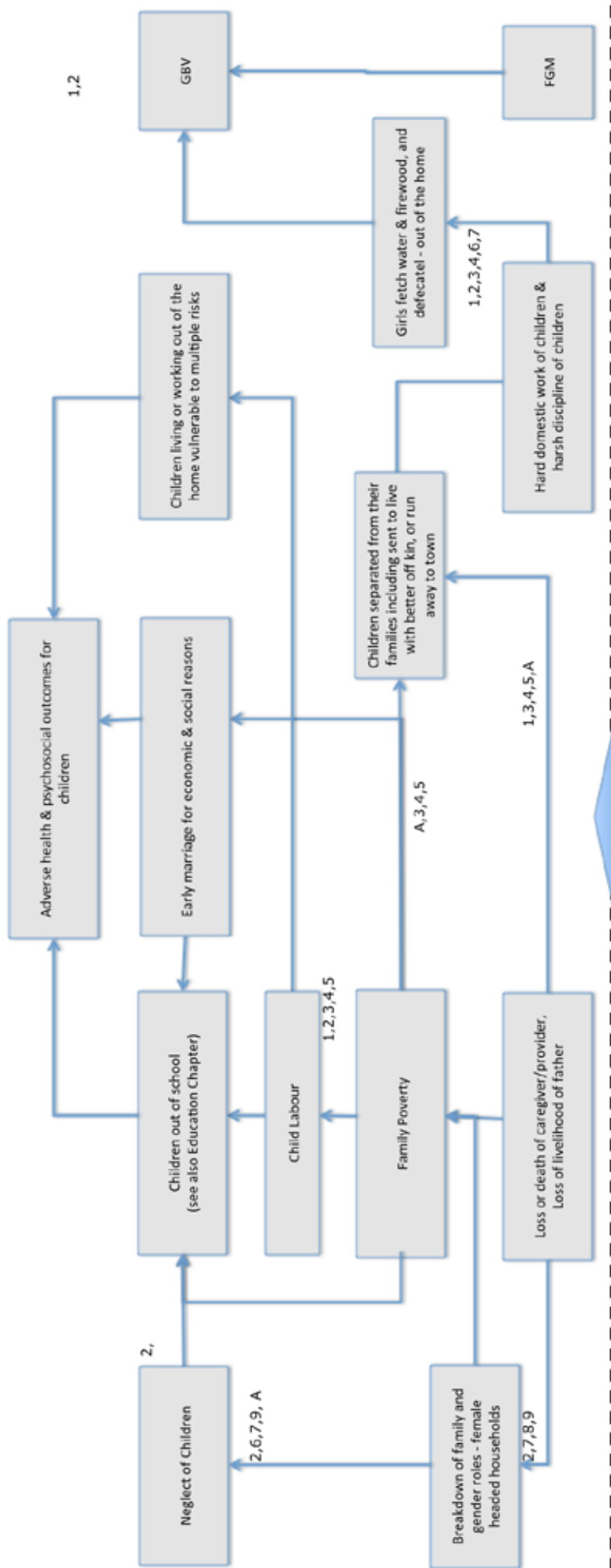
Level	MAIN ACTORS	ROLES	CAPACITY GAP
Family	Fathers, mothers, step-parents, older siblings, grandparents	Ensure that the family/home is an environment that protects and enhances the realization of child rights.	<p>Lack of financial capacity (i.e. poverty) is a fundamental capacity constraint for parents wishing to safeguard the rights of their children.</p> <p>Families are not well informed on the health and psychosocial issues relating to the violation of child rights, as with FGM. They may hold false beliefs such as that FGM is required by Islamic law.</p> <p>Parents and other family members need knowledge of the Rights of the Child and to understand their key role of duty bearer in putting that knowledge into practice.</p> <p>Fathers should help mothers to ensure the family stays together despite livelihood and other difficulties. Fathers should take action to avoid separation of children as far as possible. Fathers have the authority to take action but may lack motivation and a lack of resources may influence their actions.</p> <p>Families should prepare children to say no to recruitment offers by armed groups and should work with other clan members to stop children being recruited into clan militias. Fathers have low motivation and inadequate resources for this activity. Mothers may be more motivated to keep the children away from recruitment but they lack authority and resources, unless they are head of the household.</p>

Overview of issues and causal pathways

Child protection issues identified above can be mapped against different lifecycle stages as shown in the diagram below.



