Strategic review of the Somali health sector: Challenges and Prioritized actions

Report of the WHO mission to Somalia

11–17 September 2015

Contents

Acronyms

ART	Anti-Retroviral Therapy
BEmOC	Basic Emergency Obstetric Care
BoD	Burden of Diseases
CHF	The Common Humanitarian Fund
CHW	Community Health Worker
CEmOC	Comprehensive Emergency Obstetric Care
CAP	Consolidated Appeals Process
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
ERP	Economic Recovery Plan
FCHWs	Female Community based Health Workers
FGM	Female Genital Mutilation
FGS	Federal Government of Somalia
FSANU	Food Security and Nutrition Unit
EPI	Expanded Programme on Immunization
GAVI	Global Alliance for Vaccine and Immunization
GAVI-HSS	GAVI - Health System Strengthening
GFATM	Global Fund to Fight against AIDS, Tuberculosis and Malaria
HAB	Health Advisory Board
HC	Health Centre
HCS	Consortium for Somali people
HIA	Health Impact Assessment
HLF	High Level Forum
HMIS	Health Management Information System
H&NCF	Health and Nutrition Coordinating Forums
HSSP	Health Sector Strategic Plan
HSAT	The Health Systems Analysis Team
HSC	Health Sector Committee
HIV & AIDS	Human Immunodeficiency Virus Infection & Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
IDPs	Internally Displaced Persons
IHR	International Health Regulations
ILO	Information Liaison Office
IMCI	Integrated Management of Childhood Illnesses
INGOs	International Nongovernmental Organizations
ITNs	Insecticide-Treated Bed Nets
IVM	Integrated Vector Management
JHNP	Joint Health and Nutrition Programme
JPLG	Joint Programme on Local Governance

LLINs	Long Lasting Insecticide Treated Bed Nets
MNCH	Maternal, New-born and Child Health
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOH	Ministry of Health
NDP	National Development Plan
NCA	National Constituent Assembly
NCDs	Non-Communicable Diseases
NHPC	National Health Professional Council
NGOs	Non-governmental Organizations
OECD	Organization for Economic Cooperation and Development
PC	Provisional Constitution
PEI	Polio Eradication Initiative
PES	Population Estimation Study
PHU	Primary Health Unit
PL	Puntland
PSGs	Peace building and State-building Goals
RHC	Referral Health Centre
RHO	Regional Health Officer
RDT	Rapid Diagnostic Test
RDF	Revolving Drug Fund
SCS	South Central Somalia
SDRF	Somali Development and Reconstruction Facility
SL	Somaliland
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UHC	Universal Health Coverage
WHO	World Health Organization

Executive summary

Somalia is one of the most fragile states in the world, with one of the most complex and protracted conflicts. A high-level forum in June 2015 asked for a comprehensive review of the Somali health sector, which was reinforced by a similar request by the Minister of Health of Somalia. The World Health Organization (WHO) responded by fielding a high-level review in September 2015. The overall objectives of the review was to assess progress made against the Somali health sector strategic plans (HSSPs) 2013–2016 and humanitarian plans of action, and provide strategic and programmatic recommendations for improvements in the health sector. The review took due cognizance of the Somali Compact and the "New Deal for Somalia" as the overarching strategic framework for coordinating political, security and development efforts.

The Somali government has endorsed a national health policy and developed comprehensive HSSPs for 2013–2016 in Somalia's three zones – South Central Somalia, Puntland and Somaliland. There are significant variations between the zones as far as implementation of the strategic plans is concerned. The decentralization policy is widely supported, however, it has not been effectively implemented and continues to face significant challenges. Loss of human capital is the main cause of weak institutional capacity. Lack of accountability and transparency is among the key challenges for the health sector. Regulation of health professionals and facilities and enforcement of health regulations are almost non-existent. Public health laws are outdated and have not been reviewed for more than 25 years.

Per capita public expenditure on health is about US$ 10–12 per person per year, which increases the risk of financial burden especially on poor populations with high out-of-pocket expenditure. In absolute terms, there has been a significant increase in funding for the Somalia health sector over the past 10 years. Conventional donors provided US$ 53.6 million in 2005, increasing to US$ 103 million in 2009 and approximately US$ 150 million in 2014. There is, however, an element of fatigue in humanitarian funding.

The number and density of doctors, nurses and midwives in Somalia remain below 4 per 10 000 population, which is far below the minimum threshold of 23. Challenges in recruitment exist as limited posts are provided by civil service commissions to employ trained health professionals. There are no incentives to attract and deploy health workers to rural and remote areas. Health workforce salaries are very low and often released after long delays. Salary top-ups are provided by donors through various externally funded projects to specific staff, leading to discrepancies and demotivation among others. The shortage of specialists is being partially addressed by the recruitment of expatriate physicians with higher salaries. The health professional education capacities are quite limited for scaling up, due to poor infrastructure and limited faculty capacity. The number of private education institutions is increasing in an unregulated manner, which has raised many quality concerns.

Health facilities density is 1.1 across the three zones and average hospital bed density is also 1.1 per 10 000 population. It is estimated that 5% of people living with HIV & AIDS are on antiretroviral therapy, and the success rate for smear-positive tuberculosis treatment cases was 89% in 2013. The essential package of health services (EPHS) is designed for the four levels of health service provision and divided into 10 programmes, of which six core programmes are provided at all levels and four additional programmes are provided only at the referral level. Full implementation of EPHS in all regions is not possible due to shortage of funds and trained staff, scarcity of medical supplies and security concerns. Nevertheless, rolling out of EPHS in a relatively short time has helped turn around deteriorated facilities, improve standards of staff performance, implement essential drug lists 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.

Quality and patient safety concerns have raised the need to establish regulatory systems. In addition, the female community health workers (*marwo caafimaad*) concept has been established to extend the limited range of promotive and preventive health services among communities. Female community health workers have been important in ensuring access to remote populations, reducing rural–urban discrepancies and improving maternal, reproductive, newborn and child health and nutrition services. The fact that the majority of patients seek help from the private sector for health care is an indication of poor access to public health facilities, particularly for rural and nomadic populations. The nomadic population has the highest multidimensional poverty index in Somalia, and access to basic services is extremely low.

In the area of essential medicines, donors agencies and nongovernmental organizations operate their own supply chain system in a parallel manner, largely as a pre-packed kit system with little coordination and integration. Until today, the push- and pre-packed kit system prevails, accounting for only 20–25% of total need in the country. A regulatory system for the pharmaceutical sector is absent in all three zones. It is estimated that the private sector provides around 60–80% of the country's medicines through importation and distribution via private retail outlets and pharmacies.

The health management information system (HMIS) is partially functional in all the three zones, supported mainly through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Global Alliance in Vaccine and Immunization (GAVI) and the Somali Joint Health and Nutrition Programme (JHNP). The country has not conducted a national survey for the past 9 years. The coverage rate of birth registration among children aged under 5 years was estimated at only 3% in 2006. Within HSSPs, a vital registration system of births and deaths is planned for pilot in some districts.

The protracted complex emergency in Somalia has attracted enormous and intensive humanitarian relief, focused on saving lives and alleviating suffering through immediate response to the needs of populations directly affected by the recurring cycles of armed conflict, poverty and natural disasters. At present, about 3.2 million people are in need of humanitarian aid inside Somalia. A key challenge is to confront the urgent and uphill demand of linking relief to rehabilitation and development to produce better and lasting impacts on health, nutrition, and water, sanitation and hygiene (WASH) services; cater to the needs of internally displaced persons; access the 2 million food-insecure population with concrete measures; and expand the shrinking humanitarian space for health.

Health sector coordination is undertaken by various stakeholders including the government (ministries of health), donors, United Nations (UN) agencies, nongovernmental organizations and civil society. Membership of the various coordination bodies is largely constituency-based. Key challenges to coordination include the lack of high-level institutional backing for the Health Advisory Board to enforce decisions; limited capacity of the Health Sector Committee to deal with a huge volume of information beyond information sharing; and no structures being in place to bring clusters and development partners to work together.

The **key challenges** facing the Somali health system are: (i) persistently high burden of disease; (ii) limited institutional capacity and stewardship role of ministries of health; (iii) inadequate, unpredictable and unsustainable level of financing, with a high share of out-of-pocket spending on health; (iii) absence of balanced, motivated, well-distributed and well-managed health workforce with the appropriate skills

mix; (iv) limited and unequal access to essential health services, and poor quality and safety of services across all levels of care; (v) inadequate procurement/supply system and irrational use of essential technologies and medicines; (vi) absence of national surveys and census, weak births and deaths registration, limited operational research and disease surveillance; (vii) lack of synergy of humanitarian response to health; and (viii) inadequate action on social determinants of health.

Strategic priorities have been proposed for reform of the Somalia health system; for each, there are well-defined action points. The following strategies are proposed.

- Improving synergy between developmental and humanitarian assistance through enhanced coordination among development partners and the government.
- Improving the stewardship and governance capacities of ministries of heath for evidence-based polices and plans, engagement with non-state actors and better partner coordination.
- Developing a medium-term strategy and a business plan that provides for a sustainable approach to health sector financing.
- Scaling up essential health workforce cadres to ensure improved access to health services in the short term.
- Rapid expansion of EPHS and community-based health services of acceptable quality through innovative approaches, including training of community-based health workers and outsourcing of service delivery to nongovernmental organizations.
- Improving the availability and use of information by strengthening management information systems, implementing household surveys and improving civil registration and vital statistics.
- Improving access to and rational use of medicines and essential technologies.
- Strengthening public health preparedness and response capacity to effectively confront and tackle health emergencies.

The **business plan provides a six-year financial outlay** and offers a distinctive blend of financing aimed at scaling up health services at all levels to cover 90% of the Somali population by 2021. This will require scaling up of both development and humanitarian health sector investments. The plan proposes a gradual increase in public-sector funding from approximately US$ 150 million in 2014 to US$ 212 million in 2016, and reaching US$ 353 million by 2021 (see Table 12).

The financial projections are based on investment trends in the health sector over the past few years. Key assumptions include: (i) improvement in the political/security situation and commitment of the government to finance at least 15% of health sector expenditure by 2021; (ii) mainstreaming the role of regional and non-traditional donors and the Somali diaspora to finance 15% of the financial outlay; and (iii) continued commitment of donors and partners to finance at least 70% of the projected expenditure through improved synergy between humanitarian and developmental assistance. It is hoped that, by 2021, the share of out-of-pocket expenditure will be brought down to 50% of total health expenditure.

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1. Introduction and mission objectives

Somalia is one of the most fragile states in the world,[1] with one of the most complex and protracted conflicts. Across all dimensions of human development, the country has suffered severe consequences from conflict, as reflected in the global Human Development Index.[2] Somalia currently has some of the lowest humanitarian and development indicators in the world, and inequalities across different social groups – a major driver of conflict – have been widening. The fragility of Somalia over the past 25 years has resulted in weakening of the health sector, its systems and its personnel, with a subsequent focus on emergency response interventions to recurrent crises.

To review and address the challenges in the Somali health sector, a high-level forum was held in Nairobi on 15 June 2015, chaired by the UN Resident and Humanitarian Coordinator for Somalia. The high-level forum was co-chaired by the three Somali ministers of health and attended by donors, UN agencies and nongovernmental organizations. In the high-level forum it was decided to:

1. undertake a comprehensive review of the health sector in Somalia by September 2015, taking prior studies and analysis into consideration;
2. utilize evidence from the review and, in consultation with all partners, design an architecture for the next phase of health-sector implementation (HSSPs);
3. enhance conversations between humanitarian and development health partners, and agree on a framework for working together and creating improved synergies.

