SECOND PHASE HEALTH SECTOR STRATEGIC PLAN 2017-2021

Ministry of Health and Human Services
Federal Government of Somalia

Contents

ACRONYMS and ABBREVIATIONS

AWD	Acute, watery diarrhoea
CMS	Central Medical Store
CPR	Contraceptive prevalence rate
CSR	Communicable-Disease Surveillance and Response
DHIS-2	District Health Information System open source software
DOTS	Directly observed treatment short course
DSS	Demographic surveillance sites
DTP3	Diphtheria-tetanus-pertussis
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunisation
FGS	Federal Government of Somalia
Gavi	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHE	Government Health Expenditure
HC	Health centre
HIV/AIDS	Human immunodeficiency virus/ acquired immune deficiency syndrome
HMIS	Health management information system
HRH	Human resources for health
HRP	Humanitarian Response Plan
HSS	Health Systems Strengthening
HSSP II	Health Sector Strategic Plan II
IDP	Internally displaced people/persons
IDSR	Integrated disease surveillance and response
INGO	International nongovernmental organisation
IRS	Indoor residual spraying
ITN	Insecticide treated nets
JANS	Joint Assessment of National Health Strategies
JHNP	Joint Health and Nutrition Programme
JRF	Joint Annual Review
M&E	Monitoring and evaluation
MICS	Multiple Indicator Cluster Survey
NCD	Non-communicable disease
NDP	National Development Plan
NGO	Nongovernmental organisation
PESS	Population Estimation Survey
PHU	Primary health unit
PMTCT	Prevention of mother-to-child transmission of HIV
PPP	Public private partnership
RHC	Referral health centre
RMS	Regional Medical Store
SDG	Sustainable Development Goal
SMS	State Medical Store
SOP	Standard Operating Procedures
STI	Sexually transmitted infection
SWAp	Sector wide approach
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WUENIC	WHO and UNICEF estimates of immunization coverage

ENDORSEMENT LETTER

The second phase of the health sector strategic plan (HSSP-II) 2017-2021, with a chapter of each sub-national Somali health authority, was developed through a consultative process with all key stakeholders at national and sub-national levels under the leadership of the Somali Health Authorities and the Ministry of Health and Human Services of Federal Government of Somalia, with the financial assistance of World Health Organization and the technical support by the IRIS Consulting Firm.

This is a combined version of the strategic priorities put forward by all the Somali health authorities including Somaliland, Puntland, Galmudug, Hirshabelle, South West, Jubbaland and Banadir Regional Administration and aims to strategize the health sector of the Federal Government of Somalia inline to the national health policy and the national development plan.

I hereby endorse the consolidated version of the health sector strategic plan II which covers the period of 2017-2021. This version (HSSP-II) aims to coordinate among the Somali health authorities and to guide all our partners to align and consolidate their operational support and investments at sub-national level to the national level strategic priorities.

Ministry of Health and Human Services of Federal Government of Somalia is grateful to the development partners, Civil Society Organizations, Private sector, the Somali health authorities and the professional associations and individuals those contributed to the development and for their commitment to support the operationalization of the HSSP-II 2017-2021.

H.E Dr. Fawziya Abikar Nur

Minister of Health

Ministry of Health and Human Services of Federal Government of Somalia

FOREWORD BY THE MINISTER

MoH has also developed the first ever Somali National Health Policy (NHP I) endorsed by all Somali health authorities and the Federal Cabinet in 2014. The HSSP II has therefore been developed to operationalise the NHP I and the health sector component of the National Development Plan (NDP I) set for 2017 - 2019. The plan details the priority interventions as identified in the NHP I and NDP I. HSSP II acknowledges that resources are limited; hence as was the case in HSSP I, it is focusing on the implementation of the essential package of health services (EPHS) that will be made accessible to all people in Somalia.

The development of the HSSP II has taken into consideration a wide range of policies, the new emerging diseases, the changing climatic conditions and issues of international health. The process also took into consideration the international treaties and conventions to which Somalia is a signatory more especially (i) the Sustainable Development Goals (SDGs), and (ii) the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness. The aim of reviewing policies and plans during the development of the HSSP II was to harmonise the strategic plan with the other existing sector and inter sectoral documents.

The development process of HSSP II was involved with the wider stakeholders in the health sector. This consultative and participatory process created the interest of all stakeholders to formalize partnership and contribute optimally in the implementation of the second phase strategic plan for Somalia for the five years to come.

Most development plans fail because they have been developed simply for having a plan for its own sake, because they do not understand the external environment, because they are too long, complicated, and detailed, and because they have unrealistic goals given level of resources – they try to solve everything. We have avoided these mistakes and I hope that therefore this plan stands a better chance of being accomplished.

Finally, Federal Ministry of Health with the support of development partners will explore all possibilities to secure adequate funding and support to HSSP II. We will create an enabling environment for the effective implementation of the HSSP II prior to the realization of the intended objectives and targets set for the five years to come.

Sincerely,

H.E Dr Fawziya Abikar Nur
The Minister
Ministry of Health and Human Services
Federal Government of Somalia

ACKNOWLEDGMENT BY THE DIRECTOR GENERAL

The second phase Health Sector Strategic Plan (HSSP II) 2017 – 2021 is the product of a long and complex process of intensive consultations, teamwork on specific assignments, detailed studies and information gathering with the full engagement and participation of all stakeholders.

The Federal Ministry of Health is very grateful to everyone who contributed to the successful development of this strategic plan. The concerted effort of all MOH staff and other stakeholders is acknowledged. Special thanks go to former Director of Policy and Planning Mr. Adam Osman Sheikh, who was leading the whole process from beginning to end as the overall coordinator of the HSSP II. I'm also grateful to all task-force members for their active participation and contributions to HSSP II. Special thanks go to Mr. Ahmed Mohamed Adam who has been an active member of the taskforce and exceptionally facilitated the state level consultations.

I would also like to acknowledge the technical support provided by IRIS Consulting Firm lead by Mr. Khadar Mahmoud Ahmed who spearheaded the whole process of developing HSSP II and being the main architect and designer of the plan. Similar gratitude goes to WHO in providing the financial and technical support necessary for the development of HSSP II.

Finally, I would like to acknowledge the efforts of all those institutions and individuals who participated and contributed in the development of this document. These include Government Ministries and Agencies at Federal and Federal Members States, Development Partners, UN Agencies, NGOs, Civil Society and Private Sector.

My thanks to you all

Dr. Abdullahi Hashi Ali
Director General, Ministry of Health and Human Services
Federal Government of Somalia

EXECUTIVE SUMMARY

A new environment is emerging in the Somali health sector, resulting from the peace dividend along with the investment made by international partners. Over the years, Somalia adopted a federal systems where Somaliland (North-West), Puntland (North-East) have been existing so long and new federal member states emerged from South Central regions of Somalia, namely Jubbaland, South-West, Galmudug, Hirshabeles states and Banadir Regional administration.

Due to decades of civil war, many health indicators are very poor. In 2015, maternal mortality ratio was estimated at 732 per 100,000 live births[1]– an improvement since 1990, when the figure was 1210 per 100,000 live births[2], but still poor compared to Kenya (510) or Ethiopia (353) in 2015.Under-5-mortality rate was 137 per 1000 live birth[3] in 2015, compared to Kenya (49) and Ethiopia (59). At 42%, Somalia has one of the lowest Diphtheria-tetanus-pertusis (DTP3) coverage rates in the world (Gavi 2016). In terms of JRF data, Penta I coverage was estimated at 50%, Penta III at 46 % and Measles at 43% (Gavi 2016).

The Federal Government of Somalia (FGS) developed a three-year National Development Plan (2017-2019) (NDP) that will replace Somalia's New Deal Compact (2014 – 2016). The NDP reflects priorities of the health sector and include key objectives defined in Somalia's National Health Policy 2014.

The first post-civil war countrywide health sector policy was developed in 2014. The Somali Health Policy provides a national frame of references, outlining health sector priorities. Some sub-sector policies have also been developed.

The vision for the health sector is "all people in Somalia enjoy the highest possible health status, which is an essential requirement for a healthy and productive nation". In order to work towards the realization of the of the vision, the health set the following mission statement: "Ensure the provision of quality essential health and nutrition services for all people in Somalia, with a focus on women, children, and other vulnerable groups and strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary Health Care Approach".

[1]Gavi (2016) Joint Appraisal Report – Somalia 2016file:///C:/Users/user/Downloads/Somalia%20Joint%20Appraisal%202016%20(1).pdf
[2]http://data.worldbank.org/indicator/SH.STA.MMRT
[3]Inter agency estimates http://www.childmortality.org/index.php?r=site/graph#ID=SOM_Somalia

HSSP II sets the following targets

1. By 2021, reduce maternal mortality ratio from 732/100,000 in 2015 to less than 400/100,000
2. By 2021, reduce <5 mortality rate from 137/000 in 2015 to less than 100/1000 live births
3. By 2021, reduce Infant mortality from 85/000 in 2015 to less than 70 per 1000 live births
4. By 2021, reduce neonatal mortality from 40/000 in 2015 to less than 35 per 1000 live births
5. By 2021, reduce the number of children who are stunted by 15% from 12%
6. By 2021, reduce incidence of TB from 285/100,000 per year to less than 250/100,000
7. By 2021, increase the coverage of Pent 3 from 43% to 80%
8. By 2021, increase skilled birth deliveries from 33% to 55%
9. By 2021, reduce child wasting from 14% to less than 10%
10. By 2021, increase contraceptive prevalence rate (CPR) to >15%
11. By 2021, increase TB case detection rate from 42% to >70%
12. By 2021, increase in per capita expenditure on health from ~$12 per person per year in 2015 to $23 per person per year; with share of Government Health Expenditure (GHE) increased to 12% of the total expenditure on health through public sector.

Strategic priorities

The Strategic Plan has nine strategic priorities that need to be addressed to achieve the Mission of the Strategic Plan. These are based on the New Somali Health Policy and the National Development Plan. They are the broad areas of work that need to be addressed to accomplish the Mission. In order of priority, they are:

1. Health Service Delivery:

The goal for health service delivery is: Reduce maternal, neonatal and child mortalities and improve access to essential health services of acceptable quality, prevent and control communicable and non-communicable diseases and improve quality of life

Strategic Objectives:

Strategic Objective 1: To increase access to and utilization of cost-effective, quality and gender-sensitive health services especially for women, children, and other vulnerable groups by 2021.
Strategic Objective 2: To enhance and ensure quality and safety of healthcare services by 2021
Strategic Objective 3: To improve and strengthen the delivery of specialized and emergency care in secondary and tertiary health facilities by 2021
Strategic Objective 4: To improve, integrate and expand community based health services by 2021
Strategic Objective 5: To improve and expand the capacity of laboratory and blood transfusion services

2. Human Resource for Health

The goal for human resource for health is to develop a workforce that addresses the priority health needs of the Somali population, which is adequate in number, well trained, equitably distributed

and motivated to provide quality, essential, non-discriminatory health services.

Strategic Objectives:

Strategic Objective 1: To provide appropriate policy and strategic framework to guide human resource development, planning, production and management by 2018.

Strategic Objective 2: To enhance and upgrade the institutional capacity for human resource for improved performance and productivity of the sector by 2021.

Strategic Objective 3: To enhance capacity and relevance for training of health workers to provide fair, equitable and non-discriminatory services, in partnership with the private sector and other stakeholders by 2021.

3. Leadership and Governance

The goal for leadership and governance is to strengthen the leadership, governance, institutional and management capacity of the health sector to deliver efficient and effective health programmes and services

Strategic Objectives:

Strategic Objective 1: To create enabling environment through provision of appropriate legal framework and provide the necessary capacities for implementation by 2018.

Strategic Objective 2: To enhance and streamline the governance, leadership and management systems and capacities at all levels of the health system by 2021.

Strategic Objective 3: To provide a viable oversight, sector planning, monitoring and supervision system from national to district levels by 2018

Strategic Objective 4: To enhance coordination, alignment and harmonization of development and humanitarian assistance with development partners, implementing agencies, civil society and private sector by 2018.

4. Essential Medicine and Supplies

The goal for essential medicine and supplies is to ensure the availability of essential health supplies, medicines, vaccines and commodities that satisfy the priority needs of the population, in adequate amounts, of assured quality and at a price that the community and the health system can afford.

Strategic objectives:

Strategic Objective 1: To develop appropriate policy and legal framework with respect to medicines, medical supplies and equipment, vaccines, health technologies and logistics by 2019.

Strategic Objective 2: To improve access to good quality, efficacious, safe and affordable medicines, medical supplies and equipment, vaccines and health technologies by 2021.

Strategic Objective 3: To improve, advance and strengthen the medicines regulations and quality assurance system by 2021.

Strategic Objective 4: To promote rational and cost effective use of medicines at all levels of the health care delivery system by 2021.

5. Health Information

The goal for health information is to establish effective health management information system based on sound, accurate, reliable, disaggregated and timely information for evidence based planning and implementation, supported by effective monitoring and evaluation and by

targeted research.

Strategic Objectives:

Strategic Objective 1: To provide a policy framework for establishing a functional health management information system by 2018.
Strategic Objective 2: To enhance and strengthen the institutional framework for implementing a functional health management information system by 2021.

Strategic Objective 3: To improve routine data collection quality, management, dissemination and use at all levels by 2021.
Strategic Objective 4: To improve and strengthen monitoring and evaluation, research and knowledge management capacity of the health sector by 2021.
Strategic Objective 5: To enhance early warning and integrate disease and nutrition surveillance systems into national HMIS by 2019.

6. Health Financing

The goal for health financing is create sustainable health financing system, which relies national financing and local resources, protects the poor from catastrophic health expenditure, ensures universal health coverage, allocates budget to priorities, accounts for spending accurately, and uses national and international funds more efficiently through SWAp

Strategic Objectives:

Strategic Objective 1: To secure adequate level of funding needed to achieve national health and health related sustainable development goals by 2021.
Strategic Objective 2: To ensure equitable access to quality health services free from financial catastrophe and impoverishment by 2021.
Strategic Objective 3: To ensure equitable and efficient allocation and use of health sector resources at all levels by 2021.

7. Health Infrastructure

The goal for health infrastructure is to ensure the Somalia health system has the necessary infrastructure to effectively respond to the healthcare needs of the people and provide quality and accessible essential healthcare services.

Strategic Objectives:

Strategic Objective 1: To enhance access to healthcare services through the establishment of network of public health facilities to support the effective delivery of EPHS at all levels by 2021.
Objective 2: To improve the institutional capacity and create conducive working environment through provision of adequate office premises, work-stations, ICT equipment and transport by 2019.
Strategic Objective 3: To procure, install and utilize appropriate medical and diagnostic equipment within the health facilities by 2021.

8. Health Emergency Preparedness and Response

The goal for emergency preparedness and response is improve the capacity of the health system to prevent, control and mitigate public health threats and emergencies

Strategic Objectives:

Strategic Objective 1: To improve access to essential life-saving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality by 2021.

Strategic Objective 2: To enhance and strengthen surveillance, early warning and disease detection to mitigate, detect and respond to disease outbreaks and other public health emergencies in a timely manner by 2021.

9. Social Determinants of Health

The goal for social determinants of health is to create social and physical environments that promote good health for all.

Strategic Objectives:

Objective 1: To enhance inter-sectoral and multi-sectoral collaboration in addressing the social determinants of health by 2021.

Objective 2: To promote actions in reducing the risks and vulnerabilities of the population to preventable social and environmental hazards by 2021.

Budget Summary

STRATEGIC AREA	2017	2018	2019	2020	2021	Total
Health Service Delivery	80,427,552	95,341,378	98,179,875	90,748,196	85,911,060	**450,608,061**
Human Resource for Health	12,320,383	13,986,472	14,322,314	13,572,944	13,211,675	**67,413,789**
Governance and Leadership	6,296,859	7,088,194	6,551,441	5,615,492	5,357,530	**30,909,516**
Health Information	6,059,456	7,753,487	8,034,841	7,238,826	6,549,128	**35,835,738**
Medicine and Supplies	18,562,931	22,959,087	23,524,412	19,628,640	17,923,758	**102,598,826**
Health Financing	5,892,480	8,111,703	7,753,909	6,877,455	6,503,368	**35,138,914**
Health Infrastructure	18,606,012	22,758,970	24,308,236	19,692,559	17,670,211	**103,035,987**
Health Emergency	6,491,344	8,646,624	8,840,341	7,416,865	6,913,946	**38,309,119**
Social Determinants of Health	4,119,983	5,141,434	5,734,404	5,234,899	4,477,511	**24,708,231**
GRAND TOTAL	**158,777,000**	**191,787,350**	**197,249,773**	**176,025,876**	**164,518,185**	**888,358,184**

Risks

The HSSP II is developed in a transitional period, where the Government is moving from emergency, ad-hoc planning to a more systematic development planning, and as such it is a high-risk exercise, dependent for its success on external support and goodwill and considerable efficiency improvements in contracting and implementation.

