



Ministry of Health and Human Services
Federal Government of Somalia

SOMALIA HEALTH SECTOR STRATEGIC PLAN 2022–2026 (HSSP III)

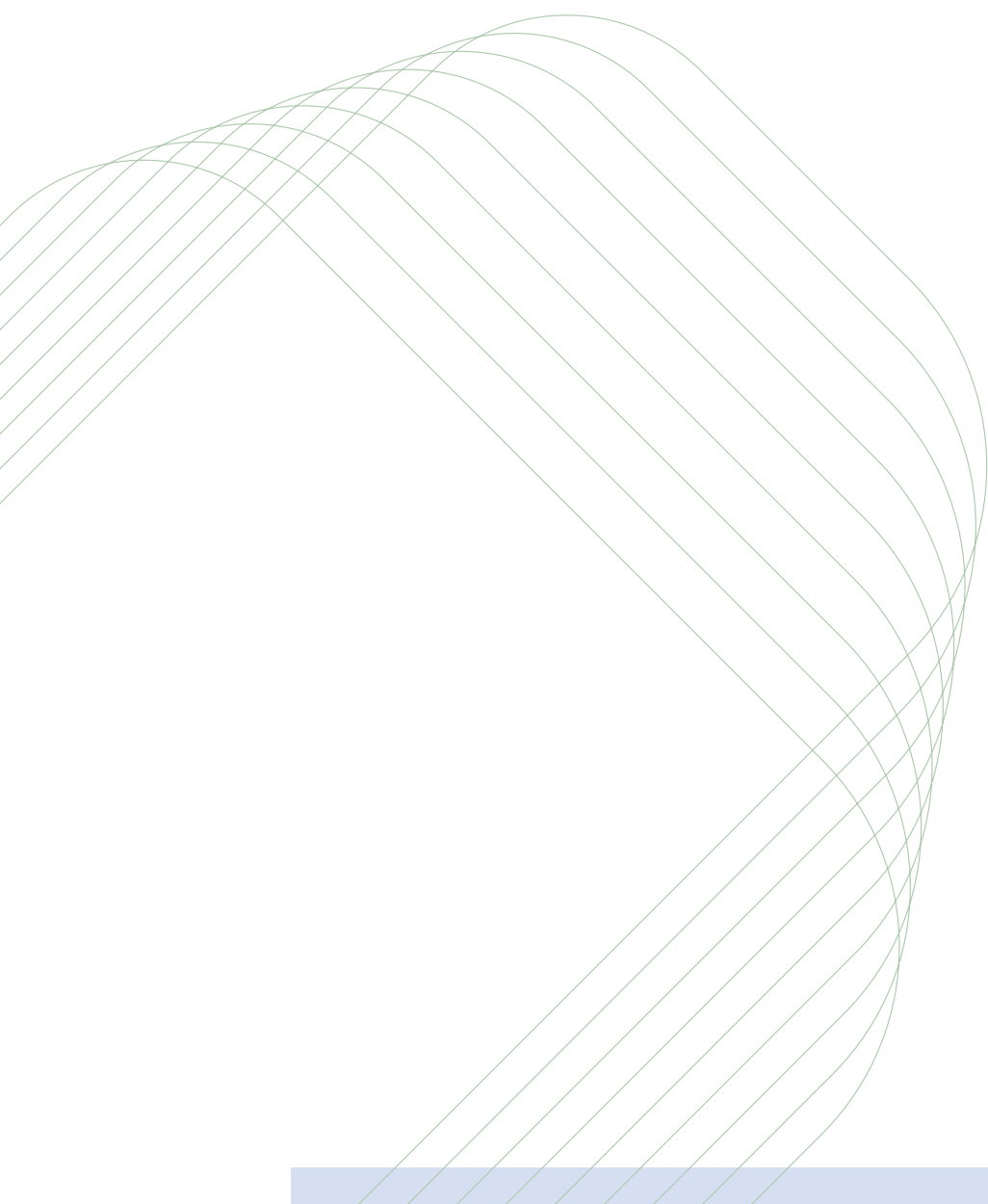
22 December 2021



Ministry of Health and Human Services
Federal Government of Somalia

SOMALIA HEALTH SECTOR STRATEGIC PLAN 2022–2026 (HSSP III)

22 December 2021



Contents

| | |
|--|-----------|
| Endorsement | 6 |
| Foreword | 7 |
| Acknowledgement | 8 |
| Acronyms | 9 |
| Executive summary | 10 |
| National HSSP | 18 |
| Introduction | 18 |
| Objectives of the HSSP III | 18 |
| Development process for the HSSP III | 18 |
| Situation analysis | 19 |
| Health care arena | 21 |
| Learning from previous (strategic) planning processes | 24 |
| Key components of the HSSP | 24 |
| Leadership and governance | 24 |
| Health information eco-system | 26 |
| Human resources for health | 26 |
| Health institutions (health service delivery system) | 27 |
| Health financing | 29 |
| Pharmaceuticals and medical devices | 30 |
| Policy priorities | 32 |
| Policy and action | 34 |
| Implementation arrangements | 43 |
| Monitoring and evaluation framework | 44 |
| Next steps | 52 |
| Annex A. Policy matrix for federal level | 53 |
| Annex B. Policy matrix for Member States | 57 |
| Annex C. Monitoring matrix (Member States, disparities) | 61 |
| References | 62 |

Endorsement

The National Health Sector Strategic Plan 2022-2026 (HSSP III) was developed through an inclusive and transparent consultative process which involved the Ministry of Health (MoH) at federal and state levels, the Ministry of Planning, Investment and Economic Development, the Ministry of Finance, our health partners including United Nations agencies, the World Bank, donors, NGOs, civil society organizations and academia, with the financial and technical assistance of the World Health Organization and the support by national and international consultants.

The HSSP III is the overarching strategic framework indicating the directions for the country's health sector development and meant to inspire decision makers with shared strategic directions for health system development capable of responding the health needs of the Somali population and its desire in achieving UHC and health security. With the guidance provided by this document, the Federal Members States have the responsibility to develop state-specific strategic / operational plans, tailored to the context and responding to the states and their people's priorities. The HSSP III remains a living document that will be revised jointly every two years or as required.

I hereby endorse the National Health Sector Strategic Plan (HSSP III) which covers the period of 2022-2026. The Ministry of Health and Human Services of Federal Government of Somalia is grateful to the Somali Authorities, Development Partners, Civil Society Organizations, Private Sector, the professional associations and individuals who contributed to the development and for their commitment to support the operationalization of the HSSP III 2022-2026.



H.E Dr. Fawziya Abikar Nur

Minister of Health

Ministry of Health and Human Services

Federal Government of Somalia

Foreword

After years of instability and lack of investment, the health sector of Somalia has moved on a recovery and rehabilitation path. The government has outlined a roadmap for establishing a resilient health system that can deliver health services to the Somali people, while responding to the growing threat of the COVID-19 pandemic.

The COVID-19 pandemic has challenged the delivery capacity of our fragile health systems as the demand for services has increased. This new disease has necessitated a whole-of-government response, which was led and coordinated by the Prime Minister of the Federal Government of Somalia (FGS). Despite these challenges, the government is determined to forge ahead and build a resilient health system.

The Health Sector Strategic Plan 2022–2026 (HSSP III) sets out our mid-term direction for health system development during the next five years. It is our framework for improving access to affordable and equitable quality health services, which will help Somalia realize its vision for Universal Health Coverage (UHC).

The development of the HSSP III was informed by the national health policy and the ninth National Development Plan (NDP-9) and is aligned with our vision for achieving UHC. It builds on the lessons learned from the implementation of its predecessor, HSSP II. The preparation of the HSSP III has benefited from the evidence that informed the design and the development of the Essential Package of Health Services (EPHS) 2020, which laid the foundation for the expansion of an integrated service delivery in the country.

It is our framework for improving access to affordable and equitable quality health services, which will help Somalia realize its vision for Universal Health Coverage (UHC)

The HSSP III proposes a set of policy options and actions aimed at addressing the major health system challenges of the country. The implementation of this strategic plan will enhance the delivery of the integrated EPHS across the country.

The HSSP III was developed through an inclusive and transparent consultative process which involved the Ministry of Health at federal and state levels, the Ministry of Planning and Economic Investment, the Ministry of Finance, our health partners including United Nations agencies, the World Bank, donors, NGOs, civil society organizations and academia.

On behalf of the MoH, I would like to thank the members of the Steering Committee and the Thematic Groups who significantly contributed to the preparation of the HSSP III.

I would like to express my deep gratitude to the World Health Organization (WHO) whose technical assistance and financial support made possible the development of the HSSP III.



H.E Dr. Fawziya Abikar Nur

Minister of Health

Ministry of Health and Human Services

Federal Government of Somalia

Acknowledgement

The National HSSP is an important document for the FMoH and Human Services of Somalia. The plan is the main output of the FMoH and Human Services and its cooperating partners. The development of this strategic plan was made possible through the engagement of Federal Member States, civil society, private providers and other health stakeholders. Therefore, the FGS wishes to acknowledge the contribution of all parties.

We would like to express our utmost appreciation and gratitude to all staff of the FMoH and Human Services of Somalia in Mogadishu and Federal Member States for providing the necessary assistance in the development of this strategic plan, which will provide guidance to the MoH for the next five-year period.

The development of this strategic plan was made possible through the engagement of Federal Member States, civil society, private providers and other health stakeholders

The development of this plan was supported by WHO. In particular the Ministry would like to express its appreciation and gratitude for their technical support Dr Marina Madeo, UHC Adviser WHO, Dr Mohamed Jama, Senior Adviser in the MoH and Human Services, and the consultants team lead by Khadija Abdullahi Jimale, Dr Tayyeb Masud and Dr Enrico Pavignani for their untiring effort in the development of this document.

Finally, we wish to acknowledge the role played by the Health Sector Coordination Committee and other partners in the sector in the conceptualization and development of this sector plan. We would also like to thank the private sectors, and academic and civil society institutions for their contribution to the development plan. We call upon all players in Somali's health sector to support this innovative National HSSP.

My thanks to you all,



Dr Abdinasir Mukhtar Ibrahim

Director General

Ministry of Health and Human Services

Federal Government of Somalia

Acronyms

| | |
|-------|---|
| BCG | Bacillus Calmette-Guérin |
| DHIS | District Health Information Software |
| EPHS | Essential Package of Health Services |
| EP&R | Emergency Preparedness and Response |
| EWARN | Early Warning, Alert and Response Network |
| FGS | Federal Government of Somalia |
| FHW | Female Health Worker |
| FMoH | Federal Ministry of Health |
| GDP | Gross Domestic Product |
| GFF | Global Financing Facility |
| GIZ | Deutsche Gesellschaft für Internationale Zusammenarbeit |
| HISSP | Health Information System Strategic Plan |
| HRH | Human Resources for Health |
| IDP | Internally Displaced Person |
| IDSR | Integrated Disease Surveillance and Response |
| JHNP | Joint Health and Nutrition Program |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| NGO | Non-Governmental Organization |
| OOP | Out-of-pocket (payment) |
| PHC | Primary Health Care |
| SARA | Service Availability and Readiness Assessment |
| SHDS | Somali Health and Demographic Survey |
| SHINE | Somali Health and Nutrition Programme |
| TB | Tuberculosis |
| TWG | Technical Working Group |
| UHC | Universal Health Coverage |
| WHO | World Health Organization |

Executive summary

The Ministry of Health and Human Services of FGS, in close collaboration with MoHs of Federal Member States including Somaliland and with the development partners, has made significant improvement in health systems strengthening efforts and sustained the delivery of the integrated EPHS. Though the 2009 EPHS has contributed to remarkable progress in the delivery of health services across different regions and states, its implementation has faced challenges. The country also gained lessons in the implementation of HSSP I (2013–2016) and HSSP II (2017–2021), alongside the multiple system reforms being done in the country, including the updated National Development Plan and the roadmap towards UHC. The COVID-19 pandemic has also highlighted the need to strengthen essential public health functions to guide development in the country's health sector.

This HSSP will be a living document and will be revised every two years or as required. The outcome of such reviews along with progress reports on its implementation may necessitate a revision for the Somalia investment case for the health sector.

Objectives of the HSSP III:

- Serve as the overarching strategic framework for the health sector development of the country;
- Provide guidance for each federal Member State in developing state specific strategic or operational plans for its implementation;
- Inspire decision-makers with a shared strategic direction for health system development capable of responding the health needs of the Somali population and its desire in achieving UHC and health security;

- Provide coherence amidst disconnected interventions and siloed programs;
- Promote the best use of resources to improve and protect the health of Somali population, a key asset for social and economic development;
- Promote multi-sectoral coordination to address the social determinants of health.

Development process for the HSSP III

The Federal Ministry of Health (FMoH), in collaboration with WHO, engaged international and national expertise. A steering committee comprising development partners (UN and other donors), government (FGS and federal Member State), private providers, professional associations, academia, civil society and NGOs lead the process. The FMoH, the MoF and Ministry of Planning provided an oversight role on the review and planning process and related accountability.

A Technical Working Group (TWG) was composed of technical experts from the health sector stakeholders grouped along thematic teams in line with the WHO health system framework. Comprehensive virtual consultation meetings were held with the FMoH and development partners, followed by in-depth technical discussions with the technical teams from the Member States and Benadir region administration to discuss the health context in each state, priorities and major challenges and issues. Key informant interviews as a supplement to discussions with key technical experts were held. The consultative process was launched at an inter-ministerial meeting held from 5 to 7 July 2021 in the capital city of Garowe, Puntland State.

The COVID-19 pandemic has also highlighted the need to strengthen essential public health functions to guide development in the country's health sector

Situation analysis

Somali politics are at a critical crossroad at the moment. The areas not currently under government control are a major concern, with limited options for improving access in them. This also creates some uncertainty around the planning process which has been mitigated by involvement and extensive consultations with stakeholders on important health aspects. Food insecurity is another serious issue, affecting a large proportion of the population.

Despite the formidable challenges faced by the country, Somalia's economy is rebounding from the "triple shock" that ravaged the country in 2020: the COVID-19 pandemic, extreme flooding and the locust infestation. Real GDP growth was at 2.4 per cent in 2021. This growth momentum is expected to continue in the medium term and reach pre-COVID-19 levels of 3.2 per cent in 2023. The latest World Bank Somalia Economic Update reports that the economy contracted by 0.4 per cent in 2020, less severe than the 1.5 per cent contraction projected at the onset of the global pandemic.

Health care arena

Sustained conflict between 1991 and 2012 destroyed the health system, sanitation and safe drinking-water systems. Currently, public health service delivery is limited. A large private sector has emerged, which delivers an estimated 60 per cent of health services concentrated in urban areas. Humanitarian health services are provided by numerous international and national NGOs with funding from the UN, donor organizations, the diaspora and other private sources.

Somalia's 2009 EPHS included six core programmes as well as four additional programmes. In 2013, the Joint Health and Nutrition Program (JHNP) and the Health Consortium for Somali People began implementing the EPHS, coordinating donors and NGOs to provide services. The closure of the JHNP in 2016 led to fragmentation of service delivery, with different partners covering different geographical areas and package components.

In 2020 the FMOH revised the EPHS to target services required to address the health needs of Somalis. Along with the problem of limited funding and health system capacity of the FMOH and NGOs, the design of the EPHS 2020 has proposed

a stepwise rollout of the EPHS across the country.

Maternal, neonatal, infant and under-five child mortality rates are gradually declining, although all remain high compared to the other countries in the region. Childhood malnutrition remains a key problem. Contraceptive use is among the lowest throughout the world.

The immunization coverage of children in Somalia is very low. The number of children who have not received a single dose of vaccine is around 60%, which indicates a critical weakness of the coverage of primary care services. The low coverage of vaccination indicates the need for urgent steps to expand immunization services.

The limited availability of health services over the past few decades has worsened inequities with displaced, rural and nomadic populations being worse off. The geographical availability of services is limited and community awareness on public health interventions is quite low, creating islands of neglect.

Urbanization is happening at a rapid pace in Somalia, with around half of the population now living in urban centres and small modernizing villages. This changes the dynamic of demand for health care as it leads to a large enough number of consumers for services. Private providers have responded to this demand by establishing service delivery outlets.

Learning from previous (strategic) planning processes

The EPHS 2009 was prepared based on immediate needs, however its implementation was limited in scope and fragmented, despite coordination efforts. It was later reviewed, and strategic areas were included to formulate the 2020 EPHS. For the previous HSSP II, priority areas and targets were identified after a lengthy consultative process. This strategic plan was quite detailed in scope. However, as it was not endorsed and financed, it did not move to implementation.

Key components of the HSSP

The HSSP, upon direction by the FMOH, is guided by the six building blocks outlined by WHO in its framework for health systems (1). This provides a foundation where key areas of the health system are accounted for and addressed.

Leadership and governance

- Health sector legislation and regulation: the government has taken steps to put in place a regulatory framework, but progress has been minimal.
- Aid coordination/management: there has been an improvement in donor coordination by the MoH, however the process needs to be consolidated with regular scheduled meetings and responsibilities.
- Emergency preparedness and response (EP&R), including epidemiological surveillance: the present setup, upgraded to respond to the COVID-19 epidemic, performs quite well. Ways to make it be more durable than its predecessors have been identified.
- Management of health systems: the current management of the health systems is weak, due to lack of capacity and attrition of personnel. Strengthening the capacity at both federal and state levels will be crucial for improving the health system.

