1. Introduction

Malnutrition in Somalia is multifaceted affecting mothers, infants, young children, adolescent girls and women. It restricts inclusive development and overall prosperity of the nation and constitutes a violation of basic children’s rights to survival and development and the highest attainable standard of health. Although there has been improvements in the nutrition status in the last five years, children in Somalia suffer from multiple nutritional deprivations. The proposed nutrition programme, which is in line with National Development Plans (NDP) and UNICEF Strategic Plan is strategically designed to address the underlying causes of acute and chronic malnutrition and contribute to the reduction of child and maternal mortality and morbidity, all the while contributing to the achievement of the Sustainable Development Goals (SDGs), World Health Assembly resolutions and Global Nutrition Targets for 2025.

The humanitarian situation in Somalia remains fragile as evidenced by the national global acute malnutrition estimate in the past 5 years varying between 12 to 19 per cent (figure 1). Although nationally there has been progressive improvement in malnutrition (annual rate of reduction of 0.8 per cent between 2011 and 2015), the situation remains critical and unstable. According to the results of the post Deyr 2016 Food Security and Nutrition Analysis Unit (FSNAU) seasonal assessment, the burden of acute malnutrition among children under the age of 5 is 944,000 cases, including 185,000 who are severely malnourished. Amongst the worst affected population groups are internally displaced persons (IDPs) for whom the situation remains critical across the country. While evidence shows that boys are more malnourished than girls, the reason for this disparity is unknown. Severely malnourished children carry a high mortality risk and require lifesaving therapeutic nutritional support.

The proposed strategy is built on the strengths of the preceding country programme, which has seen successes in the roll-out of the basic nutrition service package (BNSP) including the annual enrolment of at least 75 per cent of cluster SAM target in the therapeutic programme while achieving treatment outcome indicators consistent with SPHERE standards. In the new programme cycle (2018-2020) the focus will remain on the first 1,000 days life of child, building the resilience of mothers, caregivers and their communities to promote nutrition seeking behaviour. The programme will support the Government and other implementing partners to enhance equitable access to, and utilization of, quality, high impact mother and child nutrition interventions that will result in the reduction of acute malnutrition and contribute to lowering child mortality and morbidity.

To achieve the aforementioned results, the nutrition programme is designed to be adaptable in order to implement recovery and development interventions while also being able to provide a swift response to emergencies. The investment in humanitarian and emergency needs will pave the way to recovery and developmental interventions. During the Country Programme period, there will be an equitable focus on upstream work, the promotion of multi-sectoral approaches to nutrition and downstream efforts, building the resilience of caregivers, households and their communities to promote preventive behaviours and increase demand for services. At the same time, the programme will strengthen the capacity of the Somali authorities to enable them to steadily lead and manage different components of the programme.

The sustained high level of malnutrition in Somalia cannot be addressed without working together with other sectors, specifically water, sanitation and hygiene (WASH) and Health. Furthermore, coordination with nutrition sector and cluster mechanisms is paramount. UNICEF will work closely
with Scaling Up Nutrition (SUN) Secretariat; Federal and Member State authorities; international and national NGO; UN agencies; and communities to achieve programme, NDP, WHA and SDG targets.

2. Prioritised issues and areas

For the last two decades, the nutritional status of Somali children has been among the worst in the world. The burden of undernutrition in Somalia remains high as evidenced by the high levels (approximately 14.9 per cent) of acute malnutrition combined with a high prevalence of micronutrient deficiencies, suboptimal breastfeeding and complementary feeding practices and low human resource capacity. In addition to the existing chronic food insecurity, there is poor access to facilities and services for health and for WASH. The aforementioned problems are exacerbated by a continuously insecure environment.

The 2016 Post Deyr assessment findings indicate high residual levels of acute malnutrition of public health significance and above-emergency threshold in IDP settlements. Out of the 13 IDP settlements surveyed, four showed critical levels of Global Acute Malnutrition (GAM ≥15%). While urban populations generally have better nutritional status than rural populations, levels of GAM are consistently higher for boys than for girls. Over 47 per cent of the Somali population does not have access to safe drinking water. At 24 per cent in 2015, the incidence of diarrhoea in children under five has not changed much over the last decades in Somalia despite the rise in use of improved water.

According to the Food Security and Nutrition Assessments being carried out by FSNAU, chronic malnutrition or stunting is not a significant public health problem in Somalia. The prevalence of stunting as per FSNAU post Deyr 2015/2016 seasonal assessment is 12 per cent and only 2 districts in Somalia have high rates of stunting. According to the same assessment, almost 6.2 million people across Somalia are projected to be in crisis and emergency (IPC Phases 3 and 4) acute food insecurity crisis – with IDPs accounting for over 70 per cent of the total.

Substantial bottlenecks to accessing SAM treatment services for many families, as evidenced by findings from recent Semi Quantitative Evaluation of Access and the coverage) (SQUEAC) surveys, revealed suboptimal case coverage of SAM treatment with a median point coverage estimate of 48 per cent observed across the 4 districts. The surveys identified the main barriers affecting the uptake of Outpatient Therapeutic Programme (OTP) services that include long distances between communities and OTP service delivery points; poor community awareness about malnutrition and its treatment; poor community mobilization and sensitization.

The finding of the nutrition causality analysis (NCA) conducted in November 2015 in selected regions and livelihood zones of central south regions (CSR) of Somalia by the Strengthening Nutrition Security (SNS) Consortium confirmed that in addition to insecurity, core drivers of malnutrition remain climate and seasonal factors, poverty among some communities, dominant child care practices and socio-
cultural beliefs. In all communities studied, inadequate infant and child nutrition and care practices, combined with poor hygiene; lack of basic health and WASH facilities; and women’s excessive workloads, which commonly take mothers away from their very young children; have a major impact on the nutritional status of children. Dominant socio-cultural beliefs and related social norms including dietary taboos and, in some communities, extremely young marriage and child-bearing ages for girls, Female Genital Mutilation (FGM) and the growing phenomenon of female-headed households in many areas, widely impact adversely on the health, well-being and nutritional status of communities studied. Dominant beliefs about the “inadequacy” of a mother’s breast milk to satisfy the needs of her newborn, continue to fuel diarrhoea and heightened vulnerability among infants.

