UNFPA

Country Programme Action Plan
Between Somalia
And

United Nations Population Fund

2011-2015

Draft- Feb 2011

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Abbreviations and Acronyms

ANC	Ante Natal Care
ARH	Adolescent Reproductive Health
CBO	Community Based Organisation
CP	Country Programme
CPAP	Country Program Action Plan
FGM	Female Genital Mutilation
GBV	Gender Based Violence
HIMS	Health Information Management Systems
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDP	Internally Displaced Persons
LNGO	Local Non Governmental Organization
M&E	Monitoring and Evaluation
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOPIC	Ministry of Planning and International Cooperation
MOWDAFA	Ministry of Women Development and Family Affairs
PAC	Puntland Aids Commission
PMTCT	Prevention of Mother to child Transmission
PUNCHAD	Puntland Centre for Human Rights and Democracy
RDP	Reconstruction and Development Plan
RH	Reproductive Health
SARC	Sexual Assault Referral Center
SBACO	Somali Birth Attendants Cooperation Organisation(
STI	Sexually Transmitted Infections
TFG	Transitional Federal Government
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNOCHA	United Nation Office for Coordination of Humanitarian Affairs
UNSAS	United Nations Somalia Assistance Strategy
UNTP	United Nations Transition Plan
VCT	Voluntary Counseling and Testing
WHO	World Health Organization


SOMALIA
DJIBOUTI
ETHIOPIA
KENYA
GULF OF ADEN
INDIAN OCEAN
Djibouti
Saylac
Asayita
Dikhil
Boosaaso
(Bender Cassim)
Bandar Murcaayo
Caluula
Breeda
Qandala
Bargaal
Butyaalo
Laasqoray
Maydh
Xiis
Karin
Ceerigaabo (Erigavo)
Hurdiyo
Xaafuun
Iskushuban
Bullaxaar
Berbera
Baki
AWDAL
SANAAG
BARI
WOQOOYI GALBEED
Hargeysa
Burco
(Burao)
Oodweyne
Kirich
Garadag
Cardho
Dudo
Bandarbeyla
Diré Dawa
Boorama
Togwajaale
Nazrêt
Hârer
Jijiga
TOGDHEER
SOOL
Xudun
Taxeex
Buuhoodle
Laascaanood
Garoowe
NUGAAL
Gori Rit
Eyl
Degeh Bur
Berdaale
Xamure
Beyra
Seemade
Gaalkacyo (Galcaio)
Garacad
MUDUG
Werder
K'ebri Dahar
Megalo
Imi
Godé
Shilabo
War Galoh
Baxdo
Mirsaale
Hilalaya
Mereer-Gur
Dhuusamarreeb
(Dusa Marreb)
Hobyo
Hargele
GALGUDUUD
Ferfer
Ceel Huur
Beledweyne
Ceel Buur
Xarardheere
BAKOOL
HIRAAN
Xuddur
(Oddur)
Buulobarde
Derri
Ceeldheere
Dolo Bay
Luuq
Tayeeglow
Garbahaarrey
Baydhabo
(Baidoa)
SHABELLE DHEXE
GEDO
Mahadday Weyn
Cadale
El Beru Hagia
Buurhakaba
Wanlaweyn
Jawhar (Glohar)
BAY
Diinsoor
Baardheere
Balcad
Afgooye
Muqdisho (Mogadishu)
BANADIR
Qoryooley
Wajir
JUBA DHEXE
SHABELLE HOOSE
Marka (Merca)
Haaway
Bu'aale
Baraawe
Afmadow
Jilib
Bilis Qoogaani
Jamaame
JUBA HOOSE
Kismaayo (Chisimayu)
Buur Gaabo
Garsen
Lamu
Somalia
Caluula
Breeda
Bandar Murcaayo
Butyaalo
Bargaal
Qandala
Boosaaso
(Bender Cassim)
Laasqoray
Maydh
Xiis
Karin
Ceerigaabo (Erigavo)
Hurdiyo
Xaafuun
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Baraawe
Afmadow
Jilib
Bilis Qoogaani
Jamaame
JUBA HOOSE
Kismaayo (Chisimayu)
Buur Gaabo
Garsen
Lamu
SOMALIA
National capital
Regional capital
Town, village
Airport
International boundary
Regional boundary
Indeterminate boundary
Main road
Track
Railroad
0 50 100 150 200 km
0 50 100 mi
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
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Introduction

1. At the time of drafting this document, Somalia remains a much divided country without a national government. In fact, one could better say that the territory of the former Somalia has been since 1991 and remains today under the rule of multiple governments and armed groups.

2. As a result, this Country Programme Action Plan (CPAP) must be regarded, at best, as an early draft of a document which will need major revision if and when Somalia develops a national government.

3. The document, at present, is based on consultations with some ministries of the various government "entities", but not on a true national planning process. All that work will need to be done, if and as a process of national formation takes place.

4. In order to address this unusual situation, the CPAP is reflected in both a "national" frame and in a "zonal" frame. For the latter,the document reflects the three zones commonly considered by the international community as : Somaliland, Puntland, and South/Central Somalia.

Part I. The Framework

1. In mutual agreement to the content of this document and their responsibilities in the implementation of the country programme, the Government of Somalia, including the self-declared independent or autonomous states of Somaliland and Puntland (hereinafter jointly referred to as the Government) and the United Nations Population Fund (hereinafter referred to as UNFPA)

   Furthering their mutual agreement and cooperation for the fulfillment of the International Conference on Population and Development (ICPD) Programme of Action;

   Building upon the experience gained and progress made during the implementation of the previous Programme of Cooperation;

   Entering into a new period of cooperation;

   Declaring that these responsibilities will be fulfilled in a spirit of friendly cooperation;

Have agreed as follows:

Basis of Relationship

2. An agreement of assistance was signed by the Government of Somalia and the United Nations Development Programme on 16 May 1977. This agreement provides the foundation under which UNFPA has operated in Somalia since that date.
3. Since the Government may lack sufficient resources to fulfill its role, UNFPA will endeavor to support its efforts, especially to assist and protect vulnerable populations. The assistance shall seek to save lives, reduce human suffering and promote self-reliance and sustainable livelihoods for all populations in Somalia. UNFPA shall ensure the widest consultation with Transitional Federal Government (TFG) and local communities before embarking on project activities.
4. The Government shall ensure free and unimpeded access of UNFPA and other organizations of the United Nations to vulnerable populations in order to assess needs, identify and reach beneficiaries and monitor the delivery of assistance in a proper and effective manner, and ensure that all international aid supplies are utilized for their intended purpose.

Part II. Situation Analysis

5. **Plans** - The Country Programme is based on overlapping and inter-linked national and zonal plans:
   - the Somali Reconstruction and Development Plan (RDP), 2007-2012
   - the United Nations Transitional Plan (UNTP), 2008- 2010
   - the United Nations Somali Assistance Strategy (UNSAS) 2011-2015
   - the Puntland Development Plan 2008-2015

- Somaliland Development Plan 2007-2012

Of these five plans, the draft UNSAS was the most important element for UNFPA in preparing a Country Programme Recommendation, 2011 to 2015, for consideration by its Executive Board. This recommendation was approved by the Executive Board on 31 August 2010 and forms the legal basis for this CPAP.

6. **Studies** - In addition, this CPAP has been prepared on the basis of several important studies:
   - The Somali Joint Needs Assessment carried out from 2005 to 2007
   - The Multiple Indicator Cluster Survey of 2006
   - The Situation Analysis of Reproductive Health in April 2009
   - OCHA's situation report of mid 2010

7. **Government** - Currently Somalia is a divided country with three governments and various armed groups control different parts of the country. The main zones and governments are as follows:
   a. Mogadishu – partly under control of the Transitional Federal Government.
   b. South / Central Somalia – under control of various armed factions and local governments.
   c. Puntland – a self-declared autonomous state under the Government of the Puntland State of Somalia
   d. Somaliland – a self-declared independent nation under the Government of the Republic of Somaliland

8. The Transitional Federal Government (TFG) was established in November 2004. Its mandate was scheduled to expire in August 2011, but it was extended by Transitional Federal Parliament for three years in February 2011. Currently consultations are ongoing between TFG and International Community how to end the transition and what will be the nature of the next political dispensation. In preparing this CPAP, concerned ministries and UNFPA have relied on the Somali Reconstruction and Development Plan (RDP), 2007-2012 as the basis of planning.

9. The Puntland State of Somalia was established as an autonomous state within Somalia in August 1998. The Government of Puntland State was elected in early 2009 and has embarked on putting in place policies and plans for implementation of the Puntland Development Plan 2008-2015.

10. The Republic of Somaliland declared its independence from Somalia on 18 May 1991. So far it has not been recognized as an independent country by the international community, nonetheless it operates independently from Somalia. Somaliland has enjoyed relative political stability and developmental progress. The newly elected Government in 2010 is focusing on the implementation of the Somaliland Development Plan 2007-2012.

11. Due to the protracted security crisis in the whole of Somalia, the consequent isolation and political divide among the political entities, the ability of United Nations and partner organisations to undertake continuous dialogue with the Government and support programme interventions has been seriously hindered.

12. **Humanitarian situation** - The humanitarian situation in Somalia remains very precarious. As of mid 2010:

    a. 3.2 million or 43 per cent of the total population needed emergency humanitarian assistance.
    b. 1.4 million People internally displaced.
    c. One in six Somali children malnourished; one in five in south and central Somalia

13. **Reproductive Health** - There are considerable unmet needs in all major fields of reproductive health in Somalia. The health system is fragmented, highly privatized and underperforming, and suffers from major deficiencies in basic funding, qualified human resources and management mechanisms.

14. Barriers to accessing reproductive healthcare are many: low awareness of beneficial effects; financial obstacles in the form of user fees and logistical obstacles hinder access to healthcare especially by nomadic and rural populations. Poor quality of services, high numbers of unskilled staff, incoherent running of services and breaks in supplies, harm trust in the public sector and further aggravate the situation. This is clearly reflected in only one out of four pregnant women attending antenatal care.

15. The present pool of qualified reproductive health staff is small, aged and under-trained, with a grave shortage of qualified midwives. Urban clustering of qualified midwives and doctors leave rural areas relying heavily on auxiliary staff, most of who are inadequately trained. Doctors are presently graduating in small numbers, whilst midwifery education supported by UNFPA is ongoing on a small scale. There is no system in place for enforced deployment of new healthcare staff within the public system particularly to rural populations. Moreover, there are few effective mechanisms for motivation and retention, especially for the rural or difficult-to-reach areas.

16. The maternal mortality ratio (MMR) was estimated at 1,044 deaths per 100,000 live births (MICS, 2006).More than 90% of women deliver at home where they can only be assisted by a traditional birth attendant. Access to skilled delivery care and emergency obstetric care is poor, with a low caesarean section rate of only 0.5%. Rural and nomadic populations have no access to timely obstetric intervention should the need arise.

17. The availability of basic emergency obstetric care is 0.8 units per 500,000 population - far below the required 4 per 500,000. Within the available emergency obstetrics units quality of care remains very low with a case fatality rate of 20-33%. This unusually

high fatality rate reflects both the quality of care as well as delays in arrival of the patient to the hospital.

18. The average age of marriage in Somalia is 15.6 years and an estimated fertility rate of 5.7 children per woman. Only 1% of Somalia women use modern contraception method while there is an unmet need of up to 26%. Post-abortion care and medical treatment for victims of sexual and gender-based violence and STIs are seldom available. FGM/C, early marriage and high fertility after marriage, play major role in Somalia's high rates of maternal mortality. The age-specific fertility rate for 15- to 19-year-old girls is 123 per 1,000.

19. **HIV** - For much of Somalia the HIV situation remains difficult to measure. It is clear, however, that there are slight zonal variations with particular problems appearing in Port cities. Available figures in Somaliland show a generalized HIV epidemic with 1.3% of pregnant women attending antenatal clinics testing positive. In Puntland and South / Central Somalia the epidemic is believed to be more in concentrated pockets. The response to HIV and other Sexually Transmitted Infections (STI) has not prioritized most at risk populations and yet STI prevalence among those most at risk is 7.8%.

20. **Sexual Assault** -Incidences of sexual attacks on women and girls is on the rise. There were 138 incidents of rape, attempted rape/sexual assault, and forced prostitution reported for the period of May to July 2010. There is particularly high rate of sexual violence against internally displaced persons, where women are often heading households and where they are often bereft of clan protection. Gang rape is reported to be a new and rapidly rising threat to such women.

21. **FGM** - Female genital mutilation remains near universal, with an average of 98 per cent of girls being circumcised. Infibulation, the most dangerous form of female genital mutilation, remains common.

22. **Young People** - Youth (aged 15-24) represent almost a fifth of the Somali population (18.7 percent), most of whom have known only conflict and hardship in their life. This has resulted in a large number of young people who are uneducated, unemployed and marginalized youth, with limited recreational opportunities and poor access to health services, including reproductive health information and counselling. Due to the population momentum built into the current age structure, their proportion will continue to grow.

23. Special needs of adolescents for information about sexual and reproductive health are not being addressed. Lack of access to correct information and an absence of youth-friendly health services put adolescents at risk of unwanted pregnancies, STIs and HIV. Cultural barriers discourage open dialogue on questions relating to sexual health. It is not surprising that only 4% of young people aged 15 to 25 could identify means of prevention for HIV.

24. **Population and Development** - The Statistical systems in Somalia like other state institutions collapsed in 1991. No national census has been completed since 1975. While the more stable zones of Somaliland and Puntland have made efforts to revive their statistical institutions, there is still a major capacity gap within these institutions. These include;
    d. Inadequate and weak capacity of staff to develop statistical systems, collect, store and analyze data.
    e. Lack of crucial statistical data such as population census to support planning and policy formulation.
    f. Limited statistical equipment and unreliable means for data transport.
    g. There is no legal framework to guide the production and dissemination of statistical information.

Part III. Past Cooperation and Lessons Learned

25. **History** - The United Nations began providing assistance to Somalia before independence and unification of the former British and Italian trusteeship territories in 1960. The first agreement between Somalia and a United Nations agency after independence was signed in 1962. UNDP signed its first assistance agreement with Somalia in May 1977, but UNFPA had already assigned its first staff to work within UNDP in the early 1970's.

26. When civil war broke out in 1988 UNFPA continued to work in Somalia until December 1990, when the last of UNFPA's staff left Mogadishu. Thereafter UNFPA and most UN agencies based their country offices for Somalia in Nairobi. In 2003, UNFPA assigned a representative to be based in Nairobi for the Somalia office. From 2003-2006, UNFPA supported comprehensive reproductive health service delivery focusing on training and provision of medical supplies for internally displaced persons.

27. In February 2007 UNFPA re-opened its office in Mogadishu and, in addition, opened four new field offices of Baidoa in March 2007 and Galkayo in August the same year. In Hargeisa the office was opened in February 2007 and Garowe in May same year.

28. By mid 2007 much of south and central Somalia had come under control by militant groups. These groups became increasingly hostile to humanitarian workers and banned many of the NGOs through whom UNFPA and other UN agencies were working. UNFPA was forced to close its Mogadishu, Baidoa and Galkayo field offices by mid 2008. The field offices in Hargeisa and Garowe, however, continued to operate.

29. UNFPA's Executive Board in 2007 approved its first regular Country Programme (CP) for a two year period, 2008-2009. The programme was later extended to cover 2010, so as to align itself with the UN Country Team's (UNCT) plan for the next programme

cycle, 2011 to 2015. The Country Programme Action Plan (CPAP) for the 2008 – 2010 period was never signed.

Part IV. Achievements, Experiences and Lessons Learnt

30. **Achievements** – During the first Country Programme, the presence of UNFPA field offices in Hargeisa and Garowe led to close cooperation with partner ministries in Somaliland and Puntland. Considerable progress was made;

31. Both Somaliland and Puntland developed a reproductive health strategy, based on a thorough situation analysis carried out in 2008. Training institutes in Hargeisa and Bosaso graduated their first batches of post-basic and community midwives. In-service courses ensured strengthened capacity of service providers to provide emergency obstetrics services, family planning, and prevention of mother to child transmission of HIV.