Health information ecosystem

The health information environment is quite fragmented, with multiple systems for different programmes functioning sub-optimally and a routine information system being managed with strong support from a technical partner. Every report, development plan, review of the health sector in Somalia points to weaknesses in the Health Information System. Until 2017, a basic Health Management Information System (HMIS) functioned across Somalia. In 2017, the online District Health Information Software (DHIS2) platform for HMIS was introduced in all districts in Somalia to collect, report, analyse, visualize, and support dissemination of HMIS data for all programmes including the Expanded program of immunization and malaria. At the same time, revised data tools were introduced. However, subsequent reviews of the HMIS show a weak system requiring continuous support for all components of the health information system. The Health Information System Strategic Plan (HISSP) 2018–2022 was prepared to address this gap. Consequently, in 2021, the DHIS2 was updated, incorporating Integrated Disease Surveillance and Response (IDSR) and Logistics management modules and facilitating the availability and use of automated dashboards, scorecards, alerts

and reports to improve planning and monitoring of services. There is still a lack of integration within the DHIS and lack of financing continues to be a major reason for its poor implementation.

Human resources for health (HRH)

The Somali health workforce is composed of diverse groups of workers, in terms of formality, employment and specialization. Training institutions have multiplied in the last three decades, producing health professionals. There are significant numbers of health workers informally active in the health sector, which must be counted to reflect the actual size and shape of the workforce. Unemployment is likely to be significant.

The 2016 Somali HRH Development Policy was formally approved by the health advisory board and is still relevant. The licensing, regulation and accreditation of the health workforce is a priority for investment in the “Damal Caafimaad” project of the MoH.

Health institutions (health service delivery system)

Health systems are inherently very complex due to the different specialties and levels of skills involved which require their own specific supporting environment. Furthermore, the majority of these are closely interlinked and the absence of one level or skill compromises the overall performance of such health facilities.

Currently in Somalia, most of the tertiary and secondary facilities are privately owned, especially in urban areas. The government and donor partners are mostly focused on providing primary health care (PHC) services in line with the EPHS including relevant primary curative care.

Health facility density and services

Excluding pharmacies, the density of private facilities stands at 0.93 facilities per 10 000 population and the density in the public sector is 0.76 per 10 000 population. In the private sector facilities 46% of hospitals and 74% of clinics are either individually or group owned. The mix of services provided at the private facilities does not fully cover the interventions contained in the EPHS 2020. The data from the Service Availability and Readiness Assessment (SARA) 2016 indicated that although

The important issue for the health sector, in terms of strategy, is how to engage private providers and ensure that EPHS services are offered at all facilities, specifically for secondary care to deliver quality services

the overall service readiness was better for public facilities compared to privately owned ones, overall levels were quite low.

The important issue for the health sector, in terms of strategy, is how to engage private providers and ensure that EPHS services are offered at all facilities, specifically for secondary care to deliver quality services. This creates an opportunity to deploy the limited resources available within the public health sector in areas where coverage and access are issues.

Health financing

From a health sector strategy point of view, the important aspects of health financing are a) households' contributions (out-of-pocket payments (OOPs), insurance, other pooling mechanisms); b) public sector (including donor investments); and c) philanthropy (including diaspora financing).

A recent resource mapping exercise identified the public funding (domestic and donors) available for the health sector over a period of three years 2018–2020. The government share in health expenditure has increased from 7.8% in 2018 to 12.2% in 2020. The government has also expanded its financing from provision of salaries to other areas such as acquisition of assets, training and education. The mapping misses out on some major contributions. These figures underestimate total health expenditure.

Most of the development assistance to Somalia is off budget, which requires coordination to achieve efficient use of available resources. Currently, the FMoH has a limited role in the decision-making on how these resources are used. The FMoH needs to build strong technical capacity in many areas, including public financial management and supply

chain management, in order to scale up the EPHS implementation across the country.

Financial barriers deter care seeking

Cost is the greatest obstacle cited by Somali women aged 15–49. Sixty-five per cent of women cite this as the main barrier to seeking care. Communities have little disposable income for OOPs for health services, while almost half of all households (48%) finance health expenses using their own income. The high rate of OOP means households often have to deplete savings, sell their assets (14% of the households) or borrow money. The rate of seeking health care is lowest for the nomadic population, with only 10% of households identified that they had someone who was ill and 68% out of these did not seek care.

Pharmaceuticals and medical devices

The pharmaceutical sector in Somalia is composed of different actors including government, international organizations and a large network of private importing firms, wholesalers and retailers who ensure the availability of medicines of disparate sources, prices and standards. Drug-selling outlets have proliferated, becoming the site of most health care encounters.

This key area is already a part of the investment of the Damal Caafimaad project of the MoH. A scoping assessment and a roadmap of the medicines regulatory framework has been prepared and National Medicines Regulatory Authority established.

HSSP

The underlying principles and foundation of the HSSP are aligned with the Somalia Health Policy:

Vision: The Somali people enjoy the highest attainable standard of health and quality of life and have universal and equitable access to essential quality health services with a priority focus on maternal, neonatal and child health and nutrition, and on the prevention and control of high burden diseases and related risk factors.

Mission: To provide equitable, efficient and affordable quality essential priority health services as close to the communities and families as possible based on the EPHS and PHC approach.

Overall goal: To improve the health status of the population through health system strengthening interventions and providing quality, accessible, acceptable and affordable health services that facilitate moving towards achieving UHC.

Core values underpin the health policy priority directions:

- Universal and equitable access to acceptable, affordable, cost-effective, and quality health services with maximum impact on Somali populations' health to ensure the realization of the right to health.
- Effective, transparent and accountable governance and leadership in managing the different components of the health system with decentralized management of health care service delivery.
- Building effective collaborative partnerships and coordination mechanisms engaging local community, national and international stakeholders and pursuing the aid effectiveness approaches.

Guiding principles

The strategic plan was designed taking the following conceptual and methodological considerations into account:

- Feasibility, given existing capacity and resource constraints. To that effect, intervention drives must be chosen with parsimony, which is what informed the selection of the interventions contained in the revised EPHS. Success in a

few areas will stimulate more ambitious steps to be taken later. Conversely, unrealistic goals prematurely pursued will discourage decision-makers and implementers.

- Sustainability (in the long term). It will depend on several factors, all interlinked: political stability, resource availability, competing priorities, implementation capacity. Establishing a core of competent managers agreeing on the main strategic drivers will contribute to progress. Solid structural foundations are needed to grant a coherent progression.
- Flexibility in light of changing conditions. Local solutions that grab opportunities and contain threats are needed to attain broad goals (themselves evolving).
- Coherence with other initiatives under way or in the pipeline, as spelled out in the Damal Caafimaad project.
- Adaptation to the Somalia's challenging context, which makes difficult a detailed upfront programming. Moreover, global standards and approaches cannot be applied straight away to the Somali healthcare arena. Instead, the incremental introduction of discrete components, along an increasing degree of difficulty, must be preferred. This consideration is consistent with the reformulation of the EPHS 2020.

The long-term goal of the HSSP is to establish institutional capacity, structure and mechanisms that foster equitable, efficient and effective health care provision.

Main pillars:

The main pillars, or drivers, to reach the long-term goals laid out in this HSSP, to establish institutional capacity, structure and mechanisms that foster equitable, efficient and effective health care provision, are to boost health care demand, engage private healthcare providers, put in place "performing" management systems, restructure the health workforce, rationalize the pharmaceutical and Steer physical infrastructure investments.

- Boost healthcare demand - by lowering the existing barriers to seek health care and enhancing quality of care. The feasibility of introducing a durable regulatory regime, based on administrative controls - will be assessed. To be enforced, regulatory

provisions must be regarded as beneficial and worthy of support by stakeholders: providers, employers, businesspeople and service users. Performance-related rewards would appeal to health operators looking for a competitive advantage in a crowded market.

- Engage private healthcare providers – first through soft measures aimed at harnessing the market through incentives, such as franchising.
- Put in place “performing” management systems – including information, aid management and EP&R.
- Restructure the health workforce – by enhancing the production, utilisation, and maintenance of health workers. The strategic focus must be on improving skills, rather than expanding the true number of health workers. Such an upgrading must be two-pronged, first through the strengthening of training programmes, and second through effective in-service training. Attempts also need to be made to rationalize the pay structures to allow for improved retention and equitable distribution.
- Rationalize the pharmaceutical field – by introducing feasible regulatory measures and streamlining fragmented supply chain system.
- Steer physical infrastructure investments – to contain imbalances between levels of care, regions and population groups.

Two key considerations, which have informed the development of this strategic plan, are stressed here because they are frequently overlooked in policy and planning decisions:

- For decades, Somalia has been a laboratory of experiments and innovations, results and lessons of which are frequently ignored. The recent response to the COVID-19 pandemic has confirmed that capacity can be productively tapped, rather than being created by outside intervention. Before importing models from

abroad, indigenous experiences must be duly recognized and scaled up when opportune. This awareness will help modify those alien models that are not appropriate to the Somali context to make them more successful.

- The large informal portion of the health care field cannot be neglected anymore, given its impact on efficiency and effectiveness in terms of quality and equity-related aspects. Engaging with informal actors presents difficulties, but also promises rewards. Examples of positive experiences in this field are welcome to build future interventions on concrete foundations.

Implementation arrangements

The EPHS delivery serves as the foundation of the health system development and the vehicle for achieving UHC in Somalia. State MoHs shall be responsible for planning, implementation, monitoring and evaluation of the EPHS in their respective states.

Governance/leadership of the plan

The plan as well as its component/accompanying documents are to be coordinated and managed by the directorate of planning in the FMoH. Specific priority programmes such as Immunization, HIV/AIDS, tuberculosis (TB) and Malaria already have the requisite management structures and should be able to liaise closely with the directorate of planning. The state MoHs will also be required to identify a directorate or section responsible for the plan and to manage the implementation process. The policy and planning department of the MoH shall be responsible for the coordination with donors, private sector organizations, NGOs and federal Member States to support the implementation of this strategic plan.

The FMoH will also assist the Member States in development of individual plans, mobilize technical expertise both internally or externally, issue

The long-term goal of the HSSP is to establish institutional capacity, structure and mechanisms that foster equitable, efficient and effective health care provision

annual progress reports, hold biannual meetings, coordinate with research institutions and prepare for the revision of the strategic and operational plans if required.

Relationship between various instruments of planning

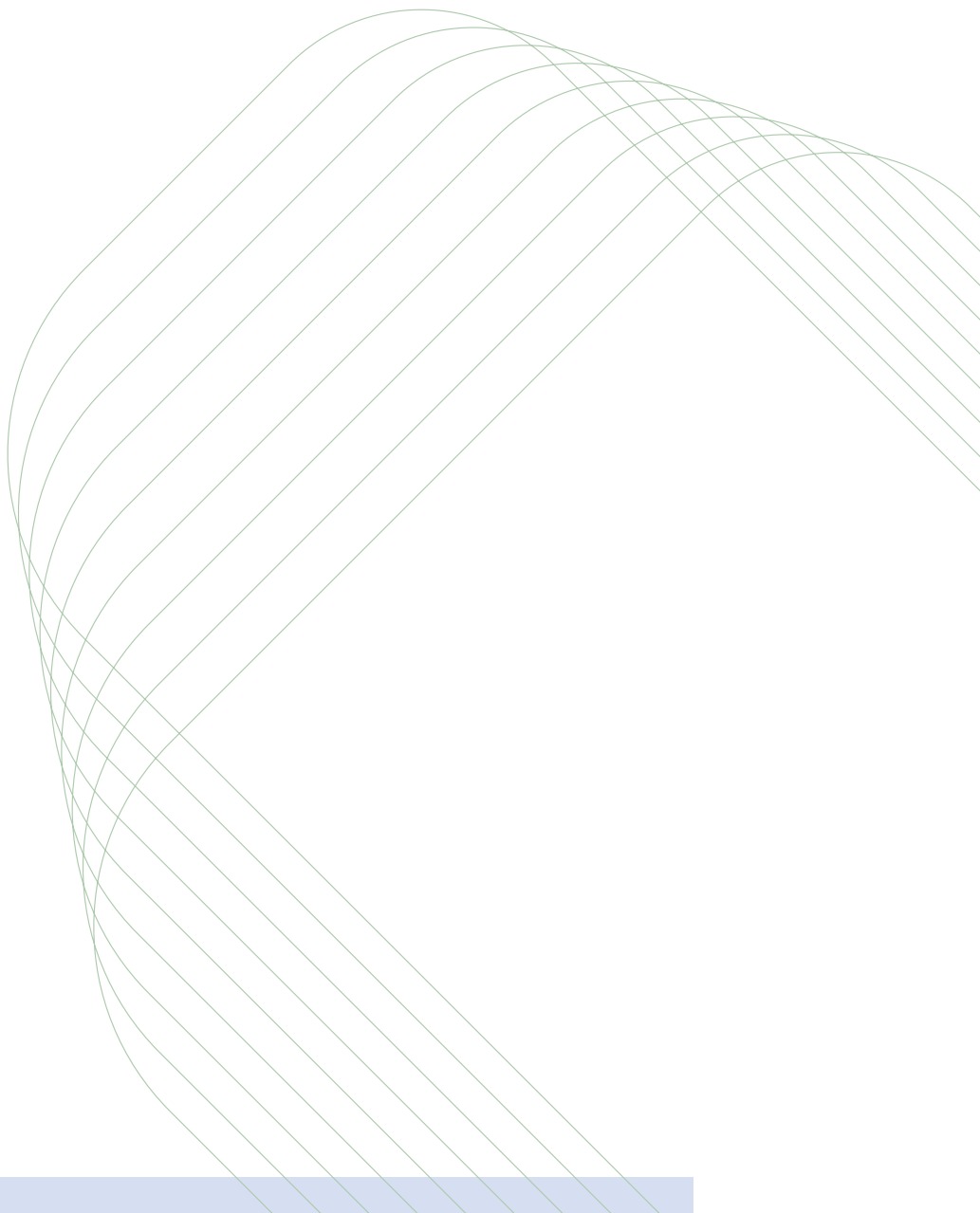
There are several documents available for the health sector for Somalia, including policy directions, disease specific policies and strategies, programme documents and agreed frameworks with partners. The positioning of the HSSP III needs to be made clear within this environment as the overarching document for the development of a functioning health system that is responsive to the needs of the Somali population.

The adoption of the revised EPHS as the flagship of health system development has made it possible for the health partners to align their support to the government priorities as outlined in the EPHS and the Global Financing Facility (GFF)-supported

investment case for the health sector. This was captured in the Improving Health Care Services in Somalia (“Damal Caafimaad”) Project of the MoH, which will be financed by the World Bank. Other development projects financed by other partners, which align to the priorities in the investment case, should follow implementation modalities similar to the Damal Caafimaad Project.

Once the national HSSP III is approved, the state MoHs will start preparing state specific plans based on the identified priorities. All these documents together should be considered as part of the HSSP III.

It is proposed that the HSSP III, together with key documents, the EPHS and the Somalia Investment Case for the Health Sector, align to define the strategic directions and the immediate actions needed to expand the health services in Somalia.



NATIONAL HSSP

Introduction

The MoH and Human Services of FGS, in close collaboration with MoHs of Federal Member States including Somaliland and development partners, have made significant improvement in health systems strengthening efforts and sustained the delivery of the integrated EPHS which showed good progress of health outcomes.

The EPHS 2009 provided a framework on ways to improve health care and related services throughout the country. The 2009 EPHS has contributed to remarkable progress in the delivery of health services across different regions and states. The health authorities and stakeholders have learned valuable lessons from the 2009 EPHS implementation and systems strengthening during the last 10 years. While the federal government and the state MoHs have achieved a lot, the implementation has faced challenges which included:

- inadequate and unpredictable funding;
- inadequate health infrastructure;
- inadequate health workforce deployed in remote and hard-to-reach areas;
- poor health sector coordination and fragmentation of aid agencies' support;
- protracted complex emergencies; and
- security challenges restricting ability to deliver and monitor quality health care services to parts of the population.

Additionally, the country also learned valuable lessons in the implementation of HSSP I (2013–2016) and HSSP II (2017–2021) together with multiple reforms including the updated National Development Plan and the roadmap towards UHC. The COVID-19 pandemic has also highlighted the need to strengthen essential public health functions of the FMoH to guide development in the country's health sector.

The World Bank's re-engagement in the health sector, in addition to other health sector development partners coupled with many other changing priorities and funding landscapes, calls for a strategic approach to increase both domestic and foreign health care financing. The growing health

sector and the emerging health care challenges necessitated the review of the health sector strategies and the development of the new HSSP III.

This HSSP will be a living document and will be reviewed and revised very two years or as required. The outcome of such reviews along with progress reports on its implementation may necessitate a revision for the investment case for the health sector.

Objectives of the HSSP III

- Serve as the overarching strategic framework for the health sector development of the country;
- Provide guidance for each federal Member State in developing state specific strategic or operational plans for its implementation;
- Inspire decision-makers with a shared strategic direction for health system development capable of responding the health needs of the Somali population and its desire in achieving UHC and health security;
- Provide coherence amidst disconnected interventions and siloed programmes;
- Promote the best use of resources to improve and protect the health of Somali population, a key asset for social and economic development;
- Promote the multisectoral coordination to address the social determinants of health.

Development process for the HSSP III

This section describes the preparatory work and the collaborative and inclusive process adopted by the FMoH in the development of the HSSP III.