SECTION I: BACKGROUND AND METHODOLOGY

1.1 Introduction

This plan covers federal level including Jubbaland, South-West, Galmudug, Hirshabelle States, Puntland State and Somaliland as well as Banaadir Region. Each sub-national health authority has developed chapter of its own.

The first Health Sector Strategic Plan (HSSP I) for Somalia covered the period 2013/2016 and it guided the Somalia health sector investment led by the Ministry of Health (MoH), Development Partners and other stakeholders over this period. Continuous monitoring through annual reviews were done to assess key achievements and challenges during the implementation of the HSSP I and this formed the basis for the development of the second phase health sector strategic plan (HSSP II) for the period 2017/2021. The HSSP II is developed in line with the Somali Health Policy (2014) and National Development Plan (2017-2019).

The new HSSP will guide the health sector investments for the next five years starting from January 2017 to December 2021. The HSSP II provides an overall framework for the health sector and its major aim is to contribute towards the overall development goal of the health sector of Somalia by accelerating economic growth to reduce poverty as stated in the National Development Plan (NDP).

MoH has also developed the first ever Somali National Health Policy (NHP I) endorsed by all Somali health authorities and the Federal Cabinet. The HSSP II has therefore been developed to operationalise the NHP I and the health sector component of the NDP I. The plan details the priority interventions as identified in the NHP I and NDP I. The HSSP II acknowledges that resources are limited; hence as was the case in HSSP I, it is focusing on the implementation of the essential package of health services (EPHS) that will be made accessible to all people in Somalia.

The development of the HSSP II has taken into consideration a wide range of policies, the new emerging diseases, the changing climatic conditions and issues of international health. The process also took into consideration the international treaties and conventions to which Somalia is a signatory more especially (i) the Sustainable Development Goals (SDGs), and (ii) the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness. The aim of reviewing policies and plans during the development of the HSSP II was to harmonise the strategic plan with the other existing sector and inter sectoral documents.

1.2 Development Process for the HSSP II

In October 2016, the MoH constituted a Task Force to oversee the development of the HSSP II. The membership of this TF was drawn from the different departments of the MoH, Development Partners, Civil Society and Private Sector. The involvement of the different stakeholders was important in order to ensure ownership of the plan. The TF was chaired by the Director of Planning and Policy of the Federal MOH "Mr. Adam Osman". In order to facilitate the drafting of the HSSP II, nine thematic groups were created namely Health Service Delivery, Human Resource for Health, Leadership and Governance, Essential Medicine and Supplies, Health Information, Health

Financing and Budgeting, Health Infrastructure, Emergency Preparedness and Response and Social Determinants of Health. With the support of Consultant from IRIS "Khadar Mahmoud Ahmed", the thematic groups reviewed the situation analysis using SWOT tools as well as formulated SMART objectives and strategies for all areas as contained in this HSSP II.

There were also consultations with a wide range of health experts in order to get their inputs into specific issues related to the development of the HSSP II. A review of a wide range of health sector documents was done to provide an in-depth analysis and understanding of the sector such as the HSSP I and its expert review and annual review reports. Consultation meetings were convened in all states. Development Partners, Civil Society and other Ministries were consulted and contributed to the process of developing HSSP II.

The HSSP II consists of 8 sections. Section 1 provides a brief overview of the background and methodology. Section II provides situation analysis of the health sector especially looking at the organisation of the sector and the delivery of health services in Somalia including review of the progress against HSSP I. Section III sets the strategic direction including the overall vision, targets, principles and values. Section IV set out the health policy priorities and is divided into nine chapters (health service delivery, human resource for health, leadership and governance, essential medicine and supplies, health information, health financing, health infrastructure, emergency preparedness and response and social determinants of health). Section V provides an overview of the financing requirements for the health sector. Section VI covers the performance framework as well as monitoring and evaluation arrangements. Section VII covers the plan management, coordination and implementation; whereas, section VIII provides an overview of the risks and assumptions for the plan.

Separate chapters were developed for the states, keeping in view of their specific situation and priorities. These chapters are annexed to the national HSSP-II.

SECTION 2: SITUATION ANALYSIS

2.1 Overview

A new environment is emerging in the Somali health sector, resulting from the peace dividend along with the investment made by international partners. Over the years, Somalia has formed Federal Systems where Somaliland and Puntland, in the north, have been existing so long and very recently several new Federal States have emerged from South Central regions, namely Jubbaland, South-West, Galmudug, Hirshabele states and Banadir regional administrations. New elections for parliament and president happened in Somalia in 2017 as the being parliament and executive branch for 2017 – 2020.

Somalia's population is rapidly increasing. The population was estimated to be 12.3 million[4] in 2014 (49.3% male and 50.7% female). Urban settlements are growing at an unprecedented rate with enormous urban-rural migration, fuelling much of the concentration of the population in and around urban centres. The population is very young, with 45.6% under the age of 15, and 75% under the age of 30. Key high-risk groups include 2.4 million children under the age of five and more than 3 million women of childbearing age. Nomads constitute one-fourth of the total Somali population and there are an estimated 1.1 million (8.6% of the total population) internally displaced people (IDP) living mainly in the outskirts of urban towns (PESS 2014). This population profile has considerable implications in an environment where public sector capacities to deliver health and related services are limited, development and humanitarian assistance are declining, and there are persistent areas of conflict, natural disasters and health emergencies such as drought and epidemic outbreaks.

Due to decades of civil war, many health indicators are very poor. In 2015, maternal mortality ratio was estimated at 732 per 100,000 live births5– an improvement since 1990, when the figure was 1210 per 100,000 live births6, but still poor compared to Kenya (510) or Ethiopia (353) in 2015.Under-5-mortality rate was 137 per 1000 live birth7 in 2015, compared to Kenya (49) and Ethiopia (59). At 42%, Somalia has one of the lowest Diphtheria-tetanus-pertussis (DTP3) coverage rates in the world (Gavi 2016). In terms of JRF data, Penta I coverage was estimated at 50%, Penta III at 46 % and Measles at 43% (Gavi2016).

Life expectancy is estimated at 53 and 56 years for males and females, respectively. One in seven children die before their fifth birthday, and a woman dies every two hours during pregnancy/childbirth. One in 18 women has a lifetime risk of death during pregnancy. The country has one of the highest total fertility rates in the world at 6.7, with unmet need for birth spacing at 26%. 98% of women experience female genital mutilation/cutting, leading to serious obstetrical and gynaecological complications. There are 202,600 acutely malnourished children in the country; 60% of children aged under-five and 50% of women suffer from anaemia. One in three Somalis suffer from some form of mental health problem due to the longstanding conflict, unemployment and socioeconomic stress.

[4]Federal Republic of Somalia, Data for a Better Tomorrow,
PESS 2014, UNFPA (2014) Population Estimation Survey 2014for the 18 Pre-War Regions of Somalia October 2014http://somalia.unfpa.org/sites/arabstates/files/pub-pdf/Population-Estimation-Survey-of-Somalia-PESS-2013-2014.pdf
[5]Gavi (2016) Joint Appraisal Report – Somalia 2016file:///C:/Users/user/Downloads/Somalia%20Joint%20Appraisal%202016%20(1).pdf

The Federal Government of Somalia (FGS) developed a three year National Development Plan (2017-2019) (NDP) that will replace Somalia's New Deal Compact (2014 – 2016). The NDP reflects priorities of the health sector and include key objectives defined in Somalia's National Health Policy 2014.

The current mechanisms for health sector coordination[8] need to be revisited and adjusted to account for these new situations, ensuring that sector coordination is implemented in a decentralized way and reflects community needs.

Capacities of public institutions have improved, but the prevailing health system weaknesses pose major challenges for ensuring equitable access to quality, safe and affordable healthcare services. These include weak coordination mechanisms and limited availability of health intelligence for informed decision making process; chronic shortage of qualified health workers; inadequate and unsustainable levels of financing and deficient procurement and supply systems.

The first post-civil war countrywide health sector policy was developed in 2014. The Somali Health Policy provides a national frame of references, outlining health sector priorities. Some sub-sector policies have also been developed.

2.2 Building blocks

The following is a brief situation analysis based on the Health Sector Strategy Plan (HSSP) 2013-2016 building blocks– services, medicines, human resources for health, health financing, health information, leadership and governance – with additional analysis for humanitarian response / emergency preparedness, and social determinants of health including inequalities. For further details of the situation analysis and strengths/weakness/opportunity/strength (SWOT) exercises that have informed priorities, see below.

2.2.1 Health Service Delivery

The Somali health situation is one of the worst in the world. The country will be unable to achieve its Sustainable Development Goals (SDGs) related to health and nutrition if concerted, coordinated and consolidated efforts are not made to revitalize the health system. The burden of disease is dominated by communicable diseases, reproductive health challenges and under-nutrition, although non-communicable diseases (NCDs) and mental disorders are also on the rise. Routine immunization coverage remains very low. Malaria and tuberculosis (TB) are highly prevalent, with malaria endemic in some parts of the country. The HIV epidemic is growing with a prevalence rate of about 1%, and higher prevalence among high-risk groups. Diarrheal diseases account for the majority of deaths among children, along with respiratory infections.

[8]The Health Sector Coordination Committee (HSC) assembles constituencies from the donor community, UN agencies and NGOs; it is chaired by the three zonal health authorities and meets on quarterly basis in Nairobi. Similar structures are established at zonal level, feeding back to the HSC. The HSC spells out recommendations to the Health Advisory Board (HAB). Led by the three health Ministers of Federal, Somaliland and Puntland].

Health service delivery is structured around the framework of an Essential Package of Health Services (EPHS), developed in 2009. It has five levels of service provision: community level, primary health units (PHUs), health centres (HCs), referral health centres (RHCs), and hospitals. There are six core programmes including immunization, four additional programmes and six management components.

However, implementation of EPHS is not being implemented uniformly across the country and covers only nine of the 18 regions, due to factors such as limited resources and security challenges. Nevertheless, by rolling out EPHS in a relatively short timeframe, the Ministry of Health (MOH) has managed to turn deteriorated facilities around, improve standards of staff performance, implement the essential drugs list and ensure good treatment. Consultation and vaccination rates have increased and, most noticeably, there has been a rapid rise in in-facility deliveries with skilled attendants. This is having a positive effect on maternal, newborn and young child survival.

In the remaining nine regions, health service delivery is inconsistent and dependent on the presence of humanitarian organizations. Vaccines, supported by GAVI, are available in all public health facilities across the country.

The funding situation of the Somali health sector beyond 2016 is uncertain. A drop in overall funding is anticipated, due the end of the largest health sector development programme, the Joint Health and Nutrition Programme, in December 2016. However funding for the implementation of the EPHS in the same locations is likely to continue under different implementation arrangements. The Global Fund renewed their commitment to support the Somali health sector through grants for HIV/AIDS, Malaria and TB with a modest contribution to Health System Strengthening (HSS), as did GAVI.

Regulatory systems are required to address quality of care and patient safety concerns. Initial actions have been taken to establish national health professions' councils in each zone. The immediate challenge is to build institutional capacity and adopt effective policies, as well as registering and licensing of all health professionals.

During the past two decades, there has been significant growth in the private health sector at all levels, from conventional private for-profit and not-for-profit health facilities, to large chains of general hospital settings providing specialized care. No reliable data are available on the size of the private sector in Somalia, although these are more commonly seen in urban areas. A main goal will be to contract the private sector to provide public health services at affordable prices.

2.2.2 Medicines and Commodities

Following the collapse of central government in Somalia in 1991, the country's public medicines supply systems collapsed. International UN agencies and NGOs engaged in provisioning of medical supplies to public health facilities as part of their humanitarian and emergency interventions. Currently, a range of donors, agencies and NGOs operate parallel supply chains, largely as pre-packed kit systems, with little coordination and integration. This push-and pre-packed kit system still prevails, meeting only 20–25% of total need in the country.

There is no regulatory system of the pharmaceutical sector to ensure the safety, quality and efficacy of medical products, as well as proper drug importation and use, particularly in relation to the private sector. It is estimated that the private sector provides around 80% of the country's medicines by importation and distribution through private retail outlets and pharmacies. This includes information technologies and equipment, apart from those provided through projects and partners' support.

In a nutshell, the essential medicines programme is in its infancy and requires a great level of support to establish the key components. A supply chain management master plan has been developed on 2017 with the support of UNFPA, but its implementation needs substantial funding. The existing kit-based "push system" often results in both stock-outs and oversupply of inappropriate medicines and equipment. Insecurity affects transportation of supplies and triggers increased costs. Rational use of drugs has not been introduced and over-prescription is widespread. The availability of paediatric formula is limited. Inadequate procurement, inventory, storage, management and distribution systems, along with lack of accredited training curricula for pharmacists compound the challenges.

However, some progress has been made. Standard operating procedures for warehouse management and storage practices have recently been introduced. In response to reports of counterfeit and low-quality drugs, six mini-labs are functioning throughout the country for basic quality testing of a range of drugs, along with additional quality testing by Kenya's National Quality Control Laboratory. A system for alert warnings on withdrawn medicines is also in place. In addition, treatment protocols for the implementation of EPHS (including hospitals) have been developed, which should standardize use of medical products based on essential drugs lists for each level.

2.2.3 Human Resources for Health

Trained human resources for health (HRH) are an essential prerequisite for efficient and effective healthcare delivery. Estimates of 6,000 doctors, nurses and midwives in the country (2014) are significantly below the WHO's minimum threshold for a health worker-to-population ratio of around 30,000 health workers necessary to achieve Somalia's health-related SDGs. In addition to a critical shortage of health workforce there are challenges in the recruitment of trained health workers.

Poor infrastructure and limited faculty capacity – in terms of both quantity and quality – constrain an increase in production of health professionals. The number of private education institutions is increasing, and lack of regulation of such institutions has raised many quality concerns. The private sector offers additional job opportunities for public-sector health workers, especially for physicians, most of who engage in private practice during office hours, with a high level of absenteeism in public sector provision.

The health expenditure review has shown low health expenditure. MOH budgets are mainly allocated to salaries, which are still far from adequate. Therefore, the need to increase health budgets and fiscal space for health workers' salaries is great, through both national and external resources.

There is no comprehensive survey or head count or human resources management information system (HRMIS) to obtain a fuller, ongoing picture of the available health workforce across the country. This lack of comprehensive, disaggregated information raises challenges in health workforce planning and management, including monitoring of vacancies.

2.2.4 Health Financing

Health financing for Somalia has been extremely limited as Somali macroeconomic performance is poor. Health sector resources are mainly from out-of-pocket payments or through donor funding. At US$10-12 per capita annual public expenditure on health is far below the global standard for health sector investment. This increases the risk of financial burden, especially on poor people with higher out-of-pocket expenditure.

In absolute terms, there has been a significant increase in health sector funding in Somalia over the past decade, with increases in financing from conventional donors of 180% between 2005 and 2014 for health sector development funding, although there are indications of donor fatigue in humanitarian funding. External financing greatly exceeded governmental contributions to the health sector.

Many donors channel their contributions to the health sector through a chosen implementing partner, depending on the type of support provided, usually by contracting out private providers to deliver EPHS or basic services. There are important differences in the model of EPHS delivery between the different programmes and in contracting arrangements.

2.2.5 Health Information

The health information system faces enormous challenges in relation to overall functioning, as well as performance, institutional frameworks, capacity and mechanisms to support information use for decision-making. However, some progress has been made under selected components of the health information system.

HMIS: The Health Management Information System (HMIS) is functional in the Federal MOH, Somaliland MOH and Puntland MOH, although functionality varies. HMIS units are non-existent in most of the districts. a District Health Information System open source software(DHIS 2) was introduced across the regions in the country.