32. In Mogadishu UNFPA supported the establishment of health facilities serving internally displaced people. In various parts of the country a fistula management campaign got underway. In addition, UNFPA provided safe delivery and hygiene kits to displaced populations in south and central Somalia.

33. Basic and comprehensive emergency obstetric care services were re-established through provision of medical kits, equipment and supplies, including blood transfusion units by UNFPA. UNFPA also financed in-service training of care providers.

34. Somaliland and Puntland developed Y-PEER youth networks and youth advisory panels. UNFPA supported training of religious leaders and community members in HIV/AIDS prevention.

35. UNFPA provided technical assistance and training for staff of ministries of planning in Somaliland and Puntland. The programme strengthened institutional capacity of ministries to respond to population and development needs in emergency, recovery and development situations. Feasibility studies were undertaken to assess the possibility of conducting major surveys and population census, with roadmap outlined for future surveys. A Human Resources Survey was conducted in Puntland with the findings expected to fill the gap in knowledge base regarding professional capacity within the Zone. UNFPA and other United Nations organizations supported local authorities and educational institutions to strengthen systems for data collection, analysis, reporting and management.

36. Somaliland and Puntland with UNFPA's support established coordination bodies for response to gender-based violence (GBV). Local NGOs working with the survivors of

sexual assault benefitted from training and commodities provided by UNFPA. These groups also undertook campaigns advocating the abolition of FGM. Ministries of health with UNFPA's support trained health care providers on medical management of FGM complications.

37. UN agencies and NGOs concerned with sexual violence established a GBV working group, chaired by UNFPA. This working group oversaw development of tools to record and report on sexual violence and helped design strategies for response.

38. **Lessons Learned** – Counterpart ministries and UNFPA during the first Country Programme learned:

    a. The need for flexibility in planning interventions according to the local humanitarian and political situation.
    b. Lack of trained manpower will continue to be a major constraint in all fields. Many highly-trained Somalis continue to leave the country, therefore training and retention of professionals continues to be an enormous task.
    c. Local NGOs play a critical role in delivering services, especially in hard to reach and remote areas where basic services are inaccessible. There is however need for close monitoring and also ensuring NGO's do not take over government mandate.
    d. Most social services have been privatized, and government provided services are at a fee. At present the government is unable to finance and manage extensive delivery of free services. Therefore, development plans need to take into account the private sector in service delivery, and government needs to adjust to a role of policy-setting and oversight.
    e. Support should be culturally appropriate especially when tackling sensitive issues like FGM and GBV.
    f. UNFPA's operational presence is critical to ensuring the projects develop properly. Well-trained national staff is key in ensuring programme activities are synchronized with government and local NGO partners, while paying attention to the political and cultural factors that may interfere with or support different projects.
    g. There is great value in inter-agency partnerships and joint programming/programme to optimize comparative advantages. However, this partnership must be strongest at the local level where activities are under implementation. It is important to co-locate project activities and to manage those activities jointly.

Part IV. Proposed Programme

39. The overall goal of the Country Programme is to bring improvement in the quality of life of the Somali people. The programme is designed to contribute to the three outcomes of the UNSAS:

i. Somali people have equitable access to basic services – health, education, shelter, water and sanitation;
ii. Somali people benefit from poverty reduction through equitable economic development and decent work;
iii. Somali people live in a stable environment where rule of law is respected and rights based and engendered development is pursued.

40. The overall strategy is two-pronged:
    a. Promoting and strengthening partnerships with Governmental, non-Governmental (NGOs) and community-based organizations(CBOs), and strengthening capacities and advocacy for delivery of humanitarian assistance aimed at reduced incidence of maternal mortality and morbidity, especially in South Central zone;
    b. Strengthening partner institutions and data availability to guide and monitor sustainable programmatic interventions in the areas of reproductive health, gender equality and population and development that specifically contribute to reduction of maternal mortality and morbidity.

41. **Reproductive Health** - The outcome of this component of the Country Programme by 2015 is intended to be an increased demand for, access to and utilization of equitable, improved reproductive health services, including in settlements for internally displaced people.

    Two outputs are planned to address this outcome.

42. **Output 1:** the programme by 2015 will reduce maternal and neonatal mortality and related morbidities by providing improved delivery of health services.

43. Many partners have shown interest in developing reproductive health and particularly maternal health. There is a common agreement on policies, strategies and activities to be taken to address the various problems. However, coordination and planning will be essential in maintaining this broad consensus. UNFPA will continue to lead reproductive health coordinating bodies at country office and zonal levels. In addition, UNFPA will provide high-quality technical assistance to counterpart ministries on training, setting standards and for development of manuals.

44. Strategies to address output 1 will include:

    b. Provision of technical capacity to partners to develop, monitor and coordinate the road map for maternal health issues - this should address currently fragmented approaches, as well as lack of ownership and leadership of the Government.
    c. Building the capacity of skilled birth attendants - this will include:

i. basic training of new midwives to increase the number of qualified midwives;
ii. In-service training for those already practicing.

d. identification of currently practicing midwives and providing them with in-service training and equipment;
e. Strengthening community midwifery – this includes equipping and staffing delivery points, while focusing in rural and remote areas.
f. Strengthening the capacity of health facilities to provide basic and comprehensive emergency obstetric care, as well as obstetric fistula repair for affected women – the objective is to reduce the high case fatality rate currently more than 20%.
g. Strengthening referral systems for emergency obstetric care - this will be mainly through targeting the 1st and 2nd delays in women reaching skilled providers.
h. Strengthening reproductive health commodity security – this will include provision of emergency delivery kits and family planning commodities and systems.
i. Increasing and consolidating partnerships to address reproductive health needs in emergencies – this will implement elements of the Minimal Initial Service Package (MISP).
j. Supporting the adaptation, production and training on standard reproductive health service protocols - the objective is to standardize the practices of care providers to ensure quality of service.

45. **Output 2**: The programme by 2015 will have increased the capacity of government and NGOs to offer:
    i. quality, comprehensive, sexual reproductive health services,
    ii. education and information for young people, with particular focus on most at risk young people.

46. Strategies to address output 2 will include:

k. Increasing the access to and use of integrated HIV/AIDS and reproductive health services; capacity building to health care providers, adaptation of standard guidelines to Somalia situation, provision of equipment and supplies. Partnership with NGOs and others are running health facilities to ensure continuity of services.
l. Supporting relevant ministries and the national AIDS commissions to lead monitoring and support for programmes; capacity building on programming process with focus on HIV/AIDS. Technical support and required information and supplies will also be provided.

m. Building the capacity of youth groups and networks to disseminate knowledge and information on reproductive health, including HIV/AIDS; capacity building on behavior change communication including training, technical support, studies and provision of information and supplies will be provided.
n. Supporting line ministries and civil society organizations to design and establish youth-friendly health facilities; technical assistance to the Gov to include youth friendly services and RH policies and provision of technical support, capacity building and supplies to implement the approved policies
o. Supporting the development of behavior change communication interventions with the goal of reducing high-risk behavior; capacity building to stakeholders, research on behavior, provision of guidelines, technical support for adaptation, development and production of materials. Support will be also extended to planning, implementation and monitoring of BCC programmes
p. Strengthening partnership with organizations, groups and networks addressing the needs of most at risk populations including the needs of the young people affected by conflict. Support the establishment of coordination mechanisms and exploring possibilities of joint programmes
q. Advocating for inclusion of Adolescents Sexual and Reproductive Health and HIV prevention in the national youth strategies; this is to be addressed through technical assistance for updating youth strategies.

47. **Population and development** - The outcome for this component by 2015 is intended to be improved systems of government for generating, analyzing and disseminating population and related data, with a focus on improving the monitoring of maternal health at zonal and levels in order to inform interventions in this area.

48. Ministries of planning with UNFPA's assistance will continue to build capacity of staff through on-the-job courses and study tours. The ministries will develop centralized data bases drawing on information from line ministries. UNFPA will support the equipping of relevant ministries with computer equipment and software needed for statistical work. Technical assistance will also be provided

49. There are two outputs planned to produce this outcome:
50. **Output 1:** Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and sub-zonal levels in order to inform interventions in this area.

51. Strategies and activities for output 1 will include:
r. Data collection and analysis of data related to reproductive health and gender; support on-job basic statistics capacity building for line ministries' data compilers, recruitment and placement of statistical experts in Ministry of Planning. Long term vision is to venture into advanced training courses on

statistics/demography for Ministry of planning and/or university lecturers who offer training to government personnel.

s. Formulation of population or statistics policies; in collaboration with Ministry of Planning, Health and Women Affairs UNFPA will support the development and maintenance of the Health Management Information System and a gender disaggregated database respectfully. In addition, there will be regular in-house training on Dev Info integrated database and IT equipment.
t. Technical assistance and capacity building for data production activities and preparation of reports by each zone on progress towards achievement of the ICPD Goals and Millennium Development Goals 4 and 5. Vital statistics collection and reporting mechanisms will be identified and supported to be publishing data on a quarterly basis. For planned surveys, UNFPA will provide technical assistance, capacity development and other logistical requirements. Publication of relevant publications such as Somaliland in figures and Development plans will be supported
u. Building the capacity and providing technical assistance to government and other partners to integrate maternal mortality and morbidity into emergency preparedness and response.
v. Formulation of population or statistics policy. UNFPA will support initial discussions' forum, technical assistance and capacity towards formulation and publishing of the initial policy document.

52. **Output 2:** Strengthened capacity of selected sectoral ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance.

Strategy for out put two will be;

a. Providing technical support and capacity building for better planning and monitoring of humanitarian assistance and recovery; UNFPA in partnership with UNHCR will coordinate IDP profiling and to improve service delivery to the IDPs in RH and Gender through use of evidence based planning.

53. **Gender** - The outcome of this component by 2015 is intended to be an improved socio-cultural environment in which gender equality, reproductive health and women's empowerment can advance.

54. UNFPA will seek in the programme period to help relevant ministries in addressing sexual violence and harmful practices that impact maternal mortality and morbidity UNFPA will continue to lead coordination groups on GBV response. In addition, UNFPA will work with various agencies in joint programmes:

a. UNFPA and UNICEF will continue joint efforts to combat FGM and early marriage.
b. UNFPA and UNHCR will continue to address sexual violence against displaced persons.
c. UNFPA and UNDP will work together to enhance access to justice for sexual violence survivors.

55. In these joint programmes UNFPA's role will be clearly defined as that of providing high quality technical expertise – including training, development of tools and curricula etc.

There are two outputs within this component**.**

56. **Output 1:** By 2015 an increased capacity for advocacy and community engagement in the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health.

57. **Output 2:** By 2015 the creation of enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situations.
58. Strategies for out put one and two include the following;

a. Capacity enhancement of law enforcement agencies and select medical providers to adequately respond to the needs of sexual violence survivors, including support to address the complication of FGM. Development and institutionalization of standard module for training in GBV response; exchange visits for police and medical providers for GBV, support setting up of sexual violence response center; development and inclusion of modules to address FGM complications in health service providers' training curricula.
b. Strengthening the institutional and community based mechanism to address the needs of sexual violence survivors including support to address FGM; Activities will include; establishing and strengthening referral networks and pathways for sexual violence survivors;
c. Addressing sexual and gender based violence as part of humanitarian response and education on the "must know" about GBV. Will focus mainly on conducting trainings and roll out mainstreaming GBV in humanitarian response; provision of services to women and girls IDPs survivors of violence; Addressing sexual and gender based violence as part of humanitarian response and as per Minimal Initial Service Package (MISP
d. Targeting community and religious leaders, young men and boys with awareness campaigns on early marriage and female genital mutilation. The activities will be aimed at: mass awareness towards enhancing attitude change among young men and boys and involving men as community leaders for attitude change ; Conducting Knowledge, attitudes and practices (KAP)

surveys among young men and boys on FGM and early marriage ; ethnographic studies on FGM

59. **Partnership** - Government authorities, agencies, and institutions will continue to be UNFPA's partners in execution of programmes. Relevant ministries, such as Planning, Health, Youth and Women's and Family's Affairs, will play key roles in providing policy and programme direction. In addition, UNFPA will continue to work through identified private institutions, such as teaching hospitals, media and pharmacies. UNFPA will continue its close partnership with local NGOs working in fields covered by the Country Programme.

60. **UN System**. Under the Somalia UNCT, the UN agencies, towards the achievement of the MDGs and the ICPD goals and in meeting the needs of vulnerable populations, including women IDPs and returnees. Aside from joint programme implementation, activities which may be done jointly include resource mobilization and pooling of resources, monitoring and evaluation, and other activities under the planned simplification and harmonization initiatives of UNCT Somalia.

61. **NGOs**. Recognizing the unique role of local and international NGOs augmenting government capacity in serving and assisting hard-to-reach poor and insecure areas, UNFPA will continue to work with NGOs on RH and gender issues, HIV/AIDS prevention and youth. Community-based organizations, in particular, will be tapped, for instance, in mobilizing community leaders and activists to effectively carry out outreach and educational activities.

62. **EU and Bilateral Donors.** These institutions will serve as partners in aid coordination and project co-financing and implementation. Exchanges of experiences and insights about development strategies and shared outcomes will be pursued in various donor fora and other venues.

63. **International Financial Institutions**. Among others, the African Development Bank and the World Bank are effective partners in supporting sector-wide assessments and interventions, as well as in conducting large-scale advocacy initiatives. Project co-financing will be explored with IFIs.

64. **Private Sector.** Initiatives to partner with the private sector in social service delivery will be explored.

Part V. Programme Management

65. At the time of drafting this CPAP, UNFPA's programme for Somalia is under direct execution by UNFPA. Once a national government has been formed, UNFPA will explore with the relevant ministries the possibility of national execution, under which national authorities would assume full responsibility for execution of the programme.

66. The overall objective of this programme management is to develop lasting partnerships with governments. This therefore means that there will be need for continued technical support to government to ensure independence in management of programmes and resources and coherence in donor reporting and accounting with UNFPA's. Therefore it is proposed that UNFPA continues working with government to support programme execution, while it explores long term ways of building government's own capacity to be self reliant both within operations and programmes.

67. Although UNFPA at present is directly executing programmes, it will do so in close cooperation with the relevant government ministries. UNFPA will carry out some activities directly or through its contractors. These contractors will include private and government institutions, as well as local and international NGOs. UNFPA will also carry out activities through government partners by reimbursing expenditures for specific activities agreed in advance in annual work plans (AWPs). In other cases UNFPA may advance funds to government partners for implementation of specific activities. In such cases government partners will provide prompt and accurate reporting of the completion of the activities and the use of the funds.

68. Government partners and UNFPA's own contractors will report to UNFPA according to an agreed format with copies to designated coordinating institutions and bodies. In case of sub-contracts, the contractor will report to the executing and implementing agency with copies to UNFPA. The executing agency will incorporate this information into its main report, which will include information on both programme and financial issues.

69. Each selected agency will submit an annual work plan to be discussed by all interested parties on the basis of guidelines provided by UNFPA. Within the year, quarterly and annual meetings will be called for implementers by UNFPA, in collaboration with coordinating institutions, to review status of implementation, achievements and results. Regular field monitoring visits in the project sites will be conducted, including during review meetings.

70. The following methods of providing financial assistance projects may be utilized by UNFPA in support of project activities:

I. Cash transferred directly to a ministry or government institution.:
   a. Prior to the start of activities (direct cash transfer), or
   b. After activities have been completed (reimbursement);

II. Direct payments to vendors or third parties for obligations incurred by UNFPA or other UN agencies in support of activities agreed with Government.

III. Following the completion of any activity, any balance of funds shall be reprogrammed by mutual agreement between the Government and UNFPA, or refunded.

71. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government ministry or institution, and of an assessment of the financial management capacity of the non-UN Government ministry or institution. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the Government ministry or institution shall participate.