To achieve the above objectives, the MoH established several forums where the input of all health partners for the HSSP were sought.

Technical assistance: The MoH, in collaboration with WHO, has engaged international and national expertise, and at federal and state levels embarked on the review of the current situation and the planning process including secondary data collection and lessons learned from the implementation of the HSSP II.

Steering committee: The MoH and Human Services has established a steering committee comprising representation from the development partners (UN, donors), government (FGS and federal Member States), private sector, professional associations, academic and civil society institutions, and NGOs. The FMOH, MoF and the Ministry of Planning provided oversight on the review and planning process and related accountability.

TWG: The TWG was composed of technical experts from the health sector stakeholders grouped along thematic teams in line with the WHO health system framework. These teams were tasked to perform in-depth analyses and propose strategic plans for their specific thematic areas such as health service delivery, HRH, health information system, access to essential medicines and health technologies, and leadership and governance together with health financing.

Consultation process: Comprehensive virtual consultation meetings were held with the FMOH and development partners, followed by in-depth technical discussions with the technical teams from the Member States and Benadir regional administration to discuss the health context in each state, priorities and major challenges and issues.

Key informant interviews: Key informant interviews, as supplements to discussions with key technical experts, were held. Interviewees included programme leaders, directors of the technical departments of FMOH, the state MoHs, private sector and donor partners.

Implementation and scheduling: The consultative process was launched at an inter-ministerial meeting held from 5 to 7 July 2021 in the capital city of Garowe, Puntland State. This meeting was attended by the Federal and State MoHs and

the senior teams who resolved to accelerate the development of the HSSP III.

Limitations of the HSSP III development process

The development process suffered delays due to lengthy formal procedures and to concomitant demanding processes requiring priority attention by the health authorities. Active consultations started late in August 2021. Some adjustments were made to accommodate the COVID-19 restrictions which limited face-to-face meetings and necessitated most consultation meetings to be held virtually. Data gaps exist and remain difficult to fill particularly in areas such as health financing and health expenditures.

Situation analysis

Somalia is the eastern most country in the Horn of Africa with the Gulf of Aden on its north, Indian Ocean on its east, Ethiopia on its west and Kenya to its southwest. Due to its geographical position, Somalia has remained at the forefront of trade as well as conflict in most part of its recent history.

The FGS is the internationally recognized government of Somalia. It replaced the Transitional Federal Government Somalia in 2012 with the adoption of the Constitution of Somalia. The Constitution comprises three branches: executive, legislative and judicial. The current governance structure is Federal with the president as the head of state and commander-in-chief of the Somali Armed Forces. The president nominates a prime minister who requires a vote of confidence by the parliament to act as head of government.

The bicameral national legislature consists of the House of the People (lower house) and the Senate (upper house), whose members are elected to serve four-year terms. The parliament elects a president, speaker of parliament and deputy speakers. It also has the authority to pass and veto laws.

Somali politics are at a critical crossroad at the moment. There is also an issue of the areas not currently under government control, which limits options available for improving access in these areas. This also creates some uncertainty around the planning process which has been mitigated by involvement and extensive consultations with



stakeholders to agree on important aspects of the health sector to be underlined in the health sector strategy.

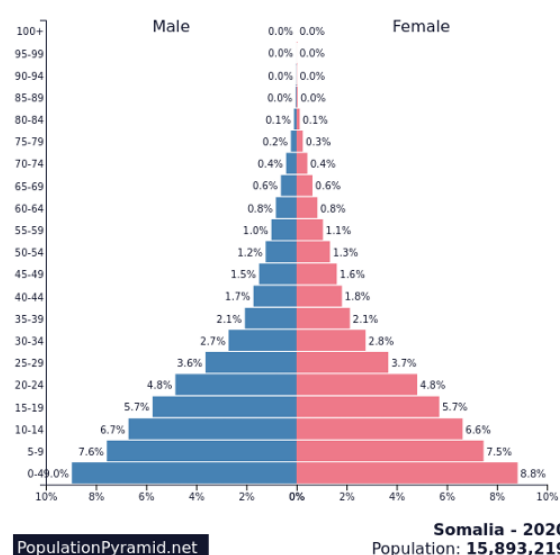
Currently, Somalia is transitioning from a prolonged conflict lasting three decades and is moving towards stability. Somalia is currently ranked among the poorest countries in the world – with a GDP 2021 at \$4.92 billion and per capita of \$309 (1), with a growth of approximately 2.8% between 2016 and 2020. An estimated 69% of the population live on less than US\$1.90 per day, with many more living just above this poverty line (1). Limited resources are being further stressed by a high population growth rate, and reduction in the annual economic growth rate due to the impact of COVID-19. The economy is highly dependent on foreign remittances (about one third of GDP), which have also been negatively affected by the pandemic.

Despite the formidable challenges faced by the country, Somalia's economy is rebounding from the "triple shock" that ravaged the country in 2020:

the COVID-19 pandemic, extreme flooding and the locust infestation. Real GDP growth is projected at 2.4 per cent in 2021. This growth momentum is expected to continue in the medium term and reach pre-COVID-19 levels of 3.2 per cent in 2023. The recent World Bank Somalia Economic Update reports that the economy contracted by 0.4 per cent in 2020, less severe than the 1.5 per cent contraction projected at the onset of the global pandemic. Higher-than-anticipated aid flows, fiscal policy measures put in place by the FGS to aid businesses, social protection measures to cushion vulnerable households, and higher-than-expected remittance inflows mitigated the adverse effects of the triple shock (1).

Somalia's economy has previously been dependent on agriculture and export of livestock (estimated to be about 75% of GDP) however there is now movement towards small scale industrialization. Most of the rural population is nomadic or semi-nomadic pastoralists, who rear livestock. Agriculture is limited to rain fed crops and hence vulnerable to climate. There is a growing number of internally displaced persons (IDPs) who are moving to urban areas due to security and economic issues.

Somalia's population is growing rapidly with an annual population growth rate of 2.9%, resulting in the doubling of the population every 24 years. Somalia's total population is estimated to be 15.89 million (2) of which 46–50% live in urban areas (3). High fertility (6.9 births per woman) has resulted in a young population, with 66%



under 19 years of age and 78% under 30 (4). Youth unemployment is high and educational attainment limited, with only 16% of the population completing primary school and 7% completing secondary school (5). Somalia's annual per capita government health and nutrition expenditure (including official development assistance) is estimated at around US\$11 in 2019.

Health care arena

Before the military regime, which began in 1969, private medical practice existed concurrently with public health care in a centralized public health system. The government ended private medical practices in 1972 in the context of the nationalization of privately owned services and economic assets. Sustained conflict between 1991 and 2012 destroyed the health system, sanitation and safe drinking-water systems. Currently, public health service delivery is limited.

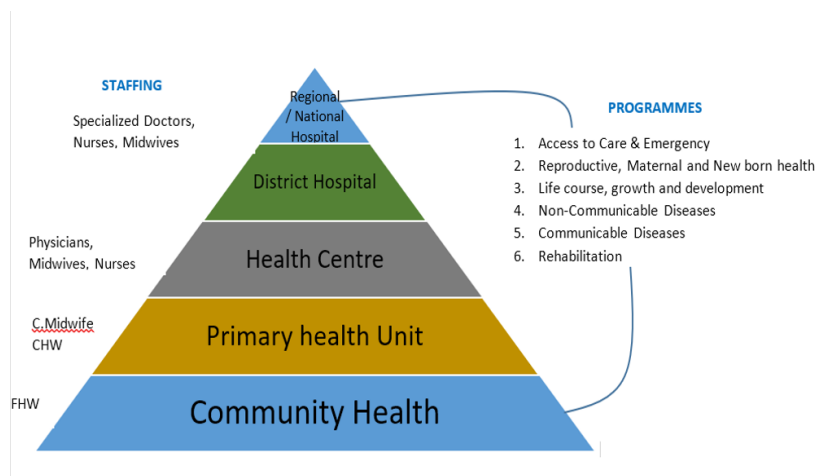
A large private sector has now emerged which delivers an estimated 60 per cent of health services which are concentrated in urban areas (2). The sector is informal and unregulated, currently several private sector networks have emerged to coordinate private sector health providers in the country. Humanitarian health services are provided by numerous international and national NGOs with funding from donor organizations, the diaspora and other private sources. The number of NGOs providing humanitarian health services is fluid and determined by short-term funding, with organizations leaving and new actors emerging, although with some sort of fragmented continuity over the past 20 years. The UN health cluster system provides some coordination for the humanitarian health sector, but this is limited (6).

Somalia's 2009 EPHS included six core programmes (maternal, reproductive and newborn health; child health; communicable disease surveillance and control; first aid and critical care; treatment of common illnesses; and treatment of HIV, sexually transmitted diseases, and TB) as well as four additional programmes (chronic disease management, mental health and mental disability, dental health and eye health). In 2013 the JHNP and the Health Consortium for Somali People

began implementing an EPHS, and coordinating donors and NGOs to provide services. Because of limited resources, the JHNP did not cover the entire country or all components of the EPHS. The closure of the JHNP in 2016 led to fragmentation of service delivery with different partners covering different geographical areas and package components.

In 2020 the FMoH revised the EPHS to target services that were required to address the health needs of Somalis. The revised EPHS focuses on six key areas: i) access to care (continuity care planning and coordination, emergency care, approach to common signs and symptoms); ii) reproductive, maternal and newborn health (maternal and newborn care, sexual and reproductive health); iii) life-course, growth and development, (childhood and adolescence including nutrition, older age and adults); iv) noncommunicable diseases (health promotion and disease prevention, cardiovascular and pulmonary diseases, diabetes, cancer, mental health and substance use disorders, injuries, other noncommunicable diseases); v) communicable diseases (immunization, management of HIV, TB, malaria and hepatitis, neglected tropical diseases, respiratory infections, gastrointestinal infections, other infections, outbreak surveillance); and vi) rehabilitation.

The FMoH is faced by a limited fiscal space of the government budget and acknowledges that the public sector may not possess sufficient resources (domestic and external) necessary for the simultaneous implementation of all components of EPHS. Along with the problem of limited funding and health system capacity, the FMoH has included



The FMoH is faced by a limited fiscal space of the government budget and acknowledges that the public sector may not possess sufficient resources (domestic and external) necessary for the simultaneous implementation of all components of EPHS.

service delivery considerations in the design of the EPHS 2020 by proposing a stepwise rollout of the EPHS in Somalia. This will allow an incremental build-up of the staffing and commodities necessary for all components of the EPHS to be implemented. It also provides for the development of capacities at district level to manage and coordinate health care provision in line with the EPHS guidance and across available providers.

An important effect of the non-availability of tertiary level services is the change in health seeking behaviour, where those with ability to pay, seek care in neighbouring countries. This decreases the number of patients for the private sector and hence also decreases incentives for the private sector to increase the number of services. On the public side it alleviates the pressure on FMoH to plan and provide for higher level services.

Changing health care needs and demands

The burden of communicable diseases and maternal, neonatal and nutritional conditions in Somalia has declined over time, however the rate of decline is very slow. The challenge is to address the communicable disease burden and also prepare the health system for the noncommunicable disease burden which will increase as the population starts ageing with improvements in child health and control of communicable diseases.

Maternal, infant and child mortality: The maternal, infant and child mortality rates are gradually declining although they still remain high compared to the other countries in the region. In 2015, the maternal mortality ratio was estimated at 732 maternal deaths per 100 000 live births, a remarkable improvement from 1600 deaths per 100 000 live births a decade earlier (estimate

for 2004–2005), and 850 maternal deaths per 100 000 live births in 2013–2014. In 2018–2019, the maternal mortality ratio further declined, although modestly, to an estimated 692 maternal deaths per 100 000 live births. The proportion of births assisted by skilled health personnel increased from 9% (2016–2017 data) to 32% in 2020.

Nutrition in children under five years old: Approximately 17.2% of all Somali children under five are stunted (7) compared to the Sub-Saharan African average of 33%. An estimated 12% of all children under five are underweight while 11% are wasted (i.e., too thin for their height) compared to the Sub-Saharan African average of 17% and 7%, respectively. Women's nutrition is vital for their health and pregnancy outcomes, while early childhood malnutrition has been linked to long-term outcomes of children. According to the Somali Health and Demographic Survey (SHDS), 15% of women aged 15–49 are thin. Nomadic areas have the highest percentage of thin women (26%), followed by women in rural areas (16%), compared to 14% of women in urban areas (8).

Family planning: Despite some knowledge of birth spacing methods, Somalia has one of the world's lowest modern method contraceptive prevalence rates alongside Chad and South Sudan. Only 7% of currently married women are using any contraceptive method and 1% are using modern methods. Among 15–19-year-olds, 11% are using contraceptives compared to 2% of those aged 40–44.

Communicable diseases: The communicable disease burden has declined from the estimated 2009 levels of 52% (as a share of all DALYs (disability adjusted life years)), but still

remains high at 47% in 2019, compared to the East African regional average of 40% (4). TB, meningitis, acute hepatitis, measles, and other respiratory and infectious diseases account for the majority (37%) of the communicable disease burden (9).

Childhood immunization: The immunization coverage in Somalia is very low. The number of children who have not received a single dose of vaccine is around 60% which indicates a critical weakness of the coverage of primary care services. According to the SHDS, only 12% have received the third dose of pentavalent vaccine, 26% have received the third dose of polio vaccine while 37 and 23% received BCG (Bacillus Calmette-Guérin) and measles vaccines, respectively (6). The disparity between this finding and administrative coverage and the overall low coverage of vaccination indicates the need for urgent steps to expand the services with more emphasis on monitoring.

Various reports, based mostly on data collected through the HMIS, do not fully cover the whole country, particularly the rural and nomadic communities which comprise 23% and 26% of the total population, respectively. These estimates provide different vaccination rates than what the SHDS found. One of the underlying issues in the variation can be the non-availability of proper population figures on which to base the targets, in addition to overreporting.

Noncommunicable diseases: Although lacking referable data, the consensus among health experts is that they are now dealing with more issues related to noncommunicable diseases than before, highlighting mental health, diabetes and hypertension as major neglected areas of the burden of disease.

Equity issues: The limited availability of health services over the past few decades has worsened the inequities with the nomadic and rural populations being worse off. The private sector services are mostly present in the urban areas and for rural areas, the provision of services has been dependant on humanitarian NGOs financed by donors. This creates a challenging situation where the availability of services is limited geographically and community awareness on public health

interventions is quite low, creating islands of neglect.

Demand for preventive health services: Service coverage is a function of service availability and demand of services. The low uptake of preventive services indicates that there is a large gap in the awareness about the benefits and consequently the low demand for these services. This creates a negative feedback loop, with low demand. The incentives for the private sector to provide these services further decreases. On the other hand, with the externally financed programmes which mainly focus on primary health services at district hospitals, health centres, primary health units and community intervention, the demand shifts to curative care interventions and service coverage for key health indicators remains low.

Urbanization: Urbanization is happening at a rapid pace in Somalia, whether it is due to diversification of the Somali economy from agriculture and livestock and nascent move towards industrialization or security issues, draughts and floods driving the population to seek safety in large numbers. It is estimated that around half of the population now lives in urban centres and small villages. This changes the dynamic of demand for health care, as it leads to a large enough number of consumers for services to which the private sector, in response, establishes service delivery outlets. The problem is that with the currently low awareness of preventive care and the economic conditions of the consumers, the services that are available are mostly targeted to curative care, with little or no emphasis on disease prevention and health promotion. (More details in the section on health institutions)

Stakeholders in health

Community: The health sector has the community as its main stakeholder, which is not only the recipient/consumer of services but also one of the main financiers. One important aspect to keep in mind is the geographical distribution and social structure of the community for provision of appropriate health services. For Somalia, the diaspora is also an important part of the overall financing of the health sector as well as provision of expertise for health.

Public sector: The FMoH as well as the state MoHs who have the primary responsibility of the health care of the Somalia populations through policy-making and oversight functions in addition to the public functions are another major stakeholder as majority of the budget decisions and health interventions have their involvement. Another important stakeholder is the Ministry of Finance, which is responsible for providing the government budget allocation for health.

Health care providers: Health care professionals of all levels, both in the public and private sector also have a major role to play in the provision of health services. They often direct or create demand, and, if they are not fully on board with the proposed interventions, coverage and results may be quite problematic. Another issue is the accreditation and licensing of service providers. This may face resistance due to varying interests and also non-qualified persons providing health care. The MoH has involved and consulted the private sector in the review and the development of the regulatory frameworks of the health workforce and the establishment of the national health professional council and the regulation of pharmaceuticals and medical devices.

Private health institutions: An expanding private sector indicates that there is a market for health service provision although the question remains as to the quality and type of service offered. Regulation of this sector is necessary, and the task will become more challenging as the private sector expands over time.

Industry and allies the pharmaceutical sector is a key stakeholder in health, and planning should always look into this aspect. In addition to the large multinational corporations and their local partners in Somalia, independent importers also play a major role in the procurement of medicines and medical equipment. The regulation of this sector is currently pending and needs to be expedited to ensure the supply of quality pharmaceuticals.

Local organizations: Professional associations, as well as networks of private hospitals, or NGOs active in the health sector also drive the agenda and have the capacity to affect demand.

International organizations: These can be classified further into those who directly finance the health sector such as the multilateral and bilateral donors, and those who provide technical assistance including the UN agencies. The organizations providing finance have a large impact on service delivery and priorities.

