NEC Policy Brief

EDUCATION AND HEALTH FOR WOMEN AND YOUTH EMPOWERMENT[1]

1. Introduction

As part of the Somali Growth and Economic Transformation Strategy (GETS) 2022-2050, the National Economic Council (NEC) commissioned a study on Somalia's social sector to inform GETS' vision. The objective of the study was to conduct an analytical assessment of the social sector (education and health) with a focus on gender and youth empowerment. In particular, the study assessed the veracity of policies, legal frameworks, and institutional capacities in promoting access and quality of health and education services across the country.

Data used in the study was collected through desk review and key informant interviews (KIIs). The KIIs were performed in person, by email, and on virtual platforms, using four instruments administered to Government Ministries and MDAs, Private Sector stakeholders; Local and International NGOs and CSOs; and UN Organizations and other Development Partners, respectively. Results from the analysis of secondary data generated from the desk research were complemented with findings from primary data obtained through KIIs.

Using a purposeful and convenient sampling approach, a qualitative questionnaire was administered to respondents selected across different regions on the basis of their key roles and involvement in the social sector.

2. Findings of the Education Sector

2.1. Access to Education

The protracted conflict spanning over three decades in Somalia destroyed the education system, typified by dilapidated learning infrastructure, unqualified teachers, and inadequate teaching and learning resources. Perennial floods and droughts lead to the massive internal displacement of people and exacerbate the poor provision of education services. The result is that Somalia has one of the lowest enrolment rates for both primary and secondary schools.

Limited access and poor job opportunities among the youth have negatively impacted their educational advancement. Among female youth, poor access, learning, and retention is made worse by the low representation of females in the teaching pool. Furthermore, negative cultural practices expose girls to early marriages and pregnancies that deter them from progressing with their education. Formal education and training also do not reach the majority of marginalized youth or adequately cater to young women, leaving them without the knowledge and skills needed to realize their potential and aspirations. Alternative Basic Education for Pastoralists (ABE), a non-formal education introduced to promote greater access for these deprived groups, is yet to make a significant impact.

Although the teacher-student ratio in Somalia is comparable to those of other poor countries, the majority of primary and secondary school teachers mostly work in urban areas. Of all

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primary school teachers, only 30 percent are based in rural schools, while 15 percent of secondary school teachers are based in rural schools. Moreover, most of the teachers are untrained, and turnover is very high.

Results from KIIs on education established that Limited education infrastructure and lack of teachers and learning materials in most schools discourage many children from going to school. And recurring droughts and floods disrupt school programs resulting in dropouts and absenteeism. Other factors reported to affect school enrolment and attendance includes poverty, high illiteracy among parents, long distances to school, widespread conflict and insecurity, and lack of school feeding programs. It was also noted that pastoralist communities are mobile and require specialized education arrangements.

2.2. Legal Provisions on Education

Some of the key government policies and legal frameworks on education are espoused in the Provisional Federal Constitution of Somalia (2012), Somalia National Education Plan 2011, Basic Education Act No. 6 of 12th February 1987, and Somalia National Development Plan (NDP-9) 2020 – 2024. Somalia is also a party to a number of international conventions and protocols on education. A major concern, however, is the low levels of implementation of the policies and legislation, largely because of inadequate funding and lack of institutional capacities.

2.3. Governance and Regulation of the Sector

Education is provided and managed by several stakeholders, government, humanitarian organizations, civil society, and the private sector. The FGS has the overall oversight, while the FMS has some degree of autonomy, including its own education budgets and oversight and licensing of private schools. Community-based organizations, non-governmental organizations, and the private sector also provide some funding and technical assistance and own and operate schools.

On governance and regulations, the KII respondents emphasized that political instability and insecurity have undermined the government's effectiveness in oversight of the education sector. Due to inadequate funding, the government has been unable to provide the required leadership, oversight, and enforcement of the sector's policies and laws. The predominant role of the private sector and other development partners in the provision of education has weakened government regulatory oversight in the sector. Different policies and legal frameworks governing the sector across different states have also weakened the education sector's governance.

2.4. Gender Mainstreaming in the Sector

Gender mainstreaming has been incorporated into the laws, policies, plans, and strategies that guide the education sector. However, implementation of gender mainstreaming programs is limited by capacity challenges, lack of gender focal points/units, absence of clear gender targets and priorities to allow accurate evaluation of progress made, and inconsistent application of affirmative action. Despite these challenges, progress is being made with some demonstrated good performance in areas such as the reduction of the gender gap in school enrollments.

However, respondents to KIIs were pessimistic about progress on gender mainstreaming in the education sector. Based on their experiences and perceptions, the respondents noted that although policies and legal frameworks were in place, they were not being implemented, especially at the school level. Some of the reasons given for the slow progress in gender mainstreaming are lack of funding and the lack of girl-friendly facilities in schools.