In addition, HE the Minister of Health of Somalia, in her visit to WHO Regional Office for the Eastern Mediterranean in May 2015, requested for a health system review to help provide strategic directions and assist in translating Somali health policy, 2014 into a strategic plan for 2017–2021.

WHO responded to the above requests by fielding a high-level mission to review the Somali health sector in September 2015, with the involvement of several other stakeholders.

The overall **objective** of the strategic review of the Somali health sector was to assess progress made against the Somali HSSPs and humanitarian plans of action; its alignment with the programmatic response and the Somali Compact/New Deal; and accordingly provide strategic and programmatic recommendations for future improvements in the health sector, while considering the changing context.

2. Review process

The mission comprised WHO staff from the three levels of the Organization and one senior staff from JHNP, United Nations Children's Fund. The mission team was joined at different stages by staff from UNICEF Somalia and United Nations Population Fund (UNFPA) Somalia, Sweden and Finland.

The mission members received a debriefing in Nairobi followed by a visit to the three zones in Somalia – Puntland, Somaliland and South Central Somalia – from 13 to 15 September 2015. Following the field visits, all mission members assembled in Nairobi from 16 to 17 September 2015 for follow-up meetings with UN agencies, donors and implementing partners/nongovernmental organizations, and provided a formal debriefing on the final day of the mission.

The review process involved the following key stages.

[1] http://library.fundforpeace.org/library/cfsir1423-fragilestatesindex2014-06d.pdf
[2] UNDP 2014, Global Human Development Report.

- Terms of reference were finalized including stakeholders' feedback.
- A review team was formed comprising staff from the three levels of WHO, UNICEF Somalia, UNFPA Somalia and donors.
- The mission team conducted a desk review of policies, plans and programme-specific documents.
- A checklist was agreed for use during field visits in order to have an assessment common approach.
- A teleconference was organized for mission members, prior to the mission.
- Three field teams were developed. Each team held in-depth 3-day discussions with stakeholders, civil society organizations and development partners in the three zonal health authorities to agree upon strategic priorities and actions. The field teams also visited health facilities, hospitals, academic institutes and health institutions.
- A summary of key findings was presented and further discussed with stakeholders in a plenary at the UN Office in Nairobi on 17 September 2015.
- A draft mission report was shared with stakeholders for feedback/comments.
- The mission/review team subsequently produced a final report with an action roadmap for the development of the Somali health sector.

3. Somali context

Puntland and Somaliland have their own constitutions, presidents and parliaments, and executive and functioning central and local levels of government. South Central Somalia is still experiencing large areas of active conflict, with the Federal Government's control being limited geographically as well as by capacity constraints. Recently, more states have been announced within South Central Somalia including Jubaland, South West and Galmudug states. According to the UN, there are 18 regions and 89 districts in the three zones, with significant variation in their administrative structures.

The Organisation for Economic Co-operation and Development (OECD) sponsors the International Dialogue on Peace-building and State-building[3] and. Somalia is among the 20 fragile and conflict-affected countries. At a high-level forum on 30 November 2012 in Busan, Republic of Korea, members committed to a New Deal[4] for engagement in fragile states that underscores commitment to necessary actions and reforms. Essential New Deal principles are: transparency of aid; risk-sharing; use and strengthen country systems; strengthen capacity; and timely and predictable aid.

On 16 September 2013, the Federal Government of Somalia and the international community agreed on both the Somali Compact and an Economic Recovery Plan[5] at the Somalia New Deal Conference in Brussels, Belgium. The Somali Compact provides an overarching strategic framework for coordinating political, security and development efforts. The vision articulated by the Compact focuses on the need to build confidence in national institutions and to improve the Government's capacity to respond to the needs of its people by improving security, justice and service delivery. There is a specific section within the Compact called the Somaliland Special Arrangement. This section sets out that Somaliland prefers their Somaliland National Development Plan as the entry point for development engagement.

The Compact's priorities are framed by the five Peacebuilding and State-building Goals of the New Deal, and represent agreement on what is required to move towards peace and recovery. These five priorities

[3] The OECD-sponsored International Dialogue on Peace building and State building was established in 2008 in Accra, in response to the need for a better and more focused effort to address the challenges of conflict and fragility.
[4] International Dialogue on Peacebuilding and State building 2011, A New Deal for Engagement in Fragile States.
[5] Note the Economic Recovery Plan largely addresses South Central Somalia.

are: legitimate politics, justice, security, revenue and services and economic foundations, in full respect of human rights.

3.1 Somali health context

- The burden of disease is heavily dominated by communicable diseases, reproductive health problems and undernutrition issues. Noncommunicable diseases and mental disorders are also on the rise. The Somali health situation is one of the worst in the world, and the country will be unable to achieve its Millennium Development Goals (MDGs) related to health and nutrition by the end of 2015.[6]
- Polio transmission has been interrupted, but routine immunization coverage remains very low. Only 42% of children received 3 doses of pentavalent vaccine in 2014.
- There were more than 610 000 malaria cases in 2014. Tuberculosis is highly prevalent with 30 000 new cases every year,[7] of which fewer than half are detected. Malaria is 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.[8]
- 70% of Somalis do not have access to safe water supply or sanitation. Half the population practice open defecation; in rural areas this is as high as 83%. Diarrheal diseases account for the majority of deaths among children, along with respiratory infections.
- Life expectancy is estimated to be 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 5 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.
- Estimates indicate that there are approximately 6000 doctors, nurses and midwives in 2014.[9] WHO's minimum threshold for health worker-to-population ratio indicates that around 30 000[10] health workers are necessary to achieve health-related MDGs in Somalia.
- Somalia is among the top four nationalities crossing the Mediterranean in 2015, accounting for 5% of all migrants to Europe. *Tahriib*, a relatively new form of illegal immigration, involves young Somalis aged 17–27 embarking on the hazardous journey to Europe without informing their parents, who are left struggling to cope psychologically. Implications for left behind women and children include lack of health care due to poor economic conditions.

[6] http://mdgs.un.org/unsd/mdg/Data.aspx
[7] http://www.emro.who.int/som/programmes/tb.html
[8] http://www.unaids.org/sites/default/files/country/documents//SOM_narrative_report_2014.pdf
[9] Health Workforce Assessment Reports for CSZ, NWZ and NEZ, 2014
[10] www.who.int/hrh/workforce_mdgs/en/

- 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 contribute significantly to the health sector, but information is not documented.

A summary of health and nutrition-related MDG indicators, in comparison with averages for Sub-Saharan Africa, are presented in Table 1.

Table 1. Health and nutrition-related MDG indicators, 2009–2010 and 2013–2014

Health and nutrition-related MDG indicators	Somalia		Sub-Saharan Africa	
	2009–2010	2013–2014	2009–2010	2013–2014
MDG 1: Poverty and hunger				
% under-5 children malnourished (underweight)*	32	32	30	21
% under-5 children chronically malnourished (stunting)*	42	42	41	38
% under-5 children acutely malnourished (wasting)*	13	13	10	9
MDG 4: Child mortality				
Under-5 mortality rate (per 1000 live births)	200	146**	144	98
Infant mortality rate (per 1000 live births)	119	91**	86	64
Measles immunization (% children 12–23 months)	24	46	72	72
MDG 5: Maternal mortality				
Maternal mortality ratio (per 100 000 live births)	1400	850***	900	500
% births attended by skilled health staff	33	33	39	50
MDG 6: HIV/AIDS, malaria and other diseases				
Prevalence of HIV (% adults aged 15–24)	0.5	0.2	5	1.9
Contraceptive prevalence rate (% of women ages 15-49)	15	15	23	24
Number of children orphaned by HIV/AIDS	–	110	10 200	15 100
% under-5 children sleeping under insecticide-treated bednets	11	11	–	36
% under-5 children with fever treated with antimalarials	8	8	42	37
Incidence of tuberculosis (per 100 000 population per year)	–	285	343	290
Tuberculosis cases detection rate (all new cases) (%)	73	43	46	51
MDG 7: Environment				
Access to an improved water source (% of population)	35	30	58	63
Access to improved sanitation (% of population)	50	24	54	30
General indicators				
Population (million)	9	12.3	772	914
Total fertility rate (births per woman aged 15–49)	6.4	6.7	5.2	5.2
Life expectancy at birth (years)	50	55	49.6	56

Sources for 2009–2010: UNICEF Somalia Statistics (2010); World Bank Millennium Development Goals Global Data Monitoring (2010).

Sources for 2013–2014: UNICEF-The State of World Children 2014; UN Interagency estimates for child and maternal mortality, 2013; Population Estimation Study, Somalia 2014; World Bank Data Monitoring (2013).

* Indicators for undernutrition are cumulative for moderate and severe malnutrition. The latest Somalia Food Security and Nutrition Unit data for 2015 for severe undernutrition indicate underweight: 13.4%; stunting 12% and wasting: 13.6%.

** Recent under-5 mortality estimate for Somalia is **137 per 1000 live births,** whereas infant mortality rate is **85 per 1000 live births** as per UN interagency estimates for 2015.

*** Recent maternal mortality estimate for Somalia is **732 per 100 000 live births** as per UN interagency estimates for 2015.

Nevertheless, a new environment is emerging in the Somali health sector. The maternal mortality ratio and under-5 mortality rates, which remained unchanged at a very high level for about two decades, are now showing a slow but persistent declining trend. Security gains in parts of the country have created space to engage in development strategies and the building of government structures and processes.

3.2 Health sector response to prevailing challenges

Over the past few years, Somali health authorities have expressed their commitment through policy and programmatic response with the support of development partners. The policy response includes approval of the Somali Health Policy (2014); three HSSPs (2013–2016); Somalia 2015 Humanitarian Response Plan; EPHS framework; Somalia Nutrition Strategy (2011–2013) and plans of action; micronutrient strategy; reproductive health strategy; community-based health-care strategy; female genital mutilation abandonment policy; one Expanded Programme on Immunization policy; health workforce policy and plans; drugs policy; behaviour change communication strategy; and mental health strategy, etc.

Some progress is also shown in programmatic response, with the enhanced leadership role of Somali health authorities and transitioning from a humanitarian to development response. Major investments on the humanitarian front are through the Common Humanitarian Fund for Somalia and the Central Emergency Response Fund. On the development front, more than 5 million people now have access to EPHS mainly through the JHNP.

Despite some visible progress over the past few years, the Somali health sector is now entering a new phase of development and reconstruction. HSSPs – with an annual cost of US$ 75–80 million – will end in 2016. It is important to develop the next phase of health sector strategic planning to ensure continuity beyond 2016. New HSSPs need to be aligned with the National Development Plan/Economic Recovery Plan and Interim Poverty Reduction Strategy Papers (I-PRSPs) to ensure the health sector benefits from cross-sectoral reforms.

4. Health system review: key findings of the mission

4.1 Leadership and governance

- **Health sector policy and plans**

As part of overall reconstruction efforts, the Somali government has placed social services among its top priorities. The health sector has a vision and has developed a comprehensive medium-term plans (2013–2016) in which strategic objectives with high-level benchmarks and indicators are clearly articulated. Working closely with the Somalia Disaster Management Agency under the Prime Minister's Office, the emergency preparedness and response unit has been at the centre of humanitarian plans, which have been developed in all three zones with the technical and financial support of WHO and other UN agencies.

Commitment and ownership of the implementation process by Somali nationals remains one of the guiding principles in ensuring the attainment of national goals and objectives. There are significant variations between the three zones as far as implementation of the strategic plans is concerned. In South Central Somalia, challenges are much more related to insecurity and instability. Loss of human capital as a result of migration to other countries is the main reason for weak institutional capacity.

Emergency-oriented and humanitarian activities dominate the health sector, and the burden of large numbers of internally displaced persons remains an overwhelming task for ministries of health and health-supporting agencies. Effective decentralization in this area is hindered by many factors, but is largely due to weak institutional capacity and instability. Partnership and contracting capacity is lacking, and the necessary instruments and skills for managing this governance function are not available. More importantly, weak accountability and transparency is a key challenge for the health sector throughout the country.