Learning from previous (strategic) planning processes

There are lessons learned from the previous planning processes and some have been incorporated into the overall understanding of the next steps in the development of this strategic plan.

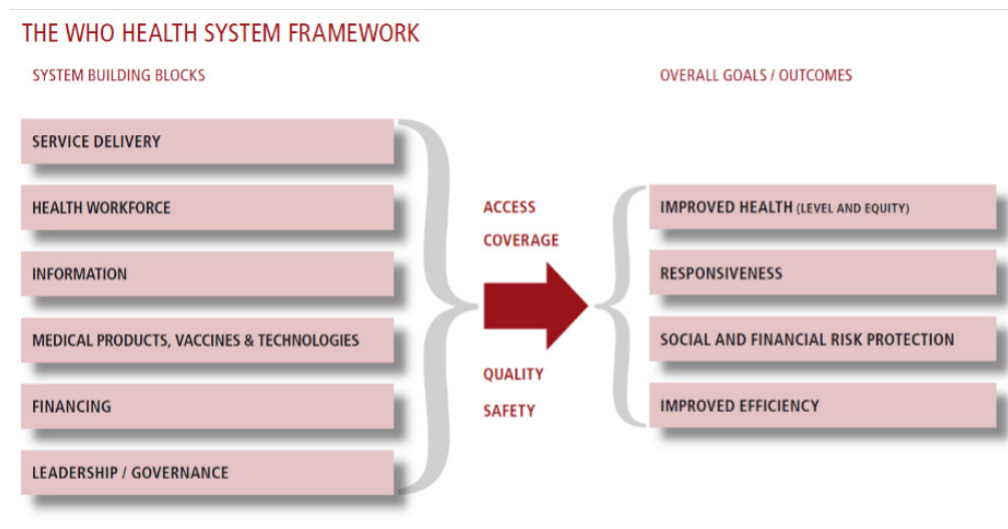
The EPHS 2009 was prepared based on immediate needs, however the implementation was fragmented despite efforts to coordinate and limited in scope. It was later reviewed, and strategic areas were included to formulate the 2020 EPHS. For the previous HSSP II, priority areas and targets were identified after a lengthy consultative process. This strategic plan was quite detailed in scope and had a clear direction. However, as the plan was not fully consulted and financed, it did not move to implementation. The failure to implement the strategic plan is also related to the political and administrative structure of Somalia, which has changed over time as new federal Member States emerged. The state MoHs are responsible for health provision in their respective areas and hence the need to be accountable for detailed planning.

Key components of the HSSP

The HSSP, upon directions by the FMoH, is guided by the six building blocks outlined in the WHO framework for health systems (6). This provides a foundation where key areas of the health system are all accounted for and addressed.

Leadership and governance

The governance of the health care arena is defined as the web of actors, actions and processes that inform health care provision as well as its dependence on broader configurations, both formal and informal.



- a. Health sector legislation and regulation: the government has taken steps to put in place regulatory framework in efforts to regulate the health sector, but the progress has been minimal. The main driver for a regulatory regime is either strong administration or financing, in this case both are sub-optimal.

Addressing with realistic measures the entrenched commoditization of health care provision stands out as the inescapable public-good priority. A better understanding of private health business (formal as well as informal) has been provided by some studies (10–12). Their insights about prices, accessibility, working hours, assets, range of services and value for money help identifying effective incentives to be deployed to affect provider behaviour.

In the present climate, the establishment of a comprehensive regulatory regime – based on legal and administrative provision which requires a whole-of-government effort including the legislative branch – may take a long time to realize.

A more promising option to consider could be a market-oriented intervention, such as franchising. Incrementally introducing discrete regulatory measures, and learning to manage them, might offer the most pragmatic way forward. This option may also look into self-regulatory mechanisms for providers, where in

the providers form their own associations and review quality and service standards. There are ongoing work and plans to engage the private sector involving major private sector associations by the FMoH with the support of health partners.

- b. Aid coordination/management: the MoH has improved its capacity to coordinate stakeholders; however, the process needs to be consolidated with regularly scheduled meetings and responsibilities. The FMoH takes the lead in presenting the progress and in discussion with the partner identified areas/interventions that need support and to agree on mechanisms for achieving common goals of implementing the EPHS and health sector priorities. Using the GFF-supported investment case as a baseline for immediately required interventions, the plan outlines broader strategies, such as focusing on essential services, plans for infrastructure which would service difficult-to-reach populations. These options require further discussion in formulating longer term strategic investments with all stakeholders

- c. EP&R, including epidemiological surveillance: several past attempts in establishing an epidemiological surveillance and response system have been short lived. The present setup, upgraded to respond to the COVID-19 epidemic, performs quite well.

Ways to make it be more durable than its predecessors have been identified through the adoption of IDSR, which will link to the DHIS2 platform. This will require concerted effort and investment to strengthen the routine information system which is suboptimal in function and provides limited use for decision-making. With the routine system equipped for surveillance, a revised and integrated DHIS2 will, in the medium term, supplement and bridge the gaps in reporting and response.

- d. Management of health systems: the current management of the health system is weak due to lack of capacity and attrition of personnel. Strengthening the capacity at both federal and state levels will be crucial for improvements of the health system. The FMOH has a major role to play in aid coordination and management, review of plans, provision of technical expertise to the federal Member States, data collection and reporting on health indicators, review of programmes. Furthermore, engagement with the other sectors, such as higher education would improve quality of training and production of appropriate cadres as per EPHS needs. The federal Member States, in addition to the above, require capacity for emergency response, management of human resources and pharmaceuticals, and engagement with private sector and other health institutions.

Health information eco-system

The health information environment is quite fragmented with multiple systems for different programmes functioning sub-optimally and a routine information system being managed with strong support from a technical partner. Every report, development plan and review of the health sector in Somalia points to weaknesses in the health information system. A HISSP 2018–2022 was prepared to address this gap, but there is little evidence of its adequate implementation. The plan provided clearly outlines targets and strategies; however, the scope of the plan appears to be quite ambitious. Lack of financing continues to be a major reason for its poor implementation.

The FMOH, through the health sector coordination mechanism, shall promote a single reporting system using the data generated by the updated DHIS2 to

avoid duplication of information and compatibility of the data sets. The reporting frequency mentioned in the HISSP is adequate and needs to be incorporated in state ministry plans. Better integrated reporting procedures would allow enhancement of the use of information and foster evidence-based decision-making.

Information which flows from logistics management systems are very weak and this aspect has been taken up by incorporating a logistics information management system in the updated DHIS2 which will become available in 2022 for implementation; however, it needs to provide timely information for it to be effective.

Human resources for health

The Somali health workforce is composed of diverse groups of workers, in terms of formality, employment and specialization. Training institutions have multiplied in the last three decades, producing health professionals entering a deregulated labour market. Unemployment is substantial, contrarily to the dominant mantra of HRH scarcity (13). Alongside the formally employed health professionals, there are a significant number of health workers informally active in the health sector who must be counted to reflect the actual size and shape of the workforce. To inform sound policies, an HRH observatory should be established (as suggested in 2016 by the HRH policy).

The Somali HRH Development Policy (14) was formally approved in 2016 by the health advisory board and is still relevant. The quality of the current health workforce and consequently the quality of service delivery remains to be a major challenge the government needs to address. In addition to the recognized cadres, there are a lot of informal health care providers which also require attention. The licensing, regulation and accreditation of the health workforce is a priority in the Damal Caafimaad project of the FMOH.

The HRH problems can be classified in two major areas: a) Available workers, category/skillset, and distribution and b) Quality of trainings for the production of relevant cadres. The available workers need to have a standard skill set and distribution is an issue that the federal Member States need to pay close attention to specifically the issues

of remuneration/incentives which have major implications for retention and availability, whereas the quality of trainings needs to be reviewed carefully to ensure that only institutions with necessary expertise are accredited to train and produce sufficient numbers of qualified health workers.

Another related area which takes up resources is on job trainings, which may have little or no impact on quality of service delivery, this is further compounded by training of community level workers on limited curricula for specific programmes instead of the broader and approved curriculum by the FMOH for community level workers. A concerted effort is currently underway to update the FMOH pre-service training curriculum for the national Female Health Worker (FHW) Program to align with the updated FHW service package and EPHS 2020. All newly recruited FHWs starting from 2021 are receiving pre-service training using this new competency and skill-based training package with the rollout of this same training package across federal Member States.

The availability of specialized medical education in Somalia is quite limited and hampered by non-availability of equipment and insufficient number of experts and professional trainers. This area can be improved with private sector taking the lead and having exchange programmes with foreign universities or teaching institutions for post graduate courses. These teaching institutions can also be linked to secondary care hospitals to provide advice and ongoing medical education for doctors as well as staff at these hospitals. The FMOH should facilitate the process and discussions as this will lead to an overall enhancement of quality of service provision.

Health institutions (health service delivery system)

Health systems are inherently complex due to the

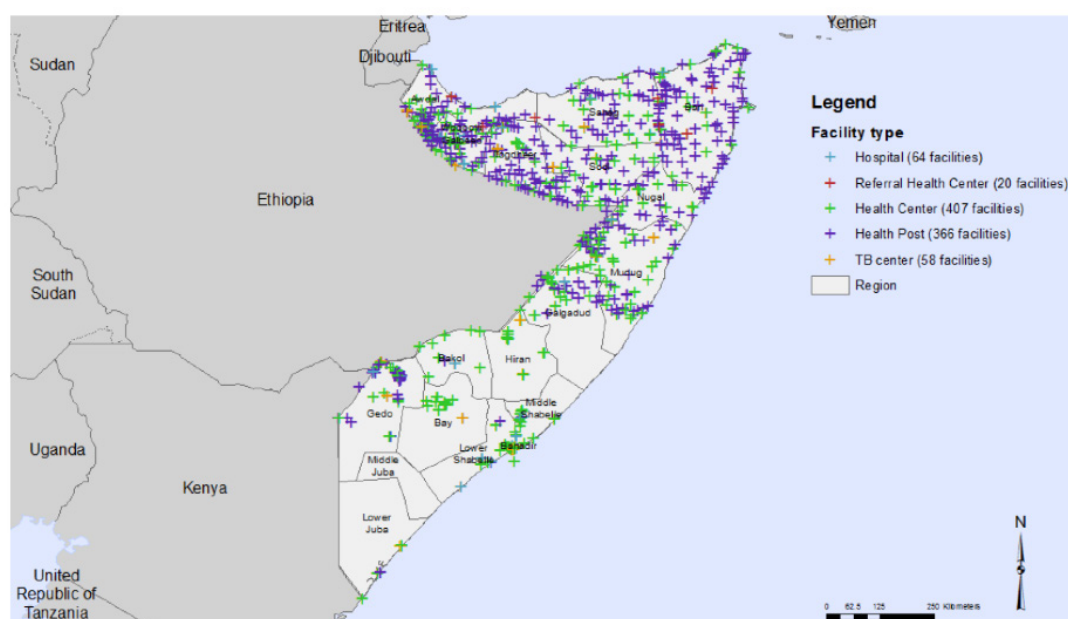
different specialties and levels of skills involved which require their own specific supporting environment. Furthermore, the majority of these are closely interlinked and absence of one level or skill makes the overall performance of such a health facility suboptimal.

A broad classification of health infrastructure required by level could be: a) community level (no or minimal level equipment and infrastructure); b) primary care level (requires equipment and dedicated qualified health workers as defined in the EPHS linking up to higher levels of care for referrals). The next delivery platform are the health centres which provide a set of health interventions defined in the EPHS; c) secondary care (requires a full set of basic equipment for the services and dedicated infrastructure, in addition, it has specific requirements for specialization) and d) tertiary care (provision of specialized services requires expertise, equipment to also serve as training sites for new cadres of health care providers).

Currently in Somalia, most of the tertiary and secondary level centres are provided by the private sector, especially in urban areas. The government and donor partners are mostly focused on provision of PHC services in line with the EPHS, including relevant primary curative care.

Health facility density and services: Excluding pharmacies, the density of private facilities stands at 0.93 facilities per 10 000 population and the density in the public sector is 0.76 per 10 000 population. According to the SARA report of 2016 for public health, the target density is two facilities per 10 000 population (15). This means the density for the private health facilities is greater than that of the public, and while neither reaches the national target alone, together, the density adds up to 1.69 per 10 000 population, which is low (12).

The availability of specialized medical education in Somalia is quite limited and hampered by non-availability of equipment and insufficient number of experts and professional trainers



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Data Source: Somalia SARA 2015/16
Map Production: WHO Somalia Country Office
World Health Organization

World Health Organization
© WHO 2015. All rights reserved.

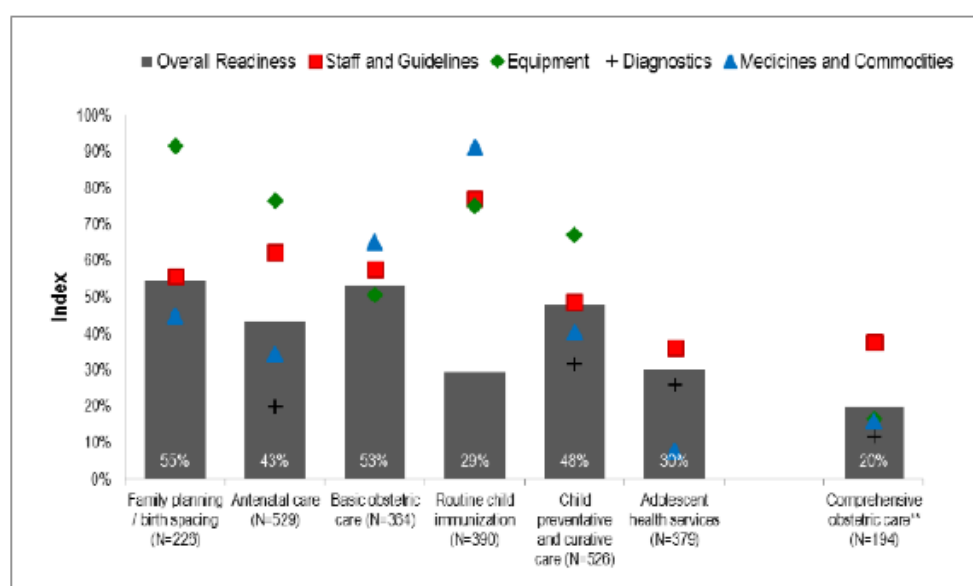
In the private sector facilities 46% of hospitals and 74% of clinics are either individually or group owned. The mix of services provided at the private facilities does not fully cover the interventions contained in the EPHS 2020.

The information regarding the private sector is incomplete but still provides a glimpse of the issues plaguing health service delivery in the country. An earlier study on the private sector (16) identifies lack of information as an issue not only about the number of facilities and services but also highlights the lack

Table 1. Proportion of facilities offering various health care procedures, by facility type

| | Overall | By facility classification | | | | Not for profit versus other | |
|-------------------------------------|---------|----------------------------|--------|-------------------|----------|-----------------------------|-------|
| | | Hospital | Clinic | Diagnostic centre | Pharmacy | NFP | Other |
| N | 2253 | 128 | 729 | 92 | 1304 | 196 | 2057 |
| Immunization | 15% | 51% | 25% | 12% | 6% | 65% | 10% |
| Routine laboratory tests | 38% | 77% | 53% | 78% | 23% | 36% | 38% |
| X-ray | 4% | 23% | 5% | 3% | 1% | 8% | 3% |
| Ultrasonography | 7% | 39% | 12% | 1% | 2% | 11% | 7% |
| Minor surgery (local anaesthetic) | 21% | 63% | 28% | 26% | 13% | 18% | 21% |
| Major surgery (general anaesthesia) | 3% | 27% | 2% | 2% | 1% | 3% | 3% |
| 24-hour emergency services | 26% | 66% | 35% | 49% | 15% | 37% | 25% |
| Blood transfusion | 5% | 40% | 7% | 3% | 1% | 9% | 5% |
| Caesarean section | 2% | 31% | 1% | 2% | 0% | 9% | 2% |
| ICU | 2% | 11% | 3% | 1% | 1% | 5% | 2% |
| None | 36% | 0% | 15% | 1% | 54% | 16% | 38% |

Source: Assessing the capacity of the private health system in Somalia, final report: Oxford Policy Management, Forcier Consulting, 2018.



* The readiness score corresponds to the average availability (%) of the tracer items of the four domains (« Staff and guidelines », « Equipment », « Diagnostic capacity » and « Medicines and commodities »).

** Only includes hospitals and health facilities offering cesarean section

of understanding of the willingness and capacity to pay attention to the communities being served. It also raises the issue of the role social support networks play in health care.

The data from SARA 2016 indicates that although the overall service readiness is better for public facilities compared to private sector, the overall levels were quite low.

The important issue for the health sector's strategic directions is how to engage the private sector and ensure that EPHS services are offered at all facilities, specifically for secondary care, to deliver quality services. This creates an opportunity to deploy the limited resources available within the public health sector in areas where coverage and access are issues.

Health financing

From a health sector strategy point of view the important aspects of health financing are a) households' investment (OOP, insurance, other pooling mechanisms); b) public sector (including donor investments); and c) philanthropy (including diaspora financing).

The GFF-supported investment case document lays out the details of the government budget and expenditures; the government allocation for health

is 1.9% of budget and 0.18% of the GDP, even out of the allocated amount the utilization is around 67%.