National surveys and census: Somalia has not conducted a national survey since long. The last multiple indicator cluster survey covering all regions was in 2006. There are ongoing discussions on conducting regular multiple indicator cluster surveys/demographic and health surveys. The draft monitoring and evaluation framework for the NDP includes a list of surveys that are planned and/or considered for the next three years.

Independent monitoring and evaluation: MOH, partners and donors have discussed and planned independent monitoring and evaluation (M&E) of some health sector components and programmes, as well as undertaking some reviews such as the strategic review of the Somali health sector conducted in September 2015. An overall M&E framework and plans were developed for Federal, Somaliland and Puntland in 2013, but not fully implemented. Nutrition M&E

has greatly improved in terms of reporting; however, the nutrition database and dashboard need to be integrated into HMIS/DHIS2 at all levels.

Birth and death registration: The coverage for birth registration among children aged under-five in Somalia was estimated to be only 3%[9]. In the first phase HSSP (2013 – 2016), pilot initiatives on vital registration system were launched in some districts, but the system requires massive development to systematically scale up to all districts across the country.

2.2.6 Leadership and Governance

The MOH has wide-ranging leadership and coordination responsibilities. It is important to ensure the MOH structure is fit for purpose at all levels to reflect these roles. This is especially critical in the ongoing federalization process, as is developing the necessary capacity during the plan period.

The MOH has developed a range of policies aimed at guiding delivery of services, along with a draft Health Act (Bill) to provide the required governance and legal framework for the health sector. It will be important to clarify roles and responsibilities between the Federal MOH and State MOHs in order to improve on implementation efficiency. In addition, MOH is in the process of establishing regulatory bodies to contribute to good governance.

Constituency-based coordination structures exist with membership across sectors; however, the functions, roles and responsibilities as well as their operating modalities need to be reviewed so as to institutionalize and make them more effective.

Federal Government of Somalia policy is to channel all donor funds through the Government to fund the national and sector plans, progressively reducing standalone vertical programmes and projects run by development partners. However, this will require development of agreed common management arrangements within the context of a sector-wide approach.

2.2.7 Health infrastructure:

While there has been no systematic review of Somalia's health infrastructure, it is clear that both the extent and the condition of the country's infrastructure are poor. Limited funding is available for infrastructure from development partners and the Government does not have a budget line for infrastructure development. There is no database of facilities or policy and plan for improvement of infrastructure or medical equipment based on population need. Infrastructure based on population need can contribute to reducing inequalities but improving access, for example by increased services (and healthcare worker housing) for rural populations, separate toilets for male and female patients and staff, or access for people with physical disabilities.

2.2.8 Humanitarian response and emergency preparedness

The long, protracted and complex Somali emergency has attracted enormous and intensive humanitarian relief and aid. This has focused on saving lives and alleviating suffering, through an immediate response to the needs of populations residing in regions and districts directly affected by the recurrent cycles of armed conflict, poverty and natural disasters. Humanitarian assistance is also delivered to the large number of internally displaced persons, whose number is progressively

[9] Reference: MICS 2006 – details?

growing as a result of the ongoing fight against the armed insurgency, with the additional challenge of resettling Somali refugees repatriated voluntarily from neighbouring countries. At present, about 3.2 million people are in need of humanitarian aid inside Somalia. During 2015, around 2.8 million people were targeted through planned humanitarian aid, and health relief operations provided access to life-saving primary health care services to enhance resilience during humanitarian crises and emergencies.

Compounding the above challenges are a lack of an emergency preparedness and response plan; lack of MOH and personnel capacity in this area; weak surveillance, early warning systems; limited logistic capacity and lack of 'buffer' stocks to supply emergencies. A 'health cluster' coordination mechanism aims to address needs in health, nutrition, and water, sanitation and hygiene (WASH) among other clusters

2.2.9 Social Determinants and Inequalities in Healthcare Provision

While health outcomes for the country as a whole are poor, some groups (e.g. women) and areas (e.g. isolated rural areas without healthcare providers) have significantly worse outcomes. Many of the factors – or determinants – that affect people's health are outside the health sector's remit (such as income, education, rural isolation, gender, disability, etc). However, there is much that the health sector can do to tackle these issues and help to reduce inequalities. Access to and use of reliable data will be critical to ensuring inequalities between groups and areas are reduced. Having accurate data helps with targeting of resources to areas that need them most as well as determining the success of efforts to reduce inequalities, Meaningful engagement of civil society - including women and representatives of the most vulnerable groups– in planning, delivery and review of services is important in ensuring services meet the needs of all. Working across all sectors with an impact on health –such as education, transport, water and sanitation, economic development – can multiply the impact of health sector efforts.

SECTION 3: STRATEGIC DIRECTIONS

The vision, mission, goal, values and principles are derived from the Somali Health Policy and the National Development Plan for the Federal Government of Somalia. They intend to contribute to the achievement of the national development goals as well as the realization of the health related SDGs.

Vision
All people in Somalia enjoy the highest possible health status, which is an essential requirement for a healthy and productive nation.

Mission
Ensure the provision of quality essential health and nutrition services for all people in Somalia, with a focus on women, children, and other vulnerable groups and strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary Health Care Approach.

Goal
Improve the health status of the population through health system strengthening interventions and provide quality, accessible, acceptable and affordable health services that facilitate moving towards UHC and accelerate progress towards achieving the health related SDGs.

Targets

1. By 2021, reduce maternal mortality ratio from 732/100,000 in 2015 to less than 400/100,000
2. By 2021, reduce <5 mortality rate from 137/000 in 2015 to less than 100/1000 live births
3. By 2021, reduce Infant mortality from 85/000 in 2015 to less than 70 per 1000 live births
4. By 2021, reduce neonatal mortality from 40/000 in 2015 to less than 35 per 1000 live births
5. By 2021, reduce the number of children who are stunted by 15% from 12%
6. By 2021, reduce incidence of TB from 285/100,000 per year to less than 250/100,000
7. By 2021, increase the coverage of Pent 3 from 43% to 80%
8. By 2021, increase skilled birth deliveries from 33% to 55%
9. By 2021, reduce child wasting from 14% to less than 10%
10. By 2021, increase contraceptive prevalence rate (CPR) to >15%
11. By 2021, increase TB case detection rate from 42% to >70%
12. By 2021, increase in per capita expenditure on health from ~$12 per person per year in 2015 to $23 per person per year; with share of Government Health Expenditure (GHE) increased to 12% of the total expenditure on health through public sector.

Strategic Objectives
The strategic objectives are meant to improve and strengthen the functions of the national health system to respond to the following performance criteria:

- Access to health services (availability, utilization and timeliness)
- Quality of health services (safety, efficacy and integration)
- Equity in health services (disadvantaged groups)
- Efficiency of service delivery (value for resources)

- Inclusiveness (partnerships)

The inputs required to influence the above performance criteria form the basis for the overall and specific objectives for HSSP II. These inputs correspond to the broad health policy objectives and national development plan. The objectives for the HSSP II are thus given under the following nine building blocks discussed in subsequent chapters of the Plan:

1. Scaling up of essential and basic health and nutrition services (EPHS)
2. Overcoming the crisis of human resources for health
3. Improving governance and leadership of the health system
4. Enhancing the access to essential medicines and technologies
5. Functioning health information system
6. Health financing for progress towards Universal Health Coverage
7. Improving health sector physical infrastructure
8. Enhancing health emergency preparedness and response
9. Promoting action on social determinants of health and health in all policies.

Core Values and Principles

The following values and principles provide the basis for the Second Phase Health Sector Strategic Plan (HSSP II):

1. 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
2. Effective, transparent and accountable governance and leadership in managing the different components of the health system with decentralized management of health care service delivery
3. Building effective collaborative partnerships and coordination mechanisms engaging local community, national and international stakeholders and pursuing the aid effectiveness approaches
4. Good quality services - well managed, sensibly integrated, available, accessible, accountable, affordable and sustainable (with a corresponding reduction in vertically-driven, standalone programmes and projects)
5. Priority emphasis on reproductive, maternal, neonatal, child and adolescent health
6. Promotion of healthy lifestyles and health-seeking behaviour among the population
7. Emphasis on prevention and control of priority communicable and non-communicable diseases, as well as on trauma and related injury
8. Addressing the special needs of vulnerable groups, rural and pastoral communities
9. Evidence-based interventions based on considered use of reliable health information
10. Meaningful engagement and participation of citizens in the management and financing of the health services
11. Increased and more diverse public-private partnerships
12. Implementation of health financing systems that promotes equitable access to priority health services.

SECTION 4: HEALTH SECTOR PRIORITIES

This section covers the nine strategic areas reflected in the Somali Health Policy 2014 discussed in the subsequent nine chapters:

1. **Service delivery**: Scaling up of essential and basic health and nutrition services (EPHS)
2. **Human resources for health**: Overcoming the crisis of human resources for health
3. **Leadership and governance**: Improving governance and leadership of the health system
4. **Medicines, medical supplies and technologies**: Enhancing the access to essential medicines and technologies
5. **Health information system**: Functioning health information system
6. **Health financing**: Health financing for progress towards Universal Health Coverage
7. **Health infrastructure:** Improving health sector physical infrastructure
8. **Emergency preparedness and response**: Enhancing health emergency preparedness and response
9. **Social determinants of health**: Promoting action on social determinants of health and health in all policies.

These strategic areas are meant to improve and strengthen the functions of the national health system to respond to the performance criteria identified in the previous section (access, quality, equity, efficiency and inclusiveness).

As noted in section three above, EPHS intervention areas, led and managed by the Federal and State Ministries of Health, will provide all operational dimensions of HSSP II, with the aim of enhancing synergy and improving efficiency. The EPHS provides a comprehensive list of services to be offered at five levels of the health system (community, the primary health unit, health centre, referral health centre and hospital). The criteria for defining EPHS services are impact, cost-effectiveness and equity.

Chapter I: Service Delivery

Situation Analysis

Health service delivery remains a key challenge in Somalia. The existing functional health facilities are inadequate and inequitably distributed across regions and districts thus prompting the Ministry to increase the number of health facilities in order to bring them closer to the beneficiaries. They are also poorly equipped to provide quality healthcare services. In brief, the Somali health situation is one of the worst in the world, and the country will be unable to achieve its SDGs related to health if concerted, coordinated and consolidated efforts are not made to revitalize the health system.

As noted in section two, the burden of disease is heavily dominated by communicable diseases, reproductive health problems and under-nutrition issues, although non-communicable diseases and mental disorders are also on the rise. Routine immunization coverage remains very low. Only 42% of children received 3 doses of Penta vaccine in 2014. Tuberculosis is highly prevalent with

30,000 new cases every year, of which fewer than half are detected. Malaria is endemic in some parts of the country and more than 610,000 malaria cases were recorded in 2014.. The HIV epidemic is growing with a prevalence rate of about 1%, and higher prevalence among high-risk groups.

70% of Somalis do not have access to safe water supply or sanitation. Half of the population practice open defecation; in rural areas this is as high as 83%. Diarrhoeal diseases account for the majority of deaths among children, along with respiratory infections.

Life expectancy is estimated at 53 and 56 years for male and females, respectively. One in seven children die before their fifth birthday, and a woman dies every 2 hours during pregnancy/childbirth. One in 18 women has a lifetime risk of death during pregnancy. The country has one of the highest total fertility rates in the world at 6.7, with unmet need for birth spacing at 26%. 98% of women experience female genital mutilation/cutting, leading to serious obstetrical and gynaecological complications.

There are 202,600 acutely malnourished children in the country; 60% of children aged under-five and 50% of women suffer from anaemia. One in three Somalis suffer from some form of mental health problem due to the longstanding conflict, unemployment and socioeconomic stress.

Concerns about quality of care and patient safety have raised the need to establish regulatory systems. Initial actions have been taken to establish national health professions councils in each zone, and these councils are in the process of developing policies and systems to regulate health professionals. The immediate challenge is to build institutional capacity and adopt right policies, as well as registering and licensing of all health professionals.

Implementation of EPHS is not being implemented uniformly across the country and covers only nine of the 18 regions, supported through two main implementing programmes (Joint Health and Nutrition Programme [JHNP] and Health Consortium for Somalia) because of severe shortage of funds, shortage of trained staff, scarcity of medical supplies, security challenges and lack of quality care.

PHUs (also called health posts) are supposed to provide limited curative, promotive and preventive services at the community level, but many do not operate properly due to lack of qualified health workforce and infrastructure development. Health centres (also referred to as maternal and child health centres) are providing at least some preventive and curative services, focused on women and children, together with basic health services for the general population particularly in rural settings. Hospitals do not provide the full range of secondary or higher level care services identified in EPHS, and most of the regional hospitals are functional for limited services only.

Nevertheless, by rolling out EPHS in a relatively short timeframe, the Ministry of Health (MOH) has managed to turn deteriorated facilities around, improve standards of staff performance, implement the essential drugs list and ensure good treatment. Consultation and vaccination rates have increased and, most noticeably, there has been a rapid rise in in-facility deliveries with skilled attendants. This is having a positive effect on maternal, newborn and young child survival. A

recent patient satisfaction assessment showed that overall 92% of clients reported receiving good (24%) and excellent (68%) health services, and 8% of clients reported that services received were unsatisfactory and poor. However, such assessments are also a reflection of the population's low level of expectation.

In the remaining nine regions, health service delivery is inconsistent and dependent on the presence of humanitarian organizations. Vaccines, supported by GAVI, are available in all public health facilities across the country.

The funding situation of the Somali health sector beyond 2016 is uncertain and a drop in overall funding is anticipated. The JHNP, which provides the largest contribution to the delivery of health services through contracted NGOs, ended in December 2016. However, the continuation of funding the implementation of the EPHS in the same location is likely to continue under different implementation arrangements. The Global Fund renewed their commitment to support the Somali health sector through grants for HIV/AIDS, Malaria and TB with a modest contribution to Health Systems Strengthening (HSS) in the area of health management information system – HMIS, supply chain and essential medicines) and so did GAVI.

During the past two decades, there has been significant growth in the private health sector at all levels, from conventional private for-profit and not-for-profit health facilities (including training institutions, small-scale clinics and diagnostic facilities) to large chains of general hospital settings providing specialized care. No reliable data on the size of the private sector in Somalia are available, but private services are more commonly seen in urban areas.

The private sector is a key player in the Somalia health sector. A main goal will be to contract the private sector to provide public health services at affordable prices, as practiced in many developing countries. There are creditable public–private partnership efforts in pre-service education of mid-level categories, especially community midwives, with the possibility to extend access to essential health services.

Laboratory and blood transfusion services are partially re-established in hospitals, but remain a big challenge in referral health centres.

Table 1 SWOT Analysis for the Health Services Delivery

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Defined package of health services based on the EPHS ✓ Improved coverage of basic health and nutrition interventions through the EPHS ✓ Functioning management structures at decentralized levels	✓ Access and coverage of health services (EPHS) is very low ✓ Inadequate and inequitable distribution of health infrastructure, equipment and transport, and weak maintenance ✓ Shortages and inequitable distribution of frontline health workers	✓ Reductions in maternal, under-five and infant mortalities ✓ Decentralization and federal system could provide opportunities for stronger local planning and implementation	✓ The burden of major communicable diseases and increasing trend in NCDs (Double burden of diseases) ✓ Worsening determinants of health and

✓ Improvements in the availability, and distribution of frontline health workers ✓ Availability of outreach and mobile services ✓ Regular support from health partners in service delivery ✓ Availability of referral system ✓ Availability of community-based health strategy	✓ Significant increases in the burden of NCDs: mental problems, hypertension, diabetes, others ✓ Lack of attention to NCDs ✓ Weak referral systems, with impact on continuity of care ✓ Inadequate numbers of specialist medical practitioners ✓ Lack of harmonization of community-based interventions ✓ Limited public confidence in public health services	☐ Strong partnerships with the communities ☐ Private financing and PPP opportunities for service delivery	implications of climate change ✓ Weak inter-sectoral linkages ✓ Unpredictable and diminishing support from development partners ✓ Lack of regulation of traditional and alternative health services

Critical Issues and Challenges

1. Limited availability of EPHS, with 50% of the population having no access to EPHS services.
2. Lack of quality assurance standards/programmes, patient safety and infection control norms.
3. Poor access to health services, including specialized medical care especially for poor and vulnerable people.
4. Low quality of available health services.
5. Inequities in accessing health services and low utilization of essential services.
6. National standards for basic services and capacity standards for health facilities by level of care have not been defined.
7. Inadequate provision of drugs, equipment and other supplies.
8. Tuberculosis and HIV have not been fully integrated in primary health care services, as a result of parallel financing.
9. Inadequate outreach and referral services.
10. Minimal involvement of communities in delivery of health services.
11. Lack of community and home based approach to service delivery.
12. Inadequate laboratory and blood transfusion services.
13. Lack of standardization of the existing broad community health workers' cadres to provide cost-effective services.
14. Lack of accurate information on the private health sector, with no system in place to collect data on the size, utilization and quality of care provided.
15. Poor/lack of regional and district leadership and managerial capacities for supervision, monitoring and evaluation of the EPHS implementation.
16. Lack of regulation and capacity to enforce standards in the private sector.
17. Service demand, utilization and uptake are very inadequate.

