REPRODUCTIVE, MATERNAL, NEONATAL, CHILD AND ADOLESCENT HEALTH STRATEGY

2019-23

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ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ARV	Antiretroviral
BCC	Behavior Change Communication
BCG	Bacillus Calmette–Guérin
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBFHWs	Community-Based Female Health Workers
CDS	Communicable Diseases Surveillance
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CSOs	Civil Society Organizations
DHIS-2	District Health Information System version two
EBF	Exclusive Breastfeeding
EMTCT	Elimination of Mother-To-Child Transmission
ENAP	Every Newborn Action Plan
ENC	Essential Newborn Care
EENC	Early Essential Newborn Care
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
EPMM	Ending Preventable Maternal Mortality
FGM	Female Genital Mutilation
GAVI	The Global Alliance for Vaccines and Immunizations
GBV	Gender-Based Violence
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HC	Health Center
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health System Strengthening
iCCM	Integrated Community Case Management
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IMAM	Integrated Management of Acute Malnutrition
IMCI	Integrated Management of Childhood Illnesses
IMNCI	Integrated Management of Neonatal And Childhood Illnesses
IMPAC	Integrated Management of Pregnancy and Childbirth
IMR	Infant Mortality Rate
iNGOs	International Non-Governmental Organizations
IPC	Inter-Personal Communication
IPV	Inactivated Polio Vaccine
IST	In-Service Training
IYCF	Infant and Young Child Feeding
JHNP	Joint Health and Nutrition Programme
KMC	Kangaroo Mother Care
L&D	Labor/Delivery
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition
MCH	Maternal and Child Health
MISP	Minimum Initial Service Package
MMN	Multiple Micronutrient
MMR	Maternal Mortality Ratio
MNCAH	Maternal Newborn Child and Adolescent Health
MNCH	Maternal, Neonatal and Child Health
MoE	Ministry of Education
MOH	Ministry of Health

MPDSR	Maternal and Perinatal Death Surveillance and Response
MUAC	Mid-Upper Arm Circumference
NICU	Neonatal Intensive Care Unit
NMR	Neonatal Mortality Rate
OF	Obstetric Fistula
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
PHC	Primary Health Care
PHU	Primary Health Unit
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
RHCs	Rural Health Centers
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SARA	Service Availability and Readiness Assessment
SBAs	Skilled Birth Attendants
SDGs	Sustainable Development Goals
STDs	Sexually Transmitted Diseases
STI	Sexually Transmitted Illnesses
TB	Tuberculosis
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
TOTs	Training of Trainers
TT	Tetanus Toxoid
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

P R E F A C E

The Somali population has suffered over the past two and half decades from a series of natural and man-made disasters. A major casualty in this entire scenario has been the health sector, with women and children becoming the biggest victims with evidently poor social accountability and inadequate quality of health services' delivery. As the country is currently transitioning towards recovery, with notable and gradual progress, it is imperative to make the strategic choices in the health sector and transform the vicious cycle of poverty and ill health through a direct focus and investment on reproductive maternal, neonatal, children and adolescent health (RMNCAH).

The current poor RMNCAH outcomes epitomize the most urgent need for attention and action. Likewise, the Somali health authorities at every operational level are determined to save all the preventable deaths of mothers and children and provide all the requisite facilities to these vulnerable population segments with utmost commitment and resolve. We need to ensure, however, that our models, approaches, and strategies keep pace with the best public health practices at the global level while, factoring in the contextual realities on the ground. The process, however, is not simplistic and requires the coordinated efforts of the health sector and the local communities to make a meaningful difference in the health, particularly, of the vulnerable population segments.

It is accordingly our collective obligation to initiate the implementation of this medium-term RMNCAH Strategic plan for 5-years, addressing the gaps in the health system that can negatively affect maternal, neonatal and child and adolescent health. These challenges will be addressed by launching essential interventions and through the collective renewed commitment to Primary Health Care (PHC), that lead the way towards Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs), while aligning the Somali RMNCAH objectives with the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). The aim is to ensure for the entire population to achieve the affordable and quality health services they need. We are therefore fully committed to the successful implementation of this Strategic plan and wish to express our gratitude to the World Health Organization (WHO) and other health partners and stakeholders, particularly The United Nations Children's Fund (UNICEF) and The United Nations Population Fund (UNFPA) and our Donor Development Partners for backing this Strategic plan, which constitutes a high-priority objective. All have worked in concert, towards making mothers and children safer in all respects, for which they all deserve our utmost appreciation. We earnestly look forward to the speedy, smooth and unhindered implementation of this Strategic plan, particularly in the interest of mothers, young children and adolescent girls and boys in the resilient Somali environment.

EXECUTIVE SUMMARY

I. Introduction and Background

The extended periods of conflict and insecurity exacerbated by recurrent extreme droughts, floods and subsequent food insecurity have together devastated the health status of the population and seriously damaged its fragile health system, resulting in some of the worst health outcomes for mothers and children globally. The shortage of the health workforce, their skills and their uneven distribution coupled with dilapidated health facilities have equally harmed the delivery of lifesaving RMNCAH services, particularly for the nomadic and rural communities, the 2.6 million internally displaced persons (IDPs) and the urban poor. The under-five, infant and neonatal mortality rates stand at 123, 80 and 39 per 1000 live births[1], respectively, which is considered the highest under-five mortality in Eastern Mediterranean Region (EMR), while the maternal mortality ratio (MMR) stands at 732 per 100,000 live births. With the transition to recovery finally underway, this is the time to consolidate the delivery of RMNCAH essential interventions and translate them into better health, population and nutrition indicators. This realization has led to the development of a five-year Somali RMNCAH Strategic plan designed in the aftermath of the 40th anniversary of revitalizing the historic PHC Declaration of Alma-Ata in 1978 and reiterating the call to the global community to strengthen their PHC mechanisms as the crucial path towards achieving UHC. This undertaking is based on the philosophy that health is an inalienable fundamental right of every human being, who needs to enjoy the highest attainable standards of health regardless of any consideration. In the framework of this global momentum, the Somali RMNCAH strategic development will accelerate its effort to eliminate or substantially mitigate the numerous barriers and bottlenecks that impede the effective utilization of these services. The envisaged RMNCAH Strategic plan provides a real opportunity for scaling up the relevant services by extending millions of the target underprivileged populations with requisite care. WHO assisted in the design of this RMNCAH Strategic plan/ Investment case led by the Somali health authorities, in close consultation with a wide range of UN and other health development partners. The concept of this Strategic Plan/ Investment case is consistent with the revitalization of PHC, lending support to UHC and the overall poverty reduction effort based on human-rights by promoting equity and recognizing health as a peace dividend and a major factor of solidarity contributing to community development.

The Somali Joint Health and Nutrition Programme (JHNP) launched in 2012 for five years was a comprehensive multi-donor venture implemented in nine regions[2]. The JHNP covered 5.7 million people accounting for 45% of the target population with extensive support from the Somali health system. The programme has now ended raising apprehensions of a growing risk of fragmentation in the absence of a robust coordination mechanism to sustain the currently planned implementation of the RMNCAH Strategic plan. To further enhance the coverage and impact of this vital programme, the recruitment, training and deployment of '*Marwo Caafimaad*' female community-based health workers (FCBHWs) and skilled Community Based Midwives (CBMWs) in the rural areas and their linkages, offering priority to the hard to reach geographical areas, will be advanced, for being instrumental in providing them with the critically needed services

The Strategic plan/ Investment plan development process was highly elaborate, inclusive and participatory to seek inputs from all the stakeholders on the key strategic RMNCAH interventions.

[1] IGME 2017

[2] Mid-term Review of the Somali Joint Health and Nutrition Programme (JHNP). Sida Decentralized Evaluation 2015. Bernt Andersson Zohra Lukmanji Hassan W. Nor Jessica Rothman

The stakeholders include government functionaries at all levels, UN agencies particularly WHO, UNICEF and UNFPA, donors, other health development partners and the multi-stakeholder reproductive working group in addition to several international Non/governmental organizations (iNGOs) and Civil Society Organizations (CSOs), fully cognizant of the contextual realities and challenges on the ground. All the partners stressed on the need to align the Strategic plan with the Somali health policies and strategic directions with the PHC approach of development and consistently pursue the SDGs, more specifically working towards UHC. The continuum of care was strongly emphasized both across the life course and the referral chain of the health services' network to effectively address the needs of the target population and improve the RMNCAH outcomes and impact. Accordingly, there is a need to reach a consensus around the priority strategic objectives for action that the Strategic plan will need to pursue. Areas singled out for urgent action, include among others, fragmentation of health care services, weak staff managerial capacity, shortage of qualified health workforce, the resource crunch of the government and the international NGOs supporting the delivery of health services. Other risks include the dilapidated health facilities, compromised referral transport services and safety challenges, insufficient service delivery space, unsafe water and sanitation facilities and the lack of healthcare waste-management system.

II. Situation, Issues and Trends

The Somali health care system comprises four levels that include the Primary Health Units (PHUs) in rural areas; Health Centers (HCs) at sub-district level; Referral Health Centers located in districts and Regional Hospitals located in the regional capitals. In 2016, a Service Availability and Readiness Assessment (SARA) survey was conducted to assess the infrastructure and its responsiveness in providing the key health services. Out of a total of 1,074 health facilities, only 799 were operational and accessible. The SARA survey findings along with the District Health Information System-Two (DHIS-2) data, were analyzed with an emphasis on the RMNCAH situation. The key RMNCAH related findings of the Situation Analysis are summarized below:

- There was an acute shortage of health facilities (even considering the private health facilities) underlining an unfulfilled capacity in terms of numbers and distribution. The cumulative score of the density of public health facilities, in terms of inpatient and maternal beds was only 28.3%, reflecting a 72% deficit in health facilities' infrastructure while the core health workforce density was 18.6% and service utilization level 6.3%, which collectively provide a total general service availability rate of 17.7%.
- The availability and implementation of infection control guidelines at the facility level was critical, as this will entail the safety and quality of provided maternal and newborn services. On average, the SARA infection control readiness score of all the facilities was 62%, while only 20% of the facilities had all the listed infection control prevention standard precautions.
- The overall availability of the routine laboratory tests at health facilities was only 19%, while only 4% of the facilities performed all the diagnostic tests on-site, and blood glucose testing was available in only 7% of the facilities suggesting that the majority of the pregnant women turn to the private sector for most laboratory investigations, posing affordability problems.
- Six of the ten Somali Essential Package of Health Services (EPHS) are core programmes including RMNCAH services' availability in the outlets at all tiers is mandatory although many components were not readily available to the care seekers. Moreover, the EPHS covered about 50% of the regions, while the remaining regions were predominantly supported through humanitarian health interventions. Close to a third of the functional facilities were able to offer birth-spacing services, with periodic stock outs of commodities, with 70% of the facilities having at least one health worker trained on birth spacing, while 28% offered these services.