72. The UNFPA country office for Somalia is temporarily located in Nairobi, Kenya and includes a representative, International Operations Manager and supporting staff. A deputy representative and supporting staff are located in Hargeisa. Other UNFPA offices are in Garowe and Galkayo, and there are plans for an additional office in Bosaso.

Part VI. Monitoring and Evaluation

73. UNFPA and relevant government ministries will monitor and evaluate this programme under the overall framework of the UNSAS. In doing so UNFPA and Government will work to ensure efficient utilization of programme resources as well as accountability, transparency and integrity at all levels.

74. UNFPA has prepared a monitoring plan to guide the process and support the Government in its reporting obligations on the Millennium Goals (MDGs) in the long term, and help UNFPA in reporting on the UNSAS and the 2011-2015 Country Programme.

75. UNFPA and the Government will conduct annual reviews to gauge performance and make changes for better programme delivery. A mid-term review of the CPAP would be conducted in the third year of the programme cycle. This review will involve a wide range of partners and stakeholders. UNFPA will also participate in the UN Country Team's evaluation of the UN Transition Plan 2008-2010.

76. UNFPA Somalia CO will support surveys and studies to determine the attitudes and opinions of people on issues like FGM and GBV.

77. Audits may also be conducted of project activities financed by UNFPA. Where more than one UN agency provides cash to the same government ministry or NGO, programme and financial monitoring and auditing will be undertaken jointly or coordinated with those UN agencies. A proper understanding and guidance to the process would be agreed beforehand.

78. While monitoring and evaluation will be fairly similar and standardised as regards to funds utilization and assessing the impact of programme interventions, UNFPA in the different zones will develop other more context specific tools and ways of monitoring and evaluation. This is primarily due to the variation in stability in the three zones and the areas of programming.

Part VII. Commitments of UNFPA

79. The Executive Board of UNFPA has authorized a regular resource allocation for the Somali programme for 2011 to 2015 of US$ 12.7 million.

80. UNFPA will attempt to mobilize an additional US$ 14.5 million from bilateral and multi-lateral funding institutions, global trust funds and the private sector. However, availability of these funds is subject to interest by funding partners and to availability of their own financial resources. In addition, in response to any humanitarian or crisis situation UNFPA may allocate emergency funds from its own resources or those of its funding partners.

Part VIII. Commitments of the Government

81. The authorities of the TFG, Somaliland, and Puntland shall ensure free and unimpeded access of UNFPA and other UN system organizations to vulnerable populations in order to assess needs, identify and reach beneficiaries and monitor the delivery of assistance in a proper and effective manner, and ensure that all international aid supplies are utilized for their intended purpose. The authorities shall support UNFPA in

its efforts to raise funds needed by the country programme. They will also organise and participate in periodic reviews.

82. Government and Government ministry or institutions agree to assist UNFPA in monitoring all activities and will facilitate access to relevant financial records and personnel responsible for the administration of funds provided by UNFPA. To that effect, Government ministry or institutions agree to the following:
    i. Periodic on-site reviews and spot checks of financial records by UNFPA or its representatives/contractors,
    ii. Programmatic monitoring of activities following UNFPA's standards and guidance for site visits.

83. The authorities will accord to UNFPA and its officials and to other persons performing services on behalf of UNFPA, such facilities and services as are accorded to officials and consultants of the various funds, programmes and specialized agencies of the United Nations. The authorities shall apply the provisions of the Convention on the Privileges and Immunities of the United Nations agencies to UNFPA's property, funds, and assets and to its officials and consultants.

84. As a contribution to the programme, UNFPA and the Government will share costs of programmes to the extent possible. UNFPA and the Government will organize periodic meetings for programme review, planning and strategy. To the extent possible, they will involve civil society and other development partners in planning, monitoring and evaluation of the progress of programmes.

85. Cash received by the Government and national NGO shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations, policies and procedures are not consistent with international standards, the UN agency regulations, policies and procedures will apply.

Part IX. Commitments of Other Partners

86. In the case of international NGO and IGOs cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the AWPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds.

87. To facilitate scheduled and special audits, each NGO or IGO receiving cash from UNFPA will provide UN Agency or its representative with timely access to:

    a. all financial records which establish the transactional record of the cash transfers provided by UNFPA;
    b. all relevant documentation and personnel associated with the functioning of the Government ministry or institution's internal control structure through which the cash transfers have passed.

88. The findings of each audit will be reported to the Government and UNFPA. Each Government ministry or institution participating in the Country Programme will furthermore:
    a. Receive and review the audit report issued by the auditors.
    b. Provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA that provided cash (and where the SAI has been identified to conduct the audits, add: and to the SAI).
    c. Undertake timely actions to address the accepted audit recommendations.

89. Report on the actions taken to implement accepted recommendations to the UN agencies (and where the SAI has been identified to conduct the audits, add: and to the SAI), on a quarterly basis (or as locally agreed).

Part X. Other Provisions

90. This CPAP supersedes any previously signed CPAP; and maybe modified by mutual consent of both parties.
91. Nothing in this CPAP shall in any way be construed to waive the protection of UNFPA accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which the Government is a signatory.

IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programmee Action Plan on this day , *month, and year* in *[name of city, name of country].*

For the government of ---------- ***For UNFPA***

(Name, Title)

The CPAP Monitoring and Evaluation Calendar

Country: Somalia

CP Cycle: Second 2011-215

	Year 1	Year 2	Year 3	Year 4	Year 5

M&E activities[1]	**Surveys/studies**	• Support MICS4 • Quick Population Count-QPC • KAP/opinion surveys • Vital statistics in one region, each, of PL and SL • Mapping of Health facilities and trained health care providers (HCPs) • Ethnographic study on drivers of FGM	• RH and GBV data collection during IDP Profiling in PL and SL • Vital statistics in all regions of PL and SL • Human resource survey in SL	• KAP surveys for FGM/C and GBV • RH Needs Assessment • Study on linkages of maternal mortality with FGM/C and GBV • Preparations for House Hold Survey	• Data collection and analysis of house hold survey • Vital statistics in one region of SCZ	• Vital statistics in all regions of SCZ • KAP surveys for FGM/C and GBV • Support the preparation of MICS5 • Feasibility study on national census

		Year 1	Year 2	Year 3	Year 4	Year 5
M&E activities[1]	**Monitoring systems**	• M&E framework, plan and annual calendar development • Monitoring visits and reports • Enhanced orientation of Y-Peer Network / contractors on M&E • Joint M&E activities with the Planning Ministries at Zones level • Analysis and follow-up on 2010 PL Human Resource Survey • Analysis of lessons learnt from vital statistics activities • Analysis of RH related data from HMIS • UNSAS reports • Annual reviews and reporting • AWP monitoring tool • IP/contractors reports • Review and analysis of all reports at CO level	• Joint M&E activities with the Planning Ministries • Analysis of RH related data from HMIS • Analysis of IDP Profiling for RH and GBV related indicators in PL and SL • Preparations for Program Cycle MTR • KAP surveys • Household survey preparations	• Second Program Cycle MTR • AWP monitoring tool • Household survey preparations	• IP/contractors reports • Preparations for Second Program End Cycle evaluation • KAP surveys • Household survey	• End Cycle evaluation • Preparations for third Program Cycle
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**

M&E activities[1]	**Evaluations**	• End of 1st cycle evaluation • Annual reviews	• Annual reviews	• Midterm review of second Program cycle • Annual review	• Annual review • Preparation for situation analysis	• Programme Evaluation • End cycle
M&E activities[1]	**Reviews**	• Programme component MYR • Annual review (December) • UNSAS Annual review (December) • COAR	• Programme component MYR • Annual review (December) • UNSAS Annual review (December) • COAR	• Program cycle midterm review (MTR) • Programme component MYR • Annual review (December) • UNSAS Annual review (December) • COAR	• Programme component MYR • Annual review (December) • UNSAS Annual review (December) • COAR	• Programme component MYR • Annual review (December) • UNSAS Annual review (December) • COAR
	Support activities	• Field Monitoring visits • Dissemination of 2010 PL Human Resources Survey	• Field Monitoring visits	• • Field Monitoring visits	• Field Monitoring visits	• Field Monitoring visits

		Year 1	Year 2	Year 3	Year 4	Year 5
Planning references[2]	**UNDAF final evaluation milestones**	• UNSAS formal launch		UNSAS MTR		UNSAS final evaluation
	M&E capacity-building	• Enhanced orientation activities of partners and contractors on M&E and SomInfo at zones level			• Refreshers on M&E activities at all levels	
Planning references[3]	**Use of information**	• Dissemination of 2010 PL Human Resources Survey • Dissemination of Vital statistics	• Dissemination of KAP survey results • Dissemination of MICS43 2011 results • Dissemination of Vital statistics • Dissemination of IDP profiling results on RH and GBV	• Dissemination of Vital statistics • Dissemination of IDP profiling results on RH and GBV • Dissemination of RH Needs Assessment results • Dissemination of SL Human Resources Survey results	• Dissemination of Vital statistics • Dissemination of IDP profiling results on RH and GBV	• Dissemination of Vital statistics • Dissemination of IDP profiling results on RH and GBV • Dissemination of Household survey results

	Partner activities	• MDG report • UNSAS review • MICS4 • QPC	• MDG report • UNSAS review • Vital statistics	• MDG report • UNSAS review • Vital statistics • UNSAS and CP Cycle midterm reviews	• MDG report • UNSAS review • Vital statistics	• MDG report • UNSAS review • Vital statistics

Somalia CPAP Planning and Tracking tool 2011-2015

RESULTS	**Indicator**	**MoV**	**Responsible party**	**Baseline**			**Target**				**Achievement**			
UNSAS outcome	Somali people have equitable access to basic services – health, education, shelter, water and sanitation.													
	Indicator	**MoV**	**Responsible party**	**YR1**			**YR2**		**YR3**		**YR4**		**YR5**	
				baseline	**target**	**achievement**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**
CP Outcome 1														
Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia,														
	% of births attended by skilled birth attendants	MICS	MOH/UN	9% (MICS 2006) To be updated once results from MICS 4 will become available,late 2011	TBD, based on MICS 4 results		TBD, based on MICS 4 results		TBD, based on MICS 4 results		TBD, based on MICS 4 results		TBD, based on MICS 4 results	

including in settlements for internally displaced people.	Percentage of most -at-risk populations reached with HIV prevention programs	UNGASS Bi-annual reports, nation-wide mapping survey	MOH/UN	No data available	TBD, based on the results of nation-wide mapping survey, conducted late 2011		TBD, based on the results of nation-wide mapping survey, conducted late 2011		TBD, based on the results of nation-wide mapping survey, conducted late 2011		TBD, based on the results of nation-wide mapping survey, conducted late 2011		TBD, based on the results of nation-wide mapping survey, conducted late 2011	
Output 1.1: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities.	Number of obstetric fistula cases successfully repaired at supported sites	M/E, health centre records	MOH/UNFPA	Baseline NA	60		60		60		60		300	
	Number of graduated midwifes	M/E, institutional records	MOH/UNFPA	Baseline NA	60		60		60		60		300	
	Number of service delivery points in target sites providing at least three modern family planning methods	M&E Facility assessment	MOH/UNFPA	Baseline 0%	5%		5%		5%		5%		25%	
	Proportion of service delivery points correctly use protocols and guidelines of maternal health (FP,ANC,PNC,EmOC)	M&E Survey, programme progress reports and training reports	MOH/UNFPA	0%	5%		15%		25%		35%		50%	

	Case fatality rate of maternal complications	Health Centre Records	MOH/UNFPA	21%	20%		18%		15%		12%		10%	
	Ratio of B EMOC facilities per 500.000 population	M/E	MOH/UNFPA	BEmOC 0.8	1		1		2		3		4	
	Ratio of C EMOC facilities per 500.000 population	M/E	MOH/UNFPA	CEmOC	1		1.2		1.5		1.8		2	
	% CS out of total births	Survey	MOH/UNFPA	0.05%	0.06%		0.08%		0.1%		0.2%		3%	

Output 1.2: Increased capacity of government and identified community based and non-governmental organizations to offer quality, comprehensive, sexual reproductive health services, education and information for young people, with particular focus on most at risk young people.	Number of youth peer educators trained in HIV/AIDS prevention and questions relating to adolescent sexual and reproductive health	M/E Programme progress reports, Focus group discussions to assess quality	MOH/UNFPA	180	240		300		360		420		480	

CP outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning,														
	Maternal mortality and morbidity monitoring system developed in selected sites.	M/E, Progress Reports	MOH/ UNFPA	System not exist	System developed and piloted on selected sites		10%		20%		35%		50% of the system fucnctional	

delivery and monitoring of humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal level ensured.														
	Number of institutions with strengthened systems in applications of data for humanitarian, recovery and development interventions.	M/E, Progress Reports, Focus Group discussions to assess quality	MOPIC/ UNFPA	2	3		4		5		6		7	
Output 2.1: Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and sub-zonal levels in order to inform interventions in this area														

Output 2.2: Strengthened capacity of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance	Number of trained personnel with expertise in collection, analysis, dissemination and application of demographic and related data for humanitarian, recovery and development interventions	M/E, Progress Reports	MOPIC/ UNFPA	40	100		50		50		50		250	

Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved	Comprehensive national policy and strategy on gender issues, integrating GBV and FGM endorsed and operational	Draft National Strategy	MOWDAFA/UNFPA	A draft national strategy exists in Puntland, In Somaliland FGM needs to be integrated to the endorsed strategy	FGM and GBV integrated into Somaliland National Strategy		National Strategy in Gender endorsed in Puntland		Draft prepared for SCZ,		National Strategy endorsed at SCZ		3zones Have operational strategy	
	Qualitative surveys on attitudes on FGM and Early marriage	Surveys	MOWDAFA/UNFPA	0	1		2		3		4		5	

Output 3.1: Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	Proportion of key decision makers, community, NGOs, women's groups and religious leaders supporting gender equality, including elimination of GBV	M/E	MOWDAFA/UNFPA	No Data available	TBD 2011		TBD 2011		TBD 2011		TBD 2011		TBD 2011	
	Types of attitude change initiatives conducted to address FGM and early marriage	M/E	MOWDAFA/UNFPA	0	1		2		5		8		10	

Output 3.2: Enhanced systems and mechanisms	Number of initiatives of support established	M/E study	MOWDAFA/UNFPA	Data not available. Target will be set in 2011

for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation	Percentage of relevant law enforcement personnel in provinces trained to identify and manage cases of domestic violence	M/E	MOWDAFA/UNFPA	Data not available. Target will be set in 2011										
	Number of community based initiatives against gender based violence especially targeting young men and boys	M/E	MOWDAFA/UNFPA	0%	5		10		20		30		50	
	Number of institutions providing services to survivors of gender based violence	M/E, facility mapping	MOWDAFA/UNFPA	5	10		20		30		40		50	

Risks and Assumptions

State major risks and assumptions that could influence achievement of CP outputs and outcomes as indicated in the CP document. Assess whether risks materialized, whether original assumptions were correct and highlight factors which facilitated or constrained results achievement.

Instructions:

1) Use one sheet per CP Outcome.
2) Where the CP is more complex, the matrix can be adapted by breaking CP outputs into sub-outputs with baselines, targets and achievements.
3) It is useful, to the extent possible, at the beginning of the CP cycle to establish tentative output/sub-output targets for each year in the cycle.

Somaliland
Situation Analysis

1. Somaliland borders Djibouti to the west, Puntland to the east, and Ethiopia to the south. The northern coast line runs the entire length of 740km border along the Gulf of Aden. Following the fall of Siad Barre, Somaliland declared independence on 18 May 1991 and a parliament was established by consensus. However, Somaliland is not recognized by the international community as an independent state.

2. Key milestones in the democratization process include the adaptation of a new Constitution in 2001, local elections in 2002, presidential elections in 2003 and the first multiparty parliamentary elections on 29 September 2005. Presidential elections scheduled for 2008 were delayed on numerous occasions but finally held on 26 June 2010. Over one million people voted and the elections were declared free and fair by international observers. A peaceful transfer of power from the UDUB party to the Kulmiye party led to the formation of a streamlined government under President Silanyo in mid-2010. It set a series of priorities for its first 100 days in office and succeeded in increasing government revenue by 24% by the last quarter of 2010.