For the public sector, a recent resource mapping exercise (17) identified the public funding (domestic and donors) available for the health sector over a period of three years 2018–2020. The government share in health expenditure has increased from 7.8% in 2018 to 12.2% in 2020. The government has also expanded its financing from provision of salaries to other areas such as acquisition of assets, training and education. The mapping misses some actors in health and this has some implications on relying on these figures for a comprehensive picture of the total health expenditure in the country. The MoH needs to develop a National Health Accounts capacity, based on the System of Health Accounts 2011 methodology, which estimates household expenditures plus the public and external funding.

A majority of the development assistance to Somalia is off-budget which requires coordination to achieve efficient use of available resources. Further prioritization and efficiency of service delivery can also encounter difficulties in later stages as the FMOH develops the relevant systems. Currently, the FMOH has limited role in the decision-making on how these resources are used. The FMOH needs to build strong technical capacity including, but not limited to areas of public financial management and

supply chain management in order to scale up the EPHS implementation across the country.

Financial barriers deter care seeking: this is the greatest obstacle cited by Somali women aged 15–49 (6). Sixty-five per cent of women cite lack of financial access as the main barrier. Somalia's annual per capita government health and nutrition expenditure (including official development assistance) was around US\$6 in 2019 (18). Communities have little or no disposable income for OOPs for health services, while almost half of all households (48%) finance health expenses using their own income (6). The high rate of OOP means households often have to deplete savings, sell their assets (14% of the households) or borrow money (6).

The rate of seeking health care is lowest for the nomadic population where only 10% of households identified that they had someone who was ill and 68% out of these did not seek care (6). This indicates the need to better understand the dynamics within the population on what role the availability of finances and access to services affects the decision-making process for health seeking.

Pharmaceuticals and medical devices

The pharmaceutical sector in Somalia is composed of different actors including government, international organizations and a large network of private importing firms, wholesalers and retailers who ensure the availability of medicines of disparate sources, prices and standards. Given the lack of reliable data of large coverage, the quality of the medicines circulating in such highly deregulated markets is a matter of speculation. Drug-selling outlets have proliferated, becoming the site of most health care encounters. Many so-called pharmacies have expanded their scope, offering rudimentary laboratory and outpatient services. Alongside this thriving pharmaceutical business, aid agencies supply essential medicines procured through multiple channels.

The key actors in the pharmaceutical field are the importers and these are: pharmaceutical firms, traders and the logistics chains of international donors. The spurious and substandard medicines circulating in the country are mostly imported through the "traders".

This key area is already a part of the investment of the Damal Caafimaad project of the MoH. A scoping assessment and a roadmap of the medicines regulatory framework has been prepared and national medicines regulatory authority established.

Pharmacies logistics chain

The last mile logistic chain within Somalia is fast. It is almost completely smartphone based, and demand is known on an almost instant basis. It is also largely cash based, in this case mainly electronic cash through mobile phone. Orders are made by phone, e-cash is paid, and the goods are shipped. From Mogadishu to the regions this usually goes by plane, as the internal flight network is now very good and cheap. Bulk goods and items with a steady turnover go by road from Mogadishu to region. From region to district and from district to village it goes by road. There is no public transport of any kind, but the informal private network is very efficient. It does not seem to matter much if frontlines must be crossed, though that does cause some delays and extra cost. The whole process is almost instantaneous. There are no formal forecasts, no requests for quotations, no contracts, no lengthy administrative procedures. It is a network of almost instant information, cash and goods flows, and very much based on trust.

Jeene, H. (2017) Strengthening affordable access to quality essential medicines in the private health sector of Somalia: options for a private medicine quality assurance system. Swiss Development Cooperation.

HSSP

The underlying principles and foundation of the HSSP are from the Somalia Health Policy which are restated below for emphasis.

Vision: The Somali people enjoy the highest attainable standard of health and quality of life and have universal and equitable access to essential quality health services with a priority focus on maternal, neonatal and child health and nutrition, and on the prevention and control of high burden diseases and related risk factors.

Mission: To provide equitable, efficient and affordable quality essential priority health services as close to the communities and families as possible based on the EPHS and PHC approach.

Overall goal: To improve the health status of the population through health system strengthening interventions and providing quality, accessible, acceptable and affordable health services that facilitate moving towards achieving UHC.

Core values: The following principles and values underpin the health policy priority directions:

- Universal and equitable access to acceptable, affordable, cost-effective and quality health services with maximum impact on Somali populations' health to ensure the realization of the right to health.
- Effective, transparent and accountable governance and leadership in managing the different components of the health system with decentralized management of health care service delivery.
- Building effective collaborative partnerships and coordination mechanisms engaging local community, national and international stakeholders and pursuing the aid effectiveness approaches.

Policy priorities:

- i. To improve access to EPHS of acceptable quality through implementation of EPHS to produce the desired health outcomes in terms of reducing maternal, neonatal and child mortalities rates, decreasing the rates of undernutrition, controlling prevalent communicable and noncommunicable diseases and improving the quality of life.
- ii. To develop a health workforce that addresses the priority health needs of the Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services.
- iii. To build institutional capacity of health authorities at both central and regional levels to provide strong leadership and effective governance to deliver core functions of the health sector and engage with private sector.
- iv. To ensure the availability of essential medicines, vaccines and commodities that satisfy the priority health care needs of the population, in adequate amounts and of assured quality and at a price that the community and the health system can afford.
- v. To establish an effective health information system that provide accurate and timely health data for evidence-based planning and implementation, supported by effective monitoring and evaluation and by targeted research as a problem-solving tool.
- vi. To raise adequate funds for health, protecting the poor and underprivileged from catastrophic health expenditure ensuring that people can access affordable service, therefore moving towards UHC.
- vii. To bridge the gap in the enormous health infrastructure paucity and create the minimum health infrastructure assets, providing the necessary operational environment for effective service delivery.
- viii. To strengthen the health system and surge its capacity to promote public health and prevent, investigate, mitigate, manage, monitor, evaluate and control public health threats and reach out to affected communities with integrated effective assistance targeting their specific needs, especially in times of public health emergencies.
- ix. Improve the health of the population and reduce health disparities by addressing the social determinants of health, integrating health perspectives into the broader development framework and emphasizing on intersectoral collaboration across all government and other stakeholder partners and building the capacities necessary for its implementation.

Guiding principles

The strategic plan was designed taking the following conceptual and methodological considerations into account:

- Feasibility, given existing capacity and resource constraints. To that effect, intervention drives must be chosen with parsimony which is what informed the selection of the interventions contained in the revised EPHS. Success in a few areas will stimulate more ambitious steps to be taken later. Conversely, unrealistic goals prematurely pursued will discourage decision-makers and implementers;
- Sustainability (in the long term). “It is better to have a lean health service functioning according to plan, than a service designed to be fatter but losing weight rapidly from resource starvation (6,19)”;
- Flexibility in light of changing conditions. Local solutions that grab opportunities and contain threats are needed to attain broad goals (themselves evolving);
- Coherence with other initiatives underway or in the pipeline as spelled out in the Damal Caafimaad project;
- Adaptation to the Somalia’s challenging context, which makes difficult a detailed upfront programming due to budget constraints. Moreover, global standards and approaches cannot be applied straightaway to the Somali health care arena. Instead, the incremental introduction of discrete components, along an increasing degree of difficulty, must be preferred. Service delivery considerations were included in the design of the EPHS 2020 to allow incremental rollout and adaptation of the package to various conditions and situation in Somalia. This could include the nomadic and rural populations, the IDPs, the health system capacity and budget constraints. This was further elaborated in the EPHS implementation strategy developed by the FMoH in collaboration with WHO and GFF and development partners.

mechanisms that foster equitable, efficient and effective health care provision.

Main pillars (all interlinked):

- Boost health care demand – by lowering the existing barriers to seek health care and enhancing quality of care. The feasibility of introducing a durable regulatory regime – based on administrative controls – will be assessed. To be enforced, regulatory provisions must be regarded as beneficial and worthy of support by stakeholders: providers, employers, business people and service users. Performance-related rewards would appeal to health operators looking for a competitive advantage in a crowded market.
- Engage private health care providers – first through soft measures aimed at harnessing the market through incentives, such as franchising.
- Put in place and accelerating use of “performing” management systems – including information, aid management and EP&R.
- Restructure the health workforce – by enhancing the production, utilization, and maintenance of health workers. The strategic focus must be on improving skills, rather than expanding only the true number of health workers. Such an upgrading must be two-pronged, first through the strengthening of training programmes, and second through effective in-service training. Attempts also need to be made to rationalize the pay structures to allow for improved retention and equitable distribution.
- Rationalize the pharmaceutical field – by introducing feasible regulatory measures and streamlining fragmented supply chain system.
- Steer physical infrastructure investments – to contain imbalances between levels of care, regions and population groups.

The long-term goal of the HSSP is to establish institutional capacity, structure and

Policy and action

The following matrix, which outlines details strategic drivers, policy options, feasibility, risks, capacity and resource requirements, linkages, is based on a review of available documentation, and on the consultations held within government, stakeholders and informants.

The matrix cannot include every possible issue of interest. To be truly strategic, it focuses on six critical drivers, and on ways to work towards these long-term goals. Operational details will be addressed later with federal Member States and stakeholders engaged in specific areas.

Two key considerations, which have informed the development of this strategic plan are stressed here because they are frequently overlooked in policy and planning decisions:

- For decades, Somalia has been treated like a laboratory of experiments and innovations, results and lessons, many of which are frequently ignored. The recent response to the COVID-19 pandemic has confirmed that capacity can be productively tapped, rather than being created, by outside intervention. Before importing models from abroad, indigenous experiences must be duly recognized, and scaled up when opportune. This awareness will help modify and adopt the alien models that are not relevant for the Somali context to make them more successful.
- The large informal portion of the health care field cannot be neglected anymore, given its impact on efficiency-, effectiveness-, quality- and equity-related aspects. Engaging with informal actors presents difficulties, but also promises rewards. Examples of positive experiences in this field are welcome to build future interventions on concrete foundations.