Strategic Goal

Reduce maternal, neonatal and child mortalities and improve access to essential health services of acceptable quality, prevent and control communicable and non-communicable diseases and improve quality of life

Strategic Objectives and Priority Strategies

Strategic Objective 1: To increase access to and utilization of cost-effective, quality and gender-sensitive health services especially for women, children, and other vulnerable groups by 2021.

Strategies

1.1 Consolidate and scale up EPHS delivery in all regions and districts in a phased approach.
1.2 Provide adequate and equipped ambulances to all hospitals and referral health centres.
1.3 Provide integrated comprehensive outreach/mobile health services to reach hard-to-reach, remote and rural areas.
1.4 Prepare and implement comprehensive roadmap and programme for maternal, newborn and child health.
1.5 Review, update and implement the comprehensive multi-year EPI plan and boost the coverage of immunization.
1.6 Scale up high impact nutrition interventions including management of malnutrition, micro-nutrient supplementation, infant and young child feeding promotion and food fortification.
1.7 Implement national malaria prevention and control strategy including indoor residual spraying (IRS), impregnated treated nets (ITN) distribution, Intermittent Preventive Therapy in Pregnancy and prompt and effective treatment services
1.8 Implement National Tuberculosis Control Strategy including provision of high quality Directly Observed Treatment Short-Course (DOTS) and control of multi-drug resistant with focus on high risk groups.
1.9 Implement the National HIV/AIDS Prevention and Control Strategy with expanded access to HIV/AIDS prevention and treatment services including antiretroviral therapy (ART) services for adults and children, sexually transmitted infection (STI) control, prevention of mother-to-child transmission of HIV (PMTCT) and provision of safe blood.
1.10 Develop and implement non-communicable diseases control strategy to control the existing and emerging NCDs.
1.11 Develop and implement a national mental healthcare strategy and programme to provide comprehensive, integrated and responsive mental healthcare services.
1.12 Develop and implement a comprehensive communication strategy and programme to promote health seeking behaviour and create demand for services.
1.13 Develop and implement national strategy and programme to address neglected tropical diseases.
1.14 Develop and implement national environmental health strategy and programme to deliver sustainable environmental health services.

Strategic Objective 2: To enhance and ensure quality and safety of healthcare services by 2021

Strategies

2.1 Develop and introduce service standards, technical tools, guidelines and protocols in all health facilities in line with the EPHS.
2.2 Provide high quality pre-service, in-service training and continuing education, including a focus on delivery of patient friendly, fair and non-discriminatory services to all.

2.3 Specify standard packages for diagnostic and radiology services and provide to all health centres, referral health centres and hospitals in line with the EPHS.
2.4 Develop and disseminate quality assurance framework and clinical guidelines to all health facilities.
2.5 Develop and implement annual calendar of joint supportive supervision.

Strategic Objective 3: To improve and strengthen the delivery of specialized and emergency care in secondary and tertiary health facilities by 2021

Strategies

3.1 Upgrade human, infrastructural and logistics capacities of referral health facilities (referral health centres, secondary and tertiary hospitals).
3.2 Conduct comprehensive assessment of the referral system and develop national guidelines on patient referral, feedback and post-referral follow-up.
3.3 Deploy appropriately skilled and motivated medical professionals in various disciplines to secondary and tertiary hospitals.

Strategic Objective 4: To improve, integrate and expand community based health services by 2021

Strategies

4.1 Implement the community-based health strategy and provide evidence-based community interventions.
4.2 Review the role and responsibilities of the community health boards and strengthen their operational capacities.

Strategic Objective 5: To improve and expand the capacity of laboratory and blood transfusion services

Strategies

5.1 Conduct a needs assessment and develop a consolidated plan for laboratory infrastructure and equipment to allow for the necessary testing at each level.
5.2 Develop and disseminate national laboratory and blood transfusion services policy.
5.3 Increase investment in the training of laboratory technicians and produce a cadre of qualified laboratory technicians and technologist.
5.4 Provide in-service training of relevant staff at all levels to improve laboratory services (new technologies and scaling up new interventions).
5.5 Build the capacity for laboratory reagents and supplies quantification, procurement and management.
5.6 Establish appropriate coordination and management within MOH at Federal, State and Regional levels to ensure effective coordination and supervision of laboratory services at all levels.
5.7 Strengthen the capacity of the blood bank through expansion and upgrading of facilities and adequate supplies for blood collection and storage in all regions.
5.8 Introduce strategies for blood donor selection, education, counselling and care, and retention of safe donors for repeated donations.

5.9 Develop and enforce quality assurance framework and ensure regular auditing and accreditation of blood transfusion services.
5.10 Provide continuous education and training in the use of blood and blood products for medical staff.
5.11 Educate and sensitize communities and prospective donors on blood safety.

Chapter 2: Human Resources for Health

Situation Analysis

Availability of appropriately trained human resources for health (HRH) is an essential prerequisite for delivery of the EPHS in Somalia. However, the country is experiencing a major crisis in responding to the disease burden, which is exerting considerable strain on the already overwhelmed health system. Lack of attention to HR has the potential to significantly increase inequalities, for example, in health outcomes between rural and urban areas.

There is a critical shortage of skilled health staff, the impact of which is worsened by the total absence of certain cadres, thus compromising the quality of care provided. Estimates indicate that there were approximately 6,000 doctors, nurses and midwives in 2014. According to the WHO minimum threshold for health worker-to-population ratio, around 30,000 health workers are necessary to achieve Somalia's health-related SDGs. Challenges are also being faced in the recruitment of trained health workers as posts provided by civil service commissions are insufficient to employ all available trained health professionals.

There are approximately 17 different community health cadres (including female health workers, community health workers, trained traditional birth attendants, hygiene promoters, community development mobilizers, community educators, mother-to-mother support groups and female health promoters). Three of these programmes – community health workers, female health workers and integrated community case management – have more advanced systems, job descriptions, training curricula and administrative systems, and therefore provide the highest potential to grow and provide community health services.

Attracting and retaining health workers remains a key challenge due to low staff remuneration; lack of incentives, especially for hard-to-reach areas, as well as lack of career development opportunities. There are no specific strategies or incentives to attract and deploy health workers in rural and remote areas. Some recent initiatives have introduced female community-based health workers to address this problem, with the aim of improving health promotion and monitoring of communities, and to facilitate linkages with health facilities for outreach services in rural communities.

Basic necessities and amenities in the form of accommodation are completely lacking and remain q major challenge for staff, female health workers such as nurses and midwives working in remote, hard-to-reach and rural areas. This is compounded by low remuneration, which has negatively affected staff morale. The situation is further aggravated by mal-distribution of staff.

Dual practice is common across all zones and the private sector offers additional job opportunities for public-sector health workers, especially for physicians, most of which engage in private practice during working hours with a high level of absenteeism in public service provision.
Unlike the past when training was fragmented and haphazard, it is now more organized due to the HRH Development Policy. This achievement is, however, constrained by existing training capacity that is yet to meet required service demand and is limited in terms of scaling-up. The low output of health training institutions is due to several factors such as limited faculty capacity (in terms of both quantity and quality), poor infrastructure, inadequate learning and teaching models, among others, to match the existing demand. Human resource development is a major constraint due to irregular or non-existent of in-service training programme and opportunities. The number of private education institutions is increasing, and unregulated mushrooming of such institutions has raised many quality concerns.

There is no comprehensive survey or headcount – or ongoing HR management information system (HRMIS) - to obtain a fuller, ongoing picture of the available health workforce across the country. This lack of comprehensive information – disaggregated by factors such as sex, location, seniority, qualifications –raises challenges in health workforce planning and management, including monitoring of vacancies.

Table 3 SWOT Analysis for Human Resource for Health

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Human resource for health strategy. ✓ Ongoing efforts towards improving production and skills-mix distribution. ✓ Improved human resource management capacities. ✓ Human resource taskforce. ✓ Health professions council to register and license health professional under development.	✓ Critical shortages in qualified health workers at all levels, especially midwives. ✓ Lack of HR master plan. ✓ Inequitable distribution of health workers often skewed towards urban centres. ✓ Poor terms and conditions of service for health workers. ✓ Lack of standardized remuneration and salary system. ✓ Lack of accommodation and housing allowances for health workers in remote and rural areas. ✓ Lack of staff performance management system. ✓ Lack of human resource database and records in both public and private sectors. ✓ Lack of accreditation and licensing of professional practice.	✓ Increasing number of health training institutions. ✓ Diaspora professionals coming back to the country.	✓ High attrition rate of health workers from public health services to private sector and donor funded projects. ✓ Inadequate funding and uncertainties of DPs' support to HRH particularly to salary top-ups. ✓ Lack of alignment of technical assistance to health sector priorities.

Critical Issues and Challenges

1. Inadequate number of trained health professionals, particularly midwives.
2. Inequities in the distribution of available health professionals.

3. Low remuneration and motivation of public health workers.
4. Poor conditions of service for healthcare staff.
5. Weak human resource for health planning and management.
6. Delay in recruitment of staff.
7. High attrition rate.
8. Absence of structured career pathway for most cadres.
9. Training institutions unresponsive to the needs of the health sector and constrained by low capacity.

Strategic Goal

Develop a workforce that addresses the priority health needs of the Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide quality, essential, non-discriminatory health services.

Strategic Objectives and Strategic Priorities

Strategic Objective 1: To provide appropriate policy and strategic framework to guide human resource development, planning, production and management by 2018.

Strategies

1.1 Review and update HRH policy and strategy to guide the planning, production, development and management of the human resource for health.
1.2 Undertake inventory and headcount of all health workers disaggregated by sex, location, seniority, qualification and make projections for the next 10 to 15 years.
1.3 Develop and implement staff recruitment and retention plan including special packages for hard to reach areas.
1.4 Conduct comprehensive and systematic training needs assessment for all cadres at all levels.
1.5 Develop and implement a comprehensive training plan based on the results of the need assessment.
1.6 Support the establishment and networking of health professional associations for all cadres.

Strategic Objective 2: To enhance and upgrade the institutional capacity for human resource for improved performance and productivity of the sector by 2021.

Strategies

2.1 Deploy adequate numbers of health professionals to ensure that 80% of health facilities have skilled staff to meet the minimum staffing requirement to deliver EPHS.
2.2 Review the salary and incentive packages for health workers and introduce performance-based incentive packages.
2.3 Establish an integrated HRH information system as part of the HMIS and keep the human resource management information system (HRMIS) regularly updated and maintained.

2.4 Create human resource management positions and recruit appropriately skilled personnel in human resource management to occupy human resource management positions at all levels.

Strategic Objective 3: To enhance capacity and relevance for training of health workers to provide fair, equitable and non-discriminatory services, in partnership with the private sector and other stakeholders by 2021.

Strategies

3.1 Strengthen the capacities of health worker training institutions/programmes and introduce an accreditation system.
3.2 Develop an appropriate plan for production of health workers, based on projected HRH needs, both in number and skill-mix.
3.3 Expand capacities of health training institutions and increase training outputs based on projected HRH needs to contribute to provision of equitable, non-discriminatory, quality healthcare services.
3.4 Provide appropriate and coordinated training of community health workers, in order to mitigate the shortages of health workers and scale up health promotion at community level.
3.5 Introduce on-the-job training, mentorship and skills development programme for all technical and managerial skills.

Chapter 3: Leadership and Governance

Situation Analysis

The MOH has a wide range of leadership responsibilities, such as policy formulation, legislation, standard setting, resource mobilization, inter-sectoral collaboration, donor coordination, performance monitoring, etc. The Ministry is expected to provide leadership in relation to these and to coordinate the efforts of all healthcare planners, providers and financers at all levels of care. It is therefore important to review the MOH structure at all levels to ensure it is fit for purpose in relation to this role. This is especially critical in the ongoing federalization process, along with ensuring the necessary capacity is developed during the plan period to effectively deliver enhanced role.

The MOH has put in place a range of policies, including the National Health Policy, developed and endorsed in 2014, Human Resource for Health Policy, developed and endorsed in 2014, National Medicine Policy developed and endorsed in 2014, Expanded Programme on Immunization (EPI) Policy and other policies aimed at guiding delivery of services. In addition to these policies, MOH has a draft National Health Act (Bill) aimed to provide the required governance and legal framework for the health sector.

With the introduction of the federal process, it has become evident that there is a need to clarify roles and responsibilities between the Federal MOH and State MOHs in order to improve on implementation efficiency. In addition, MOH is in the process of establishing regulatory bodies such as National Health Professions Council and National Pharmacy Regulatory Authority.

Constituency-based coordination structures exist with membership from the Government, development partners, UN, NGOs and civil society; however, the functions, roles and responsibilities as well as their operating modalities need to be reviewed so as to institutionalize and make them more effective to represent the interest of the population including the vulnerable groups.

Procurement and contract management are in the hands of the financiers (Development Partners). The Federal Government of Somalia policy is to channel all donor funds through the Government to fund the National Development Plan and Sector Strategic Plans, progressively reducing standalone vertical programmes and projects run by development partners. However, this will require development of agreed common management arrangements within the context of a sector-wide approach.

Table 2 SWOT Analysis for the Leadership and Governance

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Oversight and governance structures at federal and state levels. ✓ Encompassing national health policy endorsed by the cabinet. ✓ Draft legal framework (National Health Act). ✓ Ongoing process in developing regulatory boards. ✓ Coordination mechanism between health authorities and development partners. ✓ Leadership/governance development plan. ✓ Defined monitoring and evaluation framework for the health sector.	☐ Delayed approval of the National Health Act. ☐ Lack of sector-wide approach (SWAp). ☐ Weak and fragmented health sector coordination. ☐ Lack of capacity in procurement and contract management. ☐ Weak governance and management structures at all levels. ☐ Lack of social &public accountability system. ☐ Weaknesses in the systems for promoting transparency, accountability and access to information.	✓ Health and nutrition sectors are prioritized in the NDP. ✓ Federal system and political commitment to decentralize services to local level. ✓ International support to harmonization and alignment, particularly the New Deal and NDP.	✓ Lack of predictability of funding from the DPs. ✓ Weak systems for coordination and harmonization of sector support. ✓ Weak linkages with other Government sectors with corresponding mandates linked to health.

Critical Issues and Challenges

- Existing health laws and regulations remain draft.
- The leadership and stewardship role of the Ministry is very weak.
- MOH has no role over the procurement and contract management, which remain in the hands of development partners.
- Weak sector coordination structures and arrangements at all levels.
- Lack of public private partnership (PPP) in the provision of comprehensive integrated health services.

- Lack of public accountability mechanism including meaningful representation from vulnerable groups.

Strategic Goal

Strengthen the leadership, governance, institutional and management capacity of the health sector to deliver efficient and effective health programmes and services.

Strategic Objectives and Priority Strategies

Strategic Objective 1: To create enabling environment through provision of appropriate legal framework and provide the necessary capacities for implementation by 2018.

Strategies

1.1 Review, update, enact and disseminate the National Health Act.
1.2 Establish and provide resources for the effective functioning of health regulatory bodies such as health professions council, national pharmacy regulatory authority and public health inspectorate.
1.3 Develop a system to monitor the compliance and enforcement of regulations including international health regulations.

Strategic Objective 2: To enhance and streamline the governance, leadership and management systems and capacities at all levels of the health system by 2021.