In Somaliland, several policy/strategy documents and programmes have been endorsed that are being partially implemented and partly implemented. In Puntland, the HSSP has been endorsed; however, limited resources have greatly hindered its full implementation. The Somali Health Policy 2014 endorses that health sector policy objectives be achieved through the collective efforts of the national governments and external assistance. It also underlines the need to ensure an effective interface between development and humanitarian assistance. The common challenges facing planning, implementation and monitoring include limited resources, weak regional/district capacities, high turnover of qualified staff and poor coordination among health-supporting agencies.

The HSSPs in all three zones are functionally linked to the Somali Compact and the New Deal. The Somali Development and Reconstruction Facility has guided government efforts to oversee the diverse activities of its partners including the health sector. Special efforts have been placed on the principles of aid effectiveness under the Somali Development and Reconstruction Facility initiative, whereby external aid to the health sector is aligned to national priorities as markedly advised by the Somali Compact. The review mission witnessed the comparative advantage of the health sector as far as coordination was concerned. It is among very few sectors that pursue the principles of partnership, although many challenges – such as limited ownership, inclusiveness of all partners, and weak accountability and transparency – still hamper progress in this area.

- **Decentralization and fragmentation: implications for the health sector**

The decentralization policy is widely supported throughout the country. However, it has not been effectively demonstrated and will continue to face significant challenges, partly due to limited local

capacity and partly due to an unfinished federal system. State boundaries are not clearly defined and administrative issues continue to be a major challenge. In Puntland and Somaliland, the capacity of the public sector has relatively improved over the past 5 years. New states, regions and districts have recently been established and several more are on their way, increasing the financial burden on the exchequer and donors.

The Federal Ministry of Health should be prepared to support and strengthen institutions at regional and state level, many of which have been seriously crippled by the armed conflict. Similarly, health-supporting agencies should reposition their technical support to ensure effective engagement with new states where local capacity is very weak.

- **Institutional capacities**

The institutional capacities in the health sector vary from zone to zone, and from region to region. There have been significant efforts in Puntland and Somaliland to strengthen leadership and governance, although this has been concentrated at central level and has not trickled down to the regions and districts. The governments in these zones are committed to addressing health-sector leadership and governance throughout the regions. They underlined in their strategic plans that without effective leadership and governance the health system will continue to be fragmented, inefficient, externally-driven and less than effective. One of the key approaches to tackle the issue of stewardship is implementation of in-service and on-the-job training programmes to develop necessary skills for enhancing leadership and governance in health. The organizational structure of the health ministry has been reviewed in all three zones. A reasonable structure that fits with policy objectives has been proposed, and job descriptions for the various departments and units have been drafted and endorsed.

Establishing a legal framework for health has been initiated; however, the process has been delayed due to lack of capacity. Regulations for health remain a major issue in health services development throughout the country. Regulation of health professionals/facilities and enforcement of health regulations are almost non-existent, although some efforts have been made in Puntland and Somaliland. Somaliland has reported the existence of an independent regulatory body, although it has not been effective. Public health laws have not been updated for more than 25 years.

- **Coordination**

Health sector coordination at Nairobi level is well structured, with fully established terms of reference and communication systems. Donor agencies, the Somalia NGO Consortium and UN agencies coordinate their activities through regular forums and share information with staff in the field. Health-sector coordination is quite active in Somaliland, and has been improving in Puntland and South Central Somalia at central and regional level. Overlap of services in certain areas and deprivation in others is common, however, due to lack of effective coordination. Moreover, government leadership to properly coordinate external assistance to the health sector has been lagging.

The main strengths and challenges in leadership and governance for the Somali health sector are shown in Table 2.

Table 2. Strengths and challenges in leadership and governance

Strengths	Major challenges
• Existence of national health policy, HSSPs and sub-sectoral policies and plans. • Availability of improved data and intelligence	• Limited institutional capacity. • Weak culture of accountability and transparency.

for policy-making in Puntland and Somaliland. • Existence of an organizational structure with clear lines of communication and job descriptions.	• Limited capacity for ensuring effective decentralization (central, state, regional and district levels). • Insecurity in many regions, especially in South Central Somalia.

4.2 Financing

Over the past few decades, the Somali health sector has predominantly been financed through out-of-pocket expenditures by the population or funding from donors and development partners. Somali health authorities continue to operate within a rudimentary health sector, with the bulk of health services being conducted "off budget and off treasury", and for many years health services were regarded as part of the humanitarian response.

Health sector financing is difficult to express in quantitative terms, to determine total health expenditure and who gets how much and for what, as for many years the bulk of external financing has been channelled through the humanitarian stream. Humanitarian funds for health are mainly disbursed by the Common Humanitarian Fund for Somalia or the Central Emergency Response Fund, either to the three key UN agencies in health – UNICEF, WHO and UNFPA – or international and nongovernmental organizations. It has also not been possible to undertake a single round of national health accounts analysis in the country thus far.

From a development perspective, global health initiatives that have contributed to funding the Somalia health sector include GFATM, GAVI and the Global Polio Eradication Initiative. Most of these funds are channelled through WHO and UNICEF, with some GFATM grants going through World Vision.

Bilateral funds at the global level or generated by international nongovernmental organizations are also channelled directly to multiple implementing partners/ nongovernmental organizations, and consolidated information is not available. The majority of these funds are currently available for South Central Somalia, whereas funding for the stable northern zones is on the decline. A major setback has been the complete withdrawal of Médecins Sans Frontières from Somalia resulting in serious financial crises for the operation of hospitals, some of which have already been closed down.

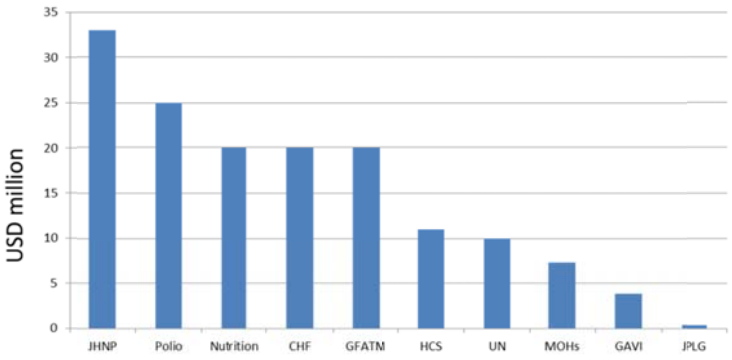


Fig 1. Health sector investment through public system in 2014
(OOP and investment from non-conventional donors not included)

Bilateral funds at country level, especially on the development side, have experienced a rise over the past few years. These funds are channelled mainly through three UN agencies (UNFPA, UNICEF and WHO) to JHNP (a pass-through joint programme) or through the Health Consortium Somalia (a nongovernmental organization consortium). More flexibility and better predictability in funding have created an enabling environment for health systems development and improvement of functions under the leadership of health authorities. Many bilateral donors are also investing in nutrition and WASH

services. In addition, non-OECD donors (including Qatar, Saudi Arabia and Turkey) are investing in the Somali health sector; however, financial tracking of this support needs to be more systematic. Fig. 1 presents health sector investment through the public system in 2014.

The government in the three zones also provide minimal funding to the health sector. The allocations add up to US$ 9–10 million per year, of which Somaliland is the major contributor (Table 3). Altogether, these funds constitute less than 5% of allocations through the public health sector. The Somali diaspora also support the public health sector, however its contribution remains undocumented.

- **Somalia health sector financing: key findings**

o Per capita public expenditure on health is approximately US$ 10–12 per person 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. A pre-payment mechanism needs to be ensured to reduce catastrophic health expenditure.

o 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,[11] reaching approximately US$ 150 million in 2014.[12] 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).

o External financing greatly exceeded the governments' contributions to the health sector. In Somaliland, while US$ 150 million was invested in 2014 (Fig 1), 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.

Table 3. Government Health Budget as a proportion of total budget, 2014

Zone	Ministry of Health budget	Total budget	% share of health
Somaliland	US$ 7.1 million	US$ 156 million	4.5%
Puntland	US$ 1 million	US$ 41 million	2.5%
South Central Somalia	US$ 0.88 million	US$ 216 million	0.4%

o The contribution of resources for vertical disease-specific programmes, financed largely through the Polio Eradication Initiative, GFATM and GAVI, fell from almost 50% to 33% of total public financing during 2014.

[11] World Bank, 2010, A decade of AID to the health sector in Somalia (2000-2009)
[12] Mission estimates

- Funding for humanitarian programmes has been progressively falling, which needs to be maintained/enhanced considering the fragile situation of the country and weak capacity of the public sector.

The key strengths and major challenges in health financing in Somalia are shown in Table 4.

Table 4. Strengths and challenges in health financing

Strengths	Major challenges
• Continuation of humanitarian assistance with a rationalized approach: more focus on conflict-affected areas and withdrawal of humanitarian funding from stable/post-conflict areas. • Access to basic health services (both through development and humanitarian investment) ensured to half the Somali population. • Use of the "contracting out" approach for purchasing of services.	• Limited institutional capacity to collect and allocate funds for health from indigenous sources. • Need to close financing gap to ensure provision of services to remaining 50% of Somali population, along with a pre-payment mechanism to reduce catastrophic/out-of-pocket health expenditure. • Lack of data on health financing, including out-of-pocket expenditure, and absence of mechanism to update data. • Urgent need for public financial management reforms in health sector, aligned to cross-sectoral public financial management reforms. • Need to develop rules/procedures for purchase of goods and services in public sector. • Need to ensure strong accountability system in public sector.

4.3 Health workforce

The Somali health workforce situation is characterized by a serious shortage of all cadres. Table 5 shows the total number of health workers in the three zones to be around 9000. Health workforce information is incomplete and inaccurate, and updated data are not available.

The number and density of doctors, nurses and midwives is low across all zones. Overall density of doctors, nurses and midwives remains less than 4 per 10 000 population, which is far below the minimum threshold of 23 per 10 000 population defined as critical shortage (Table 6).

Table 5. Overall number of health workers by zone

Zone	Public	Private	Total
Puntland	1962	830	2792
Somaliland	2370	–	2370
South Central Somalia	–	–	3694
Total	–	–	8856

Source: Ministry of Health estimates, 2014

Table 6. Number and density of doctors, nurses and midwives by zone

	Somaliland		Puntland		South Central Somalia		Total
	Number	Density (per 10 000 population)	Number	Density (per 10 000 population)	Number	Density (per 10 000 population)	
Doctors	111	0.3	110	0.4	400	0.6	621
Nurses	789	2.2	664	2.4	1200	2	2653
Midwives	165	0.4	321	1.2	150	0.25	636
Total	1065	2.9	1095	4	1750	2.9	3910

Source: Ministry of Health estimates 2014

Although still limited in scope and numbers, health professional education capacities are gradually improving and new training programmes are being introduced. A brief overview of capacities is shown in Table 7.

Table 7. Overview of health professional education programmes by zone

	Total number of education programmes	Number of currently enrolled students		
		Somaliland	Puntland	South Central Somalia
Medical	13	429	314	4094
Nursing	25	395	450	2966
Midwifery	9	151	137	86
TOTAL	47	975	901	7146

All three zones have acknowledged the health workforce challenges and developed policies and strategic plans identifying a vision and strategies to scale up health workforce.