Policy matrix for action

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|--|---|---|--|
| Boosting health care access and demand | <ul style="list-style-type: none"> Lowering existing barriers: extending opening hours, reducing the cost incurred by patients, ensuring regular supplies, motivating staff to raise their performance and improving communication. Interventions must pay attention to cultural norms, because they affect health-seeking behaviour. In rural Somalia, "societal norms may be the main barrier to accessing health care (20)". Simply adding facilities and staff will not be sufficient. Alongside conventional supply-side measures, innovative approaches aimed at encouraging demand are needed. | <ul style="list-style-type: none"> Nomadic populations need adapted service delivery models, premised on mobility, flexibility and cultural appropriateness. Internally displaced population is another major area which requires further effort. IT applications can greatly contribute to disseminate information, as well as raise access to health services. <p>Risks:</p> <ul style="list-style-type: none"> standardized health services ignore local circumstances; health messages inapplicable in real settings do not resonate with people; costs borne by remote patients remain high, even with officially free services; patients will not travel long distances if health care provision are unreliable or deemed substandard. | <ul style="list-style-type: none"> Training of female health workers must be coupled with local recruitment policies and adequate incentives to deploy them where needed. Effective communication is built on mutual respect, and recognition of the actual patterns of health care provision in each circumstance. Other providers supplement formal health services: folk healers, traditional birth attendants, community health workers, itinerant traders, nomadic link workers. Supporting these practitioners, rather than competing with them, appears as a realistic option to serve hard-to-reach populations. Subsidies aimed at making services more affordable, for instance by supplying quality medicines at reduced cost, should be considered. | <ul style="list-style-type: none"> Valuable experience has been gained in Somalia about stimulating health care demand. See for instance the Sahan component of the Shine (Somali Health and Nutrition) programme. Improved management, by raising workloads at underused facilities, would provide obvious returns at modest cost. The decentralized, relevant training of scarce categories, such as midwives, is needed to make a difference. |
| | <ul style="list-style-type: none"> Enhancing the quality of care requires protracted efforts on multiple fronts to induce progress. A valuable lesson is that "...simply scaling up interventions in weak health systems that deliver poor-quality services is likely to waste precious resources and fail to show the anticipated improvements in health (21)". Some private health providers intend to gain a competitive edge in a highly competitive market by raising their quality standards. See the self-regulation measures taken by the Caafinet network. | <ul style="list-style-type: none"> The main quality-enhancing interventions underway and in the pipeline should be appraised by independent bodies. Enhancing quality is better conceived as a system-wide goal. A long-term, collaborative programme built on the most effective programmes and projects, must be designed. <p>Risks:</p> <ul style="list-style-type: none"> the focus on expanding service coverage leads to neglect quality of care; enhanced quality of care is not perceived as such by users; imbalanced progress is induced by donor priorities; cost and business factors negate and undermine quality improvements. | <ul style="list-style-type: none"> Software is needed as much as hardware (which usually dominates quality-enhancing projects). PHC facilities must receive as much support as hospitals (which tend to be privileged by quality-oriented initiatives). Mystery surveys – carried out by pretend patients looking for health care – may provide valuable indications about diagnosis, prescription and advice patterns. Quality improvement is often equated to in-service training, which must be associated to other measures to yield results. Telemedicine can play an important role in raising quality of care. | <ul style="list-style-type: none"> Linked to all the other strategic drivers. For instance, credibly accredited health facilities staffed by skilled workers prescribing affordable, quality-assured medicines would attract patients. Effective communication supported by sound evidence-based planning is needed to nurture public awareness of quality improvements, as well as of harmful practices. Messages must be technically sound and attractively packaged to gain attention in the competitive information environment. In Yemen, the Quality Improvement Programme, supported by GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit), has attained promising results in challenging circumstances (22). |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|--|--|--|--|
| Engaging private health care providers | <ul style="list-style-type: none"> Short-term: through measures aimed at harnessing the market: <ol style="list-style-type: none"> disclosure franchising licensing and accreditation contracting partnership in planning. <p>To be used successfully, incentives demand a sound grasp of the health care market and of providers' behaviour.</p> | <ul style="list-style-type: none"> Private health care providers have created networks to be closely followed (23). The time is ripe for a productive dialogue, aimed at negotiating mutually beneficial arrangements. <p>Risks:</p> <ul style="list-style-type: none"> only some stronger health facilities serving the wealthy manage to upgrade their operations; unrealistic provisions force underground many providers unable to abide by them; informal providers, who represent a large portion of the market and the main source of care for the poor, are neglected. | <ul style="list-style-type: none"> Many approaches have already been tried in Somalia; building on those experiences looks more promising than importing models from abroad. To be enforced, provisions must be regarded as beneficial and worthy of support by stakeholders – providers, employers, businesspeople and service users. The links between informal providers and community health workers should be considered in designing interventions targeting them. | <ul style="list-style-type: none"> Managing a mixed, pluralist health care arena requires sophisticated skills and relevant information. Unlikely to succeed without progress in the management strengthening area. Improving the performance of informal providers would greatly enhance quality of care, and in turn benefit the poor. Of great appeal on equity terms, it requires a well-integrated mix of communication, training, incentives and support (24). |
| | <p>Long term: by progressively introducing administrative controls, which together will constitute a complete regulatory regime.</p> | <ul style="list-style-type: none"> Opening the dialogue with private providers may prove challenging, even, even in contexts more conducive than Somalia's. International experience suggests that effective regimes are co-constructed by health authorities and entrepreneurs, refined over time and adapted to new conditions. <p>Risks:</p> <ul style="list-style-type: none"> ineffectiveness. Regulatory procedures turn into hollow paperwork, which encourages bribing; regulatory capture; enforcement costs exceeding health benefits. | <ul style="list-style-type: none"> Imported regulatory blueprints are unlikely to work in the Somalia settings. Patient experimentation of alternative measures seems opportune instead. Regulation authorities must be autonomous, reputable, capable and well resourced. Such a satisfactory outcome can be attained only after many years of sustained efforts. Given the business orientation of public providers, regulations must be applicable to them as well. | <ul style="list-style-type: none"> Effective regulation would boost quality of care and health care supply (by aligning the behaviour of private providers to public health guidelines) but raise its costs. The market-harnessing measures proposed above will provide the information and capacity needed to design, test and assess hard regulations. |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|---|--|---|---|
| Strengthening management systems | <ul style="list-style-type: none"> • Fostering a culture of informed decision-making, through improved information management. • The available health information is quite rich, having improved over the years. It is not used optimal by decision-makers. • Moreover, memory is undermined by the quick turnover of stakeholders. Newcomers tend to launch new study rounds, ignoring the wealth of personal and collective knowledge already available in the environment. | <ul style="list-style-type: none"> • Information management must be adapted to the fluid, fuzzy, fragmented health care arena with strengthened data analysis and use. Routine data must be integrated and complemented by surveys and research findings, participant observations, local insights. The resulting patchwork will present gaps, which have to be filled by dedicated studies. • Risks: <ul style="list-style-type: none"> • insights on health care provision fail to influence decisions taken on other grounds; • huge effort may be taken to put in place complex but ill-adapted health information systems, moulded on global standards; • initiative is stifled by claims of 'insufficient data', while valuable information might be available, if looked for. | <ul style="list-style-type: none"> • Information collection and analysis need to be done collaboratively by health authorities, providers, funding bodies, research institutions and the media. • A better use of the DHIS2 platform, with standardized data analysis and use, passes through an enhanced state-led information management. This setup would be more useful and more resistant to shocks than a central routine health information system (which takes time to work properly). • Several information management hubs, able to store knowledge and carry out studies upon request, already exist in Somalia. Their development should be supported. | <ul style="list-style-type: none"> • Reliable, relevant and timely health information, if recognized as such, could inspire choices and guide operations. In turn, decision-makers would commission studies to shed light on challenging issues. • Information relevant to health systems development must take precedence over data collection driven by donor requirements. Funding to that effect is needed. • Enhanced knowledge would give an edge to health authorities vis-à-vis old and new partners and signal their intention to lead on firm foundations. |
| | <ul style="list-style-type: none"> • Improving aid architecture and management to optimize the use of external resources and attract additional ones. • Given the resource requirements of all the activities foreseen by the strategic plan, their success will largely depend on effective aid management and coordination. • However, aid management has to remain a means to pursue health systems development under the overall umbrella of the health sector strategy. • Where this lesson is forgotten, "...the overfocus on the processes of how aid is provided has distracted attention from what aid achieves (25)". | <ul style="list-style-type: none"> • Effective aid management is hard work: slow, labour-intensive and contentious, it may achieve partial results, while many donors proceed in isolation. • Risks: <ul style="list-style-type: none"> • ceremonial events absorb stakeholders, without generating coordinated actions; • meanwhile, in the background, influential actors make key decisions whose consequences will become apparent only later; • cumbersome aid management tools slow down operations and inhibit innovation. | <ul style="list-style-type: none"> • Technical skills, political acumen and networking capacity are required to manage external resources productively. • Results are more likely to materialize when efforts focus on concrete issues of consequence. • Thus, aid management close to the ground is usually more productive than at country level. • Establishing aid management tools, such as pool funds, may pay off, provided they are lean and responsive to changing conditions. | <ul style="list-style-type: none"> • Aid informs investments and disease-control programmes, creating long-lasting imbalances. On the other hand, it keeps some services afloat, promotes studies and pushes delivery models. • A long and valuable experience with aid management arrangements has been gained in the Somali health care arena. It should be duly studied before new models are adopted. |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|--|--|---|---|
| | <ul style="list-style-type: none"> • EP&R are vital in a crisis-prone country. Consolidating procedures, capacity and resources, now split across programmes, such as EWARN, polio eradication and the COVID-19 response, is the way forward. • Warning: several past attempts at establishing permanent emergency surveillance and response capacity have been short lived. The ongoing efforts to establish and implement an IDSR must be expedited. | <ul style="list-style-type: none"> • EP&R – an inherently public function – is indispensable in a fragmented environment dominated by private providers. <p>Risks:</p> <ul style="list-style-type: none"> • support is conceded short-term, only to respond to challenges of donor interest; • response approaches are derived from alien, ill-adapted and unsustainable models; • political fragmentation impedes cohesive responses across Somalia. | <ul style="list-style-type: none"> • Ways to ensure the durability of this vital public health function must be identified: • funding must be ensured, maybe through a permanent donor pool. (A percentage of resources diverted to the pool); • the National Institute of Health must be strengthened, making it capable of detecting threats and projecting responses where needed. | <ul style="list-style-type: none"> • Responding effectively to emergencies restricts disruptions in routine health services and induces trust in the health system. • Investing in EP&R may weaken the health system, if poaching its capacity and proceeding in isolation. Otherwise, it can strengthen the health system, by deploying assets benefiting services across the board. |
| | <ul style="list-style-type: none"> • Performing local management structures are the foundation of any health system. Their development must be encouraged by long-term support. • Assessing capacity of state departments of health and strengthening their capacities is the first step to improve health systems in Somalia. | <ul style="list-style-type: none"> • Given the highly decentralized management of the Somalia health sector and the large number of health authorities and their territorial dispersion, progress will be costly and slow. • Putting in place management strengthening hubs in selected market towns/large districts might be the first step towards identifying needs, learning by doing and refine approaches. <p>Risks:</p> <ul style="list-style-type: none"> • local management teams starved of resources cannot apply skills learned in the classroom; • conventional management strengthening initiatives remain ill-adapted to Somali conditions; • successful experiences are not recognized as such. | <ul style="list-style-type: none"> • Management strengthening initiatives must be thoroughly designed and tested, drawing on many past experiences in this field. • Approaches must be fully contextualized, building on existing foundations (often informal). • Management capacity is already available at many sites, but is distributed between private providers, NGOs and charities. • Resources must be allocated predictably and without interruptions, beyond the usual project time frame. | <ul style="list-style-type: none"> • To fulfil their potential, the other strategic drivers need capable health management teams, endowed with adequate decision space and sufficient resources. • Public-private partnerships must be encouraged, rather than spurned by health officials. |
| Restructuring the health workforce | <ul style="list-style-type: none"> • By improving skills, addressing HRH imbalances and productively managing the workforce. • Given the complexity of the HRH field, the huge investments needed and the delay occurring between interventions and results, a thorough study of the main issues is required. | <ul style="list-style-type: none"> • Being HRH development a slow process, which takes decades to materialize, putting in place the mechanisms to sustain it takes strategic precedence. • Funding must be adequate and sustained over many years, before progress can be measured. A pool fund might protect HRH development from the vagaries of both domestic and donor financing. | <ul style="list-style-type: none"> • Stronger and comprehensive information is required. Routine data are not sufficient to plan, regulate, manage and evaluate the mixed and fragmented health workforce. The establishment of an HRH observatory is recommended. | <ul style="list-style-type: none"> • HRH development is influenced by each component of the health system, and in turn shapes them all. Moreover, the health workforce is part of society, and is influenced by it. |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|--|---|--|---|
| Upgrading the health workforce has four pillars (all interlinked): | <ul style="list-style-type: none"> Regulation: accreditation of training institutions and certification (or licensing) of health workers. | <ul style="list-style-type: none"> Challenging: the best performing training institutions should be rewarded, while the worst ones identified and sanctioned/penalized in the competitive labour market. Category profiles, job descriptions, career paths need to be revised and standardized to allow for a fair and objective certification process. Qualifications earned abroad will need to be converted into Somali ones (a demanding process, maybe better left to a later stage). <p>Risks:</p> <ul style="list-style-type: none"> unrealistic standards cannot be adhered to by institutions and professionals; under-resourced regulatory bodies serve the interests of whoever funds them; unlicensed health workers practice off-radar. | <ul style="list-style-type: none"> Criteria for accreditation and certification must be applicable and relevant in the Somali health field. Thus, international standards must be tested, modified and refined. A powerful lever to motivate training institutions to enhance their performance is the introduction of licensing examinations, provided they are fair and relevant. Accreditation and licensing might be entrusted to reputable third-party bodies. Incompetent health workers – formally qualified or not – should be offered training opportunities to upgrade their skills. | <ul style="list-style-type: none"> Regulatory regimes ignoring links within and outside the health system are counterproductive, or unenforceable. To improve training programmes, insights from employers about job description and performance are needed. Task-shifting – as practiced at the service delivery point – should be considered in the design of training programmes. Adequate funding must be guaranteed to regulatory bodies, which need time to establish their functions and acquire a reputation. |
| | <ul style="list-style-type: none"> Production: strengthening training programmes and producing under-represented categories. | <ul style="list-style-type: none"> A sample of the training programmes of the key categories should be assessed and discussed with prominent training institutions, encouraging their convergence. Underrepresented categories must be studied in some detail to identify ways to expand their production and strengthen their competences. Bottlenecks in career progression must be addressed by training institutions in collaboration with funding bodies and health authorities. <p>Risk:</p> <ul style="list-style-type: none"> training of under-skilled health professionals continues to exceed absorption capacity. | <ul style="list-style-type: none"> Flexible funding is needed to promote the training of scarce professionals (including medical specialists), counteracting market preferences. Training outputs over 5 and 10 years must be appraised against projected staffing needs. Mismatches must be conveyed to the public to training institutions and to funding bodies. | <ul style="list-style-type: none"> The quality of training will impact on the quality of the services provided by new health professionals. Perverse incentives can however work against good skills. The results of competently designed and carried out licensing examinations will provide valuable indications for improving training programmes and actual practice. |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|------------------|--|--|---|--|
| | <ul style="list-style-type: none"> Utilization: Deployment is constrained by a host of factors, including security, working conditions, social norms and career prospects. Competent management and supervision must reward performance. | <ul style="list-style-type: none"> Adequate incentives are needed to motivate staff to take up hardship jobs. Productivity must take precedence over staffing norms. <p>Risks:</p> <ul style="list-style-type: none"> HRH management remains dominated by administrative mindsets and norms, disconnected from events on the ground; poor routine data convey a distorted picture of the HRH field, encouraging wrong decisions. | <ul style="list-style-type: none"> Effective HRH management is information intensive, thus demanding and costly. Adequate skills and resources are required to improve this crucial aspect. Underpaid health professionals will perform poorly, their competences notwithstanding. Realistic arrangements are needed to remunerate health workers according to their market value, productivity and deployment. Performance depends on the working environment, which has to improve – as much as the skills and the motivation of health workers. | <ul style="list-style-type: none"> Health workers left to fend for themselves will practice according to customer preferences, whatever their health worth. |
| | <ul style="list-style-type: none"> Maintenance, by effective supportive supervision and in-service training. These two functions should work together (which is seldom the case). Supervision – a critical function usually neglected – needs to be overhauled through a dedicated programme. IT offers opportunity to slash supervision costs and multiply encounters. In-service training needs to be restructured, by focusing on health workers and the problems they face, rather than on health services. | <ul style="list-style-type: none"> Hands-on practice in the workplace is always to be preferred to workshops and other classroom-based events. <p>Risks:</p> <ul style="list-style-type: none"> incompetent supervision is carried out piecemeal, without tangible benefits but at high cost; ineffective in-service events continue to be held, due to the preferences of organizers and participants. | <ul style="list-style-type: none"> Effective supervision requires a balanced skills mix to be acquired hands-on; technical competence, interpersonal ability, tact and understanding of demanding situations. In-service training must be tailored to tackle diverse professional shortcomings. Competent professionals need maintenance training to keep their skills and upgrade them. In contrast, under-trained workers need well-crafted upgrading training programmes. | <ul style="list-style-type: none"> Competent supervision will inform stakeholders about the main service provision shortcomings, and in turn suggest appropriate corrective measures. In-service training opportunities must be offered to private health care employees, who tend to be neglected by interventions in this field. |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|--|---|--|--|
| Rationalizing the pharmaceutical field | <p>By incrementally introducing feasible regulatory measures:</p> <ul style="list-style-type: none"> Quality assurance controls (first outsourced to a reputable foreign laboratory) would discourage the circulation of substandard medicines. Meanwhile, steps towards the establishment of a laboratory in country could be taken. Strengthening warehousing and transportation capacity, public and private. Engaging informal vendors of medicines to enhance their performance. | <ul style="list-style-type: none"> Regulating the thriving private market is difficult, but potentially rewarding. Incentives rather than administrative controls have to be relied upon. Supporting private dealers and pharmacists in upgrading their quality standards might provide public-good returns. Quality control labs, approved by international standard-setting institutions, may be private or public? <p>Risks:</p> <ul style="list-style-type: none"> unenforceable regulatory provisions fuel rent-seeking behaviour; a large portion of pharmaceutical imports escape quality controls; the training imparted to informal drug sellers fails to change their behaviour, in the absence of adequate incentives. | <ul style="list-style-type: none"> Adequate resources are needed to ensure effective regulatory functions. Regulatory fees must be used with caution, given their potential side-effects. The cost of complying with regulatory provisions must be affordable to operators. An understanding of the market in which informal vendors of medicines and medical devices operate will inspire measures aimed at increasing their knowledge, modifying their behaviour, offering recognition and informing the public. | <ul style="list-style-type: none"> By exposing substandard medicines to the public, quality controls would be synergistic with the large-scale competitive procurement of generics. Containing the circulation of substandard medicines and limiting the deterioration of quality products through enhanced warehousing would raise quality of care. Engaging informal vendors of medicines will provide valuable information about the pharmaceutical market, with a positive impact on policies meant to govern it. |
| | <p>By streamlining fragmented supply chains:</p> <ul style="list-style-type: none"> Encourage the merging of existing procurement systems of generic medicines of proven quality into larger, more efficient operations. Support initiatives aimed at rationalizing private procurement and distribution, as the proposed franchising network (Somalia Economic Update, 2020). Assess the respective performance of the existing schemes, in order to support and expand the most promising ones. | <ul style="list-style-type: none"> Public procurement mechanisms have run into serious problems virtually everywhere. Flexibility, redundancy and managed competition are desirable attributes of integrated supply systems, particularly in unstable settings, such as Somalia. Quality generics may be more costly than questionable competitors, which would be preferred by public and private buyers. <p>Risks:</p> <ul style="list-style-type: none"> disconnected procurement arrangements are consolidated into fewer cumbersome, unresponsive and expensive mechanisms, due to fiduciary risk concerns; vested interests impede progress in a multi-million business sector. | <ul style="list-style-type: none"> To manage a pluralist and so far, deregulated pharmaceutical market, health authorities need to acquire technical capacity as well as reputation. A funding pool might be created to purchase medicines in large amounts from existing sources. This experience might later inform the introduction of new funding arrangements (if desirable). Non-profit pharmaceutical suppliers might be established in each Member State. | <ul style="list-style-type: none"> By reducing the prices of medicines, efficient procurement would boost service demand and in turn, equity. Medicines available and affordable at the service delivery point would enhance quality of care. The rational use of medicines, which would greatly reduce waste and iatrogenic effects, must be promoted as well. |

| Strategic driver | Policy options (not mutually exclusive) | Feasibility and risks | Capacity and resource requirements | Linkages |
|---|---|---|---|--|
| Steering physical infrastructure investments | <ul style="list-style-type: none"> By managing gaps and overlaps in the existing health care network which are results of decades of piecemeal investments and spontaneous developments. | <ul style="list-style-type: none"> A slow process, requiring sound, updated information and negotiation capacity to influence autonomous investors and in turn inform the public about the choices made. Data must cover public, private and hybrid facilities, with the respective equipment and services to offer a valid picture of the health care network. <p>Risks:</p> <ul style="list-style-type: none"> business, political, kinship, siloed and professional considerations converge to expand an already fragmented, inefficient and poor-quality health care network; scarcity of funds – or their earmarking – impedes investments to fill identified major gaps. hospitals getting the lion's share of future investments will also absorb most health care resources, in this way starving preventive and primary services; unwieldy, costly and demanding building license or accreditation requirements motivate private entrepreneurs to bribe their way out; duplication/competition with already existing infrastructure; neglecting existing private provision capacity. | <ul style="list-style-type: none"> Considerable analytical and networking skills are needed to collect valuable data and turn them into actionable information. Functional, dynamic assessments of local health care networks and of the facilities composing them are preferable to territorial, static ones. Particular attention must be paid to urban and peri urban settings, including IDPs settlements. By aggregating privileged and derelict population groups, service uptake data may hide large differentials. The mobility of users informed about availability, price and perceived quality of health services must be considered in making health investment decisions. Referral flows must be tracked, first step to manage them through positive and negative incentives. | <ul style="list-style-type: none"> The resource needs of the projected physical health care network must be estimated and conveyed to the concerned decision-makers. Related to accreditation and quality improvement interventions. Synergistic with measures intended to enhance information management. If amended, existing redundancies would free resources to fill existing service gaps. |

Implementation arrangements

The HSSP III follows the “Prioritization of Health Policy Actions in Somali Health Sector” (approved by the Health Advisory Board in September 2014). It builds on the foundations from the HSSP I & II to identify priority actions for implementation and for specific disease and programme initiative. The EPHS delivery serves as the foundation of the health system development and the vehicle for achieving UHC in Somalia. State MoHs shall be responsible in the planning, implementation, monitoring and evaluation of the EPHS in their respective states.

Governance/leadership of the plan

The plan as well as its components and accompanying documents – the GFF-supported Somalia Investment Case for Health and the Federal Member States operational plans – are to be coordinated and managed by the directorate of planning in the FMOH. Specific priority programmes for immunization, HIV/AIDS, TB and malaria already have the requisite management structures and should be able to liaise closely with the directorate of planning. The state MoHs will also require identifying a directorate or section responsible for the plan and to manage the implementation process. The policy and planning department of the MoH shall be responsible for the coordination with donors, private sector organizations, NGOs and federal Member States to support the implementation of this strategic plan.

The FMOH will also assist the Member States in development of individual plans, mobilize technical expertise both internally or externally, issue annual progress reports, hold biannual meetings, coordinate with research institutions, and prepare for the revision of the strategic and operational plans if required.

Relationship between various instruments of planning

There are several documents available for the health sector for Somalia, including policy directions, disease specific policies and strategies, programme documents and agreed frameworks with partners. The positioning of the HSSP III needs to be made clear within this environment as the overarching document for the development of a functioning health system that is responsive to the needs of the Somali population.

The HSSP III will focus on the general directions for the health sector and provide policy options for key strategic areas. The health system in Somalia is currently transitioning from a humanitarian focused and emergency response to a more development, stable and forward-looking system. In this context, for the country’s immediate needs, the MoH, in collaboration with the GFF, the World Bank, the UN agencies, multilateral and bilateral donors, and NGOs have developed the first Somali investment case for the health sector. The investment case outlines the immediate needs for the health system development with the focus on the delivery of prioritized cost-effective interventions across the five delivery levels of the health care system in Somalia.