SOMALIA CHILD PROTECTION CAUSAL PATHWAYS



UNDERLYING CAUSES

DISPLACEMENT, CHILDREN ASSOCIATED WITH ARMED GROUPS, LACK OF CHILD PROTECTION RELATED LAWS & POLICIES AND WEAK GOVERNMENT CAPACITY TO IMPLEMENT THEM, SOCIAL CLIMATE OF IMPUNITY TO CHILD ABUSES & LACK JUVENILE JUSTICE, EXTREMELY LOW BIRTH REGISTRATION

ROOT CAUSE

CONFLICT & DROUGHT, COLLAPSE OF GOVERNANCE, BREAKDOWN GOVERNMENTAL LAW & ORDER, UNDERDEVELOPMENT INCLUDING LOSS OF LIVELIHOODS & UNEMPLOYMENT, DEMOGRAPHY WITH HIGH FERTILITY, SOCIAL NORMS INCLUDING GENDER DISCRIMINATION

Sources:

- A. Alternative Care Assessment Somaliland, and Puntland, UNICEF, 2015
- 1. Interagency Child Protection Rapid Assessment, CPWG, 2014
- 2. Rapid Ethnographic Study Somaliland & Puntland, Colombia, 2013
- 3. Research to Support Learning Child Protection , Save Children, 2013
- 4. Pastoral Situation Assessment 2012, Adesco/UNICEF
- 5. Somaliland Child Labour, ILO, 2011
- 6. National Study Street Children Somaliland, Save Children, 2013
- 7. Impact of War on Somali Men, Judith Gardner et al, 2015
- 8. Somalia the Untold Story: War through the eyes of Somali Women, Judith Gardner et al, 2004
- 9. Impact of War on Family, Saacad Cabdi, 2002
- 10. Hidden Dimensions of the Somali Famine, Majid/McDowell, 2012

Somali children share their hopes and fears

– The Ladder of Life –

Children were asked to think about a ladder and to imagine that a child at the top of that ladder represented a child in their community who was doing very well, and a child at the bottom of the ladder who was not doing well.

What are children saying about those at the top?

“They don’t need to go to school because they depend on themselves” – girl, 7-12, Baidoa

“They feel happy because they think they are superior to other children” – girl, 7-12, Baidoa

“They feel that they can live without us.” – boy, 7-12, Baidoa

“They don’t talk to us... they are proud... they feel as if they are the elites... they feel superior” – boys, 7-12, Baidoa, out-of-school

“This child has everything. He has a good education and health services. In holidays, he affords to go on tours with his family. He goes to school by car. He is happy with this life. He does not worry about school expenses such as school fees. He does not worry about a black future” – boy, 13-18, Dangarayo.

What are children saying about those at the bottom?

“This child is from a very poor family. He has completely nothing. He cannot buy anything. He does not go to school because his parents cannot pay school fees and cannot also get all learning materials such as books, pens and uniform. This child always works at market and polishes shoes for the people in the tea shops” – boy, 13-18, Dangarayo

“Actually, this child lives a very low life. He finds inadequate, inferior food. He patrols around the markets. He works for the people and they give him very little food. He eats left-overs, He has no opportunity to go to school. He gets no health services. He does not get full parental care. His life is always at risk” – boy, 13-18, Dangarayo

“They feel demoralized... unhappy... unwanted... unhealthy...unprotected... like they don’t belong in the community” – girls, 13-18, Baidoa

“They are very poor in many ways, either in school or in social life” – boys, 7-12, Baidoa, out-of-school

“They feel happy because they are contented with what they have” – girl, 7-12, Baidoa.

Strategic recommendations

Governments to enact laws and policies in support of CRC and allocate resources for implementation

- Somaliland has an existing juvenile justice law, and Puntland has a draft version of its own juvenile justice law in the final stages of consultation prior to submission to Parliament.
- Somaliland has a final draft 'Child Rights Law' prepared for legislative consideration, and Puntland has expressed the intention to draft such a law in 2016.
- Work is needed to lobby the FGS to ratify the Optional Protocols of the CRC and to remove its reservations to Articles 20 and 21 of the CRC itself.

Establish a national civil-registration system, linking current birth-registration pilot schemes to the system

Advocate for social transfers to protect children

- Provide social transfers to families to prevent family separation of children due to poverty

Strengthen social welfare and community-based systems

- Provide integrated services to children and families and respond to the situation of children vulnerable to exploitation and abuse

Advocate on issues related to cross-border trafficking/smuggling, and the protection of children at the risk of cross-border trafficking and smuggling

Establish systems for compliance and accountability in respect of child rights

Strengthen social-welfare services and community-based child protection systems

- Invest in prevention, sensitization and engagement at the community level
- Prioritize changing social norms
- Use global partnerships to leverage resources

Research to better understand key issues:

- The impact of kinship care arrangements
- The plight of children from minorities/IDPs/families in poverty
- Social norms around harmful practices.

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