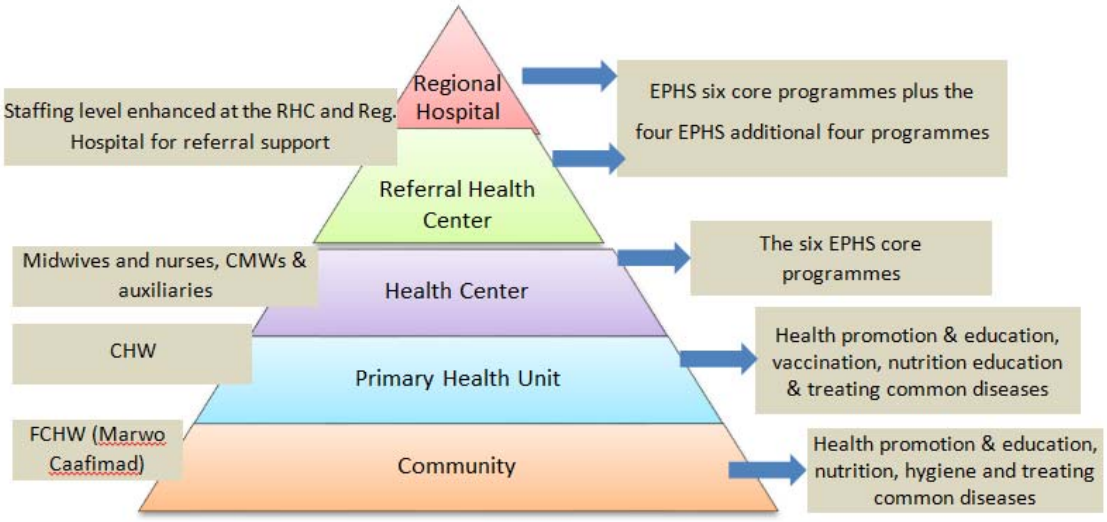
Main findings

- While a critical shortage of health workforce is being experienced, 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. In 2015, the Ministry of Health of Somaliland did not receive any new posts from the civil service commission. The health expenditure review has shown low health expenditure and ministry of health budgets are mainly allocated for 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 are no specific strategies or incentives to attract and deploy health workers in rural and remote areas. Recently, female community-based health workers have been introduced 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. Female health workers are selected from within the communities and they are expected to undertake 9 months training. The initial feedback from health facilities seems positive.

- Salaries are very low, and often released after long delays. Salary top-ups are provided by donors through various externally funded projects. Although there is common agreement among development partners to standardize incentive amounts on the basis of a 2012 remuneration study, the incentives paid are project-based for specific staff, leading to discrepancies among health personnel even within the same facility. This has led to demotivation of some staff. Additionally, the dependency on external resources for incentives/top-ups reduces the involvement of ministries of health in decision-making and raises sustainability concerns.
- The shortage of health workers, especially specialist physicians, is being partially addressed through the recruitment of expatriate physicians. Their salaries are paid by externally funded projects at a higher level than local health workers' salaries. Expatriate physicians help to improve the availability of services, but their cost implications and regulation need to be taken into account.
- In addition to a critical shortage of health workers, health professional education capacities are quite limited for scaling-up. 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 unregulated mushrooming of such institutions has raised many quality concerns. In Somaliland, the Ministry of Health does not recognize private training institutions, and thus does not employ their graduates. 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 office hours with a high level of absenteeism.
- In Somaliland, a health workforce survey has been undertaken to obtain a fuller picture of the available health workforce. However, by the time the survey is completed and findings are made available, data are likely to become outdated. Ministry of Health data do not provide up-to-date information about staffing at health facilities, and so-called volunteers are not included in databases. This lack of information raises challenges in health workforce planning and management, including monitoring of vacancies. The National Health Professions Commission's registries can help in providing a more complete picture of health workforce in the public and private sectors.

4.4 Service delivery

Health service provision for the Somali population is structured on a four-tier system comprising hospitals, referral health centres, health centres and primary health units, all of which provide some elements of EPHS (although this is not followed in practice). Table 8 presents the distribution of health facilitates in the three zones. 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. Primary health units (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. 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. Fig. 2 presents the regional health system organization, staffing and performance functions.



Source: Somali Health Policy, 2014

Fig. 2. Regional health system organization, staffing and performance functions

Density of health facilities is 1.1 across the three zones, and average hospital bed density is 1.1 per 10 000 population. The density of primary health units (health posts) per 10 000 population varies from 4 (in South Central Somalia) to 2 (in Puntland). It is estimated that 5% of people living with HIV/AIDS are on antiretroviral therapy (2013, HMIS), and the success rate for smear-positive tuberculosis treatment cases is 89% (2013).[13]

Table 8. Distribution of health facilitates across the zones

	South Central Somalia		Puntland		Somaliland		Total	
	Number	**Density (per 10 000 population)**	**Number**	**Density (per 10 000 population)**	**Number**	**Density (per 10 000 population)**	**Number**	**Density (per 10 000 population)**
Health posts	264	3	192	1	164	2	620	2
MCH centres/ health centres	197	4	79	2	109	3	385	3
Hospitals	47	15	8	23	23	15	78	16
Total	508		279		296		1083	

Source: Based on calculations from different sources

[13] Somalia Health Sector Situation Analysis, WRO Somalia, 2015

- **EPHS coverage**

EPHS is designed for the four levels of service provision, and is divided into 10 programmes. Six core programmes are provided at all levels and four additional programmes are to be provided only at the referral level.[14] Fig. 3 shows the 10 EPHS programmes and levels of implementation at the four health-care provision levels, and the recently introduced community-based level of care.

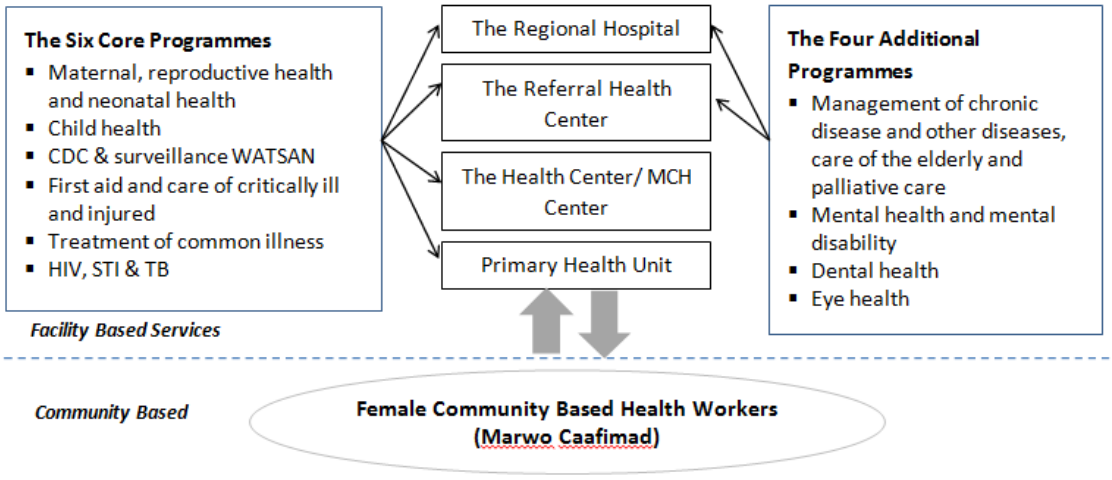


Fig. 3. EPHS programme implementation at the four levels of health care provision

Full implementation of EPHS has not been possible so far due to severe shortage of funds, shortage of trained staff, scarcity of medical supplies, security challenges and lack of quality care. Nevertheless, by rolling out EPHS in a relatively short timeframe, the Ministry of Health 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.[15] Such assessments are also a reflection of the population's low level of expectation.

Quality of care issues and patient safety concerns 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.

- **Community-level services**

There are about 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),[16]

[14] Essential Package of Health Services, 2012. UNICEF. Nigel Pearson and Jeff Muschell

[15] Review of the implementation of the essential package of health services. Nigel Pearson & Saba Khan. 2013

[16] Somali Community Health Strategy. WHO Ref Number 2014/413682-0. 2014

each with different training and scope of work. 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 forthcoming community health services.

The female community health worker (*marwo caafimaad*) concept was established to extend a range of promotive, preventive and limited curative health services to communities on their doorstep. A package of health services at community level was developed through 200 female community health workers, who were trained for 9 months and supplied with essential medicines. In 2015, an additional 300 female community health workers were recruited and will be trained. On average, each female community health worker covers 600–1000 people (100–150 households) in her community. The Somali health authorities plan to boost the number of *marwo caafimaad* to 8000 or more, giving priority to rural and urban poor areas. Deployment of female community health workers is an important intervention in ensuring access to health services to remote populations, reducing rural–urban discrepancies, and improving maternal, reproductive, newborn and child health.

- **Private health care**

Reliable data on the size of the private sector in Somalia are not available. However, it is estimated that there are 194 private clinics in addition to 190 private pharmacies. During the past two decades, a significant growth in the private health sector has been observed at all levels, from conventional private for-profit and private not-for-profit health facilities (including training institutions, small-scale clinics and diagnostic facilities) to large chains of general hospital settings providing specialized care. This widespread network is more commonly seen in urban areas.

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 nongovernmental organizations, the largest bilateral funding scheme is the JHNP, followed by the Health Consortium Somalia, active in different regions in the three Somali zones. There are important differences in the model of EPHS delivery between the different programmes and within the three zones, alongside a difference in contracting arrangements.

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.

Main challenges

- Limited availability of EPHS, with 50% of the population having no access to EPHS services. There is also a need to ensure quality assurance standards/programmes, patient safety and infection control norms, strengthening of infrastructure and proper maintenance.
- Weak regional and district leadership skills and managerial capacities for supervision, monitoring and evaluation of EPHS implementation.
- Tuberculosis and HIV have not been fully integrated in primary health care services, as a result of parallel financing.

- Ministry of health activities for community-level services are patchy resulting in overlapping or gaping of services, and there is a need for extensive harmonization.
- The existing broad scope of community health cadres with diverse talents is not sustainable. It is important to apply a standardized approach, which will provide cost-effective services for women and children particularly in underserved districts.
- There is a pressing need to enhance the number of community based Female Health Workers, allowing them to take on greater responsibility and play an effective role in the community. Traditional birth attendants also require training to help improve their services, because they are well respected.
- There is a 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.
- Regulation and enforcement of standards in the private sector is among the greatest challenges facing ministries of health in the three zones.

4.5 Essential medicines and pharmaceuticals

Following the end of central government in Somalia in 1991, the public medicines supply systems collapsed. International UN agencies and nongovernmental organizations started engagement in provisioning of medical supplies to public health facilities as part of their humanitarian and emergency interventions.

Under current arrangements, donors, UN agencies and nongovernmental organizations operate their own supply chain system in a parallel manner, 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, Expanded Programme on Immunization and nutrition are supplied based on request. In South Central Somalia, emergency supplies are mainly delivered through a kit system, utilized by international and national nongovernmental organizations; this also applies to UNFPA's reproductive health kits. WHO and international nongovernmental organizations such as World Concern and World Vision, also provide medicines for some neglected tropical diseases. Until today, this push- and pre-packed kit system is still prevails, accounting for only 20–25% of total need in the country.

A regulatory system of the pharmaceutical sector is absent in all three zones. 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 information technologies and equipment, apart from those provided through projects and partners' support.

Issues and challenges

- The essential medicines programme is in its infancy and requires a great level of support to establish the key components.
- Access to quality medicines is limited. A supply chain management master plan has been developed, but its implementation needs substantial additional 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.