- Ante-Natal-Care (ANC) is essential for imparting preventive care services as well as the detection and treatment of any emerging health problems during pregnancy. The SARA survey illustrated that 66% of the facilities provided ANC services although not comprehensively, with 43% of facilities providing less than half of the service components.
- Although the prevalence of HIV infection among the general population remained at about 1% or lower, it was higher among high-risk groups such as sex workers (5%) Tuberculosis **(**TB) patients with estimated HIV prevalence among TB incident cases of 6.8%, necessitating that pregnant women get unimpeded access to HIV testing routinely[3]
- The mean availability of Basic Emergency Obstetric and Neonatal Care (BEmONC) services as reported by the SARA survey was 45% among urban facilities compared to 20% in rural areas, while Essential Newborn Care (ENC) was offered in 29% of urban and 12% of rural facilities. The 2014 reported rate of the skilled birth attendants at delivery was 33% with a target set at 55% for 2021[4]. The establishment of ENC is, therefore a core priority of the RMNCAH Strategic plan, necessitating urgent attention to avert newborn deaths through simple, evidence-based cost-effective and low-cost technology interventions.
- The MMR fell from 1,300 in 1990 to 732 deaths per 100,000 live births in 2015, yet with the current pace of effort it is not likely to reach the SDG target of 70 per 100,000 live birth by 2030 unless an innovative Strategic plan is scaled up through universal access to Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC) services in all urban and rural areas. CEmONC services are offered in 6% of urban facilities and only 1% of rural facilities. Only 26 CEmONC centers were operational, while several more were in different stages of implementation. Access to BEmONC facilities was also constrained by the physical distances involved.
- Routine immunization services are offered to children and women, however, the programme is confronted by operational challenges such as inaccessibility, insecurity and the shortage of trained health workforce. An additional challenge is the low density of health service delivery outlets, especially in rural areas with inadequate community demand for health care services. The assessment revealed that less than half (49%) of the health facilities provided routine childhood immunization, while the outreach services were offered by only 13% of the facilities. 89% of referral health centers, 87% of health centers and 50% of the hospitals offered child immunization, while only 6% of health posts/Primary health units did so.
- The key child preventive and curative care services were provided by 526 (66%) of the functioning facilities, whereas the treatment of pneumonia in under-five children with amoxicillin was at 59%, though only 13% of this age group with Acute respiratory infection (ARI) symptoms were taken to a health facility[5] and only 20.8% of those with diarrhea received ORS solution, of which 61% were also offering zinc supplementation.
- Child growth monitoring was conducted in 41% of the health facilities. The undernutrition among the under-5 children was estimated at 42.1%, corroborating it as a major underlying cause of childhood morbidity and mortality. The corresponding data in DIHS-2 detected under-nutrition in over 25% of the under-5children.
- The adolescent age (10-19 years) is a critical phase in a girl or a young women's development, and assuredly they constitute a vulnerable group, as the majority lack the information and necessary skills for self-protection when they reach their sexual maturation. Somali adolescent girls are therefore at high risk for child marriage, early pregnancy, Female Genital

[3] Strategic Plan to Control Tuberculosis Somalia 2010-2014, Equitable Access to Quality Diagnosis & Treatment of TB version 17 March 2010

[4] Somali federal Ministry of Health. Second phase of health sector strategic plan 2017-2021

[5] WHO, 2015. Global Health Observatory Somalia Summary Statistics, January 2015 Profile.

Mutilation/Cutting (FGM/C) and mental health issues, which limit their ability to access the required health services, obtain education and achieve the life skills they need.

- Family disruption and the IDP crisis has enhanced the prevalence of gender-based violence (GBV), by exacerbating the existing social and economic gender inequality limiting educational opportunities for girls along with a weak judicial system. National efforts are currently underway to address this emerging social challenge.
- A major boost for the RMNCAH workforce capacity lies in the in-service training (IST) programmes regularly organized to improve performance at the operational level. The 2015 IST survey illustrated that out of 4,134 health workers trained for two years, 54.5% were health workers performing Reproductive Maternal, Neonatal and Child Health (RMNCH) and nutrition services. However, most of these training opportunities lacked clinical practices. The lack of community embedded health workers in peripheral areas is also a major gap, without which UHC cannot be attained.
- The Somali health sector has experienced severe challenges in its managerial and governance dimensions such as limited institutional capacity and stewardship role of the ministries of health, including coordination, management, regulation, and limited leadership experience. Additional challenges are inadequate health financing, absence of skilled and well-distributed workforce, unequal access to quality services, lack of integrated health information systems, and an inadequate synergy between humanitarian and development/recovery response in addition to donor dependent health system and private sector dominant health care system with a high level of out of pocket expenditure. However, the steady recovery phase in recent years has generated young health professionals with good leadership skills capable of driving forward the evolving health interventions, such as the RMNCAH Strategic plan.
- The electronic Somali DHIS-2 implemented in all health facilities enables health management teams to use the generated information for effective monitoring of the RMNCAH services. Communicable disease surveillance (CDS) is also being carried out through this unified data collection process.
- WHO has taken the lead in improving the accessibility, optimal storage and proper use of medicines in the health system, and conducted a large number of training courses on essential medicines in recent years. The EBHS implementation in all the four public sector levels of care provision benefits from the introduction of the Somali treatment guidelines where the essential medicines for RMNCAH services ensure the rational use of medicines and contribute to the quality of care[6].
- The low level of domestic public sector health financing, fuels high levels of out-of-pocket spending on health leading to catastrophic expenditures for vulnerable population groups. Moreover, most of the health services' delivery is predominantly funded by the development partners with limited public sector investment, a major weakness that needs to be gradually rectified. The aid mapping for the health sector was estimated in 2017, 2018 and 2019 at US $ 116.8 m, 108.6 m and 137 m, respectively.
- The RMNCAH interventions are also supported through the emergency reproductive health cluster that monitors its implementation process. There is a severe shortage of health workforce, reflected by the low number of doctors, nurses and midwives, accounting to only 4 for every 10,000 population. The latter is considered to be a way short of the WHO stated 44.5 per 10,000 which is the minimum required[7]. The situation has further deteriorated by

[6] Somali Treatment Guidelines in line with the Essential Package of Health Services. Somali Health Authorities World Health Organisation Primary Health Unit STGs November 2015.

[7] Global Human Resources for Health Strategy, 2016

their inequitable distribution and the insufficient skills-mix, task shifting and task sharing in most facilities.

III. Guiding Principles of the RMNCAH Strategic Plan: 2019-2023

The Vision of the Strategic plan / Investment case is to ensure that every Somali woman of childbearing age, newborn child and adolescent realize their rights and enjoy the highest attainable standards of health and wellbeing, regardless of their location and status. The Mission is to promote and provide quality RMNCAH services to all its target groups to achieve better health outcomes and reduce all preventable maternal, child and adolescents' deaths.

The guiding principles of the strategic plan include equity, efficiency, universality, sustainability, people-centered, and human rights-based approach with transparency, accountability, and ownership. There is a need to adopt the latest global initiatives such as ending preventable maternal mortality (EPMM), Every Newborn Action Plan (ENAP) and Accelerated Action for Health of Adolescents (AA-HA) Implementation Guidance**.** The Somali RMNCAH strategic plan is aligned with the new Global Strategic plan for Women's, Children's and Adolescents' Health (2016–2030), envisaged for the post-2015 SDGs era. New tools for the assessment of quality were developed and employed particularly in countries with high maternal and child mortality. The Strategic Plan will also aim at ensuring the availability of and access to fully functional BEmONC, and the lifesaving CEmONC service that secures the availability of safe blood transfusion and Cesarean section operations when required. In addition to the Essential Newborn Care (ENC) with focus on early interventions after birth, the strategic plan endorses the Maternal Newborn Child and Adolescent Health (MNCAH) continuum of care concept across the life course and the effective use of the referral chain. The strategic plan also emphasizes the application of the integrated management of neonatal and childhood illnesses' (IMNCI) best practices across the health system. A major component in this strategic plan will be the integrated training of community-based female health workers (CBFHWs) and community based CBMWs, trained in providing RMNCAH services to become an integral part of the public health workforce, replacing the untrained Traditional Birth Attendants (TBAs), who are currently assisting labour for 60% of the Somali mothers.

IV. Priority interventions Underlined in the RMNCAH Strategic plan

The Strategic plan has been developed with a view to bring about continuum of care through the life course, along the primary health care approach with huge elements of community participation and intersectoral action for health. The latter envisages coordination with other social sectors involving the provision of basic education, gender equality, safe water, sanitation and hygiene and other environmental health actions as beneficial to the health system. The main priority interventions are summarized below:

1. **Antenatal Care (ANC):** The quality and utilization of ANC services will be improved and scaled up by training nurses, midwives for health facilities and community based female health workers (CBFHWs) and CBMWs for the rural areas in adequate numbers. The availability of requisite equipment and logistics will also be ensured. Social mobilization and awareness creation are necessary to ensure antenatal visits, with proper screening for danger signs throughout pregnancy. Counseling on pregnancy complications is also mandatory along with the negation of harmful cultural practices and perceptions. MUAC monitoring will be carried out to screen for malnutrition in expectant mothers. TT immunization, provision of

anthelminthic, iron and folic acid supplementation is essential, as well as the diagnosis and treatment of STIs.