<table>
<thead>
<tr>
<th>Key Nutrition Figures¹</th>
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<tbody>
<tr>
<td>✓ GAM 14.3%</td>
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<tr>
<td>✓ SAM 2.9%</td>
</tr>
<tr>
<td>✓ Stunting: 12%</td>
</tr>
<tr>
<td>✓ Exclusive Breast feeding :33%</td>
</tr>
<tr>
<td>✓ Anaemia among CBW : 41.5%</td>
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<tr>
<td>✓ Anaemia among children &lt;5: 59.3%</td>
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As per the findings of the 2009 micronutrient survey conducted by UNICEF/FSNAU/Ministry of Health (MOH), there are high levels of micronutrient deficiencies among women (pregnant and lactating) and children under-5. Iron deficiency among women of child bearing age was 41.5 per cent, among children under-5 it was 59.3 per cent, but significantly higher rates (73.7 per cent) were observed among children under-2. Similarly Vitamin A deficiency among children under-5 was 33.3 per cent which is above the 20 per cent WHO cut-off. Household utilization of iodised salt was 3.9 per cent. The National Micronutrient Survey in 2009 reported median excessive urinary iodine concentrations of 325.1 µg/L among non-pregnant women and 417.1 µg/L among preschool aged children in Somalia (the normal range is 100–199 µg/l). Since the 2009 survey, some programmes have been made to combat micronutrient deficiencies in Somalia. However, coverage of Vitamin A for twice yearly supplementation has been less than 80 per cent for all children aged 6-59 months. Coverage for Iron Folate and multiple micronutrient supplementation for women has also been poor. According to recent surveys, coverage for both interventions is less than 30 per cent. UNICEF has also piloted and scaled up the delivery of micronutrient powders integrated in infant and young child nutrition (IYCN) to improve nutrition status of children under 5 years old.

According to findings of an IYCN assessment of 2016, Somalia has been making exponential progress in timely initiation of, and exclusive, breastfeeding. Ninety-eight per cent of children aged 0-23 months in Somalia have been breastfed. Eighty three per cent of children in Somalia are breastfed within one hour of birth and 32.8 per cent of children 0-6 months are exclusively breastfeed. However, beliefs and practices against early initiation of breastfeeding and intake of colostrum still exist. Continued breastfeeding up to 1 year postpartum is sustained by less than 50 per cent of mothers. By age 6-8 months, 92 per cent of children in Somalia have been introduced to solid, semi-solid or soft foods. However, a large proportion of children aged 6-23 months old are not fed with the recommended number of meals and not given at least 4 groups of foods as well as iron rich foods. Bottle feeding is practiced by about half of mothers in Somalia.

The focus of the nutrition programme has been principally on increasing the availability and range of services, mostly at the facility level i.e. supply of services. Given the good results in geographic coverage and a more holistic package, the programme now needs to develop approaches to improving quality and case coverage while maintaining a focus on the use of the BNSP approach.

Nutrition coverage surveys conducted have demonstrated the ability to pin-point bottlenecks to access of facility based nutrition services. The nutrition programme needs to expand the use of coverage surveys and the development of action plans to reduce barriers to access throughout the country.

¹ Food Security and Nutrition Analysis Unit (FSNAU) seasonal assessments; Somalia IYCN Assessment (2016); Micronutrient Survey (2009)
To develop the quality of nutrition interventions, the programme triangulates reports by implementing partners with third party monitoring reports or with supportive supervision visits. The third party monitoring system allows the programme to identify gaps and opportunities for supportive supervision. Supportive supervision and strategic follow-up of reporting and monitoring issues through third party monitors and UNICEF staff resulted in significant improvements in reporting rates, identified as a priority gap area.

Nutrition programming over the last 20 plus years has focused on life saving activities through national and international NGOs. These activities have not prioritised human resource capacity development and the development of institutional capacity. Therefore, priority should be given to supporting the establishment of the nutrition sector in terms of institutional arrangements at national, regional and district levels, and sector governance structures including coordination.

The difficult and continually changing security situation, predominantly in CSR, complicated implementation of some aspects of the emergency response, as well as supply chains and pipelines, especially passing through Al Shabaab controlled areas. Additionally, actual case coverage was difficult to assess, communication channels need further diversification to diffuse key messages in order to ensure optimal nutrition practices, generate and strengthen understanding and ownership of the BNSP at community level.

Somalia became a member of the SUN initiative in May 2014, and as such is at an early stage in the development of SUN processes. Signing up to SUN constitutes a valuable starting point for Somalia to explore discussions and processes which are important dimensions of governance for nutrition. Somalia recognises that under-nutrition is a complex, multifaceted problem that needs multi-sectoral responses. While Somalia is moving towards increased government oversight and leadership, the country still requires an enabling environment that includes human resource capacity as well as management and monitoring systems for sustainable service delivery. It needs effective leadership, governance and coordination to be established at all levels. The development of a quality nutrition workforce for Somalia is part of the country’s health sector strategic plan (HSSP) and policies for human resources for health. It is an essential precondition for the implementation of the nutrition plans of action that the MOHs have developed and costed in FGS, Puntland and Somaliland.

The prioritization of nutrition within the UNICEF Somalia Country Programme supports the renewed momentum of commitments of the NDP. It also contributes to the attainment of the declaration of 2012 WHO health assembly aligned to SDG goals and targets. The NDP, as well as the Somaliland Development Plan, recognises malnutrition as a major public health issue. At the outcome level the NDP prioritises the reduction of Underweight (weight-for-age) Stunting (height-for-age) and Wasting (weight-for-height) along with addressing the micronutrient needs of women and children.

Success in improving nutrition outcomes will rely heavily on coordination with other programmes and actors, e.g. working together with WFP in linking supplementary feeding programme (SFP) with OTP, working with UNFPA on maternal malnutrition, working with FAO to strengthen the link between agriculture and nutrition and with WHO on updating the health strategies and updating the treatment protocol.