Strategies

2.1 Review the functions, structures, roles and responsibilities of the Ministry of Health in line with the Federal Constitution.
2.2 Develop clear-cut and effective line of communications between Federal, State, Region and District levels and vice versa.
2.3 Review, update and implement the leadership and management capacity building plan in line with the updated functions, roles and responsibilities.
2.4 Develop and implement health facility governance and management framework for all levels (PHU, HC, RHC, Hospitals).
2.5 Strengthen citizen and civil society engagement and accountability in management and review of health services through the establishment of community health boards with clear operational protocols and guidelines ensuring meaningful involvement of women and other vulnerable groups.

Strategic Objective 3: To provide a viable oversight, sector planning, monitoring and supervision system from national to district levels by 2018

Strategies

3.1 Develop tools for sector-wide planning, supervision, monitoring, review and evaluations including meaningful involvement of service users and communities including hard-to-reach areas.

3.2 Develop annual plans (consolidated plan from districts, regions and states) inclusive of all actors (Government, Civil Society, Private Sector, Development Partners, Academic and Training Institutions, etc).
3.3 Undertake joint review missions, based on annual performance review report and organize annual health review forum to discuss the joint review mission findings and recommendations.

Strategic Objective 4: To enhance coordination, alignment and harmonization of development and humanitarian assistance with development partners, implementing agencies, civil society and private sector by 2018.

Strategies

4.1 Review the health sector coordination arrangements and structures including its membership, terms of references and meeting procedures.
4.2 Move the centre of gravity of the health sector coordination from Nairobi to Somalia.
4.3 Develop and adopt Somalia health sector partnership compact.
4.4 Develop monitoring framework for the Somalia health sector partnership compact.
4.5 Strengthen capacity of coordinating structures at federal, state, region and district levels.
4.6 Develop joint funding arrangement based on the health sector compact.
4.7 Develop policy and guidelines for Public-Private Partnership based on health sector compact to ensure long-term sustainability of the health system.
4.8 Develop common management approaches across the sector by all partners, covering procurement, disbursement and accounting of funds, and joint reviews of health sector performance in line with agreed Partnership Principles between federal government and development partners.

Chapter 4: Medicines, and Technologies

Situation Analysis

Following the collapse of central government in Somalia in 1991, the public medicines and supply systems also collapsed. The UN agencies and International Non-Governmental Organizations (INGOs) began to engage in provisioning of medical supplies to public health facilities as part of their humanitarian and emergency interventions.

Under current arrangements, donors, UN agencies and NGOs operate their own parallel supply chain systems, largely as a pre-packed kit system, with little coordination and integration. UNICEF provides medicines and supplies to health facilities and health posts using a kit system, while medicines for malaria, HIV, EPI and nutrition are supplied based on request. This also applies to UNFPA's reproductive health kits. WHO and INGOs such as World Concern and World Vision, also provide medicines for some neglected tropical diseases. Emergency supplies are mainly delivered through a kit system, utilized by international and national NGOs. This push- and pre-packed kit system still prevail meeting for only 20–25% of total need in the country.

It is estimated that the private sector provides around 80% of the country's medicines through importation and distribution through private retail outlets and pharmacies. This includes medical technologies and equipment, apart from those provided through projects and partners' support.

The essential medicines programme is in its infancy and requires a great level of support to establish the key components. The rational use of drugs has not yet been introduced and over-prescription is widespread. The availability of paediatric formula is limited. There is no regulatory system for the pharmaceutical sector to ensure the safety, quality and efficacy of medical products, as well as proper drug importation and utilization, particularly for private importers.

In addition to the above challenges, medicines are poorly managed and are stored at facility/warehouse level without a proper inventory system. A supply chain management master plan has been developed, but its implementation needs substantial funding. The existing kit-based push system often results in stock-outs and, at the same time, oversupply of medicines and equipment that are not appropriate or in use. Insecurity in many geographical areas poses an additional challenge to the transportation of supplies and triggers increased costs. The distribution system is often inefficient due to lengthy funding and procurement procedures, resulting in a short shelf life by the time medical products reach the health facility.

Departments or units in charge for pharmaceutical services are not included in the organizational structures of the central health administrations. There are no accredited training curricula for pharmacists and structured pharmacy training is not included in pre- or in-service training of health professionals.

Added to the above mentioned issues, the medical products that reach health facilities are inefficiently utilized due to a lack of operational guidelines, tools and appropriate training.

The existing laboratory services are inadequate to provide reference and quality assurance services including testing of drugs imported into the country. With the countless emergencies and disasters that the country faces, there is also need for a functional and vibrant blood transfusion service that collects sufficient quality blood.

However, there has been important progress. Treatment protocols for the implementation of EPHS (including hospitals) have been developed, which should standardize use of medical products based on essential drugs lists for each level. Standard operating procedures for warehouse management and storage practices have recently been introduced. In response to reports of counterfeit and low-quality drugs in the mass media, six mini-labs have been established and are functioning throughout the country for basic quality testing of anti-retrovirals, anti-tuberculosis drugs, anti-malarials, anti-bacterials and some analgesic medicines. Additional quality testing is performed in Kenya's National Quality Control Laboratory. A system for sending alert warnings on withdrawn medicines is in place.

Table 4 SWOT Analysis for Essential Medicine and Technology

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Essential medicine policy in place. ✓ Supply distribution and logistics management systems. ✓ Costed supply chain master plan. ✓ Trained personnel on logistics and supply management. ✓ Regular procurement and distribution of essential drug kits to health facilities including priority health programmes such as TB, malaria, ART. ✓ Existence of standard treatment guidelines.	☐ Lack of government budget in drug supply. ☐ Stand-alone procurement and supply management systems of vertical programmes. ☐ Inadequate staff trained in logistics management. ☐ Lack of medical stores at all levels. ☐ Limited supervision of staff involved in logistics at certain levels. ☐ Poor communication and coordination in the supply chain. ☐ National drug policy not implemented. ☐ Insufficient funding to supply chain master plan. ☐ Absence of department in charge for pharmaceutical services. ☐ Irrational use of medicine ☐ Critical shortage of skilled staff in pharmacy profession. ☐ Absence of pharmaceutical association. ☐ Lack of therapeutic committees in health facilities (hospitals). ☐ Lack of comprehensive quality control laboratory for medicine and food. ☐ Lack of pharmacy regulatory authority.	☐ Availability of financial and technical support from partners towards commodity security. ☐ Commercial private companies importing medicine and supply. ☐ Diaspora contributions to supply and commodities.	✓ Over-dependence on donor funding of the drugs budget.

Critical Issues and Challenges

1. Essential medicine policy is not implemented and no guidelines are in place for medicines, medical supplies and equipment, vaccines, health technologies and logistics.
2. Presence of sub-standard, inefficacious and unsafe drugs in the local market.
3. A weak supply chain management system.
4. Lack of monitoring and surveillance system (pharmaco-vigilance) for drugs.
5. A regulatory authority is absent (especially of private importers) to ensure the safety, quality and efficacy of medical products, as well as proper drug importation and utilization.
6. Access to quality medicines is limited.
7. Accredited training curricula for pharmacists are not developed and structured pharmacy training is not included in pre- or in-service training of health professionals.

Strategic Goal

Ensure the availability of essential health supplies, medicines, vaccines and commodities that satisfy the priority needs of the population, in adequate amounts, of assured quality and at a price that the community and the health system can afford.

Strategic objectives and Priority Strategies

Strategic Objective 1: To develop appropriate policy and legal framework with respect to medicines, medical supplies and equipment, vaccines, health technologies and logistics by 2019.

Strategies

1.1 Review, update and disseminate national medicine policy.
1.2 Develop, approve and disseminate national pharmacy regulatory authority act and related guidelines.
1.3 Develop, approve and disseminate national laboratory and blood transfusion services act.
1.4 Review, update, approve and disseminate national immunization policy.
1.5 Develop, approve and disseminate drug donation guidelines.
1.6 Develop a traditional medicine policy.

Strategic Objective 2: To improve access to good quality, efficacious, safe and affordable medicines, medical supplies and equipment, vaccines and health technologies by 2021.

Strategies

2.1 Provide adequate and appropriate drugs, equipment and medical supplies (ensure that facilities have at least 80% of identified tracer essential drugs in stock all year round).
2.2 Introduce drug revolving programme to address the frequent shortages of medicines and medical supplies and equipment, and health technologies in the public sector.
2.3 Develop and implement training programme on medicines and medical supplies and equipment, vaccines and health technologies to address the inadequate technical and managerial skills of health workers and pharmacists.
2.4 Establish supervision and monitoring system for both public and private health services in the area of management of supplies.
2.5 Introduce and maintain effective logistic management information system at all levels.
2.6 Construct/expand/rehabilitate and equip Central Medical Store (CMS), State Medical Stores (SMS) Regional Medical Stores (RMS), and Hospital Stores to ensure proper storage and handling of medicines, medical supplies and equipment, vaccines and health technologies at all levels.
2.7 Develop and implement stock and inventory control system and tools at all levels.

Strategic Objective 3: To improve, advance and strengthen the medicines regulations and quality assurance system by 2021.

Strategies

3.1 Develop a code of ethics and a conduct for pharmacy practice; guidelines and standard operating procedures for medicines inspection, medicines registration, pharmaco-vigilance and quality control analysis.
3.2 Develop drug registration and inspection systems.
3.3 Procure quality control equipment, including spares, chemicals, reagents and reference standards and secure a maintenance contract for quality control equipment
3.4 Monitor and report adverse drug reactions.

Strategic Objective 4: To promote rational and cost effective use of medicines at all levels of the health care delivery system by 2021.

Strategies

4.1 Establish a department for pharmaceutical services (rational medicine use, drug information and sensitization).
4.2 Establish medicine information centres and therapeutic committees at tertiary and secondary health facilities.
4.3 Undertake consumer sensitization on the rational use of medicines.

Chapter 5: Health information system

Situation Analysis

An integrated and properly functioning health information system is a prerequisite for sound decision-making and planning through provision of timely, reliable and relevant information. Collection and use of data disaggregated by factors such as sex and location (combined with others as available such as age) is central in identifying inequalities, and planning and review of progress in tackling these. Effective use of data can help ensure that overall improvements in health outcomes are not hiding lack of improvements for vulnerable groups. Routine health data in Somalia is collected through a network of some public health facilities that are unevenly distributed throughout the country.

HMIS: The HMIS is functional only in the Federal MOH, Somaliland MOH and Puntland MOH supported mainly through GFATM, GAVI and JHNP. Functionality varies across the country in terms of established structures, timeliness and completeness of reporting at the various levels (facility, region and central MOH). HMIS units are non-existent in most of the districts. Data is currently captured in a manual form from health facility to regional HMIS and then submitted to central HMIS. This has partly facilitated the production of ad-hoc reports only at national level with limited or no feedback to health facilities. Data is rarely used for planning and decision making.

The current HMIS platform uses an Excel database. However, as part of the process of strengthening the HMIS, a district-based electronic data management system, known as the district health information system (DHIS2) is underway to integrate and improve the quality and efficiency of data storage, transfer, analysis and dissemination.

Despite the achievements so far, the HMIS still needs to strengthen its data collection capability, improve quality of data collected and enhance analytical capacity at all levels.

National surveys and census: Somalia has not conducted a national survey for the past nine years. The last multiple indicator cluster survey covering all regions was in 2006. The 2011 multiple indicator cluster survey covered only Somaliland and Puntland and, as such, the findings cannot be used for all regions. There are ongoing discussions on conducting regular multiple indicator cluster surveys/demographic and health surveys. The NDP's draft monitoring and evaluation framework includes a list of surveys that are planned and/or considered for the next three years.

Independent monitoring and evaluation: MOH, partners and donors have planned or implemented independent monitoring and evaluation of some health sector components/programmes. Examples of completed reviews include: a joint annual review of HSSP I/annual work-plans, review of the GAVI, midterm review of the JHNP and a strategic review of the Somali health sector (conducted in September 2015)). To further strengthen the M&E capacity of MOHs, and to guide programmatic planning and implementation, an M&E framework and plans were developed in 2013, but not fully implemented. Nutrition M&E has greatly improved in terms of reporting; however, the nutrition database and dashboard need to be integrated into HMIS at all levels.

Birth and death registration: The coverage for birth registration among children aged under-five in Somalia was estimated to be only 3% (MICS 2006). During the first phase HSSP (2013 – 2016), pilot initiatives on vital registration system were launched in some districts, but the system requires massive development to systematically scale up to all districts across the country.

Table 6 SWOT Analysis for Health Information

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Established system capturing routine health information, including HMIS, CSR, and others. ✓ HMIS units at central and regional levels. ✓ District health information software (DHS2) under development. ✓ Standardized recording and reporting tools in place. ✓ Established channels for information flow/feedback. ✓ M&E units in place. ✓ M&E framework and costed plan of actions in place.	✓ HMIS is not yet functioning optimally. ✓ There are challenges in respect of scope of coverage, timeliness & completeness of reports, etc. ✓ Lack of standard case definition and disease classification. ✓ Lack of HMIS in pre and in-service training curricula. ✓ Lack of data verification and quality assurance. ✓ Low data demand and information use. ✓ Lack of feedback system.	✓ Support from DPs towards. strengthening HMIS ✓ Increased demand for information by stakeholders.	✓ Parallel and vertical reporting systems. ✓ Lack of interest and support for population-based data (priority surveys).

Critical Issues and Challenges

1. Inadequate financial and human resources for implementing HMIS plans.
2. Weak capacity for data analysis, reporting, dissemination and use.
3. Incomplete reporting at all levels.
4. Weak hospital statistics.
5. Lack of private sector and community data.
6. Lack of standards and guidelines for data collection, analysis and reporting.
7. Lack of feedback at all levels.
8. Absence of mechanisms for data verification and quality assurance.
9. Weak relationship between HMIS and management, planning and review of health plans and programmes.
10. Catchment area population not well defined
11. The quality of the data collected and reported to the HMIS is questionable.
12. No systematic and comprehensive national household-level health surveys conducted since 2006 covering all the regions of the country to generate comparative and representative values for core health indicators.
13. Health information system of vertical programmes and surveillance systems not integrated with HMIS
14. System for vital statistics and civil registration not in place.

Strategic Goal

Establish effective health management information system based on sound, accurate, reliable, disaggregated and timely information for evidence based planning and implementation, supported by effective monitoring and evaluation and by targeted research.

Strategic Objectives and Priorities

Strategic Objective 1: To provide a policy framework for establishing a functional health management information system by 2018.

Strategies

1.1 Develop, produce and disseminate a HMIS policy based country needs.
1.2 Develop a costed health management information system strategic plan and share it with stakeholders and donors for funding.
1.3 Review utilization of the HMIS for policy development, planning, monitoring and evaluation.

Strategic Objective 2: To enhance and strengthen the institutional framework for implementing a functional health management information system by 2021.

Strategies

2.1 Strengthen the capacity of the national and sub-national HMIS offices to effectively implement the HMIS policy and strategic plan.
2.2 Establish district health management information offices and introduce DHIS 2 in phased approach.

2.3 Develop HMIS standards, guidelines and standard operating procedures (SOPs) for the data collection, analysis, and reporting.
2.4 Identify relevant HMIS stakeholders, establish national HMIS steering committee and revitalize HMIS technical working group.

Strategic Objective 3: To improve routine data collection quality, management, dissemination and use at all levels by 2021.

Strategies

3.1 Establish an integrated HMIS portal for dissemination of all available data and meta-data resources.
3.2 Establish an integrated data warehouse and archive system.
3.3 Integrate vertical data collection and reporting systems into the routine health management information system, including disaggregation by sex, location and other factors.
3.4 Review and harmonize all data collection and reporting tools.
3.5 Build the capacity of staff at all levels to follow HMIS standards, guidelines and SOPs for data collection, analysis and reporting.
3.6 Produce quarterly and annual health statistics for both operational and strategic management.
3.7 Undertake advocacy for policy makers, planners and implementers for use of health data in planning and decision making at all levels.
3.8 Provide information communication technology (ICT) technology to HMIS units and health facilities and increase access and use of ICT technology for health management information system.
3.9 Mobilize adequate resources for national health management information system.
3.10 Conduct a comprehensive assessment of the vital registration system and develop a plan to strengthen the vital registration unit both technically and logistically.
3.11 Establish management information systems for logistics and supply management information, human resource information system, health infrastructure information system, income and expenditure tracking system, etc.
3.12 Establish data collection system at community level
3.13 Establish data collection system from private sector

Strategic Objective 4: To improve and strengthen monitoring and evaluation, research and knowledge management capacity of the health sector by 2021.