2. **The Delivery Care with positive childbirth experience:** This Strategic plan will emphasize on the organization of maternal delivery care services that are provided to all women while maintaining their dignity, privacy and confidentiality, and rendering them free from harm or mistreatment. Offering continuous support during labor and childbirth is critical to ensure that every delivery is assisted by a skilled birth attendant within the community or in health facilities, with the availability of Basic EmONC facilities at an accessible location. The staff at the care provider level will be trained to hold effective interpersonal communication (IPC), creating a respectful working environment that generates a positive experience among the care-seeking mothers, bridges inequities and improves quality. A sizable number of midwives, nurses and auxiliaries will be provided with regular in-service training activities on the Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines and tools. Families are to be encouraged to register their newborn infants at the local government municipality for their legal recognition and entitlement to basic rights including health and education.
3. **Improved access to CEmONC services:** The coverage of the well-functioning CEmONC health facilities will be scaled up to reach out to the targeted expansion of at least 60 equitably and geographically well-distributed centers. The Strategic plan aims to introduce a cash voucher system in identified hard-to-reach areas encompassing 100 health facilities to scale up the demand for facility-based delivery and postnatal care services. Capacity building will also be carried out for 160 CEmONC staff operating in 40 facilities, one or two in every region, through short neonatal intensive care training course enabling them to manage newborn babies who need acute medical treatment conducted by qualified staff. The Strategic plan also envisages the training of 120 physicians on CEmONC courses of 9 months in different regions to expand the health system referral support and improve the quality of service delivery. Guidelines will also be developed and implemented on Maternal Perinatal Death Surveillance and Response (MPDSR). Access challenges to RMNCAH will be mitigated through the provision of BEmONC facilities in the PHC units (PHUs) of the district health system.
4. **Post-Natal Care and Birth Spacing:** Several strategic components will be prioritized to ensure safe post-delivery practices across the health system, entailing the establishment or renovation of 400 recovery rooms in health facilities. Effective health promotion and awareness raising programme on early initiation and exclusive breastfeeding (EBF) for six months for all newborns will also be established, while refresher training for 500 qualified midwives and nurses on contraceptives and birth spacing will be organized. A similar number of CBMWs will also be trained on the promotion and counseling of mothers on birth spacing while monitoring and ensuring a steady supply chain of family planning logistics with a buffer stock of contraceptives in each district. Psychosocial support must always be at hand to address postnatal depression and other mental health issues.
5. **Neonatal Care:** To effectively respond to the suboptimal care provided to newborns, Essential Newborn Care (ENC) will be established as a key priority of this Strategic plan for the provision of critical elements of care. Accordingly, the training of trainers (TOTs) will build the capacity of health workers caring for normal, small and sick newborns which is a top priority. Early Essential Newborn Care (EENC) will be introduced in targeted EmONC facilities. Neonatal Care Units will be created in the regional hospitals in the immediate term and in the referral health centers on the medium- and long-term perspective. ENC units will regularly stock the key essential medicines and initiate EBF within the first hour of birth. Through this Strategic plan, EENC training will be organized for around 200 midwives and nurses to provide the necessary care for every newborn. The establishment of 9-18 fully

equipped Neonatal Intensive Care Units (NICUs) will be established at every region or at least one in every two regions with lifesaving referral support and with basic equipment and necessary trained staff. The basic neonatal equipment for conducting newborn resuscitation will be freely available in health facilities and at the community level. A total of 400 staff working in EmONC health facilities will be trained on EENC including Kangaroo Mother Care (KMC) for stabilizing low birth weight infants, with the early initiation of breastfeeding and other corrective measures.

6. **Focus on IMNCI and child survival:** It is imperative to scale up the IMNCI programme approach including the ENC package to prevent deaths, improve the nutritional status and immunity of neonates and young children. For this purpose, health facility staff and community-based workers will be provided IMNCI training. Mothers will be introduced to the best practices in breastfeeding including exclusive breastfeeding, weaning and complementary feeding for infants and young children and on child immunization. Efforts will also be made to ensure that all the target children are provided routine immunization and periodic vitamin A supplementation, where appropriate, in collaboration with the Expanded Programme on Immunization (EPI). To accelerate action and reach out to underserved children, the Integrated Community Case Management (iCCM) will be introduced and scaled up to support the implementation of effective health interventions that reduce under-five mortality from preventable causes.
7. **Nutrition Stabilization:** The recurrent drought situations and deteriorating health environment have led to a continuous decline in the nutrition indicators of the country. All major indicators relating to the proportion of severe acute malnutrition, stunting, wasting, micronutrient deficiencies, and low birth weight babies are some of the worst in the world. To reverse this trend and related preventable mortality, the health staff will be trained on the management of severe acute malnutrition (SAM) and moderate acute malnutrition (MAM)[8]. These will include facility-based doctors, nurses and paramedics and community health workers including CBMWs and nutrition staff deployed across the board. These health facilities will be equipped with the necessary medicines and supplies. Besides, 50 nutrition stabilization wings/ centers will be established in regional hospitals and referral health centers for children requiring hospital-based management with counseling rooms for mothers and playrooms for children.
8. **Adolescent Health:** This is often the missing link in health services of developing countries including Somalia although it represents a major proportion of the population. Parents and adolescent girls will be cautioned on the health consequences of early marriages and advised to delay them at least until the legal age of 18 years while the choice of extending their education will enable them access equal opportunities and realize their full potential during their adult life. Eligible adolescent school girls in rural areas will be encouraged to be trained as CBFHWs or CBMWs to respond to the pressing health needs of their communities with the integration of these PHC services.
9. **Addressing GBV:** Community awareness will be enhanced for the prevention of GBV including forced marriages and FGM/cutting, that often results in long term health, psychological and physical manifestations from these traumatic experiences. These will become an integral part of the reproductive health services and training activities imparted on health staff on its clinical management highlighting the need for psychosocial care and provision of health care counseling needs.

[8] Somali National Micronutrient Deficiency Control Strategy (2014 – 2016)

10. **Strengthening Leadership and Governance for RMNCAH Activities:** The planning and delivery of RMNCAH services require concerted efforts, coordination and accountability mechanisms at central, state, regional and district levels in harmony with the established decentralization process. It will require all the stakeholders to improve their performance and demonstrate measurable health outcomes of the programme components that were designated to them. The public health sector in collaboration with WHO and other technical partners such as UNICEF and UNFPA will provide the needed technical assistance to upgrade the RMNCAH units to departments at national and state levels, bringing together all its components under a unified and integrated management structure. In addition to building the managerial skills of RMNCAH teams at national and subnational levels. Cross-sectoral efforts through building partnerships with local government authorities are also mandatory and should complement the delivery of RMNCAH services. The latter will address issues related to nutrition, safe water, sanitation and other environmental issues for more effective implementation scope and sustainability.
11. **Ensure the availability of trained RMNCAH workforce for effective service delivery:** A well trained RMNCAH health workforce constitutes the backbone of this entire Strategic plan and is critical to the entire implementation effort. RMNCAH technical committee will be established to develop the curriculum of various cadres of the health workforce including community health workers. Six hundred (600) qualified midwives and nurses trained in formally accredited institutions and 500 CBMWs for the hard to reach rural communities will be recruited, training and subsequently deployed to serve their respective communities. Advocacy training workshops of short duration will also be organized to enhance the responsiveness of 400 RMNCAH care provision facilities.
12. **Strengthen RMNCAH information systems for evidence-based decision making:** The DHIS-2 implementation mechanism will need to be strengthened in relation to data collection, analysis, printing, dissemination and use for decision making. This will help the public health sector and its partners to identify the priority RMNCAH operational gaps and undertake implementation research to bridge the knowledge gap and generate context-based solutions to the challenges encountered during implementation. Improvement of recording at health facilities and community level will be also targeted during the implementation of EENC, IMNCI and community based interventions.
13. **Ensure the availability of essential RMNCAH drugs, equipment, and supplies:** The RMNCAH Strategic plan will ensure the availability of medicines, equipment and supplies essential for the delivery of the required interventions. The Strategic plan will also strengthen the rational use of drugs through IST and supportive supervision. Guidelines for procurement of essential medicines and supplies, management, and rational use practices will also be developed. This aims at ensuring the availability of essential RMNCH drugs including pediatric formulations in the national essential drug list while preventing any stock outs.
14. **Humanitarian Emergencies:** Humanitarian emergencies are the new norm in the major part of the world. It is imperative for health staff to be well versed on how to address all the phases of an emergency and take the necessary steps for disaster mitigation. Five hundred staff within the target population will be provided with a minimum initial service package (MISP) training on the outset of humanitarian emergencies. Context-sensitive RMNCAH preparedness and response plans will be developed for the emergency-affected population. Emergency health kits prepositioned in specific warehouses will be mobilized and made available for the prompt response. The capacity of health programme managers at national and subnational levels on addressing child and adolescent health in humanitarian setting will also be strengthened.

1 INTRODUCTION AND BACKGROUND

1.1 Challenges Facing the Health System

The planning and implementation of RMNCAH strategic interventions that ensure the availability, accessibility, acceptability, and quality of essential health care services necessary for achieving universal health coverage is of paramount importance. In the current framework of the Somali health sector recovery process, a protracted cumulative decline in health standards has hit the nomadic and rural populations, the IDPs and the urban poor more severely. The under-five, infant and neonatal mortality rates stand at 123, 80 and 39 per 1,000 live births, respectively, while the MMR is 732 per 100,000 live births. The corresponding total annual death toll is estimated at 64,938 for under-5's. Considering a population of about 12 million and an annual crude birth rate of 39.5 per 1000 population, 40,290 of these child deaths occur before completing the age of one year, while 18,480 die within the first 28 days following birth. The years of conflict are now gradually and steadily being replaced by a visible recovery phase where the RMNCAH attained gains, will be largely retained and translated into a good health and nutrition status.