The adoption of the revised EPHS as the flagship of health system development has made it possible for the health partners to align their support to government priorities as outlined in the EPHS and the GFF-supported investment case for the health sector. This was captured in Caafimaad Project of the MoH which will be financed by the World Bank. Other development projects financed by other partners will align to the priorities in the investment case and is being guided to follow the similar implementation modality as the Damal Caafimaad Project.

Once the national HSSP III is approved and endorsed, the state MoHs the necessary adaptation to start their process of preparing state specific plans based on the identified priorities. All these documents together should be considered as part of the HSSP III.

It is proposed that the HSSP III, together with key documents, the EPHS and the Somalia Investment Case for the Health Sector, align to define the strategic directions and the immediate actions needed to expand the health services in Somalia. This will also allow the development partners to align their resources to the government.

Monitoring and evaluation framework

Mechanisms must be put in place to ensure that the strategic plan evolves in response to changing conditions and the implementation experience. A dedicated effort is needed to equip the health care arena with analytical capacity of detecting the changes occurring during the period covered by the strategic plan.

Guiding principles

- Monitoring and evaluation must adopt a sector-wide perspective, one that identifies and tracks all important events and processes. Within this Somalia-wide framework, local situations must be studied in tune with priority interventions chosen by Member States. Promising innovations should be supported, and studied on a small scale before they are expanded. Other Member States might host different pilots and take the lead in the corresponding area.
- Service uptake needs to be disaggregated by population groups. Some survey data are already split by urban, rural and nomads. However, urban users of health services often include city dwellers as well as IDPs living in peri urban areas. Aggregating the data of these population groups is misleading and should be avoided as much as possible. Additionally, the provenance of service users must be assessed.
- Trends must be monitored to capture the progress registered in supplying health services, as well as their uptake. Given the volatility of population figures, trends would be better monitored by using absolute output figures. By tracking the availability of health services and their respective consumption, progress in implementing the strategy will be monitored.
- The chosen indicators must be coherent with the strategic drivers, as well as with realistic time frames. Monitoring and evaluation must also capture developments not encompassed by the strategic plan, but impacting on its implementation, or imposing its revision.
- Most aspects of great consequences, such as health care demand, productivity and quality of care, cannot be monitored through routine indicators only. Dedicated surveys are needed, first to establish a baseline, and later to monitor

the impact of the chosen interventions. Surveys must be standardized – building on the many tested tools available – and a contingent of surveyors trained in their use.

- Monitoring and evaluation have to be enriched by insights gained by researchers and field operators, be they written or obtained through personal exchanges.

Below, quantitative and qualitative indicators are proposed for consideration. They have to be tested and refined. If convenient, others could replace the proposed ones. This indicator set will have to be periodically revisited in light of the activities underway and those in the pipeline, and of the reliability and relevance of the observations made.

Trends and indicators must be aggregated at regional as well as disaggregated at state/local level. Operational plans will have to add other, mostly quantitative indicators, intended to monitor the activities foreseen by them.

Collecting and analysing information at the proposed level would constitute a quantum leap in the understanding of events and help decision-makers allocate resources (be they funds, personnel, facilities or supplies), as well as assess performance. The implementation of the proposed activities should strengthen the related information which in turn would inspire stronger decisions and better practices.

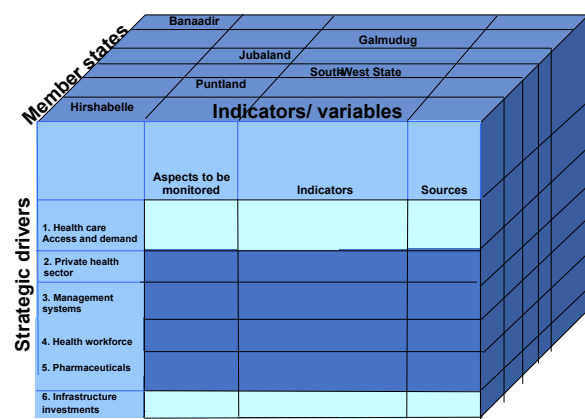
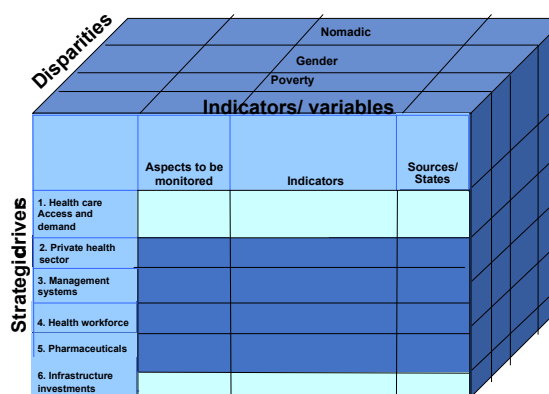
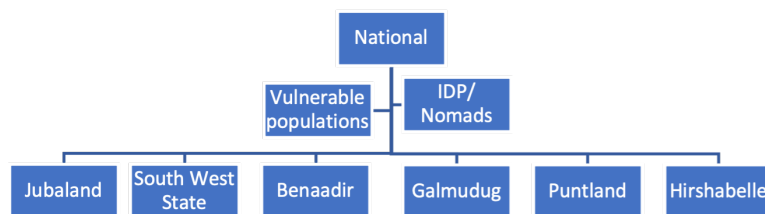
Multi-dimensional Approach to monitoring

An important aspect of monitoring the HSSP III matrix is that it needs to be multi-dimensional. Firstly, there is geographical variation, hilly areas, plains, highlands, coastal areas with varied climate ranging from hot and humid to arid desert. Then there are considerations for the population groups; urban populations, IDP, nomadic or semi-nomadic pastoralists, farmers and fishers. Another group is the vulnerable population groups, socially disadvantaged, females, children and elderly. This necessitates a need to look at the results with a different lens to understand the effects of interventions on these groups and not to be misled by the average result, which hides these disparities.

One approach could be to use specific indicator sets to look for these variations and compile them into the final matrix, however this approach has chances that the disaggregated data is not focused by decision-makers and the movement of the average is touted as the results to show performance.

Another method of visualising the relationship is to look at the matrix as a three dimensional construct.

The nation wide matrix is composed of monitoring matrices from the Member States and as each state may have adopted different policy options, not all the drivers and indicators need to be reported; however, at the national level it is imperative that the whole matrix is compiled and monitored to allow for evidence based decisions. The relationship between the matrices at the Member State level and national level is presented in the figure.



| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|---|---|---|---|--|
| Boosting health care access and demand | <ul style="list-style-type: none"> Service uptake, by setting, access and population group | <ul style="list-style-type: none"> Service outputs, per year: <ul style="list-style-type: none"> fully immunized children; number of malnourished children identified and successfully managed; deliveries attended by skilled personnel; number of outpatient contacts; cases of communicable diseases timely and correctly identified and managed; and ... Barriers (cost, availability etc.). User provenance. | <ul style="list-style-type: none"> Routine data Registers and exit interviews Surveys Reports | <ul style="list-style-type: none"> Figures must include services by private providers. Indicators related to vertical programmes should not be regarded as illustrative of health system's performance. The provenance of users informs about their mobility and preferences, influenced by the cost and reputation of the accessed services. Special attention must be given to the service consumption of disadvantaged population groups. See below health-seeking under indicators heading |
| | <ul style="list-style-type: none"> Quality of care | <ul style="list-style-type: none"> Diagnostic, prescription and advice patterns. Availability of tracer essential medicines. Quality of tested medicines. Availability of apex health professionals and key equipment. Working environment, in a sample of health facilities. Workloads, in a sample of health facilities. Proportion of post-surgery infections. Prices of services of adequate quality, across levels. | <ul style="list-style-type: none"> Supervision findings Surveys | <ul style="list-style-type: none"> If competently done, accreditation and licensing would provide additional information about quality of care. Better quality of care, if perceived by users, would increase utilization and in turn revenues for fee-charging facilities. |
| | <ul style="list-style-type: none"> User satisfaction | <ul style="list-style-type: none"> Health-seeking decisions. | <ul style="list-style-type: none"> Population surveys | <ul style="list-style-type: none"> The non-users must be surveyed alongside users. |
| Engaging private health care providers | <ul style="list-style-type: none"> Market-harnessing measures: <ol style="list-style-type: none"> Disclosure Franchising Licensing and accreditation Contracting Partnership in planning | <ul style="list-style-type: none"> Number of health care providers engaged by each mechanism, over time. Number of informal private providers reached by supportive measures. Performance improvements observed. Utilization of private health services enrolled in each mechanism. Public-private synergies attained – such as service redundancies reduced, and gaps filled – with their results. | <ul style="list-style-type: none"> Reports by the respective authorities / mechanisms Surveys Supervision Joint assessments | <ul style="list-style-type: none"> The effects of intervening in this field will be detectable only after some time. Any assessment of the behaviour of private providers must include also public ones, because the two arms of the health care market influence each other. |

| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|---|--|--|---|--|
| | <ul style="list-style-type: none"> Introducing administrative controls | <ul style="list-style-type: none"> Regulatory bodies created, funded and operational. Soundness and applicability of the regulatory provisions issued. Inspections carried out and measures taken. Compliance by inspected private providers. Improvements detected in the performance of regulated providers. Side-effects of the regulatory regime. | <ul style="list-style-type: none"> Reports by regulatory authorities Feedback from private providers Independent assessments | <ul style="list-style-type: none"> The behaviour of private providers outside of the regulatory regime must be understood (to strengthen provisions and their enforcement). The benefits and the costs to regulators of enforcing the adopted provisions and to regulated providers to abide to them need to be studied. |
| Strengthening management systems | <ul style="list-style-type: none"> Informed decision-making | <ul style="list-style-type: none"> Information influence on management processes, at different levels. Opinion of decision-makers on the health information available. Circulation of unfounded beliefs accepted as facts by many. Studies commissioned to fill information gaps. Quality (reliability, completeness, usefulness and timeliness) of the collected information. Dissemination of the collected information. | <ul style="list-style-type: none"> Participant observation Reports Opinion polls Review of documents and meetings Information repositories | <ul style="list-style-type: none"> The relevance to health system's development of the studies carried out must be assessed. Unstated decisions must be considered alongside official ones. Sound analysis must include also risks and side-effects – alongside benefits – to be helpful. |
| | <ul style="list-style-type: none"> Aid architecture and management, at federal and state levels | <ul style="list-style-type: none"> Decisions taken at coordination venues. Consistency of donor agendas with domestic priorities. Gaps and overlaps in donor allocations. Quality of aid-related information. Aid management tools under discussion or established. Aid-related decisions taken in country, vis-à-vis those taken abroad. Execution of selected aid programmes. | <ul style="list-style-type: none"> Participant observation Review of reports Informants | <ul style="list-style-type: none"> Information about donors operating outside coordination circles is scarce, but essential to make sense of the whole aid horizon. The preparation and follow-up of coordination meetings are instructive of their worth. |

| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|------------------|---|--|--|--|
| | <ul style="list-style-type: none"> EP&R | <ul style="list-style-type: none"> National Institute of Health funded, staffed, equipped and operational. National Institute of Health branches opened and operational in Member States. Quality of epidemiological bulletins. Dependence on external support, over time. Continuity of operations, over time. Promptness and effectiveness of the responses to emergency threats. Integration of the EP&R with the health system. Breadth of the threats addressed, and their relevance in the Somali context. | <ul style="list-style-type: none"> Reports Participant observation Independent evaluation | <ul style="list-style-type: none"> The appropriateness of the responses in Somali settings must be assessed, given the risk of adopting unsustainable imported models, supported by generous but short-term inputs. Grassroots responses to threats by communities, local authorities, volunteers, NGOs and private actors must be studied as well in order to support positive responses and limit the waste or harm caused by others. Two-way communication is essential to manage effective response networks. Channels must be kept open between crises to be promptly activated. For instance, the community health workers who contributed to the response to COVID-19 should remain ready for the next threat. |
| | <ul style="list-style-type: none"> Local management capacity | <ul style="list-style-type: none"> Number of local health authorities and facilities funded, staffed and equipped, which show acceptable levels of performance, better if accredited by a reputable body. Knowledge held by local health authorities and managers of facilities. Resource allocation in the operational area, and respective outputs. Scope and strength of partnerships between public and private bodies, at local level. Comprehensiveness, efficiency and quality of the provided services. | <ul style="list-style-type: none"> Reports Supervision Informants | <ul style="list-style-type: none"> The performance of vertical programmes should not be regarded as indicative of local management capacity. Specific indicators will be chosen according to the management strengthening interventions eventually launched. A comprehensive view of the local health system is needed in assessing management capacity. Actual functions – even if executed in unconventional ways – say more about management performance than adherence to formal procedures. |

| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|---|--|--|--|---|
| Restructuring the health workforce | <ul style="list-style-type: none"> Regulation: accreditation of training institutions and certification (or licensing) of health workers. | <ul style="list-style-type: none"> Adapted accreditation and licensing criteria formulated and tested. Regulatory bodies funded, staffed and operational. Job descriptions and training programmes are revised to enable meaningful licensing procedures. Number of training institutions accredited, by training programme. Number of health professionals licensed, by category. Student enrolment of accredited training institutions/programmes, vis-à-vis the others. Employment of licensed health professionals, vis-à-vis the others. | <ul style="list-style-type: none"> Assessment of training institutions (including the skills of their trainees) Expert appraisals Employers' assessment of health workers competences Supervision findings | <ul style="list-style-type: none"> See above indicators related to regulation. Regulatory bodies need to acquire skills incrementally, through trial and error, starting with the least demanding tasks. Coercive measures should be resisted, until most parties concerned feel ready to respect the enacted norms. Improving training standards to pass the accreditation bar would be facilitated by the availability of sound programmes and materials for students and teachers alike. Adapted regulatory provisions must be conceived for informal health workers, via supportive measures followed by training programmes intended to confer professional qualifications, even if of low level. |
| | <ul style="list-style-type: none"> Production: strengthening training programmes and producing under-represented categories. | <ul style="list-style-type: none"> Number of students enrolled, by category, institution and location. Projected number of new health professionals entering the health labour market over the coming years, by category. Appropriateness of the adopted training programmes, against labour market needs. Quality of the imparted training, in a sample of institutions and courses. Number of trainees unable or unwilling to find a professional employment. | <ul style="list-style-type: none"> Surveys Reports Supervision findings | <ul style="list-style-type: none"> Subsidies might be granted to training institutions producing competent cadres required by the health system. The convergence of training institutions towards the use of similar programmes and materials, chosen for their quality, should be encouraged. The expansion of training capacity in states now deprived of it should be supported. Duties executed in the workplace must be considered in the design of job descriptions and training programmes. |
| | <ul style="list-style-type: none"> Utilization: Deployment Performance | <ul style="list-style-type: none"> Staffing patterns, by health facility, state, setting and ownership. Ghost workers and absenteeism. Active health workers not included in the payroll. Workloads for key categories. Hiring patterns, including positive and negative incentives, offered in different settings. Professional qualifications/skills versus actual job duties executed. | Surveys Supervision findings Reports | <ul style="list-style-type: none"> Empirical criteria are needed to classify both health facilities and workers, giving more weight to the functions provided and executed than to official attributions. Direct observation of operations – in representative sample of facilities – is needed to estimate staffing patterns and workloads. The causes of understaffing and under-utilization must be explored. |

| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|---|---|--|---|---|
| | <ul style="list-style-type: none"> Maintenance, by effective supervision and in-service training | <ul style="list-style-type: none"> Supervision patterns. Supervision perceptions. Number and duration of the supervisions carried out. Focus of the supervisions carried out. Impact of supervision findings on in-service training, and the other way around. Person and day of in-service training carried out, by category or service, level of care and state. Contents, inputs, process and relevance of in-service training events. | <ul style="list-style-type: none"> Participant observation Interviews Surveys Supervision guidelines and training materials Supervision reports In-service training reports | <ul style="list-style-type: none"> Given the dispersion of the information related to supervision and in-service training, dedicated studies are needed. The measures taken to equip supervisors with adequate skills must be assessed. The issues overlooked by supervisions and in-service training events must be identified and covered. In-service training opportunities must be offered also to health workers usually excluded from them, with activities tailored to their duties. |
| Rationalizing the pharmaceutical field | <ul style="list-style-type: none"> Quality assurance controls | <ul style="list-style-type: none"> Quality controls carried out, by laboratory, preparation, supplier, collection location. Quality control findings, discrimination is between fake/substandard and genuine meds and substandard medicines. Soundness of the measures adopted in light of the quality control findings. Reactions of the pharmaceutical market to quality controls. | <ul style="list-style-type: none"> Reports Participant observation Informants | <ul style="list-style-type: none"> The reputation of the bodies charged of quality controls is critical to the acceptance of their results. Disclosing quality control results to the public – in an appropriate way – might be more effective than issuing sweeping provisions, likely to be ignored. The prices of medicines must be monitored to gauge the impact of quality controls. |
| | <ul style="list-style-type: none"> Warehousing and transportation capacity, public and private | <ul style="list-style-type: none"> Warehousing conditions, across levels, ownership and states. Transportation standards, affecting the conservation of medicines. | <ul style="list-style-type: none"> Participant observation Informants | <ul style="list-style-type: none"> To be linked to quality controls, which should detect deteriorated medicines. |
| | <ul style="list-style-type: none"> Engaging informal vendors of medicines | <ul style="list-style-type: none"> Quality and penetration of interventions targeting informal vendors of medicines. Behaviour of informal vendors of medicines, by type of intervention. | <ul style="list-style-type: none"> Participant observation Reports Surveys | <ul style="list-style-type: none"> Interventions aimed at enhancing the performance of informal vendors must encompass several business-related aspects, beyond their knowledge: profit, recognition and customer demands. |

| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|---|--|---|---|--|
| | <ul style="list-style-type: none"> Supply chains | <ul style="list-style-type: none"> Performance of private supply chains, in relation to product quality, prices and market coverage. Performance of public (aid-linked) supply chains, in comparison to private ones. Prices of quality-assured marker medicines against international comparators, by supply chain, setting and state. | <ul style="list-style-type: none"> Surveys Reports Market assessments | <ul style="list-style-type: none"> Harnessing the market by competitively purchasing low-cost quality medicines from strong private dealers appears a better option than competing with them. Establishing public procurement mechanisms entails long-term investments of uncertain success. Chains supplying street sellers, itinerant vendors, community health workers and nomad link workers must be included in any pharmaceutical supply appraisal. |
| Steering physical infrastructure investments | <ul style="list-style-type: none"> Gaps and overlaps in the health care network | <ul style="list-style-type: none"> Quality and comprehensiveness of the available data about health facilities and the services provided by them. Health network structure over time: hospitals vis-à-vis PHC facilities and hybrid ones. Gaps filled and overlaps corrected, with related explanatory information. Referral flows, within Somalia and outside it, for a sample of facilities and patients. Health service delivery contracted out to private providers. | <ul style="list-style-type: none"> Registers Reports Supervision visits Surveys | <ul style="list-style-type: none"> Caution is needed before encouraging public investments in deprived areas where demand is weak. Spontaneous referral flows must be discriminated from structured ones. Investments in IDP settlements must be preceded by a thorough assessment of their permanence. In dubious cases, temporary structures are preferable to permanent ones. Local health networks centred on market towns should be studied, in order to rationalize them through tailored investments. |

Next steps

Next steps to be taken in the coming 6–12 months:

The FMoH should develop a costed operational plan with timelines and monitoring indicators for Somalia-wide interventions.