- Medicines are poorly managed and are stored at facility/central warehouse level without a proper inventory system. However, standard operating procedures for warehouse management and storage practices have been introduced.
- 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. Reports of counterfeit and low-quality drugs appear in the mass media. A small contribution is supporting the establishment and functioning of six mini-labs throughout the country for basic quality testing of antiretrovirals, anti-tuberculosis drugs, antimalarials, antibacterials 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 also in place.
- Medicine and therapeutics committees have been established at zonal level to ensure oversight by health authorities of essential medicines-related activities, and a medicines policy has been developed and endorsed. However, a pharmaceutical unit at health-authority level is not in place and not included in respective organizational structures of the central health administration. Accredited training curricula for pharmacists are not developed and structured pharmacy training is not included in pre- or in-service training of health professionals.
- So far, the rational use of drugs has not been introduced and over-prescription is widely spread. The availability of paediatric formula is limited. However, 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.

4.6 Health information system

The health information system faces enormous challenges in respect 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 management information system (HMIS).

- **HMIS**

The HMIS is functional in all three zones, supported mainly through GFATM, GAVI and JHNP. Functionality varies across Puntland, Somaliland and South Central Somalia in terms of established structures, timeliness and completeness of reporting at the various levels (facility, region and central Ministry of Health). HMIS units are non-existent in most of the districts. The current HMIS platform uses an Excel database and there are plans to introduce DHIS 2. Introduction of DHIS 2 will initially be as a pilot before rolling out to all three zones. Table 9 summarizes HMIS reporting in Somalia, as of the first quarter of 2015.

Table 9. Percentage of HMIS reporting by zone

Period	Somaliland (117 facilities)	Puntland (79 facilities)	South Central Somalia (239 facilities)
2014 (Q1 & 2)	95%	94%	41%
2015 (Q1 & Q2)	94%	93%	43%
Timeliness (2014)	77%	79%	NA
Timeliness (2015)	86%	82%	NA

Source HMIS, ministries of health 2015

- **National surveys and census**

Somalia has not conducted a national survey for the past 9 years. The last multiple indicator cluster survey covering all regions was in 2006. The 2011 multiple indicator cluster survey covered only Puntland and Somaliland 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. Furthermore, HSSPs and the monitoring and evaluation framework and plans include a list of surveys that are being planned and/or considered for the next 3 years. One of which is a health facility assessment using service availability and readiness assessment (SARA) methodology, which is scheduled for completion by mid-2016. The last census was in 1975; however, the Government and partners conducted a population estimation study in 2014 at regional and district level.

- **Operational research**

Research committees with defined terms of reference (led and owned by the Ministry of Health) have been established in Puntland, Somaliland and South Central Somalia. Research agendas have been drafted in Puntland and Somaliland. Training on operational research has been conducted in Puntland and is planned in Somaliland and South Central Somalia by end-2015.

- **Independent monitoring and evaluation**

Ministry of Health, partners and donors have discussed and planned independent monitoring and evaluation of some health sector components/programmes. Examples include: a joint annual review of HSSPs/annual workplans, review of the GAVI programme (currently ongoing), midterm review of JHNP and a strategic review of the Somali health sector (conducted in September 2015, and covered in this report). To further strengthen the monitoring and evaluation capacity of ministries of health, and to guide programmatic planning and implementation, a monitoring and evaluation framework and plans were developed in 2013. Nutrition monitoring and evaluation has greatly improved in terms of reporting; 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 5 in Somalia was estimated to be only 3% (MICS 2006). Coverage varied across the three zones, with Puntland at 3%, Somaliland at 7% and South Central Somalia at 2%. Within HSSPs, a vital registration system of births and deaths is planned for pilot in some districts.

The key achievements and major challenges for HMIS in Somalia are shown in Table 10.

Table 10. Key achievements and challenges

Key achievements	Major challenges
• HMIS units established at different levels. • Baseline survey conducted in South Central Somalia (2014). • National monitoring and evaluation framework and costed plans developed. • Health systems analysis team, monitoring and evaluation, HMIS and research units (health information delivery team) conduct regular data analysis and produce quarterly reports. • Maternal mortality study conducted in Somaliland in 2013–2014.	• Questionable quality of data reported through HMIS. • National household-level health survey not conducted in last 9 years. • Health information system of vertical programmes and surveillance systems not integrated with HMIS. • System of civil registration of vital statistics not in place. • Incomplete HMIS reporting from South Central Somalia.

5. Humanitarian response in health

- **Humanitarian health relief paradigm**

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 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.

- **Humanitarian interventions: challenges and achievements**

Humanitarian interventions in the protracted complex emergency of Somalia are being challenged to expand beyond immediate relief work. Substantive achievements have been made, as outlined below.

Issues and challenges

- Confronting the urgent uphill demand of linking relief to rehabilitation and development to produce better and lasting impact on health, nutrition and WASH services.
- Catering to the needs of the growing number of internally displaced persons.
- Accessing the over 2 million food-insecure population with concrete measures.
- Responding to persisting security challenges in large areas of the country.
- Expanding the shrinking humanitarian space for health.

Achievements

- Ensuring access to essential health services in conflict-affected regions/districts, where such assistance remains the major means for ensuring human survival, along with food aid, nutrition and WASH interventions.
- Interrupting indigenous wild poliovirus transmission.
- Bringing a considerable number of health facilities back to a functional status.
- Supporting a large number of health workers through creating in-service skill development opportunities to acquire minimum competence in the delivery of essential services.
- Mitigating the effects of major natural and manmade disasters, within the context of tragic famines witnessed in 1992 and 2011.

6. Coordination: overall organizational and governance arrangements

Health sector coordination for Somalia is undertaken by various stakeholders, including government (ministries of health), donors, UN agencies, nongovernmental organizations and civil society. Membership of the various coordination bodies is largely constituency-based. Constituencies are mandated to undertake specific tasks through agreed terms of reference. Each constituency selects its own representatives, including alternates.

The Health Advisory Board, chaired by the ministers of health, is essentially a policy and planning endorsement forum that brings together ministers of health, heads of UN agencies, donors, nongovernmental organizations and civil society to discuss and set overall health policy objectives, strategies and priorities. It provides guidance and support to the Health Sector Committee to support the implementation of its functions and responsibilities. The Health Sector Committee is the main coordination mechanism, chaired by the Director-General for Health, and also undertakes functions relating to GFATM and JHNP through separate steering committees. It provides a coordination platform for Somali health authorities and development/implementing partners to discuss and develop comprehensive strategies and health policies, as well as developing technical health-sector components for service delivery. Health Sector Committee decisions, policies, strategies and proposed interventions are referred to the Health Advisory Board for review and endorsement. Zonal/state health and nutrition coordinating forums, led by the Director of Planning, have helped to promote health authority leadership and are constructive forums for addressing operational issues; however, their working needs to be further streamlined.

The cluster system was introduced in Somalia in 2006, with clusters for health, nutrition, WASH, protection, food security, education and logistics. Structures and processes vary from cluster to cluster; while some link well with other clusters and development actors, others do not. Health sector and cluster coordination meetings involve many of the same partners and there is some collaboration. However, there have been historical challenges in linking the cluster system with health sector coordination. From the perspective of health sector coordination, the cluster system is seen by many as a well-resourced, parallel mechanism reluctant to share information and work together. Considerable resources pass through the cluster system, providing opportunities for implementing partners to secure funding for “their” projects. Governments are excluded from this mechanism, particularly from the control of funds.

The key challenges to coordination are outlined below.

- Health Advisory Board lacks institutional backing from a higher level body that would give it the authority to enforce decisions.
- Health Sector Committee deals with a huge volume of information, in addition to limited capacity of health authorities, poor feedback from some constituencies, slow pace of decision-making and difficulties in effective coordination of development and humanitarian actors.
- There is a need for the Health Sector Committee to increase its scope beyond information sharing, and facilitate improved coordination around programme implementation, technical assistance, monitoring and evaluation and oversight. The focus of attention should be on building capacity in the governments to perform these functions.
- There are no structures in place to bring clusters and development partners to work together, and although the cluster system encourages collaboration with governments, this does not include direct funding. This appears to be the major concern of Somali governments.
- Emergence of new states with no clarity on governance/coordination arrangements.

7. Synopsis of health system challenges

This section provides a summary of the key health system challenges that Somalia faces, which have accumulated as a result of continued instability prevailing over two decades. The analysis of such challenges and their prioritization is helpful in developing and identifying strategic priorities and key actions to be collectively addressed by all actors in health. These strategic priorities and actions are presented in the subsequent section.

- **Persistently high burden of disease**

The neonatal mortality rate is 40 deaths per 1000 live births and the under-5 mortality rate is 137 deaths per 1000 live births.[17] The maternal mortality ratio is extremely high, estimated at 732 per 100 000 live births, and Somali women have a 1 in 18 lifetime risk of dying due to pregnancy and childbirth-related causes.[18] Communicable diseases are still the main cause of morbidity and mortality in Somalia, while noncommunicable diseases and mental illnesses are on the rise.

- **Limited institutional capacity and stewardship role of the Ministry of Health**

Loss of human capital is the main reason for weak institutional capacity. There is limited capacity for ensuring effective decentralization at state, regional and district levels. Institutional capacity varies across states in relation to policy analysis, planning, coordination, outsourcing and regulations. At the regional level, institutional capacity varies in terms of monitoring, supervision and operational planning. The capacity of the public sector to partner with private sector is limited, although the role of private sector in service delivery is enormous and requires a demonstrated Government policy for contracting-in and contracting-out of interventions.

- **Inadequate and unsustainable level of financing with a high share of out-of-pocket spending on health**

There is a financing gap to ensure provision of services to the remaining 50% of the Somali population, and a pre-payment mechanism to reduce catastrophic/out-of-pocket health expenditure is lacking. There are limited data on health financing, including out-of-pocket expenditure, and limited capacity for updating public financial data for the health sector.

- **Shortage of balanced, motivated, well-distributed and well-managed health workforce with the appropriate skills mix**

A severe shortage in health workforce continues to be a key bottleneck to strengthening health systems in Somalia. The total number of doctors, nurses and midwives is around 6000, resulting in an extremely low density of less than 4 per 10 000 population – far below the minimum threshold of 23 per 10 000. This highlights a gap of approximately 24 000 health workers across three cadres to reach the threshold level. This shortage is accompanied by misdistribution in rural and remote areas: only 9% of physicians are employed in rural settings.

- **Limited and unequal access to essential health services, and poor quality and safety of services across all levels of care**

Less than 30% of the Somali population has access to health services. EPHS implementation is uneven across regions and is principally dependent on budget availability. Implemented EPHS is missing quality standards, and a referral system and clinical guidelines are unavailable at most facilities. Although

[17] UN interagency estimates for child mortality, 2015
[18] UN Interagency estimates for maternal mortality, 2015

female community health workers (numbering 300 in 2015) have the potential to rapidly scale up promotive, preventive and limited curative health services, increasing their numbers to 8000 to ensure essential coverage to rural/poor urban areas is a major challenge.

- **Inadequate procurement/supply system and irrational use of essential technologies and medicines**

The provision of products for use in public facilities is not based on consumption patterns or quantification of needs (pull/indent system) and thereby faces frequent shortages and stock-outs and/or oversupply. There is no regulatory body for drug importation and utilization, with 80% of medicine provision and supply belonging to private sector.

- **Absence of national surveys and census, weak births and deaths registration, limited operational research and disease surveillance**

HMIS is non-existent at both the district and primary health unit level. Somalia has not conducted a national survey for the past 9 years. The coverage for birth registration among children aged under 5 in Somalia was estimated to be only 3% (MICS 2006). The situation of civil registration of vital statistics is precarious throughout the country.

- **Lack of synergy in humanitarian response to health**

Somalia is being challenged to expand beyond immediate relief work, with an urgent need for linking relief to rehabilitation and development. It is imperative that immediate humanitarian needs are linked to medium- and long-term priority development needs in order to sustain the attained health gains.

- **Inadequate action on social determinants of health**

The conflict in Somalia has had negative impact on the social determinants of health resulting in political instability, population displacement, unemployment, weak health and educational institutions, environmental effects, gender disparity and food insecurity. Effects on the conflict-stricken society include lack of social cohesion, fear and insecurity, distress and increasing levels of mental disorders due to social upheaval.