3. Although Somaliland has experienced comparative stability and has succeeded in the establishment of nascent authorities, institutional capacity remains limited. The border dispute with Puntland and localized struggles over resources means Somaliland continues to be susceptible to conflict. Somaliland has also been negatively affected by the conflict in South Central Somalia as evidenced by the three vehicle bombs in Hargeisa in October 2008. Somaliland authorities have successfully foiled a number of possible attacks in recent years through arrests and confiscations of explosive devices.

4. The humanitarian context in Somaliland is markedly different from that in most parts of Somalia where conflict-related humanitarian needs dominate. Somaliland's, humanitarian needs are mostly a result of natural factors, such as a long drought and floods. Somaliland continues to receive IDPs and influx increases at the times of security deterioration in the South Central zone of Somalia. Authorities continue to need support in dealing with the response and coordination of these, as well as the support for strategies to ensure equitable delivery of services, and ultimately the integration of displaced persons, should they decide to remain in Somaliland.

5. **Reproductive health;** despite scarcity of reliable statistics, evidence show that Somaliland is characterized by high disadvantage reproductive health indicators. The Maternal Mortality ratio figure for Somaliland is not available. The fertility rate is high at 5.9 children per woman and the unmet need for family planning is 29%. Modern contraceptives use rate is at 4.6% and one in four antenatal visits are 32% and 10.3% indicating low contact with health services. TT2 coverage is 17% and deliveries at health facility or under the supervision of skilled birth attendant are 21%. Despite this relatively high coverage of institutional delivery, case fatality rate

for obstetric complications is as high as 21% indicating poor quality of services at health facilities or delayed reporting to facility when complications arise. Case fatality rate is an important policy directive that health facilities are to be targeted for improvement of quality of care as well as targeting the community for minimizing the 1st delay at home and 2nd delay on the road.

6. There are no facilities to handle basic emergency obstetric care as indicated by only 1.1 Basic Emergency Obstetric Care facilities available for 500,000 populations far below the recommended level of 4. Although availability of comprehensive Emergency Obstetric Care is at 1.7 higher than the recommended 1, accessibility is a considerable factor for utilization as indicated by the very low caesarean section rate of only 0.4% out of total deliveries far below the recommended (5%) to respond to major complications.

7. The met need of emergency obstetric care was less than 12% (% treated of expected obstetric complications) as compared to the standard of 100%. This indicates the under utilization of the existing facilities, a factor attributed to barriers of accessing Reproductive Health services such as; low awareness of RH benefits amongst the targeted population; financial obstacles in the form of almost universal user fees and expensive and inaccessible logistical issues that hinder access to health facilities, poor quality of services, a high number of unskilled staff, incoherent running of services and breaks in supplies, harm trust in the public sector and further aggravate the situation.

8. Obstetric fistula and FGM related complications especially those related to child birth are common among cases reported in hospitals. For instance every year since 2007 when UNFPA started the 1st fistula repair campaign in Somaliland, as many as 100 cases have been operated annually in Hargeisa group, Buroma Fistula Centre and Edna Eden Hospitals.

9. The current trend of vertical programs does not favour maternal health programs due to the need for a health system approach. Innovative service financing mechanisms are sorely needed to replace the present system of major out-of-pocket payments for Reproductive Health services, which gravely hamper access, performance and utilization.

10. **HIV/AIDS;** The latest HIV data highlight generalized features in Somaliland with HIV among pregnant women attending antenatal clinics at 1.3 percent. HIV prevalence among STI patients is above 5% indicating that a routine provision of HIV testing and counselling to STD patients is limited. The prevalence of HIV among Commercial Sex Workers is 5.2% while syphilis is 3.1%, and with 0.4% co-infected. The ANC site in the port city of Berbera where there is high cross border mobility and trade has shown a steady increase in HIV prevalence between 1999(0.0 %,) and (2.7 %) in 2007. This confirms the potential contribution of mobile populations and associated behaviours in transforming cross border towns and ports into potential cores of HIV transmission.

11. There is limited access to information on services available, prevention, treatment, care and support to populations at risk; including access to condoms, VCT and STI treatment. Therefore the need to target interventions more effectively focusing on reducing risks to HIV Infection among most at risk populations is critical.

12. The Somaliland health system does not comprehensively address HIV prevention within the existing major health facilities; Maternal Child Health centres, a factor that is affecting access to SRH and HIV information and services for Most at risk groups. Healthcare workers and programs are ill equipped to provide integrated /linked HIV and RH services in the existing Primary health care setting.

13. **Gender**; Prevalence rates of female genital mutilation remain high at an average of 94 per cent in Somaliland and infibulation, the most dangerous form of female genital mutilation, is still practiced. Female genital mutilation persists, due to deep-rooted traditions and cultural practices and any legislative framework to ban it prompts strong social resistance.

14. The formal justice system to address women's rights violations is very weak. The low capacity of the law enforcement agencies and lack of adequately equipped facilities to respond to violations, mean that cases of violence including cases of sexual violence like rape are still referred to the traditional justice mechanisms with negative outcomes for women and girls who are violated.

Proposed Programme

15. The overall strategy for Somaliland will be in line with the approved 2011-2015 CPD. It will focus on: (i) promoting and strengthening partnerships with Governmental, non-Governmental (NGOs) and community-based organizations (CBOs); and (ii) strengthening partner institutions and data availability to guide and monitor sustainable programmatic interventions in the areas of reproductive health, gender equality and population and development that specifically contribute to reduction of maternal mortality and morbidity. The human rights-based approach will be integrated into planning and implementation of the programme.

16. **Reproductive health component;** the outcome of this component is: demand for, access to and utilization of equitable, improved reproductive health services are increased in Somaliland, including in settlements for internally displaced people.

17. **Output 1**: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities. Strategies include
    a) Develop, monitor and coordinate the implementation of the road map for reduction of maternal mortality;
    b) Building the capacity of skilled birth attendants;
    c) Strengthening the concept of community midwifery to improve maternal health;
    d) Strengthening the capacity of identified health facilities to provide basic and comprehensive emergency obstetric care as well as obstetric fistula repair for affected women;
    e) Strengthening referral systems for emergency obstetric care;

f) Strengthening reproductive health commodity security, including provision of emergency delivery kits;
g) Increasing and consolidating partnerships to address reproductive health needs in humanitarian context and emergency situation as per Minimal Initial Service Package (MISP);
h) Supporting the adaptation, production and training on standard reproductive health service protocols.
i) Awareness raising and building of community based mechanisms to address service utilization and minimization of the 1st and 2nd delays in improving maternal health outcomes.
j) Strengthening partnerships and coordination with organizations, groups and networks addressing maternal health.
k) Capacity building to national planners at all levels to better manage maternal health programmes.

18. **Output 2:** Increased capacity of government and identified community based and non-governmental organizations to offer quality, comprehensive, sexual reproductive health services, education and information for young people, with particular focus on most at risk young people. Strategies include:
    a) Advocating for inclusion of Adolescents Sexual and Reproductive Health and HIV prevention in existing National Youth Strategy;
    b) Increasing the access to and use of integrated HIV/AIDS and reproductive health services;
    c) Supporting community based interventions with selected line ministries and the National AIDS Commissions;
    d) Building the capacity of youth groups and networks to disseminate knowledge and information on reproductive health, including HIV/AIDS;
    e) Supporting line ministries and civil society organizations to design and establish youth-friendly health facilities;
    f) Supporting the development of behaviour change communication interventions with the goal of reducing high-risk behavior;
    g) Strengthening partnership with organizations, groups and networks addressing the needs of most at risk populations including the needs of young people affected by conflict.

19. **Population and development component** The outcome for this component is: Availability of reliable demographic and related data, institutional capacities and systems development for planning, delivery and monitoring of recovery and development policies and programmes, especially regional level in Somaliland ensured. Two outputs will contribute to this outcome

20. **Output 1:** Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on regional and sub-regional levels in order to inform interventions in this area. Strategies include;
    a) Supporting establishment, strengthening and periodical updating of integrated population database on indentified issues; will continue strengthening the planning units through provision of IT equipment when required and support to data harmonisation initiatives.
    b) Development of the framework and support for evidence-informed advocacy on maternal health promotion; Currently there is no population policy or data production strategy in place in somaliland and this permits statistics collection and dissemination to be done in an uncoordinated

manner, without set targets or agreed standards. A population Policy to guide data production and dissemination will be formulated through involvement of all stakeholders.

c) Supporting collection, analysis and use of data on maternal mortality and morbidity; UNFPA will work closely with relevant ministries in the development of the Health Information Management System (HMIS), vital statistics systems and other social demographic data to ensure that the systems captures information relevant for maternal mortality reduction strategies.
d) Building the capacity of government and other partners to integrate maternal mortality and morbidity into emergency preparedness and response. UNFPA will work in collaboration with UNHCR in IDP profiling to get information on their reproductive health needs.

21. **Output 2**: Strengthened capacity of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance. Strategies include

a) Improving the capacity of selected sector ministries and partner organizations in data collection and analysis; UNFPA in collaboration with local education institutions will continue conducting in-service training courses for staff from statistical departments of line ministries. Follow up training courses on DeVInfo will also be conducted.
b) Providing technical support for better planning and monitoring of humanitarian assistance and recovery; this will be achieved through recruitment of consultants and study tours for relevant ministry of planning personnel

22. **Gender component:** The outcome of this component is: Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved. There are two outputs within this component.

23. **Output 1:** Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health. Strategies include

a. Awareness raising on the effects of female genital mutilation and early marriage on maternal and neonatal mortality and morbidity;
b. Advocating for implementation of laws prohibiting female genital mutilation;
c. Enhancing community-based efforts to address harmful effects of early marriage and female genital mutilation;
d. Strengthening community based initiatives to enhance the retention of girls in formal and non formal education
e. Targeting community and religious leaders, young men and boys with awareness campaigns on early marriage and female genital mutilation.

24. **Output 2:** Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation. Strategies include

a. Strengthening the capacity of selected non-governmental and community-based organizations to provide health and psychosocial support to survivors of gender-based violence, including support to address complications of female genital mutilation;

b. Supporting the institutionalization of modules on prevention of gender based violence in a training of trainers curricula for health care providers;
c. Strengthening community level safety nets for survivors of gender based violence;
d. Promoting interventions for men, boys and community leaders involvement in prevention of gender based violence;
e. Addressing gender based violence as part of humanitarian response and as per Minimal Initial Service Package (MISP).

Key Partners

1. Ministry of Labor and Social Affairs
2. Ministry Planning and Development
3. Ministry of Health
4. Ministry of Justice
5. Edna Aden Hospital
6. Somaliland Nurses and Midwife Association
7. Manhal Hospital
8. Hargiesa Group Hospital
9. Borama Fistula Center
10. Borama Nursing School
11. Burao Social Science Institute
12. Burao Hospital
13. Sexual Assault Referral Center (SARC)
14. Somaliland National Aid Commision (SOLNAC)
15. Horn Youth Develoment Association (HYDA)
16. Somaliland National Y-Peer Network (SYPN)
17. Action for Women Health and Development (AWHAD)
18. Somaliland Women Lawyers
19. UN agencies

Programme Management

25. UNFPA programme will be executed in cooperation with the Government and national NGOs. The Ministry of Planning and International Cooperation will coordinate the programme. UNFPA will encourage and support the execution and implementation of the programme by the Somaliland authorities NGOs, community based organizations and civil society organizations. The criteria for selecting executing and implementing agencies will be based on their sound management systems including financial management, institutional and technical capacities, past experience in implementing related activities, comparative advantage and potential to contribute to the programme outcomes and outputs. Implementers will be expected to put in place mechanisms to monitor and report on results of activities.

26. In instances where there are common interests among UN agencies such as strengthening capacities in health systems, for data collection and analysis and HIV/AIDS, joint programming, monitoring and annual reviews will be held to assess the progress.

27. The programme will utilize the direct execution modality as per the UNCT guidelines, where capacity building in partner institutions will be high priority. The programme will emphasize decentralized implementation as well as joint monitoring and evaluation by the Somaliland authorities, international experts, UNFPA Country Office and Arab States Regional Office.

Somaliland monitoring and evaluation

28. Monitoring and evaluation (M&E) of the Somaliland CPAP will be undertaken in line with the UNSAS results-based matrix and M&E plan. UNFPA, in collaboration with other UN agencies, will be responsible for ensuring regular monitoring and evaluation of the CPAP, with the view to ensuring efficient utilization of programme resources as well as accountability, transparency and integrity.

29. The aim of the monitoring and evaluation (M&E) plan is to effectively track the progress that is being made to achieve the expected programme outcomes. The plan will be based on selected indicators and means of verification that are found in the results and resources framework.

30. Harmonized or joint evaluations and reviews with partners will provide feedback and guidance on management of the process, results and outcomes and will ensure that the programme is focused on Somali priorities, that achievements and lessons learned are recognized, that difficulties are addressed and that best practices are acknowledged. In cooperation with partners, donors and the rest of the UN system, joint monitoring will be undertaken on a regular basis. For purposes of harmonization, the basis for evaluation are indicators agreed by various UN agencies and those indicated in this document.

31. An annual programme review will assess achievement of results against proposed outputs. This will include both technical and financial review to assess progress, achievements, lessons learned, issues and challenges. Key results and findings will be shared with all stakeholders.

32. Monitoring of the programme activities will be undertaken through joint visits and on-going consultation with major stakeholders. Participatory monitoring processes will be undertaken and where appropriate baseline surveys will be conducted with relevant partners.

33. To facilitate assurance activities, Implementing partners and the UN agency may agree to use a programme monitoring and financial control tool allowing data sharing and analysis.