2.5. Policy Recommendations

What follows are measures recommended to address the challenges facing the education sector.

i) *Increase education access and equity by mobilizing more resources to the sector; ensure development partners align their education programs with government policies; provide bursaries to needy students; expand educational facilities, including teacher training colleges; incorporate GBV in education programming; diversify and expand the Alternative Basic Education (ABE) programs, and improve the quality of education by enhancing teacher training and accreditation.*

ii) *Enhance the governance of the education sector through centralization of policies and regulations governing the sector and curriculum and examinations; revision and implementation of teacher's code of conduct; strengthening capacities of education ministries, and increase budget allocations to the sector.*

iii) *Strengthen education management by setting up education offices closer to communities.*

iv) *Promote gender mainstreaming in education by integrating gender perspectives in program design, implementation, monitoring, and evaluation.*

Strengthen human rights in the sector by implementing child protection policies; and promoting moral values, ethics, and citizenship in education.

3. Findings of Technical, Vocational Education and Training (TVET)

Prior to the collapse of the State in 1991, TVET was fairly developed, but the civil war weakened the system leaving an entire generation without quality education and formal TVET. This has created a huge gap between the demand for skills and their availability in the country, resulting in high youth unemployment.

3.1. Governance of TVET

The Federal Ministry of Labour and Social Services coordinates TVET, while both government and non-governmental organizations provide training. However, the TVET system is characterized by weak coordination, fragmented implementation, and a lack of qualified teaching staff. Legal frameworks governing the TVET system are not in place. TVET curriculum, training practices, accreditation, and appraisal systems are also not standardized across the country.

Most TVET institutions lack adequate equipment and machines for practical learning. Other challenges facing TVET training are equity and accessibility, quality and relevance, efficiency, and sustainability. Training costs are also high, and TVET is perceived negatively as a course for those who have failed to obtain education elsewhere.

3.2. Potential Employment Opportunities for TVET Graduates

The private sector in Somalia is dominated by micro, small and medium-sized enterprises (MSMEs). Although some private-sector employers offer internships to TVET graduates, their participation in the TVET system remains minimal, and some employers do not recognize the qualifications of TVET graduates. Some of

the sectors where TVET training could provide skills to the youth are the blue economy, livestock, construction, agriculture, hospitality, ICT, and beekeeping.

3.3. Survey Results on TVET

Respondents to KIIs reported that IDPs and other marginalized groups had limited access to TVETs. It was pointed out that the sector was male-dominated, and the curriculum did not give trainees useful skills in their areas of training. It was also observed that employers do not recognize TVET qualifications, resulting in most trainees taking many years before being absorbed in the job market after training.

3.4. Policy Recommendations

Below are some priority policy interventions necessary to transform the TVET sector into a tangible contributor to skills and youth employment in Somalia:

i) Increase access and equity of TVET programs by enhancing advocacy on the importance of TVET at the community level through career guidance, counseling, and sensitization in primary and secondary schools, and scale up TVET programs in rural and remote areas.

ii) Strengthen linkages between TVET and the private sector by conducting regular labor-market surveys to assess employer needs and use the results to review policies, accreditation, curricula, and training of instructors.

iii) Strengthen TVET governance through enacting policies and guidelines for assessing instructors; develop a national record of TVET institutions; provide opportunities for higher qualifications and career progression in the TVET secto**r.**

Upgrade the Skills of TVET instructors and center managers by establishing institutions for training TVET trainers and managers and standardizing guidelines governing the training of TVET instructors.

4. Key Findings of the Health Sector

4.1. Access to Health

Globally, Somalia has some of the lowest health indicators; for example, maternal mortality is estimated at 732 deaths per 100,000 live births, one of the highest in the world. This is a result of over three decades of armed conflict which has led to immense damage to health care infrastructure, mass displacement, and physical and mental suffering to many citizens.

Women and girls face discriminatory and negative traditional practices, including early child marriages, female genital mutilation (FGM), and limited access to education. Further, traditional, and cultural practices discourage women and girls from utilizing modern contraceptive methods for birth spacing. There is also low demand for deliveries assisted by skilled birth attendants.

Most health facilities are concentrated in the capital and major towns compared to rural areas. Access to health care services in rural areas is also constrained by long distances to health facilities, poor road networks, and a lack of ambulances. Moreover, the dominance of the private sector in the provision of health services limits access by the poor due to the higher costs of the services. The resulting inequality in access is accentuated by an acute shortage of health staff in public hospitals.

Budget allocation to the health sector in Somalia is 1.3 percent of the total government budget and is well below the 15 percent stipulated by the Abuja declaration. The implication is that households must meet health expenses from their income or through family or friends'

support. The nonexistence of a national health insurance scheme in Somalia complicates the situation.