In light of the above, the following four programmatic domains have been prioritised to support a reduction in malnutrition and contribute to the reduction of child mortality.

**Enabling Environment:** Fostering multi-sectoral approaches across stakeholders; and nurturing equity-focused national nutrition policies, legislation, strategies and plans that encompass vulnerable and socially excluded populations;
**Supplies:** Scaling up access to, and utilization of, integrated quality basic Nutrition, Health and WASH services focusing on vulnerable populations including IDPs.

**Quality:** Individual service provider, institutional and departmental capacities along with government ownership and leadership increased

**Demand:** Individuals, households and communities with improved knowledge and practices of essential nutrition behaviours and increased capacity to plan, manage and monitor recurrent shocks and stresses.

UNICEF’s comparative advantages include a 35 year footprint working in Somalia, established partnerships with close to 60 nutrition implementing partners, and a well-established supply chain system including a network of strategically located warehouses, together with global expertise and mandate. UNICEF Somalia has proven capacity in multiple sectors with a wide range of staff; the experience that covers the development-humanitarian continuum in Somalia with a strong field presence; and a capacity to engage concurrently at multiple levels. UNICEF will continue to apply an equity lens (including gender equality).

### 3. Theory of Change

The overall vision of change for UNICEF Somalia is that by 2030, the most vulnerable children in Somalia will be healthy, in school, protected from harm, and living in resilient communities which access government-led social services. Contributing to that vision, the goal of the Somalia Nutrition programme is to improve nutritional status of women and children, so that the potential for healthy development and inclusive prosperity is realised and a downward trend in child and maternal morbidity and mortality sustained.

To attain the above, and in line with the NDP and Somaliland Development Plan, at the outcome level UNICEF and its partners aim to ensure proportions of under 5 girls, boys and women including IDPs and those in emergency setting have equitable access to and use essential services and adopt optimal nutrition practices to reduce malnutrition.

The premise for this outcomes is that acute malnutrition, specifically severe acute malnutrition is a major threat to child survival in both humanitarian and development settings. To reduce the burden of acute malnutrition there is a growing need to focus on preventive measures by strengthening the continuum of care, community based programing and multi-sectoral coordination. Children and pregnant and lactating women (PLW) are among the most vulnerable people in the event of humanitarian crises, with those children in the first 1,000 days of life at particular risk of malnutrition. While scaling up quality facility-based interventions provide the opportunity for the children and PLW to get the required treatment, the community-based approaches are an innovative means to increase access to curative, preventive and promotive services close to the communities where children and PLW are and builds the resilience of the families.

To accomplish this outcome, progress will only be possible if several critical actions happen concurrently over the next five years including the political will to support efforts to scale-up nutrition and improve equity on the assumption that the number of humanitarian crises will not overwhelm capacity. The four outputs listed in the next section focus on nutrition specific interventions which are the basis for the theory of change of the nutrition programme, while the strong link with health and WASH outputs need to be maintained.

In the framework of the theory of change, the programme recognizes that if there is an improvement in enabling environment (policy/legislation and social norms), then supply and demand on knowledge will be generated; if demand and supply on knowledge is generated, then services will be available...
and sustained leading to demand and changes in behaviour and utilization of services or new practices or new norms through advocacy, social mobilization, and behaviour change communication.

Summary of TOC for the 2018-2020 Nutrition Programme

If the enabling environment including human resource capacity and management systems for service delivery and effective leadership, commitment, governance and coordination is established at all levels; then government-led multi-sectoral approaches across stakeholders will be harmonised to drive the formulation of equity-focused national nutrition policies, legislation, strategies and plans that serve the most vulnerable and socially marginalised groups

If national nutrition policies, legislation, strategies and plans foster an environment that directs, regulates and subsequently influences the behaviour of communities, and if these policies, legislation, strategies and plans empower women to play a key role in decision making over household resources to improve effective care for children, then knowledge and practice of basic nutrition behaviour for optimal nutrition and care for women and children particularly within the 1,000 days window of opportunity will increase leading to increased demand for services and accountability from service providers.

If entire communities and duty bearers are empowered to demand for quality nutrition services and accountability from service providers including government, national and international non-governmental civil society organizations and the private sector and; if the multi-sectoral approaches become functional such that partners (WFP/FAO/WHO/UNFPA/UNICEF/NGOs) and the different UNICEF programmes (WASH, Health, ECD, Child Protection) work in synergy; then integrated high impact multi-sectoral services will be delivered at scale.

If households have improved knowledge and practice of essential nutrition behaviours and; if children and women particularly the socially marginalised groups have access to high quality basic nutrition services at facility, mobile and community outreach level, then communities will become resilient to overcome recurrent shocks and stresses;

If declared nutrition emergencies are responded to according to the Core Commitments for Children in Humanitarian Action (CCC), then excess mortality and morbidity will be averted.

Ultimately, malnutrition among under-5 girls and boys, as well as women including IDPs and those in emergency settings, will be reduced, resulting in the reduction in child and maternal mortality and morbidity.

Assumptions, Risks and Mitigation measures

The achievement of the vision of this Theory of Change is based on a number of key assumptions, risks and mitigation measures. First, communities are open to receiving information, behaviour change messages and other efforts to change sociocultural beliefs and practices. While initiatives aimed at sharing knowledge and promoting behaviour change have generally been readily embraced by communities and families in Somalia, there is always a risk that other issues (e.g., religious and household power dynamics particularly the role of women in decision making) could be a barrier to effective behavioural change. The key risk mitigation measure is continued advocacy efforts by engaging with political, religious and community leaders to highlight the key role of women in achieving optimal infant and child nutrition and by publicizing information in forms that reach the general public to trigger change.
Second, a minimum level of capacity exists within governments and other partners so that capacity development efforts are not rendered useless through brain drain and absence of human resources with whom UNICEF can engage. The major risk to this is in humanitarian situations, where human resources are sometimes extremely limited due to attrition and recruitment by civil service organizations. Poor coordination in the sector is another risk, as it results in inefficiencies that weaken capacity in some settings. To mitigate this, UNICEF will endeavour to build resilience in communities, including by building capacity of some non-traditional actors (e.g. community volunteers to deliver basic services such as deworming tablets and oral rehydration salts), including the delivery of services by the private sector.