ANNEX 1 CPAP RESULTS AND RESOURCES FRAMEWORK- Somaliland

ZONE SOMALILAND

CP Cycle Second 2011-2015

UNSAS OUTCOME 1 **Somali people have equitable access to basic services – health education, shelter, water and sanitation.**										
Country programme Outcome	**Country programme output**	**Output indicators**	**Implementing Partners**	**Indicative resources by output (per annum, USD in**					
				Y1	**Y2**	**Y3**	**Y4**	**Y5**	**total**
Outcome 1 Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people. **Outcome indicators.** • Modern contraceptives prevalence rate Baseline: 1.2% Target: 10% • Percentage of births attended by skilled health personel	**Output 1:** Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities	• Number of obstetric fistula cases successfully repaired at supported sites • Number of graduated midwifes • Number of service delivery points in target sites providing at least three modern family planning methods • % of service delivery points using standard service protocols • Case fatality rate of maternal complications	Ministry of Health Ministry of Labor and Social Affairs; Training institutes, Universities Local and International NGOs, Community based organizations United Nations organizations; Professional Associations	**Regular Resources**					
				.3735	.3735	.3735	.3735	.3735	1.8675
				Other Resources					
				.64	.45	.368	.21	.21	1.878
	Distribution of Total resources for output 1			1.0135	.8235	.7415	.5835	.5835	**3.7455**
	Output 2: Increased capacity of government and identified community based and non-governmental	Output indicators: • Number of Youth Peer Educators trained in HIV/AIDS Prevention and ASRH	Ministry of Health National AIDS Commission Ministry of youth and Sports. Local and International NGOs, Community based organizations	**Regular Resources**					
				.0765	.0765	.0765	.0765	.0765	.3825
				Other Resources					

Baseline: 9% Target: 20% • Percentage of most -at-risk populations reached with HIV prevention programs Baseline: 0% Target: 15%	organizations to offer quality, comprehensive, sexual reproductive health services, education and information for young people, with particular focus on most at risk young people.	Baseline: 100 Target: 320	United Nations organizations;	.16	.15	.092	.09	.09	**.582**
	Distribution of total resources for output 2			**.2365**	**.2265**	**.1685**	**.1665**	**.1665**	**.9645**
UNSAS OUTCOME 11 : Somali people benefit from poverty reduction through equitable economic development and decent work									
Outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning, delivery and monitoring of humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal level. Outcome indicators: • Common understanding of operational linkages between population, reproductive health, gender and poverty reduction. • Annual MDG and poverty related reports	**Output 1:** Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and subzonal levels in order to inform interventions in this area	• Number of up-to-date databases on key humanitarian, recovery and development variables to guide achievement of the country programme outputs and monitoring maternal mortality and morbidity. • Number of quality reports on utilization of the datasets for measuring attainment of the country programme outputs and monitoring of maternal mortality and morbidity.	Ministry of Planning and Development Ministry of Health Training institutes, Universities Local and International NGOs, United Nations organizations;	**Regular Resources**					
				.171	.171	.171	.171	.171	.855
				Other Resources					
				.462	.28				**.742**
	Distribution of total resources for output 1			.633	.451	.171	.171	.171	**1.597**
	Output 2: Strengthened capacity	• Number of trained personnel with expertise in collection, analysis, dissemination and application of demographic and	Ministry of Planning and Development Training institutes,	Regular Resources					
				.129	.129	.129	.129	.129	.645

take into account population dynamics and gender issues.	of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance.	related data for humanitarian, recovery and development interventions. • Number of quality reports on progress in integration of ICPD and MDG concerns in humanitarian, recovery and development programmes.	Universities United Nations organizations; Ministry Health, Ministry Labor and Social Affairs Municipalities	Other Resources	.238	.12				**.358**
	Distribution of total resources for output 2				.367	.249				1.003

UNSAS OUTCOME 11 1: *Somali people live in stable environment where rule of law is respected and rights based and engendered development is perused.*										
Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved. There are two outputs within this component. **Outcome indicators:** • Number of young girls	**Output 1** Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	• Number of religious leaders trained to address negative impact of female genital mutilation Baseline: 0 • Number of initiatives conducted to address FGM and early marriage Baseline: 0 •	Ministry of Labor and Social Affairs; Ministry of Planning and Development; Training institutes, Universities Regional and district Authorities NGOs, Community based organizations. United Nations agencies	Regular Resource	.102	.102	.102	.102	.102	.51
				Other Resources	.2	.225	.15	0	0	.575

between 5 to 15 years of age who have undergone FGM/C • FGM/C prevalence rate Baseline: 98%. Target: 85% • Laws, policies and strategies to incorporate gender equality and human rights of women and girls • Net Enrolment Rates (NER) of girls Baseline: 20% Target: 30%	**Distribution of Total resources for output 1**		.	.302	.327	.252	.102	.102	1.085
	Output 2 Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation. .	• Number of community based initiatives against gender based violence especially targeting young men and boys • Number of institutions providing services to victims of gender based violence.	Ministries of Labor and Social Affairs Women and human rights networks International and Local NGOs UNDP,UNICEF,UNHCR	Regular Resources					
				.048	.048	.048	.048	.048	.24
				Other Resources					
				.2	.225	.15	0	0	.575
	Distribution of total resources for output 2			.248	.273	.198	.048	.048	0.815
Distribution of total resources	**Regular**			.9	.9	.9	.9	.9	4.5
	Regular (PCA)			.02	.02	.02	.02	.02	.1
	Others			1.9	1.45	0.76	.3	.3	4.71
Total resources				**2.82**	**2.37**	**1.68**	**1.22**	**1.22**	**9.31**

The CPAP Planning and Tracking Tool -Somaliland

Country: Somaliland

CP Cycle: Second 2011-2015

RESULTS	Indicator	MoV	Responsible party	Baseline	Target	Achievement

UNSAS outcome	Somali people have equitable access to basic services – health, education, shelter, water and sanitation.															
	Indicator	**MoV**	Responsible party	**YR1**			**YR2**		**YR3**		**YR4**		**YR5**			
				baseline	**target**	**achievement**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**		
CP Outcome 1																
Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people.	Modern contraceptives prevalence rate	MICS	MOH/UN	MICS 2006) to be updated when results from MICS 4 are released during 2011	TBD based on MICS 4 results		TBD based on MICS 4 results		TBD based on MICS 4 results		TBD based on MICS 4 results		TBD based on MICS 4 results			
	% of births attended by skilled birth attendants	MICS	MOH/UN	21% (MICS 2006). to be updated when results from MICS 4 are released during 2011	TBD based on MICS 4 results		TBD based on MICS 4 results		TBD based on MICS 4 results		TBD based on MICS 4 results		TBD based on MICS 4 results			

	Percentage of most -at-risk populations reached with HIV prevention programs	UNGASS Bi-annual Reports. Nation Wide Mapping Survey	MOH/UN	No data	TBD based on the results of nation wide mapping		TBD based on the results of nation wide mapping		TBD based on the results of nation wide mapping		TBD based on the results of nation wide mapping		TBD based on the results of nation wide mapping	
Output 1.1: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities.	Number of obstetric fistula cases successfully repaired at supported sites	M/E, Health Centre Records	MOH UNFPA	Baseline NA	50		50		50		50		200	
	Number of graduated midwifes	M/E, Institute Assessment	MOH UNFPA	54	40		60		40		60		200	
	Number of service delivery points in target sites providing at least three modern family planning methods	*M&E* *Facility Records*	MOH UNFPA	*Baseline 0%*	*5*		*5*		*10*		*15*		*20*	
	Proportion of service delivery points correctly use protocols and guidelines of maternal health (FP,ANC,PNC,EmOC)	M&E Programme Progress and training reports	MOH UNFPA	0%	5%		30%		50%		70%		100%	
	Case fatality rate of maternal complications	M/E, Facility Records	MOH UNFPA	21%	20%		10%		7%		5%		1%	

	Ratio of B EMOC facilities per 500.000 population	M/E	MOH UNFPA	BEmOC 1.1	2		2.2		3		3.2		4	
	Ratio of C EMOC facilities per 500.000 population	M/E	MOH UNFPA	EmOC	1.7		1.8		2		2.2		3	
	% CS out of total births	Survey	MOH UNFPA	0.4%	0.6%		2%		4%		6%		7%	
	Proportion of service delivery points correctly use protocols and guidelines of STIs	M/E	MOH UNFPA	0	5%		20%		40%		80%		100%	
	Number of youth peer educators trained in HIV/AIDS prevention and ASRH	M/E	MOH UNFPA	100	140		180		220		260		320	
CP outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning, delivery and monitoring of humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal level ensured.	Annual MDG and poverty related reports take into account population dynamics and gender issues	M/E	MOH UNFPA UNDPA	NA	Report		Report		Report		Report		Report	
	Maternal mortality and morbidity monitoring system developed in selected sites.	M/E	MOH UNFPA	System not exist	3%		10%		20%		35%		50%	
	Data on each of the programme sectors for assessment of programme impact on reduction of maternal and neonatal mortality and morbidities.	M/E	MOPIC/ MOH/ UNFPA	Data not available	3%		10%		20%		35%		50%	
	Number of institutions with strengthened systems in applications of data for humanitarian, recovery and development interventions.	M/E, Institutional mapping, institutional Records, Progress Reports	MOPIC/ UNFPA	2	3		4		5		6		7	

Output 2.1: Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and sub-zonal levels in order to inform interventions in this area	Number of up-to-date databases on key humanitarian, recovery and development variables	M/E	MOPIC/ UNFPA	Database is not available	1		2		3		4		5	
	Number of quality reports on utilization of the datasets for measuring attainment of the CP outputs and monitoring of maternal mortality and morbidity.	M/E	MOPIC/ MOH/ UNFPA	Database is not available	1		2		3		4		5	
	Quick population count is conducted; analyzed, disseminated, and results translated into program follow-actions	M/E, The results of the QPC	MOPIC/ UNFPA	NA	QPC conducted		Data used in planning and M&E		Data used in planning and M&E		Data used in planning and M&E		Data used in planning and M&E	
	National mechanisms to elaborate and monitor integrated population and development plan functioning	M/E	MOPIC/ UNFPA	NA	1		2		3		4		5	
Output 2.2: Strengthened capacity of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance	Number of trained personnel with expertise in collection, analysis, dissemination and application of demographic and related data for humanitarian, recovery and development interventions	M/E, Progress Reports, Training Reports	MOPIC/ UNFPA	20	40		40		40		40		40	
	Number of quality reports on progress in integration of ICPD and MDG concerns in humanitarian, recovery and development programmes	Reports Availabl e	MOPIC/ UNFPA	1	1		1		1		1		1	
	Statistical departments in Min of Planning and other line Ministries work with DevInfo, and are able to collect development data and process and analyze these at a basic level	M/E	MOPIC/ UNFPA	NA	1		1		1		1		1	

Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved	Comprehensive national policy and strategy on gender issues, integrating GBV and FGM endorsed and operational	National policy and Strategy Document	MOWDAFA/UNFPA	National Strategy has been en endorsed but FGM and GBV need to be endorsed and the document operationalized	Policy reviewed inputs on FGM/GBV included								Comprehensive policy with FGM and GBV fully integrated, endorsed and operational	
	Laws, policies and strategies to incorporate gender equality and human rights of women and girls	Laws, policies, strategies	MOWDAFA/UNFPA	Data not available	TBD 2011								TBD 2011	
	FGM/C prevalence rate reduced	Survey	MOH/MOWDAFA/ UNFPA	98%	98%		96%		94%		90%		85%	
	Net Enrolment Rates (NER) of girls	Survey	MOE/MOWDAFA/ UNFPA	20%	25%		30%		40%		50%		70%	
	Proportion of young girls between 5 to 15 who have undergone FGM/C	Survey	MOWDAFA/UNFPA	Data not available. Target will be set after the 2011 MICS										
Output 3.1: Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	Availability of data on gender based violence and harmful practices	M/E	MOWDAFA/MOH/ UNFPA	System not exist	3%		10%		20%		35%		50%	
	Proportion of key decision makers, community, NGOs, women's groups and religious leaders supporting gender equality, including elimination of GBV	M/E	MOWDAFA/UNFPA	System not exist	3%		10%		20%		35%		50%	
	Number of religious leaders trained to address negative impact of female genital mutilation	M/E	MOWDAFA/UNFPA	System not exist	10		30		50		70		90	

	% of SDP correctly use SGBV protocols for management of cases	M/E	MOH/UNFPA	System not exist	5%		10%		40%		70%		100%	
	Number of initiatives conducted to address FGM and early marriage	M/E	MOWDAFA/UNFPA	0	1		2		5		8		10	
Output 3.2: Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation	Percentage of decision makers who are aware of domestic violence issues.	M/E study	MOWDAFA/UNFPA	Data not available. Target will be set in 2011										
	Percentage of relevant law enforcement personnel in provinces trained to identify and manage cases of domestic violence	M/E study	MOWDAFA/UNFPA	Data not available. Target will be set in 2011										
	Number of community based initiatives against gender based violence especially targeting young men and boys	M/E Facility Mapping	MOWDAFA/UNFPA	0%	5		10		20		50		70	
	Number of institutions providing services to survivors of gender based violence	M/E Facility Mapping	MOWDAFA/UNFPA	5	10		20		30		40		50	

Risks and Assumptions

State major risks and assumptions that could influence achievement of CP outputs and outcomes as indicated in the CP document. Assess whether risks materialized, whether original assumptions were correct and highlight factors which facilitated or constrained results achievement.

Instructions:

1) Use one sheet per CP Outcome.
2) Where the CP is more complex, the matrix can be adapted by breaking CP outputs into sub-outputs with baselines, targets and achievements.
3) It is useful, to the extent possible, at the beginning of the CP cycle to establish tentative output/sub-output targets for each year in the cycle.

Puntland

I Puntland Situation overview

1. The Puntland State was established in 1998, as a result of a series of community-wide consultations and constitutional conferences, aimed at setting up an administration that could bring law and order in the territory, secure stability, reinstitute collapsed public institutions and promote development for its people, as it waits to be part of a future federal system of Somalia.

2. However in the past three years Puntland state has experienced high political tension and insecurity with Piracy being seen as a symptom of deeper underlying issues related to poor governance, inter and intra clan friction. All of which have given rise to militant groups notably the Islamist movement.

3. The population of Puntland continues to be a contested issue with varied estimations ranging from 2.1 million to as high as 3.7 million. It is approximated that 70% of the population is below age 30 years and 60% experiencing a nomadic lifestyle, with 30% of the population living in the rapidly growing urban centers. The variations in population statistics is a result of inflation of numbers by clans due to the belief that large clans can exert more power

4. The ongoing war between Transitional Federal government and militia groups in South central Somalia including Al shabaab has led to a massive influx of IDP's into Puntland. IDP's, most of whom are women and girls, coming into an environment with no protection mechanisms or any systemic support in place creates dire situation of vulnerability to Gender based violence including rape and forced commercial sex work

5. The IDP situation in Puntland was worsened by the deportation of 1,000 men leaving behind women and girls even more vulnerable to exploitation. The current fight between government forces and alleged Al Shabaab linked militia led by Sheikh Mohamed Said Atom has only further contributed to deterioration of the situation as thousands of families continue to be displaced into neighboring towns. This further worsens an already harsh environment with considerable unmet needs of RH and more women and girls are becoming vulnerable to sexual violence.

6. The existences of piracy in Puntland has contributed to various socio economic challenges including spread of HIV/AIDS as a result of unprotected sex , single motherhood and unwanted pregnancies.

7. Increased natural disasters have left people more vulnerable to risk of loss of livelihood and insecurity, the massive displacement of local people due to loss of livestock and pasture have also increased needs of unmet reproductive health as well as vulnerability to GBV.

8. **Reproductive health;** Years of conflict, continued instability and the lack of a government, the health system collapsed and paved way for high privatization, under performance and lack of basic funding, qualified human resources and management mechanisms.

9. Fertility rate is very high at 6.2 per woman and unmet family planning need at 19.3%. Contraceptive prevalence rate is 11.8% of married women in age 15-49 and only 0.1% of women are using a modern method (pills) and 11.7% using LAM. According MICS data in Puntland only 30.2% of women receive antenatal care one or more times during pregnancy, with the antenatal care being limited to physical examination and blood pressure measurement. Most MCH clinics do not have laboratory services.

10. More than 90% of women deliver at home and 36.8% assisted by any skilled personnel and only 7.9% deliver in a health facility. Rural and nomadic populations have no access to timely obstetric intervention should the need arise. There is lack of basic facilities to handle emergency obstetric care and shortage of qualified midwives and medical practitioners to manage these complications.

11. While there is an even distribution of health facilities to provide Comprehensive Emergency Obstetric Care, 2.2per every 500000population, these services are underutilized, of poor quality with a high case fatality rate of 33.1%. Caesarean section rate is very low 0.6% which could be interpreted as low technical capacity of health facility and service providers. The main causes of maternal mortality can be classified as 1) direct obstetric and 2) indirect obstetric causes. Direct obstetric causes relate directly to the pregnancy and the most common in Somalia are hemorrhage, obstructed labour, eclampsia and sepsis. The Pharonic form of Female Genital Cutting is experienced almost universally among Somali women and this is thought to be a contributing factor to a high incidence of hemorrhage and obstructed labour.

12. Based on Emergency Obstetric Care needs assessment report the main causes of maternal death have been identified as; obstructed labor 48%, retained placenta 31% and Severe eclampsia 10%.

13. Due to logistical and infrastructural challenges, women with pregnancy complications (ante partum hemorrhage, postpartum hemorrhage, and obstructed labor) cannot access to health care in hospitals, a common cause of first and second delays. For women with obstetric complications, the duration between first consultation in the health facility and specific intervention ranged from one hour to 30hours (Mean 14.4hours, Median 2hours). Lack of qualified human resources and "lack of blood collection and transfusion service in the health facility" are a major cause of third delay

14. Home deliveries are as high as up to 90% in some areas, attended by traditional birth attendants. This trend highlights the challenge not only of making reproductive health (RH) services more accessible and affordable, but also of changing the social norms, behaviors and attitudes that inhibit the utilization of the RH services.