Formulation of costed state specific strategic or operational plans in each federal Member State to translate the strategic drivers into realistic operational plans in light of respective priorities and context. This round will provide valuable insights for revisiting the national strategic plan.

The FMoH shall then compile these plans into a consolidated national plan with relevant monitoring indicators and costing estimates.

Engaging the main stakeholders to ensure their support. The creation of a dedicated pool fund would be the best way to kickstart implementation;

however, other measures consistent with the strategic plan might be covered by other funding sources. Once the capacity and resource envelope made available by stakeholders is estimated with some confidence, both ambition and drivers of the strategic plan need to be adjusted.

Establishing a strategic planning unit to monitor developments, spot opportunities and threats, conceive new measures in response to changing conditions, communicate with stakeholders, and promote collaboration. This unit will be first created at federal level. Later, branches will be opened within state health authorities.

Collecting a solid baseline of data related to the main drivers to assess progress.

Annex A. Policy matrix for federal level

| Strategic driver | Policy options (not mutually exclusive) | Options identified for federal intervention | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|---|--|--|-----------------|--|-----------------|
| Boosting health care access and demand | <ul style="list-style-type: none"> Lowering existing barriers: extending opening hours, reducing the cost incurred by patients, ensuring regular supplies, motivating staff to raise their performance, and improve communication. Cultural norms must be considered. Simply adding facilities and staff will not be sufficient. Alongside conventional supply-side measures, innovative approaches aimed at encouraging demand are needed. | | | | |
| | <ul style="list-style-type: none"> Enhancing the quality of care requires protracted efforts on multiple fronts to induce progress. | | | | |
| Engaging private health care providers | <ul style="list-style-type: none"> Short-term: through measures aimed at harnessing the market: <ol style="list-style-type: none"> Disclosure Franchising Licensing and accreditation Contracting Partnership in planning. To be used successfully, incentives demand a sound grasp of the health care market and of providers' behaviour. | | | | |
| | <ul style="list-style-type: none"> Long term: by progressively introducing administrative controls, which together will constitute a hard regulatory regime. | | | | |

| Strategic driver | Policy options (not mutually exclusive) | Options identified for federal intervention | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|----------------------------------|---|--|-----------------|--|-----------------|
| Strengthening management systems | <ul style="list-style-type: none"> Fostering a culture of informed decision-making, through improved information management. The available health information is quite rich, having improved over the years. It is not used to its full capacity by decision-makers. Moreover, memory is undermined by the quick turnover of stakeholders. Newcomers tend to launch new study rounds, ignoring the wealth of personal and collective knowledge already available in the environment. | | | | |
| | <ul style="list-style-type: none"> Improving aid architecture and management to optimize the use of external resources and attract additional ones. Given the resource requirements of all the activities foreseen by the strategic plan, their success will largely depend on effective aid management. However, aid management has to remain a means to pursue health systems developments. | | | | |
| | <ul style="list-style-type: none"> EP&R are vital in a crisis-prone country. Consolidating procedures, capacity and resources, now split across programmes, such as EWARN, polio eradication and the COVID-19 response, is the way forward. Warning: several past attempts at establishing permanent emergency surveillance and response capacity have been short lived. The ongoing efforts to establish and implement an IDSR must be expedited. | | | | |
| | <ul style="list-style-type: none"> Performing local management structures are the foundation of any health system. Their development must be encouraged by long-term support. | | | | |

| Strategic driver | Policy options (not mutually exclusive) | Options identified for federal intervention | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|---|--|--|-----------------|--|-----------------|
| Restructuring the health workforce | <ul style="list-style-type: none"> By improving skills, addressing HRH imbalances and productively managing the workforce. | | | | |
| Upgrading the health workforce has four pillars (all interlinked): | <ul style="list-style-type: none"> Regulation: accreditation of training institutions and certification (or licensing) of health workers. | | | | |
| | <ul style="list-style-type: none"> Production: strengthening training programmes and producing under-represented categories. | | | | |
| | <p>Utilization:</p> <ol style="list-style-type: none"> Deployment is constrained by a host of factors, including security, working conditions, social norms and career prospects. Competent management and supervision must reward performance. | | | | |
| | <ul style="list-style-type: none"> Maintenance, by effective supervision and in-service training. These two functions should work together (which is seldom the case). | | | | |
| Rationalizing the pharmaceutical field | <p>By incrementally introducing feasible regulatory measures:</p> <ol style="list-style-type: none"> Quality assurance controls (first outsourced to a reputable foreign laboratory) would discourage the circulation of substandard medicines. Meanwhile, steps towards the establishment of a laboratory in country could be taken. Strengthening warehousing and transportation capacity, public and private. Engaging informal vendors of medicines to enhance their performance. | | | | |

| Strategic driver | Policy options (not mutually exclusive) | Options identified for federal intervention | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|---|---|--|-----------------|--|-----------------|
| | <p>By streamlining fragmented supply chains:</p> <ul style="list-style-type: none"> a. Encourage the merging of existing procurement systems of generic medicines of proven quality into larger, more efficient operations. b. Support initiatives aimed at rationalizing private procurement and distribution, as the proposed franchising network (3). c. Assess the respective performance of the existing schemes, in order to support and expand the most promising ones. | | | | |
| Steering physical infrastructure investments | <ul style="list-style-type: none"> • By managing gaps and overlaps in the existing health care network which are results of decades of piecemeal investments and spontaneous developments. | | | | |

Annex B. Policy matrix for Member States

| Strategic driver | Policy options (not mutually exclusive) | Options identified for state | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|---|--|---------------------------------|-----------------|--|-----------------|
| Boosting health care access and demand | <ul style="list-style-type: none"> Lowering existing barriers: extending opening hours, reducing the cost incurred by patients, ensuring regular supplies, motivating staff to raise their performance, and improving communication. Cultural norms must be considered. Simply adding facilities and staff will not be sufficient. Alongside conventional supply-side measures, innovative approaches aimed at encouraging demand are needed. | | | | |
| | <ul style="list-style-type: none"> Enhancing the quality of care requires protracted efforts on multiple fronts to induce progress. | | | | |
| Engaging private health care providers | <ul style="list-style-type: none"> Short-term: through measures aimed at harnessing the market: <ol style="list-style-type: none"> Disclosure Franchising Licensing and accreditation Contracting Partnership in planning. To be used successfully, incentives demand a sound grasp of the health care market and of providers' behaviour. | | | | |
| | <ul style="list-style-type: none"> Long term: by progressively introducing administrative controls, which together will constitute a hard regulatory regime. | | | | |

| Strategic driver | Policy options (not mutually exclusive) | Options identified for state | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|---|---|---------------------------------|-----------------|--|-----------------|
| Strengthening management systems | <ul style="list-style-type: none"> Fostering a culture of informed decision-making, through improved information management. The available health information is quite rich, having improved over the years. It is not used optimal by decision-makers. Moreover, memory is undermined by the quick turnover of stakeholders. Newcomers tend to launch new study rounds, ignoring the wealth of personal and collective knowledge already available in the environment | | | | |
| | <ul style="list-style-type: none"> Improving aid architecture and management to optimize the use of external resources and attract additional ones. Given the resource requirements of all the activities foreseen by the strategic plan, their success will largely depend on effective aid management. However, aid management has to remain a means to pursue health systems developments. | | | | |
| | <ul style="list-style-type: none"> EP&R are vital in a crisis-prone country. Consolidating procedures, capacity and resources, now split across programmes, such as EWARN, polio eradication and the COVID-19 response, is the way forward. <p>Warning: several past attempts at establishing permanent emergency surveillance and response capacity have been short lived. The ongoing efforts to establish and implement an IDSR must be expedited.</p> | | | | |
| | <ul style="list-style-type: none"> Performing local management structures are the foundation of any health system. Their development must be encouraged by long-term support. | | | | |

| Strategic driver | Policy options (not mutually exclusive) | Options identified for state | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|--|--|---------------------------------|-----------------|--|-----------------|
| Restructuring the health workforce | <ul style="list-style-type: none"> By improving skills, addressing HRH imbalances and productively managing the workforce. | | | | |
| Upgrading the health workforce has four pillars (all interlinked) | <ul style="list-style-type: none"> Regulation: accreditation of training institutions and certification (or licensing) of health workers. | | | | |
| | <ul style="list-style-type: none"> Production: strengthening training programmes and producing under-represented categories | | | | |
| | <ul style="list-style-type: none"> Utilization: <ol style="list-style-type: none"> Deployment is constrained by a host of factors, including security, working conditions, social norms and career prospects. Competent management and supervision must reward performance. | | | | |
| | <ul style="list-style-type: none"> Maintenance, by effective supervision and in-service training. These two functions should work together (which is seldom the case). | | | | |
| Rationalizing the pharmaceutical field | <ul style="list-style-type: none"> By incrementally introducing feasible regulatory measures: <ol style="list-style-type: none"> Quality assurance controls (first outsourced to a reputable foreign laboratory) would discourage the circulation of substandard medicines. Meanwhile, steps towards the establishment of a laboratory in country could be taken. Strengthening warehousing and transportation capacity, public and private. Engaging informal vendors of medicines to enhance their performance. | | | | |

| Strategic driver | Policy options (not mutually exclusive) | Options identified for state | Reasons/factors | Scope of intervention and type of population | Estimated costs |
|---|--|---------------------------------|-----------------|--|-----------------|
| | <ul style="list-style-type: none"> By streamlining fragmented supply chains: <ol style="list-style-type: none"> Encourage the merging of existing procurement systems of generic medicines of proven quality into larger, more efficient operations. Support initiatives aimed at rationalizing private procurement and distribution, as the proposed franchising network (Somalia Economic Update, 2020) Assess the respective performance of the existing schemes, in order to support and expand the most promising ones. | | | | |
| Steering physical infrastructure investments | <ul style="list-style-type: none"> By managing gaps and overlaps in the existing health care network which are results of decades of piecemeal investments and spontaneous developments | | | | |

Annex C. Monitoring matrix (Member States, disparities)

| Strategic driver | Aspects to be monitored | Indicators | Sources | Remarks |
|--|--|------------|---------|---------|
| Boosting health care access and demand | • Service uptake, by setting, access and population group | | | |
| | • Quality of care | | | |
| | • User satisfaction | | | |
| Engaging private health care providers | • Market-harnessing measures: <ul style="list-style-type: none"> a. Disclosure b. Franchising c. Licensing and accreditation d. Contracting e. Partnership in planning. | | | |
| | • Introducing administrative controls | | | |
| Strengthening management systems | • Informed decision-making | | | |
| | • Aid architecture and management, at federal and state levels. | | | |
| | • EP&R. | | | |
| Restructuring the health workforce | • Local management capacity. | | | |
| | • Regulation: accreditation of training institutions and certification (or licensing) of health workers. | | | |
| | • Production: strengthening training programmes and producing under-represented categories. | | | |
| | • Utilization: <ul style="list-style-type: none"> a. Deployment b. Performance. | | | |
| Rationalizing the pharmaceutical field | • Maintenance, by effective supervision and in-service training. | | | |
| | • Quality assurance controls. | | | |
| | • Warehousing and transportation capacity, public and private. | | | |
| | • Engaging informal vendors of medicines. | | | |
| Steering physical infrastructure investments | • Supply chains. | | | |
| | • Gaps and overlaps in the health care network. | | | |

References

1. Everybody's business – Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007.
2. World Bank Group. World Development Indicators. 2020.
3. World Bank Group. Somalia Economic Update: Impact of COVID-19: Policies to manage the crisis and strengthen economic recovery. 2020.
4. World Bank Group. Somalia Economic Update: Investing in Health to Anchor Growth. 2021.
5. World Bank Group. Population totals. 2021. (<https://data.worldbank.org/indicator/SP.POP.TOTL?locations=SO>, accessed 14 January 2022).
6. Somali Health and Demographic Survey (SHDS), 2020. Somalia National Bureau of Statistics. 2020. (<https://www.nbs.gov.so/somali-health-demographic-survey-2020/>, accessed 14 January 2022).
7. Somalia CPF, 2018.
8. Buckley J, O'Neill L, Aden AM. Assessment of the Private Health Sector in Somaliland, Puntland and South Central. Heart: Oxford; 2015. (<https://assets.publishing.service.gov.uk/media/57a0899bed915d622c0002e3/Assessment-of-the-Private-Health-Sector-in-Somaliland-Puntland-and-South-Central.pdf>, accessed 14 January 2022).
9. Ministry of Health FGS, FMS, Somaliland, UNICEF, Brandpro, Ground Work. Somalia Micronutrient Survey, 2019. Mogadishu, Somalia; 2020.
10. Jeene, H. Strengthening affordable access to quality essential medicines in the private health sector of Somalia: options for a private medicine quality assurance system. Swiss Development Cooperation. 2017.
11. Lipcan, A. Zaman, R. Maschhaupt, G. Brouwer, L. Morris, R. Thayil, S. Assessing the costs of private healthcare in Somalia. Final Report. Oxford Policy Management and Forcier. 2018.
12. Zaman, R. Morris, R. Law, B. Brouwer, L. Thayil, S. Lipcan, A. Assessing the capacity of the private health system in Somalia. Final Report. Oxford Policy Management and Forcier. 2018.
13. Tulenko, K. Bile, K. Dlima, N. Somalia Health Regulatory Landscape. HRH landscape report. World Bank Group. 2021.
14. Ministries of Health of Somalia, Puntland and Somaliland (2016) The Somali Human Resources for Health Development Policy 2016-2021.
15. Service availability and readiness assessment (SARA). Geneva: World Health Organization; 2016.
16. Buckley, J. O'Neill, L. Aden, A.M. Assessment of the Private Health Sector in Somaliland, Puntland and South Central. Oxford. 2015.
17. Health Sector Resource Mapping and Expenditure Tracking Report, GFF, World Bank, Ministry of Health Somalia. 2021.
18. Health sector spending supplementary data, The Lancet <http://www.healthdata.org/somalia>.
19. Segall, M. Health sector planning led by management of recurrent expenditure: an agenda for action research. *Int J Health Plann Manage*. 1991;6(1):37-75.
20. Jeene, H. The first mile, analysis of the demand side of the health system. Karkaar Region of Puntland State, Somalia. 2014.
21. Rowe AK, de Savigny D, Lanata CF, Victora CG. How can we achieve and maintain high-quality performance of health workers in low-resource settings? *Lancet*. 2005;366: 1026-35.
22. GTZ. Quality improvement for health care providers: with friendly guidance and support. 2010. (<https://health.bmz.de/?s=Quality+improvement+for+health+care+providers%3A+with+friendly+guidance+and+support>, accessed 14 January 2022).
23. Olsanmokun, D. Ashkin, R. et al. Private sector partnerships in health (PSPH) Somalia – market systems assessment. Cardno, SORDI, Swiss TPH and SDC. 2021.
24. Bloom G, Standing H, Lucas H, Bhuiya A, Oladepo O, Peters DH. (2011) Making health markets work better for poor people: the case of informal providers. *Health Policy Plan*. 2011; 26:i45–i52 doi:10.1093/heapol/czr025.
25. Dodd, R. Dickinson, C. Hannah, E. Young, R. Fairfax, J. Waddington, C. Aid effectiveness: a relevant agenda for the Asia Pacific Region? HLSP Institute. 2013. (https://www.mottmac.com/download/file/127/6991/2013_aid_effectiveness_asia_pacific.pdf, accessed 14 January 2022).