8. Strategic priorities and actions

- **Improve synergy between development and humanitarian assistance through enhanced coordination among development partners and government**

There is a range of life-saving health interventions that virtually bridge relief and development aid in Somalia. Efforts are needed to harmonize programmatic interventions, streamline financing mechanisms, set coherent operational guidelines and standards, monitor disease trends, introduce disease surveillance including early warning systems, and promote comprehensive reporting systems to facilitate service integration and coordinate linkages.

Action points

- Establish programmatic coherence/synergy between humanitarian and development planned interventions, through country-owned and country-led partnership approaches; and undertake periodic multilateral joint assessments within a framework of shared mutual accountability.
- Establish a participatory regulatory framework for contracting out of services to nongovernmental organizations; and enhance the public health sector's capacity to assume a lead role in sustaining the effective delivery of essential services.
- Create mechanisms for regular information sharing and coordination of humanitarian and development funding, with strong Government participation in planning and implementation of priority health and nutrition interventions.
- Establish joint humanitarian and development coordination mechanisms for planning and implementation, with coherent adaptation of the partners' applied institutional arrangements to concurrently address these dual commitments.
- Reinforce health and nutrition programmes for internally displaced persons in their areas of origin (to prevent further displacement and encourage their return) as well as in geographical areas where they sought refuge; and generate local ownership to mitigate health threats/risks to these vulnerable populations.
- Establish partnerships and collaborate across clusters, with full involvement of national authorities, to implement initiatives that promote safe water, sanitation and hygiene, environment, protection, education and food security.

- **Improve the stewardship and governance capacities of ministries of heath for evidence-informed polices and plans, engagement with non-state actors and better partner coordination**

Strengthening current institutional arrangements/mechanisms for policy-makers to access, analyse and use data for developing sound policies and effective strategies is a priority.

Action points

- Finalize the proposed organizational structure of the Federal Ministry of Health offering key functions for various departments and job-descriptions for staff, and clarify functional linkages with regions and states.
- Review current HSSPs to identify achievements and gaps against the predefined targets, followed by a comprehensive new planning cycle for 2017–2021.
- Establish independent regulatory bodies for systematically accrediting service-delivery institutions and licensing of health professionals.
- Strengthen the role of civil society organizations and community boards for managing health-care delivery systems at the various levels through continuous engagement in the decision-making process.

- Engage the private sector through contracting-in and contracting-out mechanisms and through involvement in the policy and strategy formulation process.
- Establish inclusive regional- and state-level coordination forums with clear roles and responsibilities, and build capacities of health management teams to lead health sector coordination.
- Establish high-level multisectoral collaboration to scale up interventions for addressing health inequities through action on social determinants of health.
- Develop and implement a package for regional/district health management teams to enhance capacities in policy analysis, strategic planning, communication and advocacy.

- **Develop a medium-term strategy and business plan that provides for a sustainable approach to health-sector financing**

Somalia needs to develop a health financing framework and action plan to elaborate how policy-makers make important decisions on mobilizing resources and increasing financial risk protection. Key factors include recognizing the organizational and regulatory context, building on existing successful interventions/programmes, and alignment/harmonization of external financing with national health policy strategic plans.

Action points

- Create high-level awareness among national policy-makers on the importance of health to increase government health expenditure.
- Mobilize more resources at country level by: (i) expanding the tax base to create more revenue (Ministry of Finance); (ii) earmarking taxes on tobacco, *khat*, air travel, etc. to health; (iii) considering community health financing schemes/social health insurance over the medium term.
- Undertake health sector expenditure reviews to ensure that contributions are more strategic, by identifying funding gaps in key areas (nutrition, reproductive health, maternal and child health and Expanded Programme on Immunization), and estimating funding requirements for other priority programmes (HIV, tuberculosis and malaria) based on real needs.
- Review and institute a programme for reforming public financial management in the health sector aligned to similar cross-sectoral reforms within the Government.
- Continue capacity-building of Ministry of Health staff in health economics and health financing, and establish functioning units under the directorates of policy and planning.
- Fund operational research to promote better understanding of health financing through: (i) health sector expenditure reviews; (ii) utilization surveys of both public and private health-care providers; (iii) estimation of health financing through the private sector, diaspora remittances and non-conventional donors; (iv) rationalization of user charges; (v) scan of suitable poverty-targeting mechanisms.

- **Scale up essential health workforce cadres to ensure improved access to health services in the short term**

Scaling up health workforce is critical in increasing access to quality health services in Somalia; however, multifaceted and extensive challenges are being faced. The identified strategic priorities are to scale up availability and quality of health workforce, and to ensure adequate skill mix of health workers with relevant competencies to implement EPHS.

Action points

- *Increase production and employment capacities* – Strengthen health professional education capacities to increase health workforce production by: introducing institutional mechanisms to improve faculty capacities, including training of preceptors; investing in infrastructure of educational institutions; and through innovative approaches to make more efficient use of existing capacities, such as double-shift teaching.
- *Reorient health professional education to the needs of EPHS* – Reorient and develop curriculum and educational approaches to produce health workers who are equipped to deliver EPHS.
- *Attract and deploy health workforce in rural and remote areas* – Revise the incentive system to encourage health workers to rural and remote areas; ensure more equitable distribution of incentives among health workers and improve motivation and productivity.
- *Increase number and expand role of female health workers* – Evaluate training and functions of female health workers and scale up production, based on positive initial results, as a short-term solution.
- *Strengthen health workforce regulation* – Strengthen national health professions councils in terms of capacity, mechanisms and procedures to ensure health professionals are well-regulated, improve quality of services and ensure protection of the public.
- *Improve health-workforce information* – Invest in improving databases on human resources for health (owned by Ministry of Health and National Health Professions Council) to include minimum information for planning and management (such as age, sex, qualifications and workplace), and improve interoperability of both databases for more comprehensive health workforce information.

- **Rapid expansion of essential and community-based health services of acceptable quality through innovative approaches including training community-based health workers and outsourcing services to nongovernmental organizations**

EPHS needs to be rolled out across the regions, especially in secured areas, to the highest level possible using all available resources (including local resources).

Action points

- Evaluate the health and nutrition programme and use recommendations as a basis for expanding access to EPHS in a phased manner, to deliver six core interventions (and later the other four) to communities in all areas of Somalia.
- Scale up production, and ensure deployment, of up to 2000 female health workers to support delivery of EPHS by end-2016.
- Establish a quality assurance system for health services through development of quality standards that complement the expansion of EPHS.
- Review current status of priority programmes related to HIV, tuberculosis, malaria and others; develop a mechanism to functionally integrate priority programmes at the service delivery, monitoring and reporting, distribution and supply-chain level.
- Integrate mental health services into core EPHS components at all levels.
- Institutionalize outsourcing of EPHS delivery to local and international nongovernmental organizations, especially in areas where public health sector is absent/weak, and build public-sector capacity to increasingly engage in contracting-out of services.
- Develop a needs-based programme offering regular in-service training to health-sector managers in leadership and management, district planning, monitoring and supervision and public–private partnership.
- Develop training programmes in acute/chronic care and quality of care for health-care providers, and provide guidelines and protocols for disease management at all health facilities.

- Engage communities in building and improving local facilities, and give them a monitoring role in their supervision through village/community health boards.

- **Improve availability and use of information by strengthening management information systems, implementing household surveys and improving civil registration and vital statistics**

The Somali health information system is weak both in terms of data generation methods/sources and in institutional capacities and frameworks to carry out data analysis, synthesis, validation and use of information for planning and decision-making.

Action points

- Conduct national-level household surveys (demographic and health surveys or MICS) every 3 years.
- Revisit HMIS indicators and tools, followed by development of a web-based HMIS system with appropriate training of staff.
- Conduct hazard/vulnerability analysis and risk assessment, as well as health system capacity analysis, to identify required levels of capacity-building for emergency preparedness and response.
- Develop an integrated disease and behavioural surveillance system, based on the established polio surveillance system.
- Enhance capacity-building efforts for operational research in both the public and private sector, and allocate sufficient resources to implement the research agenda.
- Establish a civil registration and vital statistics system on a pilot basis.
- Establish a health system observatory and a mechanism for knowledge management to ensure easy access to information on key indicators.

- **Improve access to and rational use of essential technologies and medicines**

Some efforts have been made to establish a medicines regulatory body in Somalia, although the country does not have such an authority to date. It is estimated that products being provisioned to the public sector by international/nongovernmental organizations account for only 20–25% of total need in the country.

Action points

- Establish a regulatory body within the pharmaceutical sector to support national authorities to exert the functions of quality control, in complementarity and collaboration with the existing structure for registration and licensing of health workers and pharmacists.
- Build national capacities to implement the various components of the supply chain management master plan including policy/legislation, selection, quantification, forecasting, logistics, procurement, storage and qualified human resources.
- Establish a Government-led system for the registration of medicines and work towards the provision of supplies in line with the established list of essential medicines.
- Seek technical assistance to improve management of central warehouses and provision of materials-handling equipment, including management support to the logistical fleet.
- Formulate a list of essential technologies (appropriate for Somalia) for usage and maintenance, and apply as a guiding document to certify donations.
- Engage in dialogue with medical faculties or alike for the planned production of pharmacists.
- Introduce the rational use of drugs through, for example, application of the Somali Standards Treatment Guidelines and establishment of therapeutic committees at hospitals.
- Introduce quality assurance of medicines through continued support to mini-labs (through provision of reagents and other critical materials) to expand the scope of quality-testing.

- **Strengthen health sector capacities in preparedness and response to effectively confront and tackle health emergencies**

Building national capacities in health emergency preparedness and response, as well as in risk reduction, should take priority in view of the frequent humanitarian crises and immeasurable damage and suffering they cause.

Actions

- Establish an emergency preparedness and response unit in the Ministry of Health to ensure a coordinated and effective response; collaborate with potential partners and promote intersectoral linkages to avert duplication and make best use of limited available resources.
- Develop health sector capacities for disease surveillance, monitoring of disease patterns and investigation of case reports (using epidemiological and laboratory methods/analyses) to ensure that disease outbreaks are quickly identified and effective response interventions put in place.
- Develop a national health emergency preparedness plan for risk reduction, prevention, mitigation and response to crises and disasters, and allocate appropriate resources for implementation.
- Conduct hazard/vulnerability analysis and risk assessment, as well as health system capacity analysis, to identify required levels of capacity-building for emergency preparedness and response.
- Protect the health workforce, health facilities, equipment, medicines and supplies; and train health professionals on managerial and technical skills for emergency preparedness and response, including effective planning in surge capacity.
- Develop a health emergency preparedness and response strategy; introduce guidelines, norms and standards for effective implementation and monitoring and evaluation; and promote mechanisms that facilitate coordination.
- Promote community resilience by enhancing their capabilities to prevent, withstand, mitigate and recover from negative health consequences of crises/disasters through advocacy, access to services, risk communication, capacity development and participation.

- **Strengthen synergies/coordination between health sector and health clusters**

There is a need to review existing health coordination structures and functions, focused on improving ownership and capacities of ministries of health, improving synergies between coordination structures and defining clear roles and responsibilities with appropriate accountability mechanisms.

Action points

- Develop and disseminate a shared vision, aim and objectives for health sector and health cluster coordination, with a focus on improved capacity, performance and accountability.
- Integrate and institutionalize health sector coordination structures into the health authorities, preferably with government funding.
- Link consolidated appeal processes to HSSPs and multi-year humanitarian programming; health cluster coordination structure to report on plans and performance at both Health Sector Committee and zonal health and nutrition coordination forums.
- Health Advisory Board to decide on coordination arrangements for newly emerging states and on the need for a health development partners' forum with clear roles and responsibilities.