15. Taboos and norms around sexuality (including practices such as early marriage and FGM) pose strong barriers to providing information on reproductive health services and other forms of education and support that young people need to exercise their rights and ensure their reproductive health desires.

16. **Gender**; Like in all other parts of Somalia women in Puntland have been excluded from participation in decision-making forums. Little has been done to enhance the role of women in peace building and conflict resolution. UN Security Council Resolution 1325 thus remains unimplemented in Puntland. Peace building and state building efforts usually follow a clan-based approach with minimal attempts to include women. This lack of recognition of women as stakeholders in the conflict has also meant that issues of gender based violence (GBV), including domestic violence remain absent from the mainstream discourse on security. The gendered nature of the clan dispute settlement system means that women's rights are not adequately protected and rulings delivered in the clan system mainly aims at preserving clan harmony and peace and does not seek to vindicate the rights of an abused woman or girl.

17. The rising incidences of violence, particularly sexual violence has reduced the morbidity of women due to fear. As a result women who are the primary providers in most Somali homes are nor able to go about performing their day to day roles of providing for their families; fetching water, firewood and petty trade to bring in income.

18. Men and boys have been targeted for systematic clan related killings, recruited into militias and forced to perpetrate acts of sexual violence like rape, forced marriage and abductions. In some instances men as husbands and male relatives have been forced to witness acts of sexual violations including gang rapes of their female relatives.

19. Early marriage and high fertility rates, particularly among the poorer and less educated segments of the population, remains an issue to be addressed. According to the MICS 8% of women age 15-49 years were married by the time they were 15, the proportion Increases to 46% by the time women are 18. Female genital mutilation or cutting is widely practiced in Puntland, at rate of 98% of women age 15-49 have been circumcised.

20. In Puntland, UNFPA has partnered with the Ministry of Women Development and Family Affairs (MOWDAFA) since 2007 to build technical capacity of the Ministry, formulation of gender and FGM policies and laws that contribute to wellbeing of Puntland women and elimination of violence against women. To date most policies are still at infancy stage and further support will be needed for the policies to gain required support to be approved and implemented. The proposed programme therefore will focus on advocacy at different levels using a multi media approach.

21. **Young people**; The Puntland Five Year Development Plan 2007 – 11 (FYDP) highlights the plight of young people as being either returnees from refugee camps, IDP's and / or child soldiers from former clan militias. They suffer from poverty, illiteracy, unemployment, drug addiction and psychological trauma from war experiences. Youth are also at risk of epidemic diseases such as HIV/AIDS due to lack of awareness and health education.

22. Puntland Youth Peer education Network has been recently established with the support of UNFPA, the network, will work to promote healthy behavior and lifestyles among young people by empowering them with the knowledge and skills to make responsible decisions and become a force for social change in their families and communities

23. **HIV/AIDS**; In the ANC Clinic, HIV prevalence among pregnant women is 1- 4.9% in some urban sentinel surveillance sites including Galcayo and 0-0.9% in rural sentinel sites. Very few facilities provide antenatal care and VCT services, with PMTCT coverage at less than 1%. Less than 1% of the Puntland population in Muduug region identifies PMTCT as an important intervention for prevention of HIV transmission from mother to child while a vast majority associate condom use with promiscuity.

24. Puntland Aids Commission (PAC) was established in 2005 to undertake coordination activities of HIV/AIDS in Puntland, advocacy and monitoring and evaluation. The commission is chaired by the president of Puntland state and six line ministries form the organizational board, and an Integrated Prevention, Treatment, Care and Support (IPTCS) system is in place.

25. **Population and Development.** The Statistics Department of the Ministry of Planning and International Cooperation (MOPIC) has had considerable success in building up its database (one product is Puntland Facts and Figures 2009). However, critical data gaps still exist with a need to reconstruct and upgrade the baseline. While some level of capacity exists in gathering statistics, institutional expertise in management and effectively linking data to policy making processes remains weak.

26. There is need for greater availability and improved analysis of gender disaggregated data in order to make an even stronger case for gender related issues; in health, education, employment and women's empowerment, leadership and decision making.

27. **Achievements**; In Puntland, UNFPA in partnership with different line ministries and local non governmental organizations have made considerable progress since 2007, these include the following;
    a) Trainings: Health care workers have been trained on different areas of RH including Basic and comprehensive emergency obstetric Care, family planning, MISP, PMTCT and community midwifery.
    b) Provide support to MOWDAFA to establish GBV working groups to coordinate prevention and response to GBV in PL,
    c) GBV mapping in all of Puntland
    d) Media campaign on dissemination of the gender policy
    e) Establishment of a RH working group in Garowe, which meet on quarterly basis.
    f) Successfully coordinated the commemoration of 16 days of activism campaign with literature dissemination, FGM stake holder coordination and media awareness.
    g) Provide support to MOWDAFA to advocate for an increase in budgetary allocation for women and more slots for women within the government. The

new UNFPA Country Programme Action plan(CPAP) will work to move forward in ensuring gender equality.

h) Provide support to end fistula in PL.
i) UNFPA supported the strengthening of national capacity in understanding population and development through support to the data collection, analysis and surveys.

Puntland Proposed Programme

28. The UNFPA CP will be results oriented and aim to contribute to and respond to humanitarian issues and to government's efforts on reconstruction and development. The programme is comprised of three mutually re-enforcing components equipped with the chain of programme results linked to the UNFPA framework: Reproductive Health, Population and Development and Gender.

29. **Reproductive health component**; the outcome of this component is: Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people. Two outputs will contribute to achieve this outcome

30. **CP Output 1**: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities.

31. UNFPA will work on integration of essential package of sexual and reproductive health services in public policies and expenditure frameworks. Strategies will include the following;

    a) Advocacy; with parliamentarians and national partners to ensure further integration of maternal and reproductive health into all national social policies and strategies, mass-media campaigns, provision of expertise and promotion of internationally accepted best practice. Advocacy for protection of reproductive rights of individuals and communities.
    b) In partnership with MoH and other partners support research on selected reproductive and maternal health topics.
    c) Development and revision of clinical guidelines and protocols, including guidelines on essential and emergency obstetrics care, antenatal care, adolescent reproductive health, family planning and STI management.
    d) Capacity building including training on quality of care, strengthening community midwifery,
    e) Improving data collection on maternal mortality and morbidity; In partnership with MoH and other stake holders to put in place mechanisms to ensure systematic improvement in the performance of the different components of Emergency Obstetric Care as well as obstetric fistula repairing and including referral services

32. **Output 2:** Increased capacity of government and identified community based and non-governmental organizations to offer quality, comprehensive, sexual reproductive health services, education and information for young people, with particular focus on most at risk young people.

33. Increasing access to and use of integrated HIV/AIDS and reproductive health services. UNFPA will support community initiatives with focus on vulnerable groups (young people, sex workers (Are we sure about sex worker groups existing in PL), migrants, and military system) and enhancing health system capacity to integrate HIV prevention within the reproductive health and antenatal care services. The specific strategies for this output will include;

    a) UNFPA to support development of partnerships between community stakeholders and health care providers to address gaps and challenges through, capacity building programs to CBO's, religious leaders and peer educators to increase their level of HIV awareness
    b) In partnership with MoH to review situation of adolescent reproductive health (ARH) services in Puntland. Develop manuals and guidelines on ARH in accordance with WHO standards and ICPD principles and establishment of youth friendly reproductive health services.
    c) Strengthen partnerships with organizations, groups and networks addressing the needs of most at risk populations including young people affected by conflict.
    d) Supporting development of behavior change communication intervention with the goal of reducing high risk behavior

34. **Population and Development component:** The outcome for this component is: Availability of reliable demographic and related data, institutional capacities and systems for planning, delivery and monitoring of humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal level ensured. Two outputs will contribute to this outcome:

35. **Output 1:** Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and sub-zonal levels in order to inform interventions in this area. The following strategies will be used for the achievement of the output:

    a) Supporting establishment, strengthening and periodical updating of integrated population database on indentified issues on zonal and sub zonal levels: UNFPA to support by providing IT equipment when and support data harmonisation initiatives.
    b) Development of a frame work and support for evidence-informed advocacy on maternal health reduction.
    c) Supporting collection, analysis and use of data on maternal mortality and morbidity. UNFPA will work closely with MOH in the development of the Health Management Information System (HMIS) to capture information relevant for maternal mortality.

d) Building the capacity of government and other partners to integrate maternal mortality and morbidity into emergency preparedness and response. Technical assistance to develop and regularly update a database on vital statistics will be provided to relevant ministries. UNFPA will work in collaboration with UNHCR in IDP profiling to get information on their reproductive health needs.

36. **Output 2:** Strengthened capacity of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance. Strategies for output 2 include:
    a) Improving the capacity of selected sector ministries and partner organizations in data collection and analysis; in partnership with local university continue in service training courses for staff from statistical departments of line ministries. Follow up training courses on DevInfo will be conducted.
    b) Providing technical support for better planning and monitoring of humanitarian assistance and recovery; study tours to countries where National Statistical Systems are efficient and recruitment and placement of demographer/statisticians in Ministry of Planning
    c)

37. **Gender component** the outcome of this component is: Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved. There are two outputs within this component.

38. **Output 1:** Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health. Strategies for output 1 include:
    a) Awareness raising on the effects of female genital mutilation and early marriage on maternal mortality and morbidity;
    b) Advocating for implementation of laws prohibiting female genital mutilation; UNFPA will provide technical and financial support needed for the development and endorsement of the FGM/c policy.
    c) Enhancing community-based efforts to address harmful effects of early marriage and FGM/C; UNFPA in partnership with CBO and LNGO, will facilitate dissemination of knowledge of socio-cultural dynamics, effects of FGM/C and early marriage,
    d) Strengthening community based initiatives to enhance the retention of girls in formal and non formal education; UNFPA with relevant partners will undertake assessment of barriers and drivers of retention of girls in both formal and non formal education.
    e) Carrying out attitude surveys amongst young men and older men on FGM/C and early marriage.

39. **Output 2:** Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation. Strategies for output 2 include;

    a) Strengthening the capacity of selected non-governmental and community-based organizations to provide health and psychosocial support to survivors of gender-based violence, including support to address complications of female genital mutilation;
    b) Supporting the institutionalization of modules on prevention of gender based violence in a training of trainers curricula for health care providers;
    c) Strengthening community level safety nets for survivors of gender based violence; in collaboration with GBV service providers support provision of small micro credit grants to GBV survivors
    d) Interventions for men, boys and community leaders in prevention of GBV-media talk shows and workshops for perception and attitude change
    e) Addressing sexual and gender based violence as part of humanitarian response and as per Minimal Initial Service Package (MISP). During emergencies UNFPA will initiate collaboration with various humanitarian agencies to mainstream GBV prevention and response into their plans, as well as put some measures to provide response.

Puntland strategy

40. The partnership strategy is guided by the principle that the attainment of the desired outcomes is possible only with the support and concerted action of stakeholders. Building consensus and creating a deeper sense of ownership and accountability of the intended outcomes among partners is critical in achieving results. Hence, establishing partnerships with local agencies and organizations and international development partners is a key to achieving desired outcomes.

41. Puntland authorities and Government agencies will continue to be the main partners for UNFPA's assistance to ensure ownership, policies and strategies formulation for delivery and sustainability of results. Relevant ministries, such as Planning, Health, Youth and Women's and Family's Affairs, will play a key role in providing policy and programme directions, and in mainstreaming certain development approaches such as gender principles and human rights-based approach.

42. Key Partners
    1. Ministry of Planning &International cooperation
    2. Ministry of women development and family affairs
    3. Ministry of Health
    4. Ministry of Justice, religious affairs and Rehabilitation.
    5. Benderqasim Hospital
    6. Galkayo Medical Centre
    7. Garowe hospital
    8. Galkayo General Hospital
    9. Baran Hospital
    10. Sexual Assault Referral Center (SARC)
    11. Puntland AIDS Commission (PAC)

12. Puntland Centre for Human Rights and Democracy (PUNCHAD)
13. Puntland Y-Peer Network (SYPN)
14. Somali Socio-Cultural Organization
15. Paralegal Aid organization
16. Ministry of Youth and Sports,
17. Somali Birth Attendants Cooperation Organisation(SBACO)
18. Las Qory Concern.

Monitoring and Evaluation

43. The aim of the monitoring and evaluation (M&E) plan is to effectively track the progress that is being made to achieve the expected programme outcomes. The plan will be based on selected indicators and means of verification that are found in the results and resources framework.

44. Harmonized or joint evaluations and reviews with partners will provide feedback and guidance on management of the process, results and outcomes and will ensure that the programme is focused on Somali priorities, that achievements and lessons learned are recognized, that difficulties are addressed and that best practices are acknowledged. In cooperation with partners, donors and the rest of the UN system, joint monitoring will be undertaken on a regular basis. For purposes of harmonization, the basis for evaluation are indicators agreed by various UN agencies and those indicated in this document.

45. An annual programme review will assess achievement of results against proposed outputs. This will include both technical and financial review to assess progress, achievements, lessons learned, issues and challenges. Key results and findings will be shared with all stakeholders.

46. Monitoring of the programme activities will be undertaken through joint visits and on-going consultation with major stakeholders. Participatory monitoring processes will be undertaken and where appropriate baseline surveys will be conducted with relevant partners.To facilitate assurance activities, Implementing partners and the UN agency may agree to use a programme monitoring and financial control tool allowing data sharing and analysis

CPAP Results Frame work and Resource Puntland

UNSAS OUTCOME 1 **Somali people have equitable access to basic services – health education, shelter, water and sanitation.**									
Country programme Outcome	**Country programme output**	**Output indicators**	**Implementing Partners**	**Indicative resources by output (per annum, USD in**					
				Y1	**Y2**	**Y3**	**Y4**	**Y5**	**total**
Outcome 1 Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people. **Outcome indicators.** • Modern contraceptives prevalence rate Baseline: 1.2% Target: 10% • Percentage of births attended by skilled	**Output 1:** Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities	• Number of obstetric fistula cases successfully repaired at supported sites • Number of graduated midwifes • Number of service delivery points in target sites providing at least three modern family planning methods • % of service delivery points using standard service protocols • Case fatality rate of maternal complications	Ministries of Health Ministries of Women's Development and Family Affairs; Training institutes, Universities Local and International NGOs, Community based organizations United Nations organizations; Professional Associations	**Regular Resources**					
				.2905	.2905	.2905	.2905	.2905	1.4525
				Other Resources					
				.4	.375	.272	.21	.21	**1.467**
	Distribution of Total resources for output 1			.6905	.6655	.5625	.5005	..5005	**2.9195**
	Output 2: Increased	Output indicators: Baseline: 0 Target: 5	Ministries of Health National AIDS Commissions	**Regular Resources**					

health personel Baseline: 9% Target: 20% • Percentage of most - at-risk populations reached with HIV prevention programs Baseline: 0% Target: 15%	capacity of government and identified community based and non-governmental organizations to offer quality, comprehensive, sexual reproductive health services, education and information for young people, with particular focus on most at risk young people.	• Number of peer educators trained in HIV/AIDS prevention and ASRH Baseline: 80 Target: 280	Ministry of youth and Sports. Local and International NGOs, Community based organizations United Nations organizations;	.0595	.0595	.0595	.0595	.0595	.2975
				Other Resources					
				.1	.125	.068	.09	.09	**0.473**
	Distribution of total resources for output 2			.1595	.,1845	..1275	.1.495	.1.495	.7705

UNSAS OUTCOME 11 : Somali people benefit from poverty reduction through equitable economic development and decent work									
Outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning,	**Output 1:** Improved systems for generation, analysis and dissemination of disaggregated population	• Number of up-to-date databases on key humanitarian, recovery and development variables to guide achievement of the country programme outputs and monitoring maternal mortality and morbidity.	Ministries of Planning Ministries of Health Training institutes, Universities Local and International	**Regular Resources**					
				.171	.171	.171	.171	.171	.855
				Other Resources					