Strategies

4.1 Revise and disseminate the list of core health sector indicators with an emphasis on identifying and addressing inequalities.
4.2 Develop and implement a comprehensive monitoring and evaluation framework for the health sector based on HSSP II.
4.3 Develop a mechanism for knowledge management.
4.4 Develop a health research policy and strategic plan that includes population based and other priority surveys.
4.5 Strengthen capacity for research on health issues, including a focus on inequalities.

4.6 Establish a forum for dissemination of local research findings.
4.7 Strengthen the national reference laboratory to contribute to evidence generation and research.

Strategic Objective 5: To enhance early warning and integrate disease and nutrition surveillance systems into national HMIS by 2019.

Strategies

5.1 Strengthen integrated disease surveillance and response (IDSR) information system.
5.2 Strengthen nutrition surveillance system.
5.3 Develop and implement community-based IDSR and nutrition surveillance strategy.
5.4 Develop and pilot demographic surveillance sites (DSS) in Somalia in collaboration with academic and population statistics' institutions.

Chapter 6: Health Financing

Situation Analysis

Health financing for Somalia has been extremely limited as Somali macroeconomic performance is poor. Health sector resources are mainly from out-of-pocket payments or through donor funding. The Somali Diaspora contributes significantly to the health sector, but information is not documented.

Per capita public expenditure on health is approximately US$10–12 per year, which is far below the global standard for health sector investment. This increases the risk of financial burden, especially on poor people with higher out-of-pocket expenditure.

In absolute terms, there has been a significant increase in funding for the health sector in Somalia over the past 10 years. Financing from conventional donors has increased by 180%, from US$53.6 million in 2005 to US$103 million in 2009, reaching approximately US$150 million in 2014 according to World Bank report. A trend of increasing *development* assistance for health has been noted over the past few years, whereas there is an element of fatigue in *humanitarian* funding (excepting 2011, when humanitarian funding for health increased to US$127 million compared to US$22 million in 2010 in response to protracted drought.
External financing greatly exceeded the governmental contributions to the health sector. In Somaliland, while US$150 million was invested in 2014, the government's budget contribution to health for the year 2014 was US$7.1 million compared to US$1 million during 2007–2009. Puntland's budget allocation to health, which was on average US$ 0.3 million per annum during 2007–2009, increased to US$1 million in 2014. Budget allocation in South Central Somalia remains the lowest despite a proportionally higher population. Actual expenditure is not documented.

Many donors channel their contributions to the health sector through a chosen implementing partner, depending on the type of support provided, usually by contracting out private providers to deliver EPHS or basic services. This is particularly true for the non-traditional donors, but it is a feature of most donors in Somalia. With the possible exception of the Islamic NGOs, the largest bilateral funding scheme is the JHNP, followed by the Health Consortium Somalia, active in

different regions in the country. There are important differences in the model of EPHS delivery between the different programmes, and in contracting arrangements.

Table 6 SWOT Analysis for Health Financing

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Draft health financing strategy and EPHS costing tool. ✓ Limited but consistent increase in Government funding to the health sector. ✓ Equity oriented financing mechanisms (no user fees in core EPHS programmes). ✓ Health financing unit in place.	✓ Lack of healthcare financing policy. ✓ Lack of social and private health insurance systems. ✓ Lack of resource allocation criteria. ✓ Inadequate funding to the health sector (both domestic and external). ✓ Weak coordination and harmonization of external sources of funding. ✓ Inequities in healthcare financing. ✓ Weak tracking mechanisms for vertical funding.	✓ Government commitment to increase health budget to 12% by 2019 (according to NDP). ✓ Global sources of support, particularly GFATM, GAVI, and other foundations. ✓ PPP in providing healthcare and other services in the sector.	✓ Unpredictable donor funding ✓ Lack of common-basket funding mechanism due to governance challenges. ✓ Inadequate funding to the strategic priorities. ✓ Escalating expenditure in private health sector.

Critical Issues and Challenges

1. Extremely limited government budgetary allocations for health care delivery.
2. Lack of pro-poor healthcare financing policy.
3. Difficult procedures for accessing donor funding.
4. Inequitable and inefficient allocation of health sector resources.
5. Healthcare is unaffordable to the majority of Somali people.
6. Lack of social and private health insurance system.
7. Weak coordination and harmonization of external funding.
8. Absence of system to track income and expenditures.

Strategic Goal

Create sustainable health financing system, which relies national financing and local resources, protects the poor from catastrophic health expenditure, ensures universal health coverage, allocates budget to priorities, accounts for spending accurately, and uses national and international funds more efficiently through SWAp

Strategic Objectives and Strategic Priorities

Strategic Objective 1: To secure adequate level of funding needed to achieve national health and health related sustainable development goals by 2021.

Strategies

1.1 Develop pro-poor healthcare financing policy and implementation strategy (including development of clear criteria for determining vulnerability).

1.2 Undertake series of advocacy and lobbying to increase government allocation to health sector to at least 12% by 2021.
1.3 Advocate for the introduction of dedicated taxes for health (e.g. on Khat, Tobacco, Cosmetics, Cell phones) to ensure that at least 12% of national budget is allocated to health sector.
1.4 Develop and implement health sector resource mobilization strategy.
1.5 Develop sound, efficient and effective financial and procurement management systems for the health sector.
1.6 Institutionalize national and sub-national health accounts to track flow of financial resources.

Strategic Objective 2: To ensure equitable access to quality health services free from financial catastrophe and impoverishment by 2021.

Strategies

2.1 Develop and implement innovative prepaid health schemes, e.g. social health insurance, or community based health insurance schemes.
2.2 Establish and strengthen safety nets to ensure that the poor and other vulnerable populations have access to quality healthcare services.

Strategic Objective 3: To ensure equitable and efficient allocation and use of health sector resources at all levels by 2021.

Strategies

3.1 Develop and implement equitable needs-based criteria for allocating financial resources.
3.2 Harness the NGO and private sector resources through contractual arrangements in pursuit of national health development goals.
3.3 Develop provider (health facilities and health workforce) payment mechanisms that create incentives for greater productivity, efficiency and equity.
3.4 Introduce and institutionalize health sector efficiency monitoring system including measurement of reductions inequalities.

Chapter 7: Health Infrastructure

Situation Analysis

The physical infrastructure of public health facilities refers to the state of the buildings, the water, electricity and communications technology available, the quality of access roads, and the availability of equipment (both medical and non-medical) in working condition. Delivering healthcare above a certain level of complexity is difficult in the absence of good infrastructure. Shelter for patients and staff, drinkable water and a source of electricity for, among other things, refrigeration for vaccinations, are fundamental for the safe provision of healthcare. A working communications mechanism is necessary for the functioning of a referral system, as well as to enable the provision of support services (such as laboratory services) to the facility.

There has been no systematic study on the conditions of Somalia's public health infrastructure over the years. A health facility assessment with component of health infrastructure is currently underway with the support of WHO and UNOPS. However, poor infrastructure has been cited in a number of studies, conducted primarily in middle and low income countries, as undermining health service delivery. Many specialized projects have not achieved their targets because of the poor infrastructure in which services are delivered. Poor infrastructure has been shown to significantly affect patients' perception of quality of care and has a significant effect on health professionals' satisfaction with their working conditions.

The state of the physical infrastructure of health facilities across the country is poor because, not only is the condition of the infrastructure poor, it is also inadequate for the needs of health facility catchment populations. Both of these problems need to be addressed in the HSSP II. One is to ensure that infrastructure is of good quality, and the other is to plan infrastructure development to better meet the needs of the populations served. Good data is essential for both of these tasks, considered in relation to disaggregated population data that looks at factors such as gender, age, location and disability. This can help ensure access that can contribute to reductions in inequalities through, for example, the availability of toilets for male and female staff and patients, beginning to work towards access for people with physical disability, facilities for healthcare workers and their families in rural areas, or access information for people who cannot read.

The collection of infrastructure data, especially that relating to the conditions of physical infrastructure and equipment may require specialist skills. However, it is necessary to collect and review such information every few years because buildings and equipment deteriorate over time.

Table 7 SWOT Analysis for Health Infrastructure

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Availability of standard construction guidelines for EPHS facilities (facility blueprint). ✓ Availability of standard equipment list for EPHS levels. ✓ Limited funding for health infrastructure development.	✓ Low levels and volume of funding toward infrastructure. ✓ Lack of capacity to manage and monitor health infrastructure projects. ✓ Lack of infrastructure database. ✓ Lack of master plan for health infrastructure development. ✓ Lack of budget line for health infrastructure. ✓ Lack of medical equipment maintenance system. ✓ Lack of management policy/standards for medical equipment. ✓ Poor planning for new constructions (white-elephant facilities widely spread across the country).	✓ Support from development partners towards infrastructure development. ✓ Diaspora contributions to medical equipment.	✓ Lack of political will to health infrastructure projects. ✓ Sparse distribution of the population. ✓ High operational and maintenance costs.

Critical Issues and Challenges

1. Low levels and volume of funding toward health infrastructure by development partners.
2. Lack of database and master plan for infrastructure development based on population needs.
3. Lack of Government budget line for health infrastructure development (acquisition of new equipment and facilities, etc).
4. Lack of physical infrastructure and medical equipment maintenance system.
5. Lack of management policy/standards for medical equipment.

Strategic Goal

Ensure the Somalia health system has the necessary infrastructure to effectively respond to the healthcare needs of the people and provide quality and accessible essential healthcare services.

Strategic Objectives and Strategic Priorities

Strategic Objective 1: To enhance access to healthcare services through the establishment of network of public health facilities to support the effective delivery of EPHS at all levels by 2021.

Strategies

1.1 Carry out an inventory of physical infrastructure and quantify the number of health facilities to be rehabilitated during the strategic planning period taking account of diverse population needs (e.g. in relation to gender, rural isolation, disability etc).
1.2 Develop a comprehensive physical infrastructure development/rehabilitation plan including rationalization plan.
1.3 Construct/re-construct/rehabilitate health facilities in accordance with the national health facility blueprint and rationalization plan (structures, water supply, toilets, and medical waste disposal facilities) and include staff quarters for remote located and rural health facilities.
1.4 Elaborate a national infrastructure databank to include information on equipment and furniture, and facilities.
1.5 Develop new standards and norms and needs assessment for each level and type of facilities.
1.6 Develop selection criteria for the construction of additional facilities.
1.7 Establish architect, engineering and infrastructure maintenance department at federal and state levels.

Objective 2: To improve the institutional capacity and create conducive working environment through provision of adequate office premises, work-stations, ICT equipment and transport by 2019.

Strategies:

2.1 Construct office premises for the head-quarter, state ministries and regional health offices.
2.2 Provide work-stations for the head-quarter office, state ministries and regional health offices.
2.3 Provide ICT equipment and transport to the head-quarter office, State Ministries and regional health offices.

Strategic Objective 3: To procure, install and utilize appropriate medical and diagnostic equipment within the health facilities by 2021.

Strategies

3.1 Conduct comprehensive needs assessment and database for medical imaging equipment.
3.2 Procure and install new equipment based on the assessed needs.
3.3 Ensure availability of consumables for the medical equipment as part of the procurement of essential medicines and health supplies.
3.4 Recruit and train both technical and maintenance staff as required and in accordance with the human resource development plan.

Chapter 8: Emergency Preparedness and Response

Situation Analysis

Essential and life-saving medical services are insufficient and overstretched, including critical public health, nutrition and water, sanitation and hygiene (WASH) services, increasing the risk of a public health emergency. Delivery of life-saving medicines and medical equipment has been irregular due to insecurity, road inaccessibility, electricity and fuel shortages, and rupture of the cold chain. Access to essential health services is an immediate need for some 3.27 million people, with health capacities severely overburdened, stocks diminished and services disrupted especially in conflict, drought and flood-affected areas, especially for IDPs.
Health Cluster partners plan to reach about 1.8 million people – or 56 per cent of the people in need – through provision of primary and secondary health care services, focusing on displaced people, host communities, underserved rural and urban areas (including newly-recovered areas), El Niño and drought-affected people. Health and WASH clusters will continue to implement joint strategies to prevent and mitigate the impact of disease outbreaks, particularly seasonal acute, watery diarrhoea (AWD)/cholera.

Healthcare for the most vulnerable people, especially girls, women and boys, is provided through international and national partners, UN agencies, and the Ministry of Health. While the NGOs remain the prime provider of healthcare services in Somalia, all cluster partners provide key frontline health services in targeted geographical areas, including mobile medical units for services in hard-to-reach and overwhelmed areas, camp-based clinics, and support to existing facilities unable to cope with increased demands. These provide life-saving healthcare services for the particularly vulnerable, such as primary health care, emergency reproductive health and nutrition and trauma care. Frontline health care providers will need to scale up the availability of life saving interventions to meet increasing needs, complementing and building upon existing national health structures whenever possible.

Child-focused interventions will include emergency immunization campaigns of measles and polio and addressing major causes of new-born and childhood morbidity and mortality. With major outbreaks of cholera occurring frequently, low immunity levels, over-crowding in camps

and shelters, and continued displacement, there is a high risk of communicable disease outbreaks, namely measles, cholera, meningitis, acute jaundice syndrome and leishmaniasis. Timely identification, treatment, and case management for communicable diseases and response to outbreaks will be managed through functional early warning system and increased availability of stocks of medicines, vaccines and medical supplies. The Health Cluster will also ensure the provision and continuous supply of life saving medicines, medical consumables, emergency health kits, trauma kits and diarrhoea kits.

The delivery of health services by all those working in the health sector is expected to continue albeit under a more regulated environment and in close consultation and/or partnership with the Government and aligned to the Somali Health Sector strategy and the respective regional Health Sector strategic plans. Cluster activities support and strengthen existing essential public health services structures in line with the New Compact priorities of expanding health facility coverage and strengthening emergency preparedness and response. The Health Cluster will focus on covering the gaps and addressing urgent humanitarian needs in terms of access to critical services and responding to public health threats to reduce avoidable morbidity and mortality.

Table 8 SWOT Analysis for Emergency Preparedness and Response

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
☐ Cluster coordination mechanism in place for health, nutrition, and WASH ☐ Surveillance and early warning system in place ☐ WASH cluster have buffer stock pre-positioned in regions ☐ Trained staff in disaster risk reduction	✓ Lack of emergency preparedness and response plan ✓ Weak MOH capacity in emergency preparedness and response ✓ Weak surveillance and early warning system ✓ Lack of buffer stocks to respond to emergencies ✓ Weak or lack of logistic capacity to immediately respond to acute emergencies ✓ Lack of trained personnel in disaster risk reduction ✓ Long-delay and time-consuming response ✓ Absence of community structure for disaster risk reduction	☐ Health, nutrition and WASH cluster ☐ Common humanitarian fund (HRP) ☐ Disaster management agency	✓ Prolonged draughts. ✓ Subsequent disease outbreaks ✓ Insecurity in most disaster-prone areas

Critical Issues and Challenges

- Absence of comprehensive emergency preparedness and response plan that contain hazard, vulnerability analysis and risk mapping;
- Weak inter-cluster and inter-sectoral coordination mechanism.
- Extremely inadequate capacity to immediately detect and respond public health emergencies.
- Weak early warning and surveillance system at all levels.

- Lack of community structures and capacity for disaster risk reduction, mitigation and resilience.
- Lack of trained personnel in disaster risk reduction.

Strategic Goal

Improve the capacity of the health system to prevent, control and mitigate public health threats and emergencies

Strategic Objectives and Strategic Priorities

Strategic Objective 1: To improve access to essential life-saving health services (quality primary and secondary health care) for crisis-affected populations aimed at reducing avoidable morbidity and mortality by 2021.

Strategies

1.1 Develop public health emergency preparedness and response strategy.
1.2 Strengthen the capacity of the health workforce to respond public health emergencies and threats.
1.3 Establish emergency preparedness and response units readied with the necessary equipment, facilities and logistics at federal and state levels.
1.4 Procure and pre-position adequate essential supplies and buffer-stocks into the regions and districts for rapid response to outbreaks and other public health emergencies.
1.5 Train health workers in disaster risk reduction.