Third, government and sector partners incorporate newly generated evidence about what works into sector plans, and that they have sufficient capacity and commitment to translate these changes into operational improvements, particularly in ways that prioritise delivery to disadvantaged populations. The major risks to this are insufficient political commitment to making these changes and insufficient capacity to implement the laws and policies that have been formulated. UNICEF will highlight the importance of nutrition efforts and building capacity to assess and use evidence, so that a broad range of stakeholders can work together to improve implementation through the use of better evidence. UNICEF’s experience on resilience in Gedo region will play a key role in mitigating this risk in addition to supporting coordination by acting as the global cluster lead for nutrition.

Fourth, UNICEF’s partners understand the importance of employing a rights-based and gender-sensitive approach to nutrition programming. The risk associated with this assumption is that there will be an increase in isolated attacks on these principles – particularly on gender equality – that could coalesce into a broader crusade against them. To address this risk, UNICEF will continue to build the evidence base for the added value of addressing gender equality and the importance of using a human rights-based approach. Additionally, UNICEF will ensure that its own staff prioritise these issues, including by providing tools and regular training on these topics.

Fifth, political leaders will continue to promote and support efforts to scale up nutrition and improve equity including their commitment and availability of capacity to translate policy changes into operational improvements. The major risks to this are insufficient political commitment to making these changes and insufficient capacity to implement the laws and policies that have been formulated. To mitigate against this, UNICEF will advocate for the continued importance of nutrition, including by highlighting the increasing consensus around addressing wasting and stunting in Somalia and regularly monitoring new global developments concerning supplementation and fortification, and responding rapidly to emerging issues with them.

Last but not least, the number of humanitarian crises remains limited and manageable. The international community in Somalia has continued to play an important role in addressing cyclic emergencies, but this support is subject to capacity limitations. Thus a risk of dramatic increase in the number of severe humanitarian situations (e.g. the current prolonged drought progressing into famine) would pose significant challenges to the ability of the international community to respond. This risk will be mitigated by developing the capacity of partners to plan for and respond to humanitarian crises, including through training and technical assistance; building the resilience of communities and families to cope with shocks.
4. Results Structure and Framework

Outcome: By 2020, increased proportion of girls and boys under the age of 5 years and women have equitable access to and use essential services and adopt optimal nutrition practices to reduce all forms of malnutrition, with a focus on vulnerable IDPs and emergency-affected communities.

Output 1: By 2020, strengthened and functional multi-sector humanitarian and development coordination mechanisms are in place and evidence based, equity-focused nutrition policies, codes, strategies and plans are developed and/or reviewed.

Addressing malnutrition requires an effective multi-sectoral nutrition system that brings nutrition sensitive and nutrition specific interventions of stakeholders from various sectors operating at different levels together. Relevant policies and strategies need to be in place to achieve higher results. UNICEF comparative advantage in this area includes global and national leadership of the nutrition sector/cluster serving as a trusted first port-of-call for government and partners and the provider of last resort; experience of providing technical guidance and support to senior government officials since the establishment of the Government; and having an extensive foot-print through the presence of qualified staff on the ground and strategically located field offices across Somalia.

UNICEF will play a key role in developing and disseminating a multi-sector humanitarian and development nutrition plan with a common results framework. This will also constitute an investment case for nutrition to stimulate broad domestic and international resource mobilization in continuous dialogue and engagement with key donors and development partners through established forums. UNICEF will elevate the visibility of nutrition as top priority for relevant government sectors and support systematic inclusion and tracking of nutrition indicators in various governments’ policies, strategies and plans. To this end, UNICEF will endeavour to increase awareness of nutrition issues, generate commitment and action, and complement resource mobilization efforts. UNICEF will support and equip champions for nutrition at the office of Vice Presidents, Prime Minister, Parliaments and Developmental Partners to raise the profile of nutrition. UNICEF will work with Federal and State Governments to improve the enabling environment for addressing all types of malnutrition by strengthening institutional coordination particularly at decentralised levels to ensure that partners’ actions contribute to the Multi-sectoral Action Plan for the Reduction of Malnutrition.

Output level core deliverables

- Multi-sector, Humanitarian and Development nutrition plans and functional coordination mechanisms at Federal, Puntland and Somaliland.
- Enabled Nutrition Champions
- Tracking of resource and advocate for equitable allocation funds to multi-sector plan
- Develop and disseminate an investment case for nutrition
- Nutrition policy, strategy and BMS code and norms in place
- Evidence generation, policy dialogue and advocacy for nutrition will include support to the development and update of IYCN and micronutrient strategies.

Nutrition policies and strategies that meet the needs of the most disadvantaged boys and girls are crucial to guide further investment in nutrition particularly from government, donors and the private sector. UNICEF will provide technical support in developing, adopting and monitoring policies and
strategies related to nutrition security including breastfeeding policy, code of Marketing of Breastmilk Substitutes Nutrition strategy and action plan, advocacy on maternity protection for women in both formal and informal sectors. UNICEF will support the SUN secretariat to track state and district public resources allocation and expenditure and advocate for equitable allocation of resources to the nutrition sector. This will be coupled with improved social accountability by increasing community participation through established partnerships with civil society umbrella organizations.

As a cluster lead for nutrition, UNICEF will draw on lessons learnt from the ongoing pre-famine scale up planning to review and update strategies and operational guidelines for swift and effective response to shocks and crises. UNICEF will continue to lead the nutrition cluster, the UN SUN nutrition group, UN Nutrition Agenda for the Reduction of Malnutrition collectively developed and endorsed by head of UN agencies. UNICEF will also build stronger linkages and partnerships across sectors particularly health, WASH, child protection and in cross-cutting areas. Because partnerships are important in the success of multi-sectoral approaches, UNICEF will work closely with a range of groups, such as the Global Alliance for Improved Nutrition, the Micronutrient Initiative, Scaling Up Nutrition, the Standing Committee on Nutrition, Renewed Efforts Against Child Hunger and UN sister agencies; WHO for the formulation of policies and technical guidelines, FAO and WFP on linkages between food security and nutrition and civil society to implement services on the ground.