If universal coverage with the essential and affordable lifesaving basic and comprehensive Emergency Obstetric(EmONC), Essential Newborn Care and IMNCI were appropriately located in all accessible and staffed health facilities and trained Community Based Female Health Workers (CBFHWs) and CBMWs were deployed in the rural communities, a significant proportion of these deaths could be averted. However, a critical challenge remains to be the highly limited access of these rural communities to basic essential promotive, preventive and curative maternal, neonatal, child health and nutrition care services, while accounting for almost 50% of the population. The 2018 State of the World's Mothers' yearly report prepared by Save the Children has labeled Somalia as the hardest place to be pregnant or a mother and ranked the country at the very bottom in the global rankings[9]. The latter is clearly a reflection of the scarcity of skilled midwifery support and poor care-seeking behavior, the existing geographic, socio-cultural, security and financial inaccessibility and the limited performance capacity and quality of the health services system.

1.2 Pursuing the Global Aspiration of Linking PHC to SDGs

The Somali RMNCAH Strategic plan / Investment case has been designed in the aftermath of the global reaffirmation to PHC in Astana, Kazakhstan in October 2018 on the 40th anniversary of the historic PHC Declaration of Alma-Ata in 1978, calling upon the global community to strengthen their PHC mechanism as an essential step toward achieving UHC[10]. This health sector aspiration is also solidly engraved in the SDGs' 2030 agenda and the pursuit of Health–for-All. The PHC affirmation also expresses a resolute national policy commitment that health is an inalienable fundamental right of every citizen[11]. The declaration also endorses the imperative to pursue justice and recognize health as a peace dividend and a major factor in promoting solidarity and contributing to security and community development. In the framework of this global momentum and on the Regional Vision 2023[12], the Somali RMNCAH strategic development will benefit from

[9] The State of Motherhood In 2018: The Best (And Worst) Countries For Moms Around The World. https://www.healthyway.com/content/the-state-of-motherhood/ Retrieved on March 20, 2019

[10] Hone T, Macinko J, Millett C. Revisiting Alma-Ata: what is the role of primary health care in achieving the Sustainable Development Goals? Lancet. 2018 Oct 20;392(10156):1461-1472. doi: 10.1016/S0140-6736(18)31829-4

[11] The Somali Human Resources for Health Development Policy 2015-2019

[12] http://www.emro.who.int/about-who/vision2023/vision-2023.html

the rich evidence put forward in recent years in this critical health domain, with UHC emerging as the single most important concept to both the urban and rural/nomadic settings. The latter has the potential to eliminate or substantially mitigate the numerous barriers and bottlenecks that impede the effective utilization of these services.

The envisaged RMNCAH plan for strategic transformation is being finalized at a time when the Somali health sector recovery is slowly getting back on track, with the overwhelming number of health service outlets securely operating under the health system both in the public and private sector, and regularly offering their services to the people. This evolving paradigm reflects a ray of hope, though there is yet a long way to go towards achieving the SDG 3 encompassing universal and equitable health coverage. The RMNCAH Strategic plan will provide a real opportunity for scaling up the maternal, newborn, child and adolescent health by extending millions of the target underprivileged populations with the requisite care.

WHO, UNICEF and UNFPA assisted in the design of the Somali RMNCAH Strategic plan under the leadership of the Somali health authorities and in close consultation with a wide range of health development partners. The concept of this Strategic plan is fully attuned to the global strategy for women's, children's and adolescents' heath 2016-2030 and the revitalization of PHC, lending support to the SDG agenda of UHC and to former national strategic reviews in health care[13,14]. Under this paradigm, the RMNCAH vital services will be provided to all the target population groups irrespective of their geographical location and socioeconomic status. The envisaged high impact interventions for this Strategic plan are substantiated by the resolute commitment of the authorities across the health system, following a human-rights based approach. Accordingly, the Strategic plan will promote equity and recognize health as a peace dividend and a major factor of solidarity contributing to community development. In the backdrop of this global momentum, the Somali RMNCAH strategic development will accrue numerous advantages from the rich evidence put forward in recent years in this critical health domain, driven by the desire for universal coverage to equitably deliver priority essential and lifesaving interventions to both urban and rural/nomadic settings while removing any barriers along the way.

1.3 The Imperative of Coordinating RMNCAH Programme

The Somali JHNP was launched in 2012 and implemented for five years as a comprehensive multi-donor venture implemented in nine regions and covering 5.7 million populations accounting for 45% of the then target population. The programme has provided the post-civil conflicts' widest access to the formulated EPHS and generated a substantial improvement in the Somali health system, in general, and to RMNCAH services in particular.

The programme coordination team created by the UN partner organizations contributed to the division of roles and responsibilities in a coordinated manner. Following the termination of the JHNP coordinated planning and implementation in end-2016, the opportunities provided by the pooled funding were extremely weakened. To avert the fragmentation risk of the newly designed RMNCAH interventions, a robust coordination mechanism for UHC needs to be considered to sustain and further enhance the coverage and impact of this vital programme. An overwhelming operational challenge facing the delivery of RMNCAH services is the absence of trained FCBHWs

[13] Strategic review of the Somali health sector: challenges and prioritized actions. Report of the WHO mission to Somalia 11–17 September2015

[14] Commitments to Every Woman Every Child Global Strategy for Women's Children's and Adolescents' Health (2016-2030). The Partnership for Maternal, Newborn & Child Health Hosted by The World Health Organization

and skilled CBMW in the rural villages and nomadic settlements especially in the hard to reach geographical areas. The above human resource gap needs to be filled with the induction of community embedded health workers to implement the critically needed RMNCAH services

1.4 The Strategic Plan Development Processes

To establish a broad-based consultative process, wide-ranging contacts were made to collectively design the key strategic interventions of RMNCAH, gathering the reflections and contributions of the different stakeholders, their expectations and recommendations on how the vulnerable target populations could best be supported while addressing the contextual realities and challenges on the ground. These deliberations included consultation meetings and workshops with key representatives and leaders from the Somali public health sector and with the development of health partners assisting the national RMNCAH programme. In all these contacts and consultations, stakeholder partners expressed their unanimous support to this initiative and contributed substantively to the RMNCAH Strategic plan analysis, design, formulation and content. Moreover, they stressed the imperative of aligning the Strategic plan with the stipulated Somali health policies and strategic directions and with the PHC approach of health development and committedly working towards UHC and SDGs.

Throughout the Strategic plan development process, the continuum of care was strongly emphasized both across the life course and the referral chain of the health services' network to effectively address the needs of the target population and improve the RMNCAH outcomes and impact[15]. Accordingly, a consensus was built around the priority strategic objectives and activities for action that the Strategic plan will need to pursue while aiming to achieve universal access for RMNCAH services, fulfilling the legitimate focus on reducing maternal, neonatal and child mortality with a sharp focus on the vulnerable rural and urban populations. There was also a resolve among the stakeholder groups to address the crucial challenges on the ground. This includes the singular lack of operational guidelines to be applied at all tiers of service delivery, the weak staff managerial capacity at the field level, shortage of qualified health workforce especially in the Referral Health Centers (RHCs) and Health Centers (HCs) of the remote districts, the resource crunch of the government and the weak coordination of the health care funding grants.

2 SITUATION AND CONTEXT ANALYSES

2.1 Process

The Somali health care system is organized into four care providing levels that include the Primary Health Care Units (PHU) located predominantly in the rural areas; the HCs at sub-district level; the RHCs located at the district's main administrative town, colloquially known as "the district hospital" and the Regional Hospital located in every regional capital. Moreover, the CBFHWs' initiative aiming to provide basic preventive, promotive and curative health services at the rural level is a promising strategy bridging the gap in RMNCAH service delivery.

In 2016, a SARA survey was conducted covering the entire Somali health sector, to assess the health infrastructure, service delivery, availability of human resources, supply-chain system, technologies, service utilization and the ability and responsiveness of the health system to provide

the key health services[15]. The total number of health facilities listed was 1,074, of which 106 facilities were found to be non-operational and 169 non-accessible, restricting the SARA data set to a total of only 799 operational and accessible health facilities. The SARA survey findings were one of the resources used to undertake in-depth descriptive analyses of the health system though the data were not categorized into public, private and/or NGOs sector management.

Moreover, the data regularly generated by the DHIS-2, which is equally covering the entire public health sector was accessed along with the data used for this RMNCAH situation analysis. The DHIS-2 data sets are meant to help the health management teams at various levels in making the right decisions based on the information collected. The application is fully operational and technically supported by UNICEF. These two major sources were used to contribute to the current situation analysis. The rich contacts and consultation workshops conducted with the major stakeholders of the health system provided a rich contextualized learning experiences about the RMNCAH situation and its related prospects of care. Other key documents in the domain of health sector policies, strategic plans and programmes were also reviewed with a view to capturing the RMNCAH status and priorities. These consultation processes gave invaluable inputs for designing the RMNCAH Strategic plan development agenda, incorporating a set of effective high impact strategic interventions that respond to the unaddressed and the insufficiently met health needs in the RMNCAH framework.

2.2 Service Delivery

2.2.1 Health Services Infrastructure

The assessment of the density of key health system infrastructures and the number of facilities necessary to serve the population were assessed. Table 1 below, vividly illustrates the shortage of infrastructure facilities and the unfulfilled capacity in terms of number and distribution. The low density of these in terms of outpatient and inpatient facilities' tracers, and the targets to be achieved in accordance to the minimum benchmarks set by WHO. The table also illustrates the average proportion of the target achieved "the score," explicitly reflecting also the gap to be filled to realize the desired infrastructure density level.