Strategic Objective 2: To enhance and strengthen surveillance, early warning and disease detection to mitigate, detect and respond to disease outbreaks and other public health emergencies in a timely manner by 2021.

Strategies

2.1 Strengthen the early warning and surveillance systems for health, nutrition, water and sanitation and related sectors.
2.2 Strengthen the laboratory capacity to detect public health threats.

Chapter 9: Social Determinants of Health

Situation Analysis

A range of factors contribute to a person's health and wellbeing. Many of these factors lie outside the remit of the health system. Education and employment are major determinants of the opportunity for families and individuals to maximize their health and wellbeing; transport and road infrastructure can be a significant factor on the ability to access essential health care services; suitable housing, access to clean water and fresh food are essential to maintaining good health; and a person's literacy levels as well as their socioeconomic position impacts on how well they can interact with the health system.

Other factors are critically important to reducing inequalities in health outcomes experienced across the country, such as worse health outcomes in rural areas compared to urban, or among women compared to men. While the health sector does not have control over these factors, there are many techniques and methods the sector can use to ensure they are tackled such as participatory needs assessment to contribute to planning of services, use of data to ensure accurate targeting of services, meaningful involvement of civil society – including the most vulnerable groups – in planning, delivery and review of services. Specific methods to increase access are important, such as ensuring husbands and mothers-in law-encourage women to attend services, making sure anti-malarial bed-nets are used by pregnant women, working with imams and other religious leaders to encourage health promoting activities, ensuring boys and girls get equal treatment in healthcare services. It will be important to ensure healthcare providers are trained to provide services that are non-discriminatory (e.g. in relation to factors such as age, gender, disability, HIV status).

An absolutely essential first step is having data that is disaggregated by factors such as sex (male/female), age (where possible) and location (e.g. rural areas). Without data it will be difficult to know where to target resources to reduce inequalities most effectively. Training for HMIS staff and planners in using disaggregated data to reduce inequalities is important to make sure that as information becomes available it is used effectively and to the benefit of those who need services most. However, even without robust data systems, it is important to ensure issues are raised, and planning and delivery staff are trained and taking these issues into account in their work. It is also important that M&E includes patient and community views in assessments, along with reviewing any disaggregated data to measure improvements in inequalities.

Raising awareness of health impacts from other policy domains and taking a multi-sectoral approach to tackle those issues can help improve population health and bridge inequalities, such as ensuring water and sanitation sector takes account of the needs of women and rural communities, or that the education sector ensures male and female students are being encouraged to take sciences to prepare for a career in healthcare provision. Therefore, a whole, coordinated government approach at all levels is required in addressing the social determinants of health to achieve better health outcomes and to ensure policy and planning decisions appropriately consider potential implications on health. This necessarily requires government to promote the meaningful engagement and involvement of organizations and service providers in and beyond the health sector and development of appropriate care pathways to address clients' social and welfare needs.

Goal

Create social and physical environments that promote good health for all.

Strategic Objectives and Strategic Priorities

Objective 1: To enhance inter-sectoral and multi-sectoral collaboration in addressing the social determinants of health by 2021.

Strategies

1.1 Establish multi-sectoral committee to spearhead the mainstreaming of health into all policies and plans of the Government

1.2 Work with government departments and agencies to include health in all policies and plans (education, water, agriculture, environment, employment, transport, disaster management agency, etc)

Objective 2: To promote actions in reducing the risks and vulnerabilities of the population to preventable social and environmental hazards by 2021.

Strategies

2.1 Target known lifestyle-related health risk factors, such as Khat, smoking, physical inactivity, poor diet and nutrition, and unsafe sexual practices.

2.2 Develop and implement a school health programme including adolescent sexual and reproductive health, nutrition and hygiene promotion

2.3 Promote a multi-sectoral approach to environmental health, hygiene promotion, water and sanitation.

2.4 Develop and implement comprehensive communication for development strategy to strengthen health promotion and disease prevention and address the social determinants of health in the country.

SECTION 5: COSTING AND FINANCIAL PLAN

Although HSSP II envisages a bigger share of the national budget being earmarked for the health sector, a realistic assessment is that external support will remain the biggest share in financing for the public health sector. The main sources of financing are likely to be the traditional donors like, WB, DfID, SIDA, Swiss, USAID, the UN, the GFATM and GAVI. Non-traditional donors may also join in financing HSSP II including Turkey, Qatar, UAE, Saudi Arabia, OIC and Islamic Bank. HSSP II is a guide to these financiers to allocate their funds in support of specific strategies in their entirety, or to stated objectives to achieve specific results.

HSSP II Resource Envelope:

STRATEGIC AREA	2017	2018	2019	2020	2021	Total
Health Service Delivery	80,427,552	95,341,378	98,179,875	90,748,196	85,911,060	**450,608,061**
Human Resource for Health	12,320,383	13,986,472	14,322,314	13,572,944	13,211,675	**67,413,789**
Governance and Leadership	6,296,859	7,088,194	6,551,441	5,615,492	5,357,530	**30,909,516**
Health Information	6,059,456	7,753,487	8,034,841	7,238,826	6,549,128	**35,835,738**
Medicine and Supplies	18,562,931	22,959,087	23,524,412	19,628,640	17,923,758	**102,598,826**
Health Financing	5,892,480	8,111,703	7,753,909	6,877,455	6,503,368	**35,138,914**
Health Infrastructure	18,606,012	22,758,970	24,308,236	19,692,559	17,670,211	**103,035,987**
Health Emergency	6,491,344	8,646,624	8,840,341	7,416,865	6,913,946	**38,309,119**
Social Determinants of Health	4,119,983	5,141,434	5,734,404	5,234,899	4,477,511	**24,708,231**
GRAND TOTAL	**158,777,000**	**191,787,350**	**197,249,773**	**176,025,876**	**164,518,185**	**888,358,184**

SECTION 6: PLAN MANAGEMENT, IMPLEMENTATION, MONITORING AND REPORTING

This section presents the implementation plan for HSSP II which builds on achievements so far and provides strategies to consolidate and enhance health system performance in the period 2017 to 2021. HSSP II will therefore guide stakeholders on how best to deliver the EPHS within a framework of systematic health systems development. It is expected to ensure improved health outcomes for all people in Somalia with a special emphasis on the most vulnerable groups. The following will be the key strategies that guide implementation of the plan:

Broad Strategies

1. Delivery of a comprehensive healthcare services using EPHS and PHC approach with an emphases on decentralization and active participation of key stakeholders;
2. Scaling up priority interventions, in an integrated manner to produce targeted outputs and outcomes, with due consideration to resource constraints;
3. Improving quality of care;
4. Improving responsiveness and accountability to consumers so as to enhance utilization of essential services;
5. Explicit consideration of women, children and other vulnerable groups in provision of essential health and nutrition services;
6. Appropriate supervision, monitoring and evaluation framework for the provision of the essential health and nutrition services;
7. Any other programme and disease specific strategic plans should be aligned to the health sector strategic priorities.

COORDINATION ARRANGEMENTS

The previous health sector coordination structure was complex and consisted of the Health Advisory Board, the Health Sector Committee, the Zonal Health Sector Coordination Forums, Thematic Working Groups, Humanitarian Clusters (Health, Nutrition, WASH), the Global Fund Steering Committee, etc. The Health Advisory Board (HAB) was an effective body in political terms. It brought together the Ministers of Health of the Federal Government, Somaliland and Puntland and the Head of Agencies of the Donors and UN. The key challenge for the HAB was that it was not linked to the higher level coordination arrangements such as the New Deal Compact. It had also no link with humanitarian cluster system and with the Global Fund Steering Committee. The Health Sector Committee (HSC) was the key coordinating mechanism at the technical level. The HSC decisions were referred to the HAB for review and endorsement. However, the HSC became an open forum with no clear agenda and policy to guide the health sector coordination leading to overwhelmed discussions and slow pace of decision making. The HSC lacked effective and efficient secretariat to support the overall health sector coordination activities. Zonal Health Coordinating Forum provided an information sharing and coordination platform for the health sector stakeholders. Zonal Forums helped to promote Health Authority leadership of the health sector; and provided a constructive platform to address operational issues, supported by Technical Working Groups (TWGs). However, Zonal Forums were too large and took too long to ensure focused discussion and clear outcomes. They also tended to lack clear accountability channels, with all stakeholders.

During HSSP II, the health sector coordinating mechanism will be strengthened and aligned to the Aid architecture of the national development plan 8 and subsequent development plan 9 to

enable it provide guidance for institutionalized sector partnership and collaboration. This will lay the foundation for broader joint partnership arrangements between the Government and Development Partners including Global Health Initiatives such as GAVI and GFATM and will discourage standalone, vertical programs and projects.

Under the Somalia Development and Reconstruction Facility (SDRF), the Pillar Working Groups are responsible for sectoral and programmatic coordination within the pillars of the National Development Plan (NDP). Development partners will use these groups to present programs at an early stage of development to discuss alignment with NDP priorities, coordinate with key actors, and avoid duplication. The groups will also be responsible for tracking and reporting on progress within their pillars, which will then be compiled by the Secretariat and inform discussions of the Steering Committee. Coordination between the pillar working groups and humanitarian cluster system will be important for ensuring coherence and coordination across the humanitarian-development-peace nexus. Pillar Working groups have a critical role to play in coordinating all activities related to NDP implementation, not only those financed through the SDRF trust funds.

Health, nutrition and WASH sector coordination (or known as HNW sub-working group) comes under the Pillar 7- Social and Human development working grop. The health, nutrition and WASH sector (HNW Sub-working group) will coordinate all related programmes and interventions under the leadership of Federal Ministry of health in collaboration with all concerned stakeholders and with support from donors, UN agencies and NGOs. Implementation of HSSP II through partnership will promote the role of government (MOH) as the overall steward in provision of health services in Somalia and the coordinator of all stakeholders' efforts. This will enable efficient and equitable utilization of all resources while minimizing duplication and overhead costs. This will be achieved through the following:

1. Health sector compact or an investment case will be developed to support the implementation of HSSP II;
2. Roles and responsibilities of the government (at various levels) and development partners will be clearly defined;
3. Regular assessment of performance against these roles and functions as well the investment case will be carried out (quarterly and annually) and will include expenditure reviews;
4. Coordination and consolidation of activities carried out by different players, with particular effort focused at the regional and district levels;
5. Involvement of the community, private sector and Civil Society Organizations will be particularly encouraged;

Sub-national health, nutrition and WASH sector coordination mechanism will be encouraged together with some technical thematic working groups at national and sub-national level those will provide technical and operational information to the national health, nutrition and WASH sector coordination arrangement.

The Coordination and Communication section under the leadership of the Director of policy and planning will act as the secretariat body and be responsible to ensure the documentation and management of the national and sub-national health, nutrition and WASH sector coordination and the technical thematic working groups to ensure coherence of information flow among the health sector coordination.

MONINTORING, EVALUATION AND REPORTING ARRANGEMENTS:

The HSSP II has been developed in line with the NHP I, NDP I and SDGs. As such, the HSSP II Operational Planning and monitoring framework will be developed to ensure achievement of the HSSP II objectives and targets. In the same manner, HSSP II indicators and targets have been set in line with the NDP I indicators and targets. The monitoring and evaluation framework will be inclusive and participatory, using joint reporting, monitoring and evaluation mechanisms.

Health sector performance will be monitored using a set of agreed indicators whose selection takes cognizance of indicators contained in the WHO Toolkit for health systems strengthening and the SDGs. Due consideration will be given to ensuring regular (preferably annually) availability of data for these indicators. The HSSP II indicators with baseline values and targets are shown in annex I, In addition to the national level indicators, program, district and hospital level indicators will be developed to facilitate regular performance assessment at the various levels and to provide an opportunity for comparing entities at these levels.

Sources of Information for Monitoring HSSP II

HMIS is the major tool for collecting information for monitoring the HSSP II. In this regard, strategies will be employed to strengthen HMIS to enable it to play its role effectively in monitoring of the HSSP II. In addition, information from other sources will be used.

Surveys commissioned by the MOH, which may be carried out directly by programs within the MOH or contracted out. They are planned to include:

- Population-based surveys such as DHS or MICS
- Health facility survey and service availability mapping to determine geographical access to health services;
- Health Facility Assessment (HFA);
- Data Quality Assessment
- Joint Review and appraisal reporting (JAR)
- Use of burden of disease or other appropriate methodology like comprehensive sentinel surveillance sites;

Surveys in other institutions, including national household surveys will be used to provide up-to-date and representative data for key HSSP II indicators. In addition, Research and other studies in the health sector will be commissioned to address appropriate issues and the strengthening and use of supportive supervision systems and reporting for the different levels of care.

HSSP II Reporting Arrangement

Quarterly and Annual Health Statistical Reports:

These reports will be compiled from the periodic statistical reports submitted through the Health Management Information System (HMIS). The quarterly and annual health statistical reports provide ample attention to data quality issues, including timeliness, completeness and accuracy of reporting, as well as adjustments and their rationale. The HMIS officers will be responsible for compiling and disseminating these reports.

Quarterly Performance Review Reports

Quarterly sector performance review reports will be presented by the various sector technical working groups during the sector quarterly review meetings under health, nutrition and WASH sector coordination mechanism. Quarterly state level performance reports will be presented and discussed at the quarterly review meetings attended by the key implementers in the states.

Annual Health Sector Performance Reports

The Annual Health Sector Performance Report (AHSPR) will be institutionalized during HSSP II to highlight areas of progress and challenges in the health sector. The review process will include all levels and all health services nationwide. Review reports will be used by all levels to assess performance, following which they will be submitted to the national level for compilation of the AHSPR by the end of October each year**.** AHSPR will be based on the national operational plan or the investment case aligned to the HSSP II to be supported by all stakeholders. The AHPSR will be developed through a jointly agreed process that will be validated through a Joint Review Mission to be held in November each year and launched in the Social and human development Pillar working group each year through the national health, nutrition and WASH sector Coordination Mechanism. This cycle will form an integral part of the national coordination mechanism for the implementation of the HSSP II.

The HSSP II Monitoring and Review Processes:

The framework for reviewing health progress and performance covers the M.E process from routine performance monitoring, Supportive Supervision, quarterly reviews, annual review and evaluation of all the HSSP indicator domains. Specific questions will have to be answered during the different review processes, especially the annual reviews, but also the performance monitoring.

Health progress and performance assessment will bring together the different dimensions of quantitative and qualitative analyses and will include analyses on: (i) progress towards the HSSP goals; (ii) equity (iii) efficiency; (iv) qualitative analyses of contextual changes; and (v) benchmarking.

Table 4: Monitoring, Review and Evaluation Processes

Methodology	Frequency	Output	Focus	Level
Performance review meeting	Quarterly	Quarterly progress reports;	Done by Joint (Government/ Partners). A review of progress against targets and planned activities.	Inputs, process, and output
Joint annual review and planning	Annually	Annual progress reports,	Done Jointly with development Partner, key stakeholders, and planning entities as from district level onwards. A review of progress against set target outcomes	Input, process, output, and outcome levels
Mid Term Review	Half-way	Midterm review report	Done by sector review progress against planned impact	Input, process, output, outcome and impact levels
End Term Evaluation	At end of HSSP II	Final evaluation report	Independent review of progress, against planned impact	Input, output, outcome and impact levels

Joint Annual Review

The JAR is a national mission for reviewing sector performance annually. The annual reviews will focus on assessing performance during the previous fiscal year, and determining actions and spending plans for the year ahead (current year+1). These actions and spending should be addressed in amendments to the HSSP II. Annual Sector Reviews should be completed by the 30th September each year, to ensure that the findings feed into the planning and budget process of the coming year. The annual review shall be organized by the MoH (Department of Planning & Policy) in collaboration with Development Partners. The proceedings of the JAR will be documented and signed by the MoH and DPs.

Programs/Projects Reviews

Detailed program/project specific reviews shall be linked to the overall health sector review processes and contribute to it. Program/project specific reviews should be conducted prior to the overall health sector review, and help inform the content of the health sector review in relation to that specific program/project area. It is important that the specific program/project reviews involve staff and researchers not involved in the program/project itself to obtain an objective view of progress. Progress review reports shall be submitted to the MoH (Department of Planning and Policy) in order to inform quarterly and annual sector reviews as well as evaluation exercises.