UNSAS OUTCOME 11 1: Somali people live in stable environment where rule of law is respected and rights based and engendered development is perused.										
Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved. There are two outputs within this component. **Outcome indicators:** • Common understanding of operational linkages between population, reproductive health, gender and poverty reduction. • Annual MDG and poverty related reports take into account population dynamics and gender issues. • Number of young girls between 5 to 15 who have undergone FGM/C • FGM/C prevalence rate Baseline: 98% Target: 85% • Laws, policies and strategies to incorporate gender equality and human rights of women and girls	**Output 1** Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	• Number of religious leaders trained to address negative impact of female genital mutilation Baseline: 0 • Number of initiatives conducted to address FGM and early marriage Baseline: 0	Ministry of Women's Development and Family Affairs; Ministry of Planning and International Cooperation; Training institutes, Universities Regional and district Authorities NGOs, Community based organizations. United Nations agencies	Regular Resource					
				.102	.102	.102	.102	.102	.51
				Other Resources					
				.15	.225	.125	0	0	.5
	Distribution of Total resources for output 1			.252	.327	.227	.102	.102	1.01
	Output 2 Enhanced systems and mechanisms for prevention of and protection from all forms	• Number of community based initiatives against gender based violence especially targeting young men and boys	Ministries of women development and Family affairs in PL, SL and SC Somalia	Regular Resources					
				.048	.048	.048	.048	.048	.24
				Other Resources					
	development assistance.								
	Distribution of total resources for output 2			.333	.249	.129	.129	.129	.969

• Net Enrolment Rates (NER) of girls Baseline: 20% Target: 30%	of gender-based violence, using a human rights perspective, including in emergency and post conflict situation. .	• Number of institutions providing services to victims of gender based violence.	Women and human rights networks in PL, SL and SC Somalia International and Local NGOs UNDP,UNICEF,UNHCR	.15	.225	.125	0	0	.5
	Distribution of total resources for output 2			.198	.273	.173	.048	.048	0.74
Distribution of total resources	**Regular**			**.8**	**.8**	**.8**	**.8**	**.8**	**4**
	Regular (PCA)			**.02**	**.02**	**.02**	**.02**	**.02**	**.1**
	Others			**1.4**	**1.35**	**0.59**	**.2**	**.2**	**3.74**
Total resources				**2.22**	**2.17**	**1.41**	**1.02**	**1.02**	**7.84**

CPAP Planning and tracking tool Puntland

Country: Puntland

CP Cycle: Second 2011-2015

RESULTS	**Indicator**	**MoV**	**Responsible party**	**Baseline**	**Target**	**Achievement**
UNSAS outcome	Somali people have equitable access to basic services – health, education, shelter, water and sanitation.					

	Indicator	**MoV**	Responsible party	**YR1**			**YR2**		**YR3**		**YR4**		**YR5**	
				baseline	**target**	**achievement**	**T**	**A**	**T**	**A**	**T**	**A**	**T**	**A**
CP Outcome 1														

Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people.	Modern contraceptives prevalence rate	MICS	MOH/UN		1% (MICS 2006) To be updated once results from MICS 4 are available late 2011		TBD To be updated once results from MICS 4 are availabl e late 2011		TBD To be updated once results from MICS 4 are available late 2011		TBD To be updated once results from MICS 4 are availabl e late 2011		TBD To be updated once results from MICS 4 are available late 2011	
	% of births attended by skilled birth attendants	MICS	MOH/UN	7%(MI CS 2006) To be updated once results from MICS 4 are availabl e			TBD To be updated once results from MICS 4 are availabl e late 2011		TBD To be updated once results from MICS 4 are available late 2011		TBD To be updated once results from MICS 4 are availabl e late 2011		TBD To be updated once results from MICS 4 are available late 2011	

	Percentage of most -at-risk populations reached with HIV prevention programs	UNGASS bi-annual reports, nationwide mapping Survey	MOH/UN	No data available	TBD, To be updated once results from Nation Wide Mapping are available late 2011		TBD		TBD		TBD		TBD	
Output 1.1: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities.	Number of obstetric fistula cases successfully repaired at supported sites	M/E, Health Centre Records	MOH UNFPA	Baseline NA	50		50		50		50		200	
	Number of graduated midwifes	M/E, Institute Records	MOH UNFPA	Baseline NA	0		20		20		20		80	

	Number of service delivery points in target sites providing at least three modern family planning methods	*M&E* *Institution al Records*	MOH UNFPA	Baseline 0	5		10		15		20		25	
	Proportion of service delivery points correctly use protocols and guidelines of maternal health (FP,ANC,PNC,EmOC)	M&E Facility Assessment	MOH UNFPA	0%	5%		10%		20%		30%		50%	
	Case fatality rate of maternal complications	M/E	MOH UNFPA	33%	25%		20%		15%		10%		5%	
	Ratio of B EMOC facilities per 500.000 population	M/E	MOH UNFPA	BEmOC 0.5	1		1.5		2		3		4	
	Ratio of C EMOC facilities per 500.000 population	M/E	MOH UNFPA	CEmOC 2.2	2.2		2.2		2.5		2.5		2.5	
	% CS out of total births	Survey	MOH UNFPA	0.6%	0.8%		1%		2%		3%		4%	

	Proportion of service delivery points correctly use protocols and guidelines of STIs	M/E	MOH UNFPA	0	4%		8%		12%		16%		20%	
	Number of Peer educators trainedon HIV/AIDS prevention and ASRH	M/E, Progress Reports, Focus group discussions to assess quality	MOH UNFPA	100	140		180		220		260		300	
CP outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning, delivery and monitoring of humanitarian, recovery and development policies and	Annual MDG and poverty related reports take into account population dynamics and gender issues	M/E	MOH UNFPA UNDPA	NA	Report		Report		Report		Report		Report	
	Maternal mortality and morbidity monitoring system developed in selected sites.	M/E	MOH UNFPA	System not exist	3%		10%		20%		35%		50%	

programmes, especially at zonal and sub-zonal level ensured.	Data on each of the programme sectors for assessment of programme impact on reduction of maternal and neonatal mortality and morbidities.	M/E	MOPIC/ MOH/ UNFPA	Data not availabl e	3%		10%		20%		35%		50%	
	Number of institutions with strengthened systems in applications of data for humanitarian, recovery and development interventions.	M/E	MOPIC/ UNFPA	2	3		4		5		6		7	
Output 2.1: Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and sub-zonal levels in order to inform interventions in this area	Number of up-to-date databases on key humanitarian, recovery and development variables	M/E	MOPIC/ UNFPA	Databa se is not availabl e	1		2		3		4		5	
	Number of quality reports on utilization of the datasets for measuring attainment of the CP outputs and monitoring of maternal mortality and morbidity.	M/E	MOPIC/ MOH/ UNFPA	Databa se is not availabl e	1		2		3		4		5	

	Quick population count is conducted; analyzed, disseminated, and results translated into program follow-actions	M/E, QPC results	MOPIC/ UNFPA	NA	QPC conducted		Data used in planning and M&E		Data used in planning and M&E		Data used in planning and M&E		Data used in planning and M&E	
	National mechanisms to elaborate and monitor integrated population and development plan functioning	M/E	MOPIC/ UNFPA	NA	1		2		3		4		5	
Output 2.2: Strengthened capacity of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance	Number of trained personnel with expertise in collection, analysis, dissemination and application of demographic and related data for humanitarian, recovery and development interventions	M/E	MOPIC/ UNFPA	20	30		30		30		40		120	
	Number of quality reports on progress in integration of ICPD and MDG concerns in humanitarian, recovery and development programmes	E	MOPIC/ UNFPA	1	1		1		1		1		1	

	Statistical departments in Min of Planning and other line Ministries work with DevInfo, and are able to collect development data and process and analyze these at a basic level	M/E	MOPIC/ UNFPA	NA	1		1		1		1		1	
Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved	Comprehensive national policy and strategy on gender issues, integrating GBV and FGM endorsed and operational	Draft Policy	MOWDAFA/ UNFPA	Draft Policy in place	Inputs on FGM and GBV are incorporated		Policy endorsed						Policy operational	
	Laws, policies and strategies to incorporate gender equality and human rights of women and girls	Policy, strategy documents	MOWDAFA/ UNFPA	No data	TBD 2011								TBD 2011	
	FGM/C prevalence rate reduced	Survey	MOH/MOWDAFA/ UNFPA	98%	98%		96%		94%		90%		85%	
	Net Enrolment Rates (NER) of girls	Survey	MOE/MOWDAFA/ UNFPA	20%	22%		24%		26%		28%		30%	

	Proportion of young girls between 5 to 15 who have undergone FGM/C	Survey	MOWDAFA/ UNFPA	Data not available. Target will be set after the 2011 MICS										
Output 3.1: Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	Availability of data on gender based violence and harmful practices	M/E	MOWDAFA/ MOH/ UNFPA	System not exist	3%		10%		20%		35%		50%	
	Proportion of key decision makers, community, NGOs, women's groups and religious leaders supporting gender equality, including elimination of GBV	M/E	MOWDAFA/ UNFPA	System not exist	3%		10%		20%		35%		50%	
	Number of religious leaders trained to address negative impact of female genital mutilation	M/E	MOWDAFA/ UNFPA	System not exist	10		30		50		70		90	
	% of SDP correctly use SGBV protocols for management of cases	M/E	MOH/UNFPA	System not exist	5%		10%		20%		30%		40%	

	Number of initiatives conducted to address FGM and early marriage	M/E, Progress Reports	MOWDAFA/ UNFPA	0	1		2		5		8		10	
Output 3.2: Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation	Percentage of decision makers who are aware of domestic violence issues.	M/E study	MOWDAFA/ UNFPA	Data not available. Target will be set in 2011										
	Percentage of relevant law enforcement personnel in provinces trained to identify and manage cases of domestic violence	M/E	MOWDAFA/ UNFPA	Data not available. Target will be set in 2011										
	Number of community based initiatives against gender based violence especially targeting young men and boys	M/E	MOWDAFA/ UNFPA	0%	5		10		20		50		70	
	Number of institutions providing services to survivors of gender based violence	M/E, Mapping of institutions	MOWDAFA/ UNFPA	5	10		20		30		40		50	

South Central Zone
Situation Analysis

1. The humanitarian situation in south-central Somalia as a result of the continued conflict is determined mainly by the long-term displacement of a large part of the population of Mogadishu, mostly in the periphery of the capital and by short-term and localized displacements from other strategically important towns. Recurring environmental shocks such as droughts and floods as well as the generalized collapse of basic social services also contribute to the deplorable humanitarian situation in south Central.

2. This has had debilitating effect on the social services infrastructure, particularly health; there has been destruction of health facilities, interruption of referral networks, and displacement of health workforce amongst other issues. This coupled with continued unrest and political instability, access to and even reach by populations that are most in need has continued to be a challenge.

3. The Transitional Federal Government (TFG) located in Mogadishu has limited control over the territory of the country. The recent surge in the conflict has resulted in an estimated 3.2 million people being in need of emergency humanitarian assistance, out of which 1.4 million are internally displaced. According to UNOCHA update, there are up to 570,000 people displaced out of which 200,000 live in South Central Somalia.

4. Access by humanitarian workers to affected population in most of south & central Somalia remains a major challenge; ranging from difficult to extremely difficult. Recent attacks on humanitarian agencies by militant groups forced up to 8 agencies to close operations in the south central region and 23 humanitarian facilities being adversely affected. Further, suspension of the WFP operations led to cessation of general food distribution and affected hospital feeding programmes.

5. Shrinking humanitarian space in the south, has led to many humanitarian agencies including NGOs &UN to shift their base to Central Somalia which is relatively calm and humanitarian access has improved. These areas include; Galgadud, south Mudug.

6. Reproductive health; The latest reproductive health situation analysis carried out early 2009 concluded that more than 90% of women deliver at home and more than half are assisted by a traditional birth attendant. Access to skilled delivery care and emergency obstetric care is poor, and the rural and nomadic populations are virtually without access to timely obstetric intervention should the need arise.

7. Lack of access to basic and emergency obstetric care is a major cause of high maternal and neonatal mortality and morbidity; primarily lack of facilities able to deliver basic emergency obstetric care, and a dire shortage of qualified midwives. The referral centers for caesarean sections are underutilized and the services are of poor quality with a high case fatality rate.

8. Newborn care is neglected, with major missed opportunities to secure immediate survival. Only one out of four pregnant women attends antenatal care where services are of poor quality, constituting another missed opportunity.

9. The total fertility rate is estimated at 5.7 children per woman. With regards to Family planning, 26% of women have unmet needs yet only 1% of Somali women uses a modern method of family planning. Post-abortion care and medical treatment for victims of sexual and gender-based violence and STIs are not universally available. The special needs of adolescents are presently not being addressed.

10. Continued conflict and unfavourable socio economic conditions coupled with high level of illiteracy for women is another major impediment to their accessing reproductive health information.

11. **HIV;** The latest HIV data highlight the reality of multiple epidemics in Somalia with generalized features in and there is a concentrated and low level epidemic in South Central.

12. **GBV;** Continued violence in south central Somalia is increasing the incidence of sexual attacks against women and girls. Like in the rest of Somalia, prevalence rates of female genital mutilation in south central zone remains high at an average of 98 per cent in all the zones including south central. This is despite the adverse effects it has on women's reproductive health.

13. Defined priority areas for action to include:
    i. Essential and Emergency Obstetric Care including skilled attendance at birth
    ii. Antenatal, Postpartum and Neonatal Care, Birth spacing/Child Limiting and Prevention of Pregnancy
    iii. Obstetric Fistula, Post abortion Care and Sexual and Gender Based Violence including FGM
    iv. Human Resources, Finances and Governance

Proposed Programme

14. The continuous displacement of large parts of the population out and within the regions of south central has resulted in a situation of instability and continuous lack of coordination a situation that has resulted in haphazard delivery in health related interventions. Together with the continuous deterioration in the position of the TFG and its inability to play the role of the government coordination authority, programme implementation needs new innovative strategies that ensure communities especially women and children are reached with health related interventions.
15. The south Central programme will therefore focus on two areas; outcome one and outcome three- Reproductive Health and Gender. Inaccessibility and complete break down of the system in south Central poses a huge challenge in relation to population and development.
16. Programmatic interventions will continue to be through networks of local non-governmental organizations having long standing partnerships with UNFPA-Somalia. Those that have

implemented activities and ensured service delivery on behalf of UNFPA in the previous Programme phase 2008-2010.

17. Focus also for south Central is proposed to be mainly within the more secure and stable central zones as these have better accessibility. With focus being primarily supporting health supplies delivery and capacity building of local partner organizations and local administration through the health institutions available.

18. Partners/Contractors will include ministry of health, international and local NGOs and CBI. Implementation of the proposed programme will involve the local levels at the regions.

19. The central part of Somalia had never been targeted during the last programme cycle, this part (3 regions) is hosting an increasing numbers of IDPs and currently enjoying relatively better access will be included during 2011-2015.

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

21. **Output 1**: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities including increased access to and use of integrated HIV/AIDS.

22. Strategies for output one include
    (a) Develop, monitor and coordinate the implementation of the road map for reduction of maternal mortality;
    (b) Building the capacity of skilled birth attendants;
    (c) Strengthening the concept of community midwifery to improve maternal health;
    (d) Strengthening the capacity of identified health facilities to provide basic and comprehensive emergency obstetric care as well as obstetric fistula repair for affected women;
    (e) Strengthening referral systems for emergency obstetric care;
    (f) Provision of reproductive health emergency kits;
    (g) Increasing and consolidating partnerships to address reproductive health needs in humanitarian context and emergency situation as per Minimal Initial Service Package (MISP).
23. **Gender;** The outcome of this component is: Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved.

24. Output 2: Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence using a human rights perspective, including in emergency and post conflict situation.