The cumulative score of the density of health facilities, inpatient and maternal beds was only 28.3%, reflecting a 72% deficit in health facilities infrastructure while the core health workforce density was 18.6% and service utilization level 6.3%, which collectively provide a total general service availability rate of 17.7%. The above-achieved rates reflect the low level of service utilization, which is to a great extent linked to the low health infrastructure density, to the distance barriers and to the limited availability of the qualified health workforce. The poor care-seeking behavior and the unaffordability are additional factors that further constrain the access and utilization of these services. These challenges predominantly reduce the access to the lifesaving RMNCAH health care services direly needed by these populations.

Table 1: Health facility, inpatient bed, and maternity bed density indicators reflected by the SARA survey

The density of key health system infrastructures and Workforce	Present status	Target	Density Score* (%)
Health facility density: Number per,10000 population	0.76	2	38
Inpatient bed density per 10,000 population	5.34	25	21

[15] Somali Service Availability and Readiness Assessment. 2016 Report. Somali Health Authorities & World Health Organization. 2016

The density of key health system infrastructures and Workforce	Present status	Target	Density Score* (%)
Maternity bed density per 10,000 population	2.55	10	25
Infrastructure density (Average score of the three indicators: facility density, inpatient bed density, and maternity bed density)		100	28
Outpatient visits per person per year	0.23	5	5
Hospital discharges per 100 per year	0.81	10	8
Physicians, nurses, and midwives per 10,000 population	4.28	44.5	19

*The country's current accomplished rate towards the density target indicator to be achieved for the development of each of the three priority health infrastructures

2.2.2 The Shortage of RMNCAH Health Services

The availability of RMNCAH services is experiencing acute shortages in the Somali fragile health system with scarcely accessible formal primary care services that address the RMNCAH needs of the population. Table 2 illustrates the availability of four of the key essential and high impact RMNCAH interventions that reduce disparities in the delivery of health services and health outcomes.

Table 2: Availability of the Different RMNACH Interventions in the Health System Network

RMNCAH services	Services Available at facility level
Birth spacing services	28%
Antenatal Care	66%
Normal delivery	46%
Neonatal resuscitation	31%
Early initiation of EBF	45%
Availability of CEmONC Facilities	
Urban	6%
Rural	1%

*Data derived from the Somali Service Availability and Readiness Assessment carried out in 2016

2.2.3 Poor Health Service Amenities and Responsiveness: An Emerging Barrier for Seeking Maternal Care

The poor availability of basic amenities such as sanitation, consultation rooms, improved water sources and power supply, communication equipment and emergency transport in health facilities is another major barrier hindering the scaling up of facility-based deliveries. According to the SARA study, only 46% of health facilities had access to an improved water source; 41% had no consultation rooms, less than 28% had a power source. and 84% were without emergency transport to facilitate the urgent referral of high-risk pregnancies. The study revealed that only 1% of the health facilities in the country had all the required health system amenities, while the mean availability of the amenity tracers was only 42%. These deficiencies negatively impinge on the quality of facility-based delivery services. Moreover, the poor responsiveness of the health workers delivering RMNCAH services was outlined during the consultation workshops, which could often discourage mothers from visiting the health facilities to express their concerns about the staff duty of care. This behavior will discourage mothers from seeking care in these facilities or talk confidently about themselves and their infants, reflecting the lack of the health service empathy and support they need to receive when visiting these facilities.

2.2.4 Challenges in Infection Control

Another highly relevant issue to RMNCAH care services is the availability and adherence to infection control guidelines at the facility level, as this will entail the safety and quality of maternal and newborn services' provision. These include safe disposal of sharp objects, safe storage, and disposal of infectious wastes, availability of disinfectants, disposable or auto-destruct syringes, soap and water/alcohol-based hand rub, latex gloves and written guidelines on the standard precautions to undertake. The required operational standards demand both the training of the staff assisting maternal, newborn and child care and the provision of the equipment and the supplies they need to carry out their assigned infection control functions. On average, the SARA infection control readiness score of all the facilities was 62%, while only 20% of facilities had all the listed infection control and prevention standard precautions. The latter implies the need for urgent implementation of all the outlined critical measures of infection control.

2.2.5 RMNCAH: Access to diagnosis and care

The availability of laboratory facilities that perform the basic diagnostics is a critical component of the provision of essential lifesaving services. The priority diagnostic tests include hemoglobin, blood grouping, blood glucose, routine urine tests including a test for pregnancy, malaria diagnosis, and the testing for hepatitis B and C viral infections and HIV and syphilis. The overall availability of all the above laboratory tests at a health facility was only 19%, while only 4% of all the listed facilities were able to perform all the required diagnostic tests on-site. The critical test of blood glucose for gestational diabetes was available in only 7% of the facilities. These findings imply that the majority of pregnant mothers turn to the private sector for most of their laboratory investigations, posing an affordability problem among low-income families.

2.2.6 Readiness to provide RMNCAH Services in the health facilities

The Somali EPHS consists of ten programmes; six of which are core programmes provided in all the four levels of care provision which include reproductive, maternal, neonatal and child health. Although adolescent health is not explicitly indicated, the adolescent reproductive health service constitutes an integral part of the EPHS service delivery[16]. The RMNCAH services' availability in all the outlets is mandated in the implementation of the package. It is worth noting that the EPHS covers about 50% of the regions, while the remaining regions are supported through other less structured health interventions, predominantly linked to humanitarian response interventions. The following is a brief outline of the key RMNCAH functions implemented under the EPHS package:

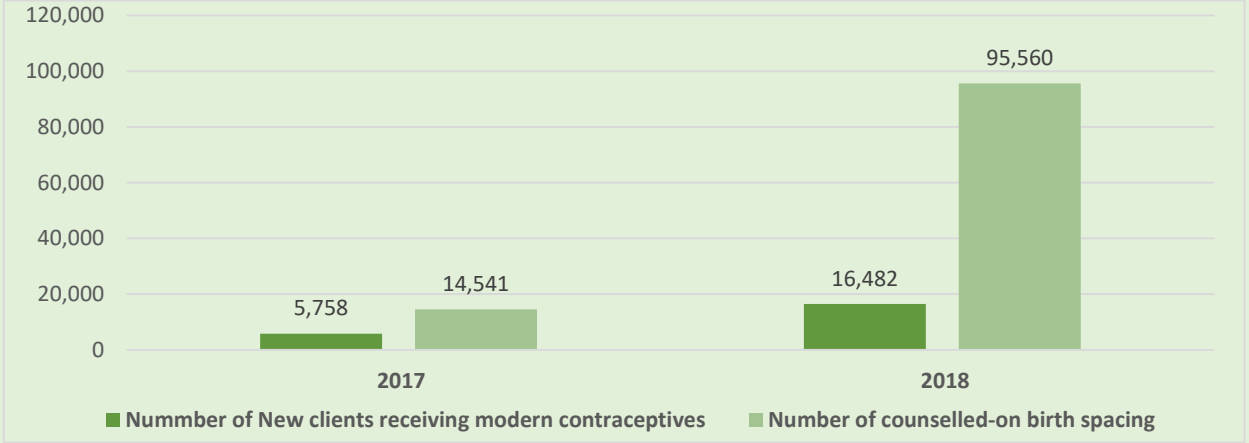
- **Birth spacing**

Close to one-third of the functional facilities were able to offer birth-spacing services, although these facilities fell short of enabling the visiting clients to make informed choices due to periodic stock outs of commodities. The SARA survey revealed that 70% of the nationwide health facilities had at least one health worker trained on birth spacing, while only around 28% offered birth spacing services, highlighting the need to bridge the huge gap urgently. The most commonly used methods being a combination of oral contraceptives, followed by progestin-only injectable contraceptives, while condoms were the least used method. Hospitals offered higher birth spacing services (52%) relative to health centers/maternal and child health (MCH) (47%), while the

[16] Nigel Pearson and Jeff Muschell. Essential Package of Health Services. Somalia 2009. UNICEF

governmental facilities performed better than the private sector (31% vs. 21%). The health facilities were required to avail the guidelines for birth spacing and checklists to routinely monitor the quality of service performance. Figure 1 below shows the DHS2 data where the proportion of mothers receiving contraceptives was higher (39.6%) among the counseled women in 2017 compared to those receiving contraceptives in 2018 (17.3%), although in the latter the number of counseled mothers was seven times higher, raising concern about the quality of counseling among a large number of mothers encountered in 2018.

Figure 1: Mothers visiting health facilities that were given contraceptives as new clients or counseled on birth spacing



- **ANC**

ANC is an essential service for imparting preventive care services as well as the detection and treatment of any emerging health problems during pregnancy. The SARA survey illustrates that 66% of facilities provided ANC services, although not very comprehensively, with 43% of the facilities having on average fewer than 5 of the 11 service components included in the ANC service package. Figure 2 below shows the high difference between the number of mothers seeking their first ANC visit and those who came back to the facility for their fourth ANC visit as reflected by the DHS-2 data set. In 2017 only 10% of the women came back for their fourth ANC visit, while in 2018 the fourth ANC seekers were 24%. This reflects a high dropout rate (ANC1-ANC4)/(ANC 1) of 90% in 2017 and 75.7% in 2018. WHO guidelines have raised the threshold of ANC visits to eight per mother during pregnancy reflecting the immense effort that needs to be made. The RMNCAH staff managing and working in these health facilities need to be trained to gain effective communication skills that foster the trust and confidence of the women seeking ANC. A comparable dropout was also observed in the intermittent preventive treatment of pregnant women (IPTp) for malaria, indicating the need to scale up the health workers' skills and capacity to improve ANC counseling across the health system. Syphilis is endemic with 12.8%, and 3.8% of the tested mothers being positive in 2017 and 2018 respectively, indicating the imperative to provide care as untreated syphilis in these women could lead to serious adverse pregnancy outcomes and neonatal and infant deaths. Figure 2 illustrates the antenatal, facility-level delivery and post-natal care visits carried out during 2018: while Table 3 reflects the care provided at the health facilities' level for ANC purpose and the performed assessments for undertaking the relevant care.