Performance Monitoring and Review of Implementing Partners

Implementing partners contribute significantly to health service delivery in the country. Most times their input and attribution to health outcomes is not captured in the sector performance reports. In order to measure their contribution to the overall sector performance they will be required to report to MOH (Department of Planning & Policy).

Performance monitoring and review for global health grants

Under the Global Health Initiatives, the health sector is supported through initiatives like the Global

Fund for Tuberculosis, HIV/AIDS and Malaria (GFTAM) and Global Alliance for Vaccines and Immunization (GAVI) which provides funds based on performance. There are other sector support programs/projects which also disburse funds such as Change and Shine Programmes. The M&E plans of those programmes shall be carried out in line with the M&E framework and plan of the health sector using tools that consider outputs and indicators to be drawn from approved work-plans and budgets for the HSSP II.

Performance Monitoring and Review for Civil Society Organizations and Private Sector

CSOs and the private sector contribute significantly to health service delivery in the country. Most times their input is not captured in the sector performance reports. In order to measure their contribution to the overall sector performance they will be required to report to the relevant sector entities.

HSSP II EVALUATION

Programme/Project Evaluation

A number of health sector investment and intervention projects will be undertaken during the period of the HSSP II 2017-2021. All projects will be subjected to rigorous evaluation. The type of evaluation to be planned for and conducted should reflect the nature and scope of the investment. For example, pilot projects that are being conducted amongst a random group of participants shall be selected for impact evaluation to determine whether or not the investment should be scaled up. As a minimum requirement, each project in this category will be required to conduct the following:

- ✓ A baseline study during the preparatory design phase of the project or the program;
- ✓ A mid-term review at the mid-point in the project to assess progress against objectives and provide recommendations for corrective measures;
- ✓ A final evaluation or value-for-money (VFM) audit at the end of the project. A VFM audit will be carried out for key front-line service delivery projects where value for money is identified

as a primary criterion. All other projects will be subjected to standard rigorous final evaluation.

Mid - Term Review

A Mid-Term Review of the HSSP II will be done after two and half year. The purpose of the MTR is to review the progress of implementation; identify and propose adjustments to the HSSP II and other government policies as required. The specific objectives of the MTR are to:

- ✓ Assess progress in meeting HSSPs targets and to make recommendations for their adjustment if found necessary;
- ✓ Review the appropriateness of outputs in terms of inputs, processes and desired outcomes;
- ✓ Review the costing and financing mechanisms of the HSSP II; and
- ✓ Coordinate the MTR process with the NDP review.

The MTR shall entail extensive review of documents including routine reports and recent studies in the sector; special in-depth studies may also be commissioned as part of the MTR; and interviews with selected key stakeholders. The MTR is undertaken in a participatory manner involving government line ministries, national level institutions, service delivery levels, DPs, civil society, private sector and academia. The analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the HSSP II indicators. The main result will be a list of recommendations for the remaining HSSP II years.

HSSP II Final Evaluation

The End Term Evaluation will be conducted during the last year of the HSSP II in order to enable the sector to make use of its findings and recommendations for the formulation of the next strategic plan. Like the mid-term review, the analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the HSSP II indicators. It will focus on expected and achieved accomplishments, examining the results chain, processes, contextual factors and causality, in order to understand achievements or the lack thereof. The evaluation will have to answer questions of attribution (what made the difference?) and counterfactual (what would have happened if we had not done A or B?) and take into account contextual changes (economic growth, social changes, environmental factors etc.), as well as policies and resource flows:

a. **Relevance:** Did the HSSP II address priority problems faced by the target areas and communities?, was the HSSP II consistent with policies of both the Government and Health Development Partners?
b. **Economy:** Have the HSSP II inputs (financial, human, Assets etc) been applied optimally in the implementation process?
c. **Efficiency:** Were inputs (staff, time, money, equipment) used in the best possible way to maximize the ratio of input/outputs in HSSP II implementation and achieve enhanced outputs; or could implementation have been improved/was there a better way of doing things?
d. **Effectiveness:** Have planned HSSP II outputs and outcomes been achieved?
e. **Efficacy:** To what extent have been the achievements of the HSSP II objectives and goal?
f. **Impact:** What has been the contribution of the HSSP II to the higher level development goals, in respect of national development goals; did the HSSP II have any negative or unforeseen consequences?

The evaluation will be conducted by a team of independent in-country institutions in close collaboration with international consultants. The purpose of conducting the evaluation prior to the conclusion of the HSSP II is to generate lessons and recommendations to inform the preparation of the HSSP III.

PERFORMANCE FRAMEWORK FOR HSSP II

Performance Framework for Health Service Delivery								
S.N	INDICATOR	BASELINE	TARGET					SOURCE
		2016	2017	2018	2019	2020	2021	
1	Maternal Mortality Ratio.	732/100000					400	DHS
2	Under-five mortality rate.	137/1000					100	MICS/DHS
3	Infant mortality rate.	85/1000					70	MICS/DHS
4	Neonatal mortality rate.	40/1000					35	MICS/DHS
5	Total fertility rate.	6.7					6	MICS/DHS
6	Average life expectancy.	54					<60	MICS/DHS
7	Prevalence of wasting in children aged 0-59 months (weight-for-height z-score <-2 SD).	14%?					<10%	Nutrition Survey
8	Prevalence of wasting in children aged 0-59 months (weight-for-height z-score <-2 SD).	14%					<10%	Nutrition Survey
9	Prevalence of underweight in children aged 0-59 months (weight-for-age z-score <-2 SD).	13.4%					<9%	Nutrition Survey
10	Contraceptive prevalence rate.	6%					<15%	MICS/DHS
11	Unmet need for family planning.	26%					<15%	MICS/DHS
12	HIV/AIDS incidence/prevalence rates.	1%					<1%	DHS/HIV Survey
13	Proportion of people who are on ARV.							HMIS
14	TB incidence rate.							TB Survey
15	TB treatment success rate.	87%	<90%	<93%	<94%	<95%	<97%	HMIS
16	Malaria incidence rate.							MIS
17	Hepatitis B incidence rate.							Hep B Survey
18	Pent 3 coverage rate for 1 yr.	43%	50%	55%	60%	65%	70%	HMIS, MICS/DHS
19	Institutional delivery.	33%	<40%	<45%	<50%	<55%	<60%	MICS/DHS
20	Prevalence of anaemia (haemoglobin concentration <11 g/dl) among pregnant women.	49%					20%	Micro-nutrient Survey
21	Exclusive breastfeeding rate.	33%					50%	MICS/DHS Nutrition Survey
22	Diarrhoea prevalence for <5 children.							MICS/DHS
23	Pneumonia prevalence < 5 children.							MICS/DHS
24	Number of new outpatients with mental health condition.							HMIS
25	Number of new outpatients with high blood pressure.							HMIS
Performance Framework of Human Resource for Health								
26	Health professionals (doctor, nurse, midwife) per 10,000 populations.							HRIMS
27	Skilled birth attendant.	33%					55%	MICS/DHS
28	Number of new graduates from health training institutions.	N.A						HRIMS
29	% of health workers who attended certified CPD course.	N.A	20%	40%	50%	60%	70%	HRIMS
30	Staff attrition rate.	N.A						HRIMS
31	% of health facilities meeting the EPHS minimum staffing plan.	N.A	<40%	<60%	<70%	<80%	<90%	HFA

32	% of health workers with signed performance-based contracts.	N.A	<20%	<40%	<60%	<70%	<80%	HRIMS
33	% of health workers with job descriptions.	N.A	<30%	<50%	<70%	<90%	100%	HRIMS
34	% of health professionals registered and licensed by NHPC.	0	<10%	<20%	<30%	<40%	<50%	NHPC
35	Proportion of health training institutions accredited by accreditation body.	N.A	<40%	<60%	<70%	<80%	<90%	NHPC
Performance Framework for Leadership and Governance:								
36	Number of districts with district health management teams.	N.A	10	30	50	70	80	MOH
37	% of development partners effected with valid partnership contracts	N.A	30%	50%	60%	70%	80%	Health Compact / IC
38	Number of policy and legal documents approved and published.							Official Bulletin
39	Existence of annual work plans and budgets linked to HSSP II priorities.	0	1	1	1	1	1	MOH
40	Number of HSC meetings held, minutes documented and actions followed up.	N.A	4	4	4	4	4	HSC
41	% of health facilities with community health boards.	N.A	30%	50%	60%	70%	80%	HFA
42	Number of regulatory bodies established and functioning.	0	1	1	1		3	MOH
43	Number of senior and mid-level managers who attended certified leadership and management courses.	N.A	20	20	20	20	20	HRIMS
Performance Framework for Essential Medicine and Technology								
44	% of health facilities reporting no stock outs of essential drugs (tracer medicine).	N.A	50%	60%	70%	80%	90%	HMIS, HFA
45	Per capita expenditure on medicine (public and private).	N.A					<20%	NHA
46	Existence of published essential medicine policy.							MOH
47	Proportion of population with access to affordable drugs.	N.A						DHS
48	% of health facilities with unexpired drugs compared to the total drugs in the shelf.	N.A					<10%	HFA
49	% of health facilities with adequately labelled drugs in stock.	N.A					>90%	HFA
Performance Framework for Health Information								
50	Existence of a national set of indicators with targets to inform health sector reviews and planning.		1	1	1	1	1	HMIS
51	Health facility reporting rate.						95%	HMIS
52	% of facilities submitting timely, complete and accurate reports.		30%	50%	70%	80%	90%	HMIS
53	Number of reports published.	N.A	1	1	1	1	1	MOH
54	Number of research and survey results published.	N.A						MOH
55	% of policy and programme documents developed based on evidence.	N.A	40%	60%	70%	80%	90%	MOH/DP
56	Share of health expenditure (Government & Donors) spent on health information.	N.A	4%	5%	6%	7%	8%	NHA
Performance Framework for Health Financing								
57	The ratio of household out-of-pocket payments for health to total health expenditure.	N.A						HH Survey
58	General government health expenditure as a proportion of total Government expenditure.	2%	4%	6%	8%	10%	12%	NHA
59	Number of audited reports published.	0	1	1	1	1	1	NHA
60	Existence of functioning national health accounts at federal and state level.							NHA
61	Proportion of aid flows that are aligned with HSSP II (national priorities).	N.A	20%	40%	50%	60%	70%	DAD/ NHA

62	Number of donors and aid flow that use public financial management system.	N.A						DAD/ NHA
63	% of disbursement released according to the HSSP II planning cycles.	N.A	10%	20%	30%	40%	50%	DAD/ NHA
Performance Framework for Health Infrastructure								
64	Number of health facilities per 10,000 populations.	N.A						HFA
65	Number of hospital beds per 10,000 populations.	N.A						HFA
66	Percentage of health facilities equipped as per the EPHS norms.	N.A	40%	50%	60%	70%	80%	HFA
67	% of health facility with WASH available for the providers/clients/patients.	N.A	30%	50%	70%	90%	100%	HFA
68	% of referral health centres and hospitals with emergency transport system (one functional ambulance).	N.A	50%	70%	80%	90%	100%	HFA
69	% of health budget (Government & Donors) spent on health infrastructure.	N.A						NHA
Performance Monitoring Framework: "Emergency Preparedness and Response.								
70	Case fatality rate.							
71	Exposure rate.							
773	Existence of EPR plan that contain hazard, vulnerability analysis & risk mapping.	N.A	1	1	1	1	1	MOH
74	% of resources mobilized that are based on the gaps and needs identified in the EPR plan.	N.A					<80%	NHA
75	Number of regions with essential supplies and buffer-stocks for health response pre-positioned.	0	5	10	14	16	18	MOH
76	Number of health workers trained in disaster risk reduction.	N.A	100	100	100	100	100	HRIMS
Performance Framework for Social Determinants of Health								
77	Number of sectors that reflect health issues in their policies.	N.A	2	4	6	8	10	JAR
78	Death rate due to road traffic accidents.	N.A						
79	Tobacco use among youth and adults.	N.A						
80	Khat use among youth and adults.	N.A						
81	Proportion of population using safely managed drinking water services.	35%					55%	WASH KAP
82	Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water.	10%					45%	WASH KAP
83	% of primary and secondary schools with WASH facilities available for the students including menstrual hygiene facilities for adolescent girls.	N.A	20%	30%	40%	50%	60%	EMIS, School Survey
84	Prevalence of Anaemia among school-age children.	59%					20%	Micro-nutrient survey
85	Prevalence of Vitamin A deficiency among school age children.	37%					20%	Micro-nutrient survey

HSSP II RISK MATRIX

RISKS	PROBABILITY (H, M, L)	IMPACT (H, M, L)	ACTIONS TO ALLEVIATE	RESPONSIBILITY
A. INSTITUTIONAL **1.** Lack of commitment / buy-in to HSSP II by Federal Member States because of lack of involvement in HSSP II process.	M	H	Meeting with Federal MOHs to generate buy-in and commitment to the plan.	DG
2. Lack of commitment/buy-in to HSSP II by development partners.	M	H	Minister to ask for a special meeting with head of agencies of development partners to ask for commitment/alignment with HSSP II priorities.	Minister
3. Overlapping and duplicative functions/responsibilities of Federal and Federal Member States leading to lack of leadership.	H	H	Review the functions, roles and responsibilities of the Federal MOH and Federal Member States.	DG
4. Shifting of donor priorities and preferences.	L	H	Regular advocacy and updates to donors, particularly around proposed new management, implementation and reporting arrangements for HSSP II.	Director of Planning
5. Lack of Government inter-sectoral coordination.	M	M	Regular advocacy and updates to support HSSP II with a focus on social determinants of health.	DG
6. Turnover of donor staff and MoH leadership – lack of institutional memory.	M	M	Proper handovers and documentation of HSSP II.	DG
7. Lack of capacity of HSSP II partners to implement the plan.	H	H	Improved contracting arrangements Attract new contractors.	Director of Planning
8. Weak capacity and commitment in Federal Member States for implementing HSSP II.	M	H	Commission and implement capacity assessment and plan for all States.	DG
9. Opposition of UN agencies, donors and others to restructure Somali health sector governance systems.	H	H	Advocate for the implementation of the new HSSP II management, reporting and implementation structure.	Minister
10. Employment of staff based on hereditary/social/ political/clan factors rather than merit.	M	H	Introduce a new appointment and appraisal system.	DG
B. POLITICAL **11.** Political unrest will make implementation difficult in some areas.	L	H	Ensure equity in distribution of services.	Director of Planning
C. TECHNICAL **12.** HSSP II is too ambitious given existing MOH and donor capacity.	M	H	Expand capacity of the MoH. Attract more donors to support the HSSP II. Conduct JAR to ensure realistic targets and milestones are set.	DG Director of Planning
13. Natural disasters (droughts) affect service implementation.	L	H	Emergency preparedness and response plan in place and team operational.	Director of Public Health

14. Geographical barriers (distance, poor communications etc) to implementation of HSSP II services.	H	M	Improved outreach and mobile services.	Director of Medical Services
15. Hard to reach groups, such as IDPs, rural and nomads make HSSP II difficult to implement.	H	M	Operational research on how to provide services for these groups. Involvement of the target communities.	Director of Policy and Planning
4. FINANCIAL **16.** Lack of increase in Government financial resources to implement plan.	M	H	Advocacy to increase health expenditure allocation.	Minister
17. Reluctance or slow pace of donors to align funding with the HSSP II.	M	H	Advocate for adherence to international principles of aid effectiveness.	Minister, DG Director of Planning
18. Lack of financial and managerial accountability systems.	H	M	Introduce appropriate, transparent and accountable financial and management systems. Publish National Health Accounts/Annual Audited Accounts.	DG, Director of Finance, Director of Planning

Key

	Unacceptable under existing circumstance and requires immediate action to mitigate
	Manageable under risk control and mitigation actions
	Acceptable risk, but requires constant monitoring

ANNEXES:

Annex I – Somaliland Chapter – Health Sector Strategic Plan
Annex II – Puntland Chapter – Health Sector Strategic Plan
Annex III – Galmudug Chapter – Health Sector Strategic Plan
Annex IV – Hirshabelle Chapter – Health Sector Strategic Plan
Annex V – South West Chapter – Health Sector Strategic Plan
Annex VI – Jubbaland Chapter - Health Sector Strategic Plan