- **Revitalize inter-zonal health coordination and shift focus of coordination to the zones**

Action points

- Health Sector Committee to develop a strategic approach to coordination of technical and programmatic issues, facilitate improved understanding of processes, conduct joint field visits, and monitor implementation and capacity-building.
- Health authorities, with the support of Health Sector Committee, to monitor performance of zonal and regional coordination.
- Health authorities, donors and UN agencies to agree on a more coherent approach to staffing health coordination positions and on financing arrangements.
- Hold regular meetings at zonal level with involvement of all stakeholders, and support greater heath authority leadership.
- Strengthen an accountable performance-based governance framework at zonal level, under the Director-General for Health and accountable to ministers of health, with effective parliamentary oversight.

9. Assess and restructure regional health management teams using well-defined mechanisms for regional-level coordination.

9. Financial outlay for Somalia health sector (2016–2021): business plan

The business plan offers a distinctive blend of financing aimed at scaling up services at all levels of the health-care delivery system (including community level), developing the health system and strengthening the leadership role of health authorities. The business plan is guided by the following principles.

- Increasing government budgetary allocations to health to substantiate commitment of the public sector, while mobilizing more donor support for the health sector.
- Effective, transparent and accountable governance and leadership.
- Universal and equitable access to acceptable, affordable, cost-effective and quality health services.
- Building effective collaborative partnerships and coordination mechanisms, engaging the local community as well as national and international stakeholders, and pursuing aid effectiveness approaches.

The plan calls for increased access to basic or essential health services to more than 90% of the Somali population, from a current level of less than 50%. This will require scaling-up of both development and humanitarian health-sector investment. The plan proposes a gradual increase in public-sector funding from approximately US$ 150 million in 2014 to US$ 212 million in 2016, and reaching US$ 353 million by 2021 (Table 12).

Table 12. Financial outlay for the health sector (development and recurrent), 2016–2021

	2016	2017	2018	2019	2020	2021
Budget estimates (in US$ million)						
Recurrent	**77.96**	**87.09**	**98.72**	**110.77**	**123.83**	**138.44**
Employee related expenses*	22.31	25.89	30.33	35.55	41.08	47.42
Operating expenses#	17.87	19.66	21.62	23.78	26.16	28.78
Coordination	2.40	2.64	2.90	3.19	3.51	3.87
Medicines, vaccines, commodities and supplies#	34.10	37.51	42.32	46.55	51.20	56.32
Repair and maintenance	1.28	1.40	1.54	1.70	1.87	2.05
Development	**134.07**	**150.08**	**165.08**	**181.59**	**199.75**	**214.60**
Expenses on physical assets	50.27	55.30	60.83	66.91	73.60	75.84
Policies, plans and legislation	6.40	7.04	7.74	8.52	9.37	10.31
Training (including pre-service and in-service)	27.90	30.69	33.76	37.13	40.85	44.93
Service delivery (excluding salaries and medicines)	39.40	45.94	50.53	55.59	61.15	67.26
Regulatory functions	1.60	1.76	1.94	2.13	2.34	2.58
Research and evidence	8.50	9.35	10.29	11.31	12.44	13.69
Total cost (recurrent + development)	**212.03**	**237.17**	**263.80**	**292.36**	**323.58**	**353.04**
Projected population (million)	13.0	13.4	13.8	14.2	14.7	15.1
Unit cost (US$) per person per year	**16.2**	**17.6**	**19.0**	**20.4**	**22.0**	**23.3**

*Extrapolated from the payroll study in Somalia; #Assumes expansion in service delivery.

Assumptions for financing the plan

The financial projections are based on investment trends in the health sector over the past few years. Key assumptions include:

- improvement in the political and security situation in all three zones;
- improvement in the macroeconomic situation and economic growth, and that the government will be able to finance at least 15% of health sector expenditure by 2021;
- non-traditional donors and the Somali diaspora will mainstream their financing to the health sector and increase their contribution to 15% of the financial outlay;
- donors and development partners will continue to finance at least 70% of projected expenditure through improved synergies between humanitarian and developmental assistance;
- national health accounts analysis will be completed by 2017 to benchmark the level of out-of-pocket expenditure; this level should be brought down to 50% of total health expenditure by 2021, for which a social health insurance scheme should be considered.

In addition, ministries of health will play a leadership role in implementing the plan with support of donors, UN agencies and implementing partners, through decentralized management of health-care service delivery and a more vibrant in-country health sector coordination mechanism.

Coverage expansion

The resources required up to 2021 will be used to expand coverage of health interventions, as follows.

- In conflict and disaster-affected areas, over 1 million women of childbearing age, nursing mothers and children will receive basic health and nutrition services.
- Around 3.2 million people will have access to basic life-saving health, WASH and nutrition services through humanitarian interventions by 2018 and beyond.
- More than 8 million people will have access to EPHS/reproductive, maternal, newborn and child health and nutrition services by 2018 and beyond.
- Number of mothers dying during pregnancy will decrease from current level of 3900[19] to less than 2400 deaths per year by 2021.
- Number of children dying aged under 5 will decrease from current level of 61 000[20] to less than 40 000 deaths per year by 2021.
- Number of skilled deliveries will increase from current level of 125 000 (33%)[21] to more than 230 000 (50%) per year, and unmet need for birth spacing will decrease from current level of 26% to 20%, by 2021.
- Number of acutely malnourished children will decrease from current level of 203 000[22] to less than 130 000 by 2021.
- Immunization coverage with 3 doses of pentavalent vaccine will increase from 42%[23] to more than 80% by 2021.
- Polio eradication will be achieved by 2017.
- A 30% reduction in tuberculosis prevalence will be achieved and effective control measures against the HIV epidemic will in place by 2021.
- More than 1000 new midwives and 2000 female health workers (*marwo caafimaad*) will be trained to address the issue of health workforce (especially female) shortage.

[19] UN Interagency estimate for Maternal Mortality, 2013
[20] UN Interagency estimate for Child Mortality, 2015
[21] UNICEF, State of World Children, 2014
[22] UNICEF estimates
[23] UNICEF, State of World Children, 2014

10. Risk analysis

There are several potential risks associated with the Somali health sector and much uncertainty in the current political, security and economic environment. To mitigate the main risks, the health portfolio should include flexible aid implementation instruments in its design to allow careful monitoring and, if necessary, to manage the flow of funds away from high-risk activities. This needs to be backed up by a strong leadership role for health sector authorities, supported by technical assistance, to enable health system strengthening. Table 11 presents the key risks and appropriate mitigation strategies.

Table 11. **Key risks and mitigation strategies**

Potential risk	Mitigation strategy
1. Lack of political commitment by governments towards health sector, especially with changing governance institutional frameworks and electoral transition.	• Contribute to the Somali Compact (followed by I-PRSP process) to promote political stability, economic growth and improvement in service delivery. • Advocate with development partners to have regular dialogue at key governance levels of the health sector, and engage these stakeholders to prioritize health during 2016 and beyond. • Ensure continuation and scaling-up of EPHS framework through a more integrated approach.
2. Conflict and security concerns pose a threat to health sector interventions.	• Contribute to the Somali Compact and I-PRSP process to support the political process and strengthen governance structures to incentivize peace and stability. • Build nationwide awareness on the principle of medical neutrality and protection of health workers and health-care services; undertake analytical review on the implications of sociocultural, political, institutional and conflict conditions on health. • Ensure good-quality health services, as communities with access to such services are more resilient than those without.
3. Poor economic status of the country and non-availability of public funds for the social sector.	• Promote policy dialogue and high-level advocacy with senior policy-makers to invest greater resources in health sector development. • Ensure more effective use of available resources for the health sector. • Advocate for pooled funding mechanisms aligned to agreed strategic priorities, in line with the 2005 Paris Declaration on Aid Effectiveness.
4. High fiduciary risks in the health sector.	• Update on fiduciary risks and help the government to implement a mitigation plan. • Disburse funds through governments on implementation with fiduciary safeguards and accountability mechanisms. • Ensure that the observations and recommendations arising from audits and/or evaluations are followed up

		and implemented, including investigations to assess irregularities.
5.	High risk of corruption in the health sector.	• Develop rules/regulations and involve different stakeholders in the decision-making process to ensure transparency when responsibilities are delegated to authorities down the line. • Provide technical support to the government authorities to follow good procurement, supply chain and financial management practices.
6.	Weak capacity of regional and district offices and lesser delegated powers at the zonal/state level.	• Ensure good coordination among partners and align capacity-building and health interventions with authorities' stipulated strategic priorities. • Provide technical support for separation of roles and responsibilities at federal, state, region and district levels. • Provide technical assistance to regions and zones/states by offering health system strengthening support, setting programmatic priorities and monitoring the delivery of services.
7.	Weak partnerships and duplication of activities.	• Provide technical support to authorities to develop a regulatory mechanism, in consultation with all stakeholders. • Encourage authorities to take a lead in aligning donor support with policy priorities under a single governance mechanism. • Align health sector financing behind HSSPs.
8.	Disasters posing a threat to achievements in the health sector.	• Highlight the importance of health sector investment while dealing with humanitarian challenges. • Support disaster risk reduction interventions through partnership by health and nutrition, and encourage clusters to train health workers to deal with humanitarian challenges. • Establish effective coordination mechanisms between national authorities and international partners.

11. Annex - Terms of Reference

Background

A stable, prosperous and democratic Somalia is a top priority for the wider Somali national interests and international community. Working within the 'Somali Compact[24]' and the 'New Deal Initiative[25]', the state is working to deliver better quality health services to more of those who need them the most.

While there is a positive trajectory after years of instability, the country still faces a fragile economy, precarious governance, infrastructure constraints, off-track Millennium Development Goals (MDGs) and deep conflict/ humanitarian challenges, while effecting transition from humanitarian to development.

The country is one of the most fragile states[26] in the world. The Somali health sector needs are vast and vulnerable to recurrent natural and man-made disasters, including fluctuating levels of conflict, poverty, economic crunch, political uncertainties, drought, floods and epidemics.

- The burden of diseases (BoD) is heavily dominated by communicable diseases, reproductive health and under-nutrition issues whereas issues related to non-communicable diseases are also on the rise. The Somali health situation is one of the worst in the world and the country is unable to achieve its Millennium Development Goals (MDGs) on health and nutrition by end 2015[27].
- 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%. Diarrheal diseases accounts for majority of deaths among children along with respiratory infections.
- Polio transmission expected to be interrupted soon but routine immunization coverage remains very low.
- One out of 18 women has a lifetime risk of death during pregnancy. The country has one of the highest total fertility rate (6.7) in the world with unmet need for birth spacing at 26%.
- Tuberculosis is highly prevalent with 30,000[28] new cases every year, of which fewer than half are detected. Malaria is endemic in some parts and HIV epidemic growing with a prevalence rate of about 1% with higher prevalence among the high risk groups[29].
- The country also faces a nutrition emergency.
- 2014 estimates indicate that there are approximately 6,000 doctors, nurses and midwives[30]. The WHO minimum threshold for health worker- population ratio states that there should be around 30,000[31] to achieve health MDGs.

Health financing for Somalia has been extremely limited as Somali macroeconomic performance is poor. Resources for the health sector are mainly out-of-pocket or through donors' funding. Somali diaspora also contribute in the health sector significantly but information is not documented.

Nevertheless, a **new environment is emerging in the Somali health sector**. Security gains in parts of Somalia have created space to engage in development strategies and the building of governmental structures and processes. The legitimacy of the authorities is critical for successful implementation of the Somali Health Policy, Health Sector Strategic Plans (HSSPs) and the Essential Package of Health Services (EPHS).