Figure 2: Trends in Health Care Seeking Behavior of Somali Mothers during Pregnancy, Delivery and the Postpartum period of 2018

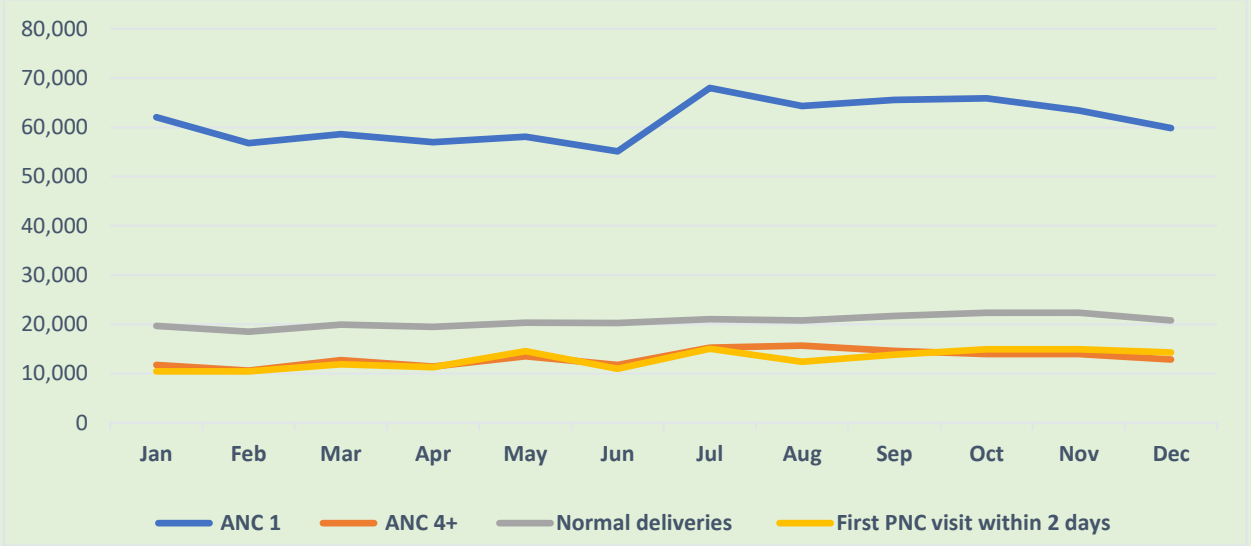


Table 3: Mothers attending health facilities for ANC purpose and key assessments performed to provide the relevant care

ANC visits and key services carried out	2017		2018	
	No.	%	No.	%
Only one ANC visit	621,702	23	667,128	16
Four ANC visits or more	61,997	2.3	161,790	4.0
Pregnant women provided with multiple Micronutrient (MMN)	862,235	31	1,180,625	29
IPTp (malaria prevention) 1st dose	47,372	1.7	108,409	2.7
IPTp (malaria prevention) 2nd dose	21,252	0.8	41,400	1.0
IPTp (malaria prevention) 3rd dose	3,553	0.1	11,421	0.3
Tested for syphilis	16,884	0.6	57,873	1.4
Syphilis positive	2,169	0.1	2,179	0.1
Haemoglobin level <10 g/dl	128,527	4.7	125,176	3.1
Iron Folate as treatment for anemia	611,130	22	770,504	19
Counselled on IYCF	370,503	13	925,988	23

- **The Elimination of Mother-To-Child Transmission (EMTCT) of HIV**

Although the prevalence of HIV infection among the general population remains at about 1% or lower, the prevalence among the high-risk groups such as sex workers in some areas was found to be approximately 5% in 2014. Although the Somali AIDS Control Programme has made a visible success, the national effort should have no room for complacency, as the high incidence among the high-low risk groups remains a real cause for concern. To accomplish this goal, pregnant women need to get unimpeded access to HIV and hepatitis B and C testing and counseling as a routine part of ANC. Considering the total number of women that attended the ANC services in 2017 and 2018, only 18.6% and 15.6% were tested for HIV, and 0.4% and 0.4 per 1000 tested positive for HIV respectively (Table 3). The provision of antiretroviral (ARV) treatment to-infected pregnant women, and their newborns should be carefully considered to reduce the risk of perinatal transmission of HIV. Table 4 below illustrates the HIV status among the Somali mothers tested during the ANC, at labor, and in the Postnatal Care (PNC) period and the maternal and infant prophylaxes carried out.

Table 4: HIV status among the Somali mothers tested during the ANC, at labor and in the PNC period and the maternal and infant prophylaxes carried out

HIV status among	2017		2018	
	No.	%	No.	%
Women with Known HIV+ status – ANC	17.088	9.5	4,849	2.7
Women with Known HIV+ status – Labour	1.570	0.9	1,353	0.8
Women with Known HIV+ status – PNC	917	0.5	1,427	0.8
Tested for HIV in ANC	115.844	64.6	104,259	58.7
Tested for HIV at Labor/Delivery (L&D)	41.954	23.4	47,811	26.9
Tested for HIV in PNC	789	0.4	14,904	8.4
+ve HIV test results in ANC	579	0.3	45	0.0
+ve HIV test results in L&D	131	0.1	24	0.0
+ve HIV test results in PNC	16	0.0	0	0.0
Maternal prophylaxis – ANC	147	0.1	2,315	1.3
Maternal prophylaxis – Labour	31	0.0	193	0.1
Maternal prophylaxis – PNC	20	0.0	250	0.1
Infant prophylaxis – ANC	90	0.1	96	0.1
Infant prophylaxis – Labour	144	0.1	26	0.0
Infant prophylaxis – PNC	18	0.0	44	0.0

Nutrition	2017		2018	
	No.	%	No.	%
Children screened in Outpatient Department (OPD)	2,390,701	100	2,881,763	100
Children with normal nutrition status	1,744,573	73.0	2,095,841	72.7
Moderately Malnourished	445,362	18.6	551,903	19.2
Severely Malnourished	149,804	6.3	173,495	6.0
Children with Oedema	4,912	0.2	6,004	0.2

- **BEmONC**

The mean availability of BEmONC services as reported by the SARA survey was 45% among urban facilities as compared to 20% in rural areas, while the neonatal resuscitation was offered in 29% of the facilities in the urban areas and 12% in rural facilities. The governmental facilities were more likely to have the necessary guidelines, trained staff, and essential supplies for BEmONC care services relative to the private health sector 55% vis 50%. Table 5 below illustrates the DHS-2 facility-based deliveries whose rates of occurrence are estimated at 39.6% and 49.5% in 2017 and 2018 respectively, while the remaining deliveries were considered to have been home-based, which were estimated to be over 50% in both years. It is important to note that several contextual factors negatively impinge on the safety of pregnancy and delivery outcomes that include the high fertility rates, undernutrition, early marriage and pregnancy at an early age and the nearly universal FGM/Cutting. Equally, the partial absence of skilled birth attendants (SBAs) in the rural areas and among the nomads is another grim reality for which no practical solutions have been made, and where the dangerous and often fatal high-risk pregnancies are common[17]. Table 5 below illustrates the reported facility-based and estimated home-based deliveries.

[17] WHO-EMRO, 2010. Country Cooperation Strategy for WHO and Somalia, 2010-2014 Report.

Table 5: Facility-based delivery versus the estimated home deliveries calculated from the country's crude birth rate and population as per DHIS-2

Place of delivery	2017		2018	
	No. of deliveries	%	No. of deliveries	%
Facility-based	189,498	39.6	236,762	49.5
Home-based	288,502	60.4	241,238	50.5
Total	478,000	100	478,000	100

It is also essential to note that the health facilities reported 284 maternal deaths in 2017 among all assisted deliveries with an estimated MMR of 159 per 100,000 live births. The maternal deaths in these health facilities rose to 1,175 in 2018 with an estimated MMR of 496 per 100,000 live births. As pregnancies with complications are referred or self-referred to the BEmONC and CEmONC facilities, many of these are frequently associated with delays in the decision to seek care including those mothers traveling from remote localities, often presenting with high-risk pregnancies. Yet it is still evident that the facility-based deliveries can significantly reduce maternal mortality and, even more so, if the capacity of these facilities is strengthened with the necessary infrastructure, technical and material support.

The establishment of Essential Neonatal Care (ENC) was therefore deemed to be a core priority of the RMNCAH Strategic plan, for which the necessary attention is to be directed. The lack of ENC facilities will inevitably raise the neonatal death rate, canceling out the mothers' perceived advantage of quality of care that bring them to the health facilities in the first place. Most of the deaths that take place during the first 24 hours or during the neonatal period could be saved through simple, evidence-based, cost-effective, and low-cost technology interventions[18].

- **CEmONC:**

A tangible reduction was made in the Somali MMR as it fell from 1,300 deaths per 100,000 live births in 1990 to 732 deaths per 100,000 live births in 2015, Yet the current level is less likely to reach or approach to the SDG target of 70 per 100,000 live birth by 2030 unless an innovative Strategic plan that scales up to universal access to basic and CEmONC services is put into action. The full range of CEmONC services is offered in 6% of urban facilities compared to 1% of rural facilities. Moreover, in the health care services network, all the care providing facilities, i.e. health centers, referral health center, and regional hospitals do offer BEmONC. However, these services are not delivered at any of the PHUs across the health system.