Output 2: By 2020, Improved, Integrated, quality basic nutrition services for children and pregnant and lactating women including IDPs are available.

Access to and utilization of basic nutrition services is a big challenge in Somalia with only 50% coverage through the BNNSP. To reduce the level of malnutrition there is a need to scale up the reach and utilization of all BNNSP components in partnership with the government, local and international organizations. Crises pose considerable risks to nutrition by undermining the provision of services, interrupting supply chains (both public and private) and rendering traditional coping strategies less effective. Ensuring that children – particularly those in their first 1,000 days – have adequate nutrition in emergencies is both an intervention that is immediately lifesaving and one that provides important lifelong benefits, given the implications of early nutritional deficits.

Ensuring that vulnerable children are protected against malnutrition requires specific nutrition interventions including facility and community-based management of acute malnutrition, infant and young child nutrition, provision of micronutrient supplementation, deworming and interventions to prevent acute malnutrition. UNICEF will provide technical, financial and logistical support to develop national capacity to deliver nutrition services, take ownership of the nutrition response and lead the sector including logistics management of the programme. Adequate micronutrient status in pregnant and lactating women and children improves the health of expectant mothers and the growth, development and survival of their children. Provision of micronutrient supplements for children under-5 and pregnant women will continue. Emergency response in accordance with UNICEF’s CCC will be incorporated at all levels. UNICEF will provide integrated Health, nutrition and WASH interventions to displaced communities. UNICEF will lead the nutrition cluster, seeking to improve the effectiveness and accountability of emergency preparedness and response across agencies. UNICEF will also build capacity for disaster risk reduction, emergency preparedness and emergency response.
Supplementation with Iron Folate, and home fortification of complementary foods with micronutrient powders and Zinc with Oral Rehydration Salts at scale for children remains a high priority. Within the collective effort to scale up Infant and Young child nutrition interventions UNICEF will look at new and innovative ways to reduce the marginal cost of distribution/social marketing of micronutrient powder supplementation through increased integration within the larger maternal, infant and young child nutrition (MIYCN) programme and through the use of new delivery mechanisms such as using a voucher system which will specifically reach vulnerable groups. Twice yearly Vitamin A Supplementation and de-worming through routine service provision will be enhanced and sustained. UNICEF will collaborate with training institutions, Ministry of Health and partners in Somalia to develop and roll out programmes to address short and longer-term capacity gaps with particular focus on delivering services at facility and community level, inaccessible and rural areas with limited coverage of health facilities.

**Output 3. By 2020, Individuals, households and communities have improved knowledge of essential nutrition behaviours and increased capacity to plan, manage and monitor recurrent shocks and stresses.**

Building capacity of communities and civil society to promote, enable and sustain behaviour change related to improved nutrition with a robust monitoring and evaluation system to inform and guide programme design and implementation as well as demonstrate impact is an important element that contributes to the reduction of acute and chronic malnutrition. UNICEF’s comparative advantage in this area includes extensive experience of working with communities and resilience programming.

The MIYCN interventions include initiating breastfeeding within one hour of birth, exclusive breastfeeding for the first six months of life and continued breastfeeding up to the age of 2 and beyond, together with safe, age-appropriate feeding of solid, semi-solid and soft food starting at 6 months of age and growth monitoring. This output includes Behaviour Change Communication (BCC) to improve caregiver practices; increasing nutrition density of complementary foods; providing complementary foods, with or without added micronutrients; and fortifying foods through home fortification including use of multiple micronutrient powder (MNP), and prevention and control of diet related non-communicable diseases, in each case paying greater attention to most vulnerable and socially marginalised groups.

UNICEF will work on increasing and sustaining demand creation for basic services for mothers and children under-5 at both facility and community levels through a comprehensive Communication for Development (C4D) strategy. Successful BCC efforts will be informed by formative assessments, including gender analysis, to better understand the varied and complex social norms and social structures of different target communities, especially among socially excluded. The agents of change will be mainly those people most trusted by the communities. Community volunteers and other key influencers (e.g. religious leaders, traditional leaders, and grand-mothers) who will ensure mothers, caretakers and children are provided with regular information, support and counselling on good nutrition practices and other key behaviours (including sanitation and hygiene and health).
The C4D strategy will also explore innovative technology such as voice messaging and leveraging community radio networks. Integration and cross-sectoral linkages among nutrition, WASH and health will be further strengthened by expanding implementation of Nutrition Health and Hygiene Promotion Package (NHHP). Capacity strengthening will support the training of health workers and community based workers in basic nutrition services including counselling and promotion of MIYCN, micronutrient supplementation and supporting communities to undertake active roles in resilience building.

To reduce the current burden of acute malnutrition in Somalia there is a growing need to focus on prevention by strengthening the continuum of care and multi-sectoral coordination. As such, maternal and child nutrition will be promoted through the integration of service delivery systems including working in collaboration with FAO, WFP, Health and WASH community service delivery platforms for timely provision of MIYCN support, NHHP, micronutrient supplements and deworming. The C4D strategy will involve community leaders and other influential people in discussing increased nutritional demands during pregnancy and lactation and the need for decreased workload and empowerment of women to play a key role in decision making regarding household resources for improved nutrition. The C4D strategy will further focus on disseminating messages to women and their families through varied channels and contact points. Dietary diversification will be promoted, coupled with food production or income-generation activities such as homestead food production, in collaboration with food security partners (FAO, WFP) that have a programme focus on production and livelihoods.

Key strategies will include policy dialogue and advocacy to institute, enforce and effectively monitor national policies and strategies that promote and support nutrition at individual, household and community level including enforcement and monitoring national policy to regulate the marketing and distribution of breast milk substitutes (Code of marketing of breast milk substitutes), and marketing of bottles for feeding children.

Communities’ capacities through the community health worker approach will be strengthened to support the delivery of basic nutrition services including prevention, promotion and the capacity to manage and withstand shocks. Participation of right holders at the community level in planning, implementation and monitoring will be important.