25. Strategies include for output two include;
    (a) strengthening the capacity of selected non-governmental and community-based organizations to provide health and psychosocial support to survivors of sexual and gender-based violence, including support to address complications of female genital mutilation;

(b) supporting the institutionalization of modules on prevention of sexual and gender based violence in a training of trainers curricula for health care providers;
(c) strengthening community level safety nets for survivors of sexual and gender based violence;
(d) Promoting interventions for men, boys and community leaders involvement in prevention of sexual and gender based violence;
(e) Addressing sexual and gender based violence as part of humanitarian response and as per Minimal Initial Service Package (MISP).

Key Partners

1. Ministry of Health
2. Ministry of Women's Development and Family Affairs
3. The AIDS commissions, SCAC
4. GMC
5. UNICEF
6. WHO
7. UNHCR
8. OCHA
9. INGOs
10. LNGOs

Monitoring and evaluation

The situation of South Central continues to be highly volatile with pockets of stability. UNFPA has previously implemented programmes through networks of organizations and built capacities of local partners through networking and bringing them out for trainings.

In the case of monitoring and Evaluation of UNFPA's activities in south Central zone; as the region is increasingly insecure and with little or no access to the hard to reach areas due to heightened insecurity. Consultants would be hired to conducted monitoring and evaluation of UNFPA's activities in most cases. The Monitoring team with time would also explore other creative ways of monitoring for instance the use of text messaging for third party monitoring. This would at least confirm deliveries to required points, and confirmations of actual implementation of activities by partners.

CP Cycle Second 2011-2015

UNSAS OUTCOME 1 **Somali people have equitable access to basic services – health education, shelter, water and sanitation.**									
Country programme Outcome	**Country programme output**	**Output indicators**	**Implementing Partners**	**Indicative resources by output (per annum, USD in**					
				Y1	**Y2**	**Y3**	**Y4**	**Y5**	**total**
Outcome 1 Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people. **Outcome indicators.** • Modern contraceptives prevalence rate Baseline: 1.2% Target: 10% • Percentage of births attended by skilled health personel Baseline: 9% Target: 20% • Percentage of most -at-	**Output 1:** Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities	• Number of obstetric fistula cases successfully repaired at supported sites • Number of graduated midwifes • Number of service delivery points in target sites providing at least three modern family planning methods • % of service delivery points using standard service protocols • Case fatality rate of maternal complications	Ministries of Health Ministries of Women's Development and Family Affairs; Training institutes, Universities Local and International NGOs, Community based organizations United Nations organizations; Professional Associations	**Regular Resources**					
				.336	.336	.336	.336	.336	1.68
				Other Resources					
				.960	.675	.560	.35	.35	**2.895**
	Distribution of Total resources for output 1			1.296	.1.011	.896	.686	.686	**4.575**
	Output 2: Increased capacity of government and identified community based and non-governmental organizations to offer quality, comprehensive, sexual reproductive health	• Baseline: 0 Target: 5 • Percentage of young women and men aged 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and other STIs	Ministries of Health National AIDS Commissions Ministry of youth and Sports. Local and International NGOs, Community based organizations United Nations organizations;	**Regular Resources**					
				.0595	.0595	.0595	.0595	.0595	.32
				Other Resources					
				.24	..225	.14	.15	.15	**0.905**

risk populations reached with HIV prevention programs Baseline: 0% Target: 15%	services, education and information for young people, with particular focus on most at risk young people.	Baseline: 4% Target: 15%							
	Distribution of total resources for output 2			.2995	.2845	.1995	.2095	.2095	**1.225**

UNSAS OUTCOME 11 : Somali people benefit from poverty reduction through equitable economic development and decent work									
Outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning, delivery and monitoring of humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal level. Outcome indicators: • Common understanding of operational linkages between population, reproductive health, gender and poverty reduction. • Annual MDG and poverty related reports take into account population dynamics and gender issues.	**Output 1:** Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and subzonal levels in order to inform interventions in this area	• Number of up-to-date databases on key humanitarian, recovery and development variables to guide achievement of the country programme outputs and monitoring maternal mortality and morbidity. • Number of quality reports on utilization of the datasets for measuring attainment of the country programme outputs and monitoring of maternal mortality and morbidity.	Ministries of Planning Ministries of Health Training institutes, Universities Local and International NGOs, United Nations organizations;	**Regular Resources**					
				.058	.058	.058	.058	.058	.29
				Other Resources					
				.132	.15	0	0	0	**.282**
	Distribution of total resources for output 1			.19	.208	.058	.058	.058	**.572**
	Output 2: Strengthened capacity of selected sector ministries and partner organizations in collection, analysis,	• Number of trained personnel with expertise in collection, analysis, dissemination and application of demographic and related data for humanitarian, recovery and development interventions.	Ministries of Planning and International Cooperation Training institutes, Universities United Nations organizations;	Regular Resources					
				.042	.042	.042	.042	.042	.21
				Other Resources					

	dissemination and utilization of disaggregated population data for planning and delivery of humanitarian, recovery and development assistance.	• Number of quality reports on progress in integration of ICPD and MDG concerns in humanitarian, recovery and development programmes.	Ministries Health, Ministries Gender Municipalities	.068	.05	0	0	0	**.118**
	Distribution of total resources for output 2			.11	.092	.42	.42	.42	.328

UNSAS OUTCOME 11 1: *Somali people live in stable environment where rule of law is respected and rights based and engendered development is perused.*									
Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved. There are two outputs within this component. **Outcome indicators:** • Number of young girls between 5 to 15 whyo have undergone FGM/C • FGM/C prevalence rate <u>Baseline:</u> 98% <u>Target:</u> 85%	**<u>Output 1</u>** Increased advocacy and community engagement for the reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	• Number of religious leaders trained to address negative impact of female genital mutilation <u>Baseline: 0</u> • Number of initiatives conducted to address FGM and early marriage <u>Baseline:</u> 0 •	Ministry of Women's Development and Family Affairs; Ministry of Planning and International Cooperation; Training institutes, Universities Regional and district Authorities NGOs, Community based organizations. United Nations agencies	Regular Resource					
				.136	.136	.136	.136	.136	.68
				Other Resources					
				.4	.3	.225	0	0	.925

• Laws, policies and strategies to incorporate gender equality and human rights of women and girls • Net Enrolment Rates (NER) of girls Baseline: 20% Target: 30%	**Distribution of Total resources for output 1** .			.536	.436	.361	.136	.102	1.605
	Output 2 Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation. .	• Number of community based initiatives against gender based violence especially targeting young men and boys • Number of institutions providing services to victims of gender based violence.	Ministries of women development and Family affairs in PL, SL and SC Somalia	Regular Resources					
				.064	.064	.064	.064	.064	.32
				Other Resources					
			Women and human rights networks in PL, SL and SC Somalia	.4	.3	.225	0	0	.925
			International and Local NGOs						
			UNDP,UNICEF,UNHCR						
	Distribution of total resources for output 2			.464	.364	.289	.064	.0464	0.815
Distribution of total resources	Regular			**.7**	**.7**	**.7**	**.7**	**.7**	**3.5**
	Regular (PCA)			**.1**	**.1**	**.1**	**.1**	**.1**	**.1**
	Others			**2.2**	**1.7**	**1.15**	**.5**	**.5**	**6.05**
Total resources				**3**	**2.5**	**1.95**	**1.3**	**1.3**	**10.05**

South Central Planning and tracking tool
CP Cycle: Second 2011-2015

RESULTS	Indicator	MoV	Responsible party	Baseline	Target	Achievement
UNSAS outcome	Somali people have equitable access to basic services – health, education, shelter, water and sanitation.					

	Indicator	Mo V	Responsible party	YR1			YR2		YR3		YR4		YR5	
				baseline	target	achievement	T	A	T	A	T	A	T	A
CP Outcome 1														

Demand for, access to and utilization of equitable, improved reproductive health services are increased in all three zones of Somalia, including in settlements for internally displaced people.	Modern contraceptives prevalence rate	MICS	MOH/UN	0.3 (MICS 2006) To be updated once result from MICS 4 are released during 2011	TBD To be updated once result from MICS 4 are released during 2011		TBD		TBD		TBD		TBD	

	% of births attended by skilled birth attendants	MICS	MOH/UN	6% (MICS 2006) To be updated once result from MICS 4 are released during 2011	TBD To be updated once result from MICS 4 are released during 2011		TBD		TBD		TBD		TBD	
	Percentage of most - at-risk populations reached with HIV prevention programs	UNGASS bi-annual reports, Nation Wide Survey	MOH/UN	No data available	TBD To be updated once result of nation wide mapping are available late 2011		TBD		TBD		TBD		TBD	

Output 1.1: Improved health care delivery to support reduction of maternal and neonatal mortalities and related morbidities.	Number of obstetric fistula cases successfully repaired at supported sites	M/E, health centre records	MOH/UNFPA	Baseline NA	50		50		50		50		200	
	Number of graduated midwifes	M/E, institute records	MOH/UNFPA	Baseline NA	process		40				40		80	
	Number of service delivery points in target sites providing at least three modern family planning methods	M&E Survey, facility mapping	MOH/UNFPA	Baseline 0%	5%		5%		5%		5%		25%	
	Proportion of service delivery points correctly use protocols and guidelines of maternal health (FP,ANC,PNC,EmOC)	M&EFacility Map[ping	MOH/UNFPA	0%	5%		10%		15%		30%		35%	
	Case fatality rate of maternal complications	M/E	MOH/UNFPA	N/A To be estimated	2% reduction of estimate		5%		10%		12%		15%	
	Ratio of B EMOC facilities per 500.000 population	M/E	MOH/UNFPA	BEmOC 1.3	4		2		3		4		4	

	Ratio of C EMOC facilities per 500.000 population	M/E	MOH/UNFPA	CEmOC 1.7	2		1.2		1.4		1.6		2	
	% CS out of total births	Survey	MOH/UNFPA	0	0.5%		0.8%		1.5%		2.5%		3%	
Output 1.2: Increased capacity of government and identified community based and non-governmental organizations to offer quality, comprehensive, sexual reproductive health services, education and information for young people, with particular focus on most at risk young people.														
	Proportion of service delivery points correctly use protocols and guidelines of STIs	M/E	MOH/UNFPA	0	1%		4%		6%		8%		10%	
	Percentage of young women and men aged 15 to 24 who correctly identify ways of preventing sexual transmission of HIV and other STIs	M/E	MOH/UNFPA	0	1%		5%		9%		10%		12%	

CP outcome 2: Availability of reliable demographic and related data, institutional capacities and systems for planning, delivery and monitoring of	Annual MDG and poverty related reports take into account population dynamics and gender issues	M/E	MOPIC/ UNFPA	NA	MDG		MDG		MDG		MDG		MDG	
	Maternal mortality and morbidity monitoring system developed in selected sites.	M/E	MOH/ UNFPA	MMA System not exist	3% of Hosp covered by MMA		10%		20%		35%		50%	

humanitarian, recovery and development policies and programmes, especially at zonal and sub-zonal level ensured.	Data on each of the programme sectors for assessment of programme impact on reduction of maternal and neonatal mortality and morbidities.	M/E	MOPIC/ MOH/ UNFPA	Data not available	3%		10%		20%		35%		50%	
	Number of institutions with strengthened systems in applications of data for humanitarian, recovery and development interventions.	M/E	MOPIC/ UNFPA	N/A										
Output 2.1: Improved systems for generation, analysis and dissemination of disaggregated population and related data, with particular focus at data for better monitoring of maternal health on zonal and sub-zonal levels in order to inform interventions in this area	Number of up-to-date databases on key humanitarian, recovery and development variables	M/E	MOPIC/ UNFPA	Database is not available	1		2		3		4		5	
	Number of quality reports on utilization of the datasets for measuring attainment of the CP outputs and monitoring of maternal mortality and morbidity.	M/E	MOPIC/ MOH/ UNFPA	Database is not available	1		1		1		1		1	
	Quick population count is conducted; analyzed, disseminated, and results translated into program follow-actions	M/E	MOPIC/ UNFPA	NA	QPC conducted		Data used in planning and M&E		Data used in planning and M&E		Data used in planning and M&E		Data used in planning and M&E	
	National mechanisms to elaborate and monitor integrated population and development plan functioning	M/E	MOPIC/ UNFPA	NA	1		2		3		4		5	
Output 2.2: Strengthened capacity of selected sector ministries and partner organizations in collection, analysis, dissemination and utilization of disaggregated population data for planning and	Number of trained personnel with expertise in collection, analysis, dissemination and application of demographic and related data for humanitarian, recovery and development interventions	M/E	MOPIC/ UNFPA	0	20		20		20		20		30	
	Number of quality reports on progress in integration of ICPD and MDG concerns in humanitarian, recovery and development programmes	E	MOPIC/ UNFPA	1	1		1		1		1		1	

delivery of humanitarian, recovery and development assistance	Statistical departments in Min of Planning and other line Ministries work with DevInfo, and are able to collect development data and process and analyze these at a basic level	M/E	MOPIC/ UNFPA	NA	1		1		1		1		1	

Outcome 3 Socio-cultural environment to advance gender equality, reproductive health and women's empowerment improved	Comprehensive national policy and strategy on gender issues, integrating GBV and FGM endorsed and operational	E	MOWDAFA/UNFPA	0	1		1		1		1		1	
	Laws, policies and strategies to incorporate gender equality and human rights of women and girls	E	MOWDAFA/UNFPA	0	1		1		1		1		1	
	FGM/C prevalence rate reduced	Survey	MOH/MOWDAFA/ UNFPA	98%	98%		96%		94%		90%		85%	
	Net Enrolment Rates (NER) of girls	Survey	MOE/MOWDAFA/ UNFPA	20%	22%		24%		26%		28%		30%	
	Proportion of young girls between 5 to 15 who have undergone FGM/C	Survey	MOWDAFA/UNFPA	Data not available. Target will be set after the 2011 MICS										

Output 3.1: Increased advocacy and community engagement for the	Availability of data on gender based violence and harmful practices	M/E	MOWDAFA/ MOH/ UNFPA	System not exist	3%		10%		15%		25%		35%	

reproductive health and rights of women and adolescents girls and the elimination of harmful practices affecting maternal health	Proportion of key decision makers, community, NGOs, women's groups and religious leaders supporting gender equality, including elimination of GBV	M/E	MOWDAFA/UNFPA	System not exist	3%		10%		20%		35%		50%	
	Number of religious leaders trained to address negative impact of female genital mutilation	M/E	MOWDAFA/UNFPA	System not exist	30		30		30		40		5	
	% of SDP correctly use SGBV protocols for management of cases	M/E	MOH/UNFPA	System not exist	3%		10%		20%		35%		50%	
	Number of initiatives conducted to address FGM and early marriage	M/E	MOWDAFA/UNFPA	0	1		2		2		2		2	

Output 3.2: Enhanced systems and mechanisms for prevention of and protection from all forms of gender-based violence, using a human rights perspective, including in emergency and post conflict situation	Percentage of decision makers who are aware of domestic violence issues.	M/E study	MOWDAFA/UNFPA	Data not available. Target will be set in 2011										
	Percentage of relevant law enforcement personnel in provinces trained to identify and manage cases of domestic violence	M/E	MOWDAFA/UNFPA	Data not available. Target will be set in 2011 20 personnel each year										
	Number of community based initiatives against gender based violence especially targeting young men and boys	M/E	MOWDAFA/UNFPA	0%	2		3		3		3		3	

	Number of institutions providing services to survivors of gender based violence	M/E	MOWDAFA/UNFPA	NA	5		10		10		10		10	

Risks and Assumptions

State major risks and assumptions that could influence achievement of CP outputs and outcomes as indicated in the CP document. Assess whether risks materialized, whether original assumptions were correct and highlight factors which facilitated or constrained results achievement.

Instructions:

2) Use one sheet per CP Outcome.

2) Where the CP is more complex, the matrix can be adapted by breaking CP outputs into sub-outputs with baselines, targets and achievements.

3) It is useful, to the extent possible, at the beginning of the CP cycle to establish tentative output/sub-output targets for each year in the cycle.