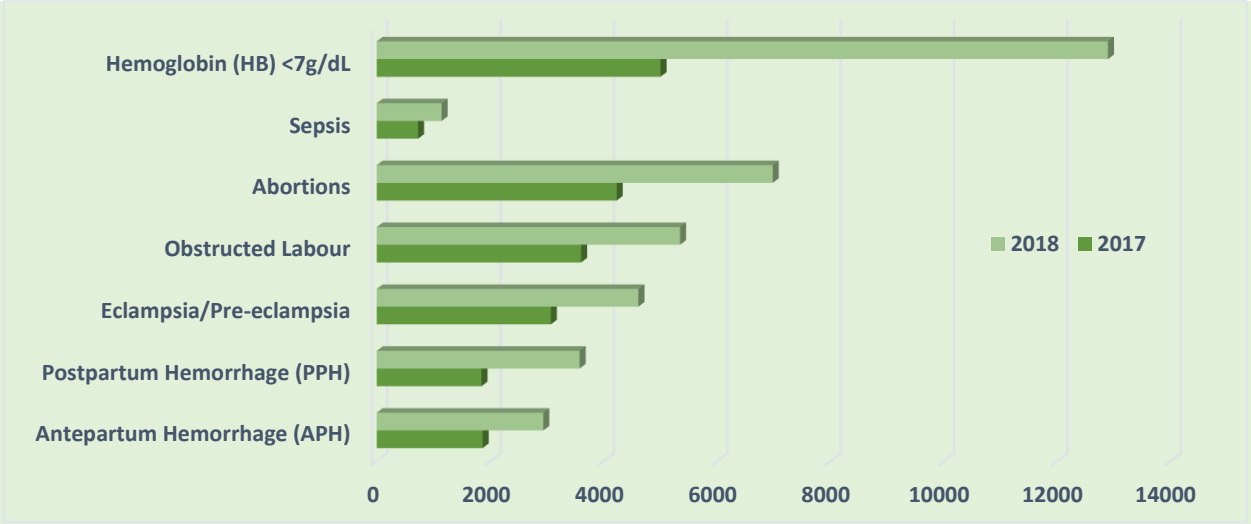
Twenty-six CEmONC centers are currently operational, while several more are in different stages of completion. These facilities are providing the lifesaving maternal services and attending to the maternal complications referred to these facilities for emergency care. Although the basic resuscitation support for the newborn is available, no intensive neonatal care facility is fully operational in any of these facilities. This highlights the attention required to achieve comprehensive newborn care. It is also worth noting that although the WHO defined required proportion rate of these facilities to the BEmONC centers is close to the capacity desired, yet the geographical distribution of these vital facilities is short of the desired equitable geographical distribution. The access to these facilities is also constrained by their physical distance from the

[18] Travers CP, Carlo WA. How to Save 1 Million Lives in a Year in Low- and Middle-Income Countries. Neonatology. 2017;111(4):431-436. doi: 10.1159/000460512. Epub 2017 May 25.

remote and hard to reach districts. This hindrance needs to be rectified while addressing the human resource needs and the supplies and equipment necessary for the delivery of these vital lifesaving services

The surveyed operational RMNCAH facilities were understaffed and underequipped, having on average only 20% of the items necessary for effective CEmONC services, whereas only 2% of these facilities had anesthesia equipment and only 5% had a safe blood supply. The CEmONC essential items were relatively more available in hospitals (49%) than the referral health centers (38%) that are close and more accessible to their urban and rural catchment area populations. Figure 3 below illustrates the commonly encountered complications of pregnancy that a large number of high-risk mothers' experience, thus failing to access the referral support provided by the CEmONC centers. In addition to the financial and geographical barriers, these opportunities are also lost for lack of consent by the male spouse and close family elders, lack of family support for women to seek referral care, or as a result of the traditional beliefs and customs that make these women less aware about the high-risk pregnancy outcomes. However, the recent establishment of several CEmONC centers in more regions is a useful indicator of the health system recovery progress.

Figure 3: Most common encountered complications of pregnancy from the total assisted in all the Somali facility based assisted deliveries during 2017 and 2018

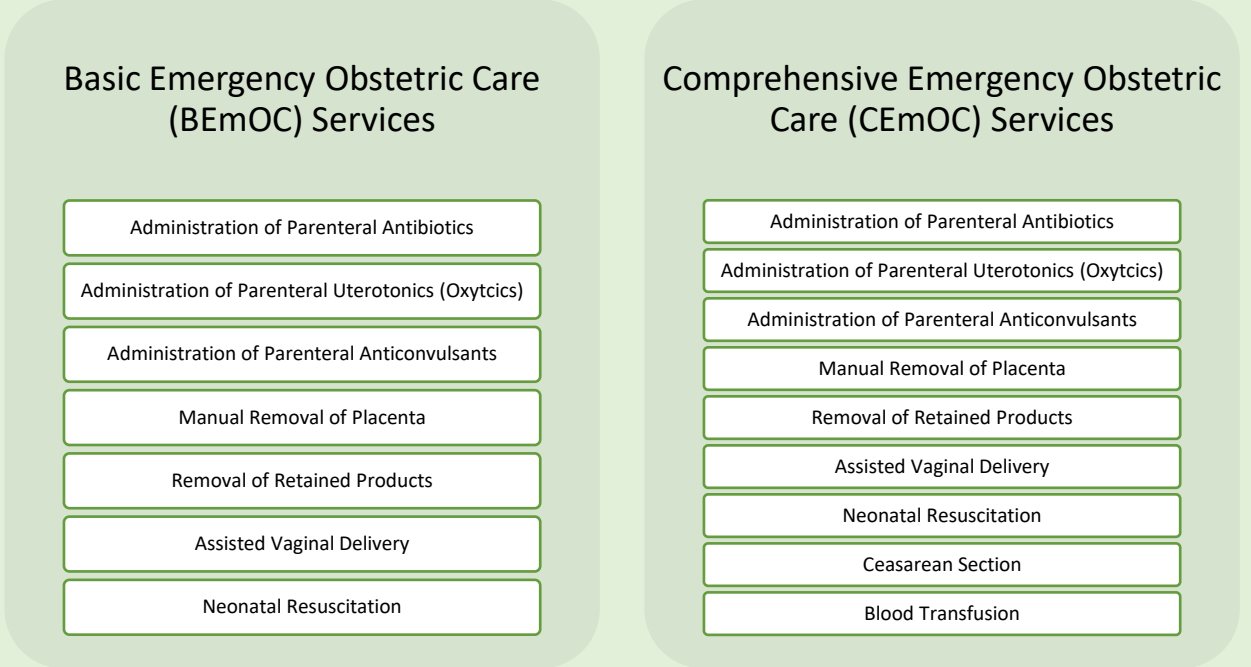


- **Availability of the Emergency Obstetric Care and the Lack of Maternity Waiting Homes**

Although the pregnancy complications are predictable, many women cannot access the appropriate health facilities where life-saving care is available, be it at the basic or comprehensive EmONC facilities. Mothers should be guided during the ANC period on referral support and about when the pregnant woman must seek care. To facilitate access, the WHO standard of establishing four BEmONC and one CEmONC facility for every 500,000 is strategically pursued by the Somali RMNCAH programme. The density and the performance of these facilities, their operational complementarity, and equitable distribution are critical junctures and necessary measures of capacity development both at the regional and district level PHC system. CEmONC centers combine the BEmONC care services plus the specific CEmONC capacities of performing cesarean section deliveries and applying the set standards for safe blood banking and transfusion, which is vital for maternal and neonatal survival. The density of emergency obstetric care facilities is a useful indicator for ensuring the required geographical access and equitable distribution of

these facilities. Figure 4 illustrates the services provided by the BEmOC and CEmOC facilities, reflecting the synergy and complementarity that link them together. Moreover, the lack of maternity waiting homes for rural women is a missing intervention except in some IDP localities. This requires the district government support for their sustained implementation.

Figure 4: Functions for Basic and Comprehensive Emergency Obstetric Care Services



- **Essential Newborn Care:**

The newborn care is a neglected component of the RMNCAH services across the Somali health system. The common challenges include conditions such as low birth weight, prematurity, birth asphyxia, birth injuries, septicemia and neonatal tetanus. Although no reliable recent estimates are available about perinatal mortality, the neonatal mortality was reported to be 38.5 per 1000 live birth. A set of Neonatal care services of insufficient quality is being delivered by all the BEmONC and CEmONC providing facilities across the health system.

- **Child Immunization:**

The sustained national efforts of EPI implementation are supported by WHO and UNICEF at the operational level with substantive international funding channeled through the The Global Alliance for Vaccines and Immunizations (GAVI). The routine immunization services that are offered to children and women include Bacillus Calmette–Guérin (BCG) for tuberculosis, oral polio vaccine (OPV), pentavalent vaccine, inactivated polio vaccine (IPV) and measles vaccines. However, the programme is confronted by operational challenges such as inaccessibility, insecurity, shortage of a trained health workforce and low density of health service delivery outlets especially in the rural areas and insufficient community understanding and demand for immunization services. The GAVI health system strengthening (GAVI HSS) initiative was also promoted to improve the management of the programme's cold chain, increase demand for immunization services and strengthen its leadership and management processes and improve the EPI epidemiological and geographic information systems for planning and decision making.

As a result of the capacity and operational challenges within the health system network, the SARA assessment revealed that only 49% of the health facilities provided routine childhood immunization at the time of the survey, while the outreach services were offered by only 13% of the facilities providing these services. However, 89% of referral health centers and 87% of health centers and 50% of the hospitals offered child immunization, while only 6% of health posts/primary health units provided this service. Similarly, urban facilities were more likely to offer child immunization (64%) than rural facilities (25%). An evident gap in the EPI implementation process is the insignificant role played by the primary health units/health posts that lack the adequate stock of vaccines, appropriate cold-chain equipment, and trained health workers to carry out this task. This evident deficit of human resources and infrastructure needs to be bridged to increase the physical access of the rural communities to these vital services that are critical to the progress toward UHC.