[24] www.pbsbdialogue.org/The%20Somali%20Compact.pdf
[25] http://eeas.europa.eu/archives/new-deal-for-somalia-conference/home.html
[26] http://library.fundforpeace.org/library/cfsir1423-fragilestatesindex2014-06d.pdf
[27] http://mdgs.un.org/unsd/mdg/Data.aspx
[28] http://www.emro.who.int/som/programmes/tb.html
[29] http://www.unaids.org/sites/default/files/country/documents//SOM_narrative_report_2014.pdf
[30] Health Workforce Assessment Reports for CSZ, NWZ and NEZ, 2014
[31] www.who.int/hrh/workforce_mdgs/en/

New Challenges:
In spite of some progress in the health sector visible over last few years, the sector is currently facing some challenges including:
The health sector strategic plans (HSSPs) - with an annual cost of $75-80 million – are ending in 2016. It is important to develop next phase of strategic plans for the Somali health sector beyond 2016 to ensure continuity.

New HSSPs need to be aligned with the National Development Plans and Interim Poverty Reduction Strategy Paper (IPRSP) to ensure the health sector benefits from cross sectoral reforms.

Linked to the new strategic priorities in health, the current humanitarian & programmatic response needs to be revisited.

- Support to main regional hospitals has decreased over time (Italian support progressively reduced, MSF withdrawal). **Some hospitals are not operational anymore**, or offering only basic services with high user charges. Way forward?
- The **Humanitarian programmes need enhanced financing** to fill critical gaps in provision of basic humanitarian health services.
- The **Joint Health & Nutrition Programme** - in **9 regions** for service delivery and supporting system strengthening in all three zones – is ending in 2016, with significant funding gap in 2016. What next?
- The new **Basic Health Services Programme** (under UN Multi-Partner Trust Fund) - in **5 regions** – still in a design stage.
- The **Health Consortium for Somali people** – in **3 regions** – is also ending in 2016. What next?
- Currently donors' support available for **nutrition** but no predictability beyond 2016.
- **New commitments** from GFATM and GAVI are at design stage.
- **Control of epidemics** – Polio, Measles, etc. and new emerging diseases demand continued investment?
- Need to augment and align efforts in **cross-cutting areas** of gender, FGM/C, WASH and other social determinants having direct impact on the health outcomes?
- Need for **infrastructure development** in health are more than $250 million.
- No significant investment on **non-communicable diseases** including mental health.

Key bilateral donors in the health sector are United Kingdom, Sweden, Japan, Finland, United States, Italy, Australia and Switzerland and their support increased from minimum of $30 million in 2011 to more than $68 million in 2014 (plus additional support for nutrition, polio, measles, etc). Annual support from Global initiatives (GFATM and GAVI) varied from a minimum of $19 million to $40 million during 2011 to 2014. Core funding from UN agencies for health is approximately $9 million per annum. Humanitarian funding (including CHF and CERF) was at the level of $15.6 million in 2014. Turkey is a new non-traditional donor with commitment of $59.6 million for health infrastructure development in 2014[32]. Qatar and Saudi Arabia are among the donors supporting the Somali health sector in close collaboration with health authorities. The challenge is whether donors can continue /enhance the level of support for health sector in 2016 and beyond through a more harmonized effort and more predictability?
True public expenditure in health is very low (less than 5% of total health expenditure through public system). The challenge is how to ensure more commitment from the Somali authorities, at least to reflect recurrent (starting with salaries) health expenditure in the public budget?
To address the challenges in the Somali health sector, a high level meeting was held in Nairobi, on 15 June 2015, chaired by UN Resident Coordinator/ Humanitarian Coordinator. The high level meeting was co-chaired by Ministers of Health and attended by donors, UN agencies and NGOs. In this high level meeting on the Somali health sector, it was decided:

4. *Undertake a comprehensive review of the health sector in Somalia by September 2015 taking into consideration already undertaken studies and analysis;*

[32] Health Public Expenditure Review – Draft report, 2015 and JHNP Resource Mobilization Strategy, 2014.

5. *Utilizing evidence from the review and in consultation with all partners design an architecture of the next phase of health sector implementations (HSSPs);*
6. *Enhance conversations between humanitarian and development health partners and agree on a framework to working together and synergies.*

Accordingly, WHO agreed to undertake review of the health sector in Somalia in September 2015 with involvement of all stakeholders.

Objective

The main objective of the strategic review of the Somali health sector is to assess the progress made against outputs of the Somali Health Sector Strategic Plans (HSSPs) and Humanitarian Plans of Action; its alignment with the programmatic response and the Somali Compact/ New Deal; and accordingly provide strategic and programmatic recommendations for future improvements in the health sector considering the changing context. The specific objectives of the strategic review are:

i) To review and assess if the health sector is aligned to the global, regional and national health priorities and linkages with the Somali Compact/ New Deal and other initiatives in health;
ii) To review overall changes in the political, economic, institutional and security environment and possible implications for the design and/or implementation of Somali health policy, health sector strategic plans and humanitarian plans of action;
iii) To track progress towards achieving six policy objectives / building blocks of health system and suggest future priorities;
iv) To analyse the effectiveness of the coordination and governance mechanisms of the health sector at different levels and suggest reforms required in the changing context;
v) To review the Somali health sector financing and suggest approach for the future to deliver results at the sectoral level;
vi) To develop broad recommendations and a roadmap for improvements in the health sector at a strategic and programmatic (both development and humanitarian) level.

Scope of Work

A mission/ review team of experts from WHO will assess the following:

- Analysis of the relevance of Somali health sector policies and plans in relation to global, regional and national health priorities.
- Review to what extent the objectives of the Somali health policy and strategic plans are consistent with the Somali Compact / New Deal.
- An assessment of progress against the results specified in the HSSPs and Humanitarian plans of action for health. Is the implementation on track?
- In-depth review of the health care delivery (PHC and hospital care) with comprehensive situation of the challenges and priorities for improving service provision.
- An assessment of the suitability of the current governance, coordination and management arrangements in achieving the defined outputs. Assess what further restructuring of the governance, coordination and management arrangements are required – especially in the context of Somali Development and Reconstruction Facility (SDRF).
- Analysis of the progress of health sector towards full MoH ownership and leadership – what capacity is being built and what else is required?
- Review the performance and efficiency of the sectoral financing in terms of availability and utilization of funds vis-a-vis achieved results.
- Assess the donor funding mechanisms and contributions for the health sector.
- Analysis of the linkages and possible synergies among national and global initiatives and funds such as the Joint Health and Nutrition Programme (JHNP), Global Fund (GFATM), GAVI, Humanitarian programmes and Health Consortium for Somali people (HCS) etc.

- Assess if planning, budgeting, monitoring and evaluation, logistics, information system and financial management systems are being strengthened and what reforms should be introduced in future.

Based on the above information and lessons learnt, the review mission should reflect on the comparative advantages of different reforms and the way forward to enhance future relevance, performance and impact.

Methodology

To achieve the desired outputs, it is envisaged that:

- The mission/ review team may take account of wider global, regional and Somali analytical work on education, gender, governance, political economy, security, social exclusion etc. In particular, the review team will take account of the health and nutrition aspects along with critical health system components/ building blocks. The mission/ review team will also need to review and understand current donors, UN agencies and public sector resources that support health sector.
- The mission/ review team will review policies, plans and programme specific documents, reports, reviews and other relevant information through a desk review.
- The mission/ review team will convene a series of consultations with different tiers of Somali authorities, health officials, donors, UN agencies, implementing partners, beneficiaries and other stakeholders.
- The mission/ review team will subsequently produce a report and presentation to share findings with stakeholders and will set a roadmap for the development of Health Sector Strategic Plans – phase II (2017-2021).

Timing

The assignment will commence no later than September 1, 2015. The mission will have an inception meeting first in EMRO and then with WHO Somalia office in Nairobi, donors, UN agencies and other stakeholders. The mission/ review team will visit Somalia and Somaliland and meet Somali health authorities during the period September 13 – September 17, 2015. Before the mission / review team leaves Nairobi they shall present their findings to the Somali health authorities, UN agencies and other relevant stakeholders. The following **tentative schedule** is proposed:

Date	Activity	Remarks
11 Sep 12	• Arrival Nairobi	
12 Sep	• Team briefing in Nairobi	Afternoon [TBD]
Sunday 13 Sep	• Travel to three zones • Meeting with the Minister of Health (brief about objectives and outcome of the mission) • Field visits (where possible)	Consult with security focal point and MOH about field visits Arrange for armored vehicle in Garowe
Monday 14 Sep	• Half day meeting with MOH technical team led by DG • Meetings with other UN agencies and partners	Meeting with RC (in Mogadishu if possible)
Tuesday 15 Sep	• Debriefing with Minister of Health • Travel back to Nairobi	
Wednesday 16 Sep	• Meeting of 3 teams to compile findings • Meeting with UNICEF and UNFPA heads • Meeting with DFID and SIDA • Meeting with OCHA head and RC (if in Nairobi)	WR office to take appointments
Thursday 17 Sep	• Half day workshop with 3 Health authorities, UN agencies, donors, NGOs to share key findings of mission, present the roadmap and reach consensus on future actions • Lunch with MOH teams	Get exceptional approval for Puntland MOH team to travel on UNHAS Send invitation to donors and partners
Friday 18 Sep	• Travel back from Nairobi	

A final report will be shared no later than September 30, 2015. The report should not exceed 30 pages and include an executive summary of maximum 3-4 pages including strategic recommendations and way forward for the Somali health sector, as well as appendices.

Mission Members

Mogadishu	Hargeisa	Garowe
Dr. Ghulam Popal	Dr Hernan Montenegro	Dr. Mohammad Assai
Dr. Sameen Siddiqi	Dr. Gulin Gedik	Dr. Khalif Mahmoud Bile
Dr. Humayun Rizwan	Dr. Abdi Momin	Dr. Samar Elfeky
Dr. Aggrey Kaijuka	Dr. Katja Schemionek	

Expected Outputs

WHO Somalia with support of WHO-EMRO and WHO HQ will constitute a mission/team of experts to carry out the strategic review. The following key outputs are expected:

- A narrative report covering objectives and sub-objectives of the review. The report should explain how strategies and activities are contributing to six policy outputs, outcome and impact of the Somali health policy and HSSPs. The report should include a quantitative and qualitative analysis of strengths, weaknesses, achievements, constraints, value for money and lessons learnt during implementation and strategic recommendations and a roadmap on how to improve performance in coming years, considering changing Somali context. The report should also include a section on how different programme/ interventions are contributing to ownership and leadership of the health authorities and what else is required in coming years.
- A presentation on the key findings and recommendations of the review, to be delivered in a plenary of stakeholders.

Reporting and Management

The Health system review will be supported by WHO-EMRO and WHO Somalia office. The call-off for consultants will be facilitated from the WHO-EMRO office in Cairo.

The contact person for Health system review at the WHO Somalia office in Nairobi will be Humayun Rizwan, e-mail rizwanh@who.int and the outputs will be sent to him electronically.

Responsibilities of WHO Somalia and Ministry of Health [pre mission preparation]

- Nominate a focal point at MoH to be in touch with WHO country office about processes of review.
- Collect and share all relevant documents on health system development, service provision, policies and strategies for health system strengthening, and most recent national health system policies and plans etc.
- Identify and arrange visit to health centers, hospitals, institutions in Somaliland in both rural and urban areas
- Accompany the mission and provide assistance in translation during interviews if needed, approaching selected health care providers and contribute in report writing
- Prepare list of stakeholders and managers to be interviewed including high level officials and make sure their availability during the mission.
- Organize one day workshop in Nairobi to present findings of the mission to national stakeholders.
- WHO Somalia will be responsible for all travel arrangements including hotel booking, security clearance, internal travel etc.