Updated evidence on micronutrient nutritional status among children, pregnant and lactating women will be generated with data on age, gender disaggregation, urban and rural disparities, to support programing for key micronutrients in Somalia. UNICEF through its partners will promote breastfeeding in the context of HIV as recommended by the WHO and invest on developing capacity of health providers, to ensure proper counselling services.

Strategic partnerships with international and local NGOs, private sectors, universities, research institutions to carry out joint mandates will be enhanced. The current partnership with NGOs for social marketing multiple micronutrient for home fortification will be scaled up in Puntland and Somaliland for all children under-5 with special focus on urban areas while free based distribution at community and facility level will focus on rural areas with a special focus on children under two years.

The resilience programming will expand partnerships beyond Gedo region and mainstream resilience across nutrition programmes. The joint resilience programme with WFP and FAO, and the strategic partnership with SAVE the Children will further support the development of an action plan for scaling up resilience programming and joint initiatives such as Milk Matters to leverage resources and enhance programme convergence. Integration and cross sectoral linkages linking nutrition, WASH and health by expanding implementation of HNNP package will continue.
Output 4: Government and partners have enhanced capacity to deliver, monitor and report on services, strengthening the quality of nutrition programmes.

Effective management of the programme requires adherence to required quality standards (national or international norms) ensuring that services, information and practices adhere to minimum national or international standards. National standards will be aligned to international conventions (including the Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities, and Convention on the Elimination of Discrimination against Women), international standards including SPHERE and standards with evidence-based practices. To achieve the delivery of quality results also requires that programme supplies consistent with international standards and as such, UNICEF’s comparative advantage in this area includes the procurement of supplies from a centralised supply division from accredited suppliers. Furthermore, programme delivery requires being informed by rigorous evidence generated through regular monitoring using internationally acceptable methodologies including the bottleneck analysis, coverage surveys, DHS, MICS and SMART surveys. Strengthening data collection, monitoring and reporting contribute to better understanding of maternal, infant and young child nutrition practices by geographical area, residence and socioeconomic status, as well as the status of interventions, which lead to better evidence-based programming and more equitable approaches to improving nutrition.

UNICEF will take the lead in supporting the government’s expansion of the nutrition workforce through implementation of a human resource development strategy for the nutrition sector. Capacity strengthening efforts will start with a systematic capacity gap analysis to define strategies and identify with partners/institutions the gaps in leadership and management. In addition to the current capacity building intervention, support will include expansion of nutrition pre-service curriculum and in-service training programmes to address capacity gaps in nutrition skills. UNICEF will work to ensure that the quality of nutrition pre-service curriculum offered across academic institutions is enhanced and standardised. UNICEF will play a key role in strengthening institutional capacities to ensure optimum delivery of results against actions. UNICEF will support government and other partners in conducting equity-focused (including gender inequality), situation analysis/bottleneck analysis for nutrition and its determinants to inform policy development and programme design and implementation that enables the sector to meet the NDP/SDG/WHA targets.

The need for timely, quality and comprehensive data availability is crucial to inform government and other stakeholder response. Focus will remain on ensuring timely generation of evidence and knowledge management. UNICEF will ensure a particular focus on gender specific analysis that acknowledges roles, risks and responsibilities of men and women particularly regarding child care and feeding practices. Evidence generated will be used for monitoring commitments against the NDP, CRC and World Health Assembly nutrition targets as well as for advocacy with government, donors and partners and to inform UNICEF’s programme design and implementation.

To ensure the timeliness, reliability and persuasiveness of nutrition information, UNICEF will partner with institutions so that population based data using SMART methodology (e.g. anthropometric, IYCN indicators and service coverage and quality) are generated and provide disaggregated
information by sex, age and geographical area. A key feature of the ‘real-time’ monitoring will be that it generates evidence about “what works” and “how it works”, with enough details so that the interventions can be replicated. UNICEF will continue to support the strengthening of the nutrition information system by improving nutrition routine data collection and analysis.

UNICEF will accelerate efforts to have a fully functional real time monitoring system that will gradually be handed over to government for complete ownership, oversight and management. The monitoring system will be applied to both facility and community-based programmes to allow results, processes and experiences to be captured, documented and used in the learning process. Identification of bottlenecks across the domains of supply, demand, quality and the enabling environment will be an integral part of the monitoring system thus enabling the ongoing assessment of issues, and the application of corrective measures and continuous quality improvement. Monitoring will be done with an equity lens, while ensuring that data is generated in a timely manner to inform key programmatic and strategic decisions.

5. Resource Requirements

<table>
<thead>
<tr>
<th>Programme budget (In thousands of United States dollars)</th>
<th>Regular resources</th>
<th>Other resources</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 700</td>
<td>11 988</td>
<td>17 688</td>
<td></td>
</tr>
</tbody>
</table>

5. Monitoring outputs and demonstrating UNICEF’s contribution to outcomes

The programme outcomes will primarily be measured at least once during this programme cycle through nationally representative surveys including DHS, Micronutrient and MIYCN. This data will be disaggregated by geographical areas, gender, wealth, rural/urban etc. to ensure ability to assess progress on the equity.

In addition, annual population based data (e.g. anthropometric – wasting, underweight) will be generated using Standardised Monitoring and Assessment of Relief and Transitions SMART methodology. However, since Somalia is prone to humanitarian emergencies, the frequency and geographical focus of SMART surveys will be determined by the need. Changes in knowledge, behaviour and social norms related to infant and young child nutrition will be measured through periodic surveys e.g. IYCN Assessment and micro-nutrient survey. To support case coverage and generation of evidence on coverage, UNICEF will work closely with partners to scale up coverage surveys annually, leveraging Cluster-led geotagging exercises currently underway which will give a more accurate account of existing nutrition service sites and services. Other critical nutrition research topics will also be included in the research agenda of the office and will be reflected in the office’s evaluation and research plan which also guides the dissemination strategy for research findings.