4.2. Legal and Regulatory Frameworks Governing the Health Sector

Somalia has developed a range of laws, policies, plans, and programs that guide the health sector, but the implementation remains very low. Article 27 of the Provisional Constitution provides for the right to healthcare. It is expected that the Sexual Offences Bill, once adopted, will provide sanctions for child marriages. The FGS has also ratified health-related international statutes, which include the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, Convention on Elimination of all forms of Discrimination Against Women, Convention on the Rights of Persons with Disabilities, and Convention on the Rights of the Child.

4.3. Status of Health Among the Youth and Women in Somalia

The health risks and challenges facing the youth and women are sexual and reproductive health, TB, HIV/AIDS and STIs, substance abuse and mental health, injuries, and disabilities.

1.1.1 *Somalia's fertility rates have remained high over the past couple of decades across most age groups. This results from the low contraceptive prevalence and cultural barriers hamper sexual and reproductive health education. The situation is worsened by low access to antenatal care and limited availability of health facilities, leading to reliance on home deliveries, thus increasing risks of morbidity and mortalities. It is estimated that 1,000 women die per 100,000 live births in Somalia.*

1.1.2 *The prevalence of Tuberculosis (TB) is considerably high and is estimated to be 6.8 percent. While HIV/AIDS prevalence is low in Somalia women, bear the burden at the family level due to their role as caregivers. However, STIs are most common among the youth and women.*

1.1.3 *The youth and even women are pre-disposed to drug abuse in Somalia. Among the youth, Khat is the most abused drug; and abuse of this drug has been found to cause mental health. Mental health disorders in Somalia are high; one person out of three is estimated to be affected by mental illness. War traumas and substance abuse are the main causes of the problem. Addressing this challenge is made difficult by a shortage of mental health workers, a lack of essential drugs, and a poor understanding of the disease.*

1.1.4 *Death from injuries caused by GBV, violent extremism, accidents, and terrorist attacks is a major problem in Somalia. Of most concern are injuries arising from GBV or domestic violence meted to women and girls and violent extremism among the youth.*

1.1.5 *Disability prevalence in Somalia is estimated at 5 percent for both males and females, but support for people with disabilities is low. Furthermore, PWDs are side-lined in humanitarian response and are often denied economic, social, and cultural rights. Women with disabilities are doubly marginalized based on their gender and disability and face a greater risk of sexual abuse and physical violence.*

4.4. Leadership and Governance of the Health Sector

Healthcare in Somalia is provided by FGS, FMS, and regional authorities. The FGS and the FMS have the responsibility for building the health

system and ensuring appropriate strategic frameworks and regulatory mechanisms exist. The Federal Ministry of Health and Human Resources is responsible for regulating the health sector across Somalia, including quality control of health services and medicine, policy, oversight of human resource capacity development, and coordination of the different health sector actors. However, in the absence of a strong state with strong line ministries, the decentralized health governance structures have remained weak. This explains the dominance of the sector by the private sector, NGOs, and donors.

4.5. Gender Mainstreaming

Although gender equality is incorporated in national policies and legal frameworks, implementation remains low. Programs targeted at benefiting women and girls are incorporated into budgets, but funding for these programs is extremely low.

4.6. Survey Results in the Health Sector

In general, KIIs respondents made important observations about the health sector. They noted that although policies and legal frameworks governing the sector are in place, their implementation is poor. As a result of the low capacity of the government to oversight, the delivery of health care services quality is poor. Generally, practitioners operate with little regard for ethical practices, regulation, and quality control. This is especially true with combating negative social norms (practices like FGM and GBV), which have largely been left to other sectors. Only Puntland actively implements legislation targeted at curbing FGM practices. Health services are mainly delivered by private-sector providers mostly located in the urban areas; thus, rural areas are disadvantaged in access to healthcare. Health infrastructure and materials are inadequate leading to poor delivery of health services even in private hospitals because of limited health facilities relative to the population, the sick face long queues and waiting times, resulting in suffering and deaths. The shortage of qualified frontline health workers is a major constraint in the delivery of healthcare. Budget allocation to the sector also remains extremely low, leaving the sector largely dependent on donor financing.

4.7. Policy Priorities and Recommendations

The following are policy measures recommended to enhance the delivery of healthcare services in Somalia.

i) *Improve access and equity in the delivery of healthcare services by: scaling-up public healthcare infrastructure in all regions of the country; setting up more health training institutes and training more healthcare staff; increasing resource allocation to the health sector; strengthening the capacity of the Ministry staff to respond to GBV, and establishing a national health insurance scheme.*

ii) *Develop more health infrastructure by constructing additional hospitals and supplying more healthcare equipment in healthcare facilities.*

iii) *Strengthen leadership and governance of the sector through improved coordination of the healthcare systems at all levels and the development of a national health information system.*

iv) Facilitate the implementation of the healthcare policies, plans and programmes by updating National GBV Strategy 2019-2019 and enacting legislation on drug abuse.