Programme outputs will be assessed through sub-national-level monitoring systems and small scale assessments and surveys, which will be used to generate, analyse and use nutrition information (including both situation analysis and programmatic data). This will ensure regular monitoring of key nutrition inputs, outputs as well as bottlenecks to achieving effective coverage of interventions across the policy and programming environment. Data on the SAM treatment programme (SAM admissions and performance indicators – cured, defaulted, died) will be collected monthly through the Nutrition Cluster mechanism. Commodity stock-out rates (supply monitoring) will be tracked monthly using the
dedicated real time (mobile) RapidPro monitoring system. Data for interventions around IYCN promotion and micronutrients (micronutrient powders, vitamin A etc.) will be collected monthly both at facility and community level through implementing partners. UNICEF will also support ongoing monitoring of the resilience approach by piloting a community scorecard to determine when a certain behaviour has been attained or adopted at community level.
Annex 1: Results Framework

UNICEF will continue to track the prevalence of wasting among 0-59 months children (weight/height), aiming to reduce the current national of 14.9 to less than 12% across all regions by 2020, as well as the prevalence of stunting among 0-59 months children (height/age), aiming to reduce this also from the current level of 12% nationally to 10% across all regions by 2020.

<table>
<thead>
<tr>
<th>Key results</th>
<th>Progress indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sustainable development goals:</strong> SDG 2 End hunger, achieve food security and improved nutrition and promote sustainable agriculture</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>UNICEF Vision:</strong> By 2030, the most vulnerable children in Somalia will be healthy, in school, protected from harm, and living in resilient communities which access government-led social services.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>National Development Plan Priorities:</strong> By 2019, increase the prevalence of exclusive breastfeeding in children &lt;6 months and reduce the prevalence of; Underweight, Stunting, Wasting, Vitamin A deficiency and Anemia among children aged 6-59 month as per targets outlined in health assembly and reduce Anemia (hemoglobin concentration &lt;11 g/dl) among pregnant women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UN Strategic Framework strategic and programmatic commitments involving UNICEF:</strong> 7 (Enhancing humanitarian collaboration with development partners on reducing risk, ending need, and tackling underlying causes), 8 (Supporting Somalia’s nascent development trajectory)</td>
<td></td>
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</tbody>
</table>

**Programme Outcome**

<table>
<thead>
<tr>
<th>Key results</th>
<th>Progress indicators</th>
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<th>Target</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2020, increased proportion of girls and boys under the age of 5 years and women have equitable access to and use essential services and adopt optimal nutrition practices to reduce all forms of malnutrition, with a focus on vulnerable IDPs and emergency-affected communities.</td>
<td>Proportion of children under-five receive Vitamin A supplementation twice per year</td>
<td>Less than 10%</td>
<td>30%</td>
<td>Coverage survey</td>
</tr>
<tr>
<td>Number of pregnant women who received multiple micronutrient supplements</td>
<td>Number of pregnant women who received multiple micronutrient supplements</td>
<td>Less than 30%</td>
<td>50%</td>
<td>Coverage survey</td>
</tr>
<tr>
<td>Proportion of children 0-6 months old who are exclusively breastfed</td>
<td>Proportion of children 0-6 months old who are exclusively breastfed</td>
<td>National - 33%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CSR - 21.5%; Puntland - 39.2%;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>45 % across all regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>National nutrition survey/ IYCN assessment /DHS IYCN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2 As per the National Development Plan.
<table>
<thead>
<tr>
<th>Key results</th>
<th>Progress indicators</th>
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<th>Target</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of children 6-59 months with SAM including IDPs who are admitted into treatment</td>
<td>CSR - 48% Puntland - 62% Somaliland - 70%</td>
<td>75% all regions</td>
<td>Coverage survey</td>
<td></td>
</tr>
</tbody>
</table>

**Programme Outputs**

| Output 1: By 2020 strengthened and functional multi-sector humanitarian and development coordination mechanisms are in place and evidence based equity focused nutrition policies, codes strategies and plan are developed and/ or reviewed. | National and Subnational Multi-sectoral nutrition action plans developed | 0 | 3 | Multi-sectoral Nutrition Action Plan available |
| | Existence of functioning cluster coordination mechanism for nutrition | 1 | 1 | UNICEF cluster coordination monitoring tool |
| | Updated Nutrition strategy with Nutrition Action Plans operationalised | 0 | SCR regions Somaliland Puntland | Nutrition Strategy and Plan of action |
| | Adoption of the International Code on Marketing of Breastmilk substitutes as legislation and subsequent relevant World Health Assembly resolutions | 0 | Yes | BMS code |

<p>| Output 2: By 2020, improved, integrated, quality basic nutrition services for children and pregnant and lactating women including IDPs are available. | Human resource development strategy in place and translated to action plan | 0 | 1 | HRDS document |
| | Proportion of staff trained on BNSP | 50% | 75% | Implementing partners activity reports |
| | % of health/nutrition facilities providing BNSP | 65% | Above 75% | Implementing partners activity reports |</p>
<table>
<thead>
<tr>
<th>Key results</th>
<th>Progress indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health facilities with zero stock out of RUTF as defined by national norms in the reporting year</td>
<td>2%</td>
<td>&lt;2%</td>
<td>Cluster reports</td>
<td></td>
</tr>
<tr>
<td>Output 3: By 2020 Individuals, households and communities have improved knowledge of essential nutrition behaviours and increased capacity to plan manage and monitor recurrent shocks and stresses.</td>
<td>IYCN Number of primary caregivers of children aged 0-23 months who received individual counselling on IYCN</td>
<td>174,327</td>
<td>382,461</td>
<td>Partners report</td>
</tr>
<tr>
<td>Proportion of community workers in targeted districts trained to provide basic prevention services for resilience including IYCN (as per national standards)IYCN</td>
<td>National 9% CSR - 11% Puntland - 7%; Somaliland - 6% Above 30%</td>
<td>IYCN reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of service delivery points (health facility or community) with adequate materials for IYCN counselling, support and communication</td>
<td>236</td>
<td>347</td>
<td>IYCN reports</td>
<td></td>
</tr>
<tr>
<td>Output 4: By 2020 government and partners have enhanced capacity to deliver, monitor and report on services, strengthening the quality of nutrition programmes</td>
<td>Existence of a national IYCN and CMAM training curriculum for health and nutrition workers</td>
<td>0</td>
<td>1</td>
<td>Consultant reports</td>
</tr>
<tr>
<td>% of nutrition centers operating with performance indicators that meet SPHERE standards</td>
<td>89%</td>
<td>95%</td>
<td>Nutrition Cluster reports</td>
<td></td>
</tr>
<tr>
<td>National management information system that includes age and sex disaggregated data on nutrition available</td>
<td>0</td>
<td>1</td>
<td>mNutrition/HMIS/DHIS2</td>
<td></td>
</tr>
</tbody>
</table>
**Annex 2: Theory of Change**

**VISION:** By 2030, the most vulnerable children in Somalia will be healthy, in school, protected from harm, and living in resilient communities which access government-led social services.

**OUTCOME:** By 2020, increased proportions of U5 girls, boys have equitable access to and use essential services and adopt optimal nutrition practices to reduce all forms of malnutrition with a focus on vulnerable IDPs and emergency affected communities.

**OUTPUT 1:** By 2020, strengthened and functional multi-sector humanitarian and development coordination mechanisms are in place and evidence based, equity-focused nutrition policies, codes, strategies and plans are developed and/ or reviewed.

**OUTPUT 2:** By 2020, improved, integrated, quality basic nutrition services for children and pregnant and lactating women including IDPs are available and utilised.

**OUTPUT 3:** By 2020, individuals, households and communities have improved knowledge of essential nutrition behaviors and increased capacity to plan, manage and monitor recurrent shocks and stresses.

**OUTPUT 4:** By 2020 the quality of nutrition programme is improved through enhanced government and partner capacity to deliver, monitor and report on QUALITY services.

**Assumptions**
- Humanitarian crises do not overwhelm capacity;
- Political support for addressing inequity remains strong;
- Evidence-based approaches plus technical solutions make a difference in children’s lives;
- Consensus continues on the importance of partnerships;
- Progress in other sectors

**Assumptions**
- Political leaders continue to support efforts to scale-up nutrition and improve equity;
- Prolonged drought does not progress to famine thus leading to total breakdown of resilience systems;
- The number of humanitarian crises remains limited and manageable.
- Other partners specifically WFP is operational on the ground and take care of MAM cases.
**Strategic interventions**

**Capacity development**
- Develop capacity of HMIS to disaggregate nutrition data by key forms of vulnerability (boys, girls, women, IDP, etc.), and analyse and use the data to identify and address barriers and bottlenecks
- Use ProPAN (Process for the Promotion of Child Feeding) to build capacity to address critical bottlenecks to improving complementary feeding
- Build capacity for disaster risk reduction, emergency preparedness and emergency response based on Core Commitment for Children principles
- Build capacity of service providers on infant and young child feeding including in emergencies
- Build human resource capacity to deliver quality nutrition services through improved pre- and in-service training curricula

**Evidence generation, policy dialogue and advocacy**
- Support MoH to develop nutrition policies and plans that are multi-sectoral and costed, include clear targets, define risk management strategies to address risks from disasters, conflict and climate change, and contain specific actions targeted to vulnerable groups
- Support legislative changes to help Somalia achieve full implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutions, and of maternity protection
- Use the costed multi-sectoral plan for SUN and investment case for policy dialogue and advocacy to increase awareness of nutrition issues, generate commitment and action, and complement resource mobilization efforts
- Use results from the national micro-nutrient survey to assist MoH to develop policies and plans for addressing micro-nutrient deficiencies

**Partnerships**
- Participate in global and regional networks and initiatives for nutrition, such as Scaling Up Nutrition, the Standing Committee on Nutrition and Renewed Efforts Against Child Hunger and undernutrition
- Serve as the national nutrition cluster lead agency for Somalia
- Develop partnerships with civil service organization both international and local including UN sister agencies (FAO, WFP and WHO) for integrated service delivery

**Identification and promotion of innovation**
- In partnership with Population Services International, pilot a market-based micronutrient powder programme
- Operationalise mNutrition dashboard to provide real-time data for nutrition
- Provide leadership on the completion of Geotagging of nutrition delivery sites database

**Support to integration and cross-sectoral linkages**
Link nutrition interventions with those of other sectors (particularly Food Security, Health, ECD, Child Protection, Education and WASH) to provide integrated services, including for early childhood development

**Service delivery**
- In humanitarian situations and settings with weak capacity, directly deliver nutrition services, including through supplementation and fortification efforts
- Use social and behaviour change communication to address knowledge, behaviours, sociocultural beliefs and practices related to infant and young child nutrition

**Assumptions**
- Openness from communities to receiving information and behaviour change messages;
- Existence of minimum level of capacity that can be supported;
- Partners support incorporating evidence into sector policies and plans;
- Political commitment and capacity exist to translate policy changes into operational improvements;
- No convergence of unmanageable numbers of crisis simultaneously;
- Coordination in humanitarian settings does not collapse;
- Partners understand the importance of employing a rights-based and gender-sensitive approach to nutrition programming;
- No collapse in the global system of coordination and partnership

**Bottlenecks**
- Weak institutional capacities at national and sub-national levels for leadership, coordination, planning, monitoring, budgeting and service
- Limited political will for public investment for long term Nutrition, Health and WASH programming
- Lack of policy framework for women empowerment over household resources to improve effective care for children
- Inadequate focus to maternal and child nutrition within the 1,000 days window
- Sub-optimal practices among caregivers around feeding, hygiene and health seeking behaviours
- Inadequate community resilience to overcome recurrent shocks and stresses
- Limited coverage of integrated community nutrition programmes in humanitarian and development settings
VISION: By 2030, the most vulnerable children in Somalia will be healthy, in school, protected from harm, and living in resilient communities which access government-led social services.

OUTCOME: By 2020, increased proportions of U5 girls, boys have equitable access to and use essential services and adopt optimal nutrition practices to reduce all forms of malnutrition with a focus on vulnerable IDPs and emergency affected communities.