Table 6: EPI coverage among the target children population and TT for pregnant mothers

Antigen	2017		2018	
	No.	%	No.	%
BCG	324,657	52	412,557	66
OPV-3	338,954	54	407,289	65
Penta 3	335,029	56	408,075	68
Measles	316,755	53	421,597	71
TT2 for pregnant women	426,538	68	490,945	78

*The denominator for the BCG, OPV and TT antigens was the annual livebirth of 627,985, while Penta and Measles was the surviving infants estimated at 596,586 calculated using the 2014 Population

- **Child Health: Preventive and curative care services**

The key child preventive and curative care services included the diagnosis and treatment of child malnutrition, vitamin A and iron supplementation, provision of Oral Rehydration Solution (ORS) and zinc to treat diarrhea, growth monitoring, treatment of pneumonia with the administration of amoxicillin and treatment of malaria in children. In total 526 (66%) of the functioning facilities in the health system have provided preventive and curative care services for which optimally 19 tracer items were required, where their mean availability was only 48%. Pneumonia, prematurity, diarrhea and, birth asphyxia are the most prevalent causes of death among the under-five children accounting to close to 50% of the mortality. The treatment of pneumonia in the under-five with amoxicillin was 59%, though only 13% of this age group with ARI symptoms are taken to a health facility[19]. Only 20.8% of those with diarrhea received ORS solution of which 61% were also offered zinc supplementation. Preventive and curative child health care services for the under-five were provided in almost all the health centers and in more than two-thirds of hospitals, while a much lower proportion of PHUs (41%) have provided these services. On the other hand, only about 44% of all facilities had guidelines for integrated management of childhood illnesses (IMCI) reflecting the limited compliance with the set standards in the IMCI. From this analysis, it is self-evident that both the demand of the communities for child care services and the available services at the health care facilities need to be strengthened. The latter implies the pursuit of a transformational Strategic plan securing universal access to RMNCAH services that are technically and organizationally strong and availing the necessary health infrastructure, amenities, diagnostic equipment, and essential medicines. The globally proven capacity of IMCI for improving the quality of care for sick children needs to be scaled up to the desired coverage level to reduce child morbidity and mortality effectively. Moreover, the reasons for the IMCI shortfall

[19] WHO, 2015. Global Health Observatory Somalia Summary Statistics, January 2015 Profile.

in the fragile Somali health system needs to be assessed through implementation research to achieve the programme's envisaged capacities, outcomes and impact. Table 7 below reflects the top 10 causes of under five deaths, while Table 8 reflects the main causes of death among those over five years of age

Table 7: Top 10 causes of <5yrs deaths (2017/2018) as reported by the DHIS-2

The reported cause of death	2017		2018	
	No.	%	No.	%
Diseases of the respiratory system (excluding pneumonia and suspected TB)	2,764	61.0	135	6.7
Malnutrition	350	7.7	393	19.4
Pneumonia	182	4.0	394	19.4
Watery Diarrhea	303	6.7	133	6.6
Suspected/confirmed measles	121	2.7	116	5.7
Diseases of the blood	75	1.7	138	6.8
Anemia	33	0.7	75	3.7
Diseases of the digestive system (excluding diarrhea and acute viral hepatitis)	43	0.9	31	1.5
Diseases of the musculoskeletal system	33	0.7	10	0.5
Other conditions (not mentioned above)	630	13.9	602	29.7
Total	4,534		2,027	

Table 8: Top 10 causes of death for age groups older than 5 years of ages as reported by the DHIS-2

The reported cause of death	2017		2018	
	No.	%	No.	%
Diseases of the respiratory system (excluding pneumonia and suspected TB)	4,152	71.2	100	2.8
Obstetric complications of pregnancy or delivery (and perinatal conditions)	153	2.6	1,014	28.6
Injuries and other consequences of external causes	183	3.1	227	6.4
Diseases of the genitourinary system, excluding sexually transmitted diseases (STDs)	132	2.3	76	2.1
Diseases of the digestive system (excluding diarrhea and acute viral hepatitis)	129	2.2	69	1.9
Pneumonia	57	1.0	93	2.6
Diabetes	123	2.1	73	2.1
Hypertension	168	2.9	70	2.0
All other conditions (not mentioned above)	734	12.6	1,829	51.5
Total	5,831		3,551	

- **Child Nutrition**

Child growth monitoring was conducted as reported by SARA in 41% of the health network facilities. Moreover, the undernutrition among the under-fives was estimated at 42.1%, corroborating it as a major underlying cause of childhood morbidity and mortality. On the other hand, the DIHS-2 data on the nutrition status of the under-fives found that over 25% suffer from undernutrition (Table 9).

Table 9: Nutrition Status among the under-five Children as reported by the DHIS-2

Nutrition status	2017		2018	
	No.	%	No.	%
Children with normal nutrition status	1,744,573	74.41	2,095,841	74.1
Moderately Malnourished	445,362	18.99	551,903	19.5
Severely Malnourished	149,804	6.389	173,495	6.1
Children with Oedema	4,912	0.209	6,004	0.2
Total Children screened in OPD	2,344,651		2,827,243	

- **Adolescent health services**

The adolescent age ranging from 10-19 years, is a critical phase in the physical, psychological and sexual development of girls or young women in which it is necessary to afford them opportunities that enable them to transit to adulthood with better health status and social and psychological maturation to pursue their full life potentials. In the Somali context, adolescent girls are a vulnerable group, as the majority lacks both the information and necessary skills for self-protection during this critical phase when they reach their sexual maturation. Special challenges are faced by adolescent girls living in the IDP camps resided by over 2.6 million people[20] and by those adolescent cohorts from the rural and nomadic remote communities. This challenge that adolescent girls face is gender-specific, often accompanied by the terrible experience of FGM/Cutting - a practice that almost all Somali teenage girls have to endure, causing irreparable physical, psychological and emotional injuries. At this stage, no targeted health programme reaches out to adolescent girls, in spite of the urgent need of providing basic reproductive health services that include the provision of menstrual hygiene services, and safety from sexually transmitted diseases.

Moreover, cultural sensitivities pose a communication barrier between adolescent girls and their parents on issues related to reproductive health. There is a need to cross these cultural barriers with the help of religious leaders, community elders and educated mothers to communicate the correct messages during this crucial phase of their life. In the alternative, Somali adolescent girls are at high risk for child marriage and early pregnancy, which can significantly limit their ability to access the required health services, obtain education and achieve the life skills and the health services they need. Some of the adolescent boys are also exposed to socio-cultural domineering characters leading to greater community violence for which school health and community-based interventions need to be planned and put into action.

- **Gender-Based Violence**

The protracted Somali conflict has forced a large number of women to become internally displaced often forcing mothers to struggle for the family livelihoods. The family disruption and the emerged IDP seem to have enhanced the GBV. National efforts are currently being advanced to address this emerging social challenge, pursuing the rights approach where social inequalities limiting the access to critically required health care services are being pursued through greater social participation and community empowerment.

[20] https://humanitariancompendium.iom.int/appeals/somalia-2018

2.3 Human Resource for RMNCAH Services

A major RMNCAH workforce capacity boost is the IST programme activities that are regularly organized to improve their performance at the operational level. The IST survey carried out in 2015 illustrated that out of 4,134 health workers given in-service training in the span of two years, 54.5% were health workers performing maternal, child health and nutrition services and hence in the MNCAH domain. Inopportunely, most of these training opportunities lacked clinical practices, and among those attending the post-training assessments and have attained improvements in knowledge, attitudes and performance skills, only 3.7% have put the competences gained into practice. The participants of these training programmes fully endorsed their utility and beneficial impact that they had on their job performance and on their service delivery outcomes. About 40% of the IST participants joined some of these activities in the capacity of trainers, corroborating the available tangible resources that could bridge the high demand RMNCAH programme master trainers at all levels of the health system. The performance of these training interventions needs to be effectively coordinated and their curricula uniformly standardized, with the pursuit of an effective and transparent selection process and their equitable distribution across the health services system. The task shifting and task sharing approaches need also to be accounted for, to respond to the needs of the local population, where the allied health professionals entitled to perform these professional tasks are severely in short.

In the sphere of midwifery training, 14 schools are currently functioning across the different regions of the country, that offer a 2-years course offered to secondary school graduates to train a cadre of qualified Midwives, and an 18-month training programme offered to already qualified nurses to produce a cadre of Post Basic Qualified Nurse Midwives. The latter programmes are supported by UNFPA and till 2019 has produced 1,300 qualified midwives that are currently working in the different regions of the country. A tangible number of these graduates, however, are not working due to the limited employment opportunities in the national health system, despite the high shortage of this midwifery workforce cadres. For the remote rural areas, where qualified midwives cannot possibly be deployed, a fast track 1-year training program of rural women as Community Based Midwives is under consideration. However, the availability of the newly developed National Midwifery Strategy (2019-2023), Private Training Institutions and the existence of Midwifery Associations are opportunities that can be availed with this RMNCAH strategy.

Another major gap in the RMNCAH service delivery is the total lack of or the severe paucity of CBFHWs that are community embedded and deployed in the hard to reach rural areas in particular. The CBFHWs' performance efforts in the field are primarily focused on RMNCAH at the grassroots level. The programme was established in several districts through the selection, training and deployment of these community health workers through the technical partnership between the national health system and WHO with GAVI financing. Several hundred of these lady health workers "*Marwo Caafimaad*" were selected from the rural villages that have completed eight years of basic school education. A training programme of one year (three months of intensive full-time course of daily attendance followed by nine months of a sandwich training of service delivery and training) was conducted. The World Bank plans to support and expand this vital programme, which along with the CBMWs, constitutes the best answer for achieving UHC in all the deprived rural communities. These community-based health workers have the potential of extending vital PHC services to the community and through their strategic deployment, effectively reduce maternal, neonatal and child mortality rates at the grass root level. The training of CBMWs will

also effectively resolve the total lack of SBAs in almost all the rural areas as demonstrated by experiences in other countries, and without which UHC would not be attained.[21]

2.4 Programme Governance

The health sector has experienced a great deal of disruption of the critical management and governance dimensions of the health service system. However, the steady recovery phase in recent years has generated young health professionals with potential leadership and governance skills. To transform this ambition into reality, the governance principles need to be further strengthened by defining and addressing RMNCAH issues vis-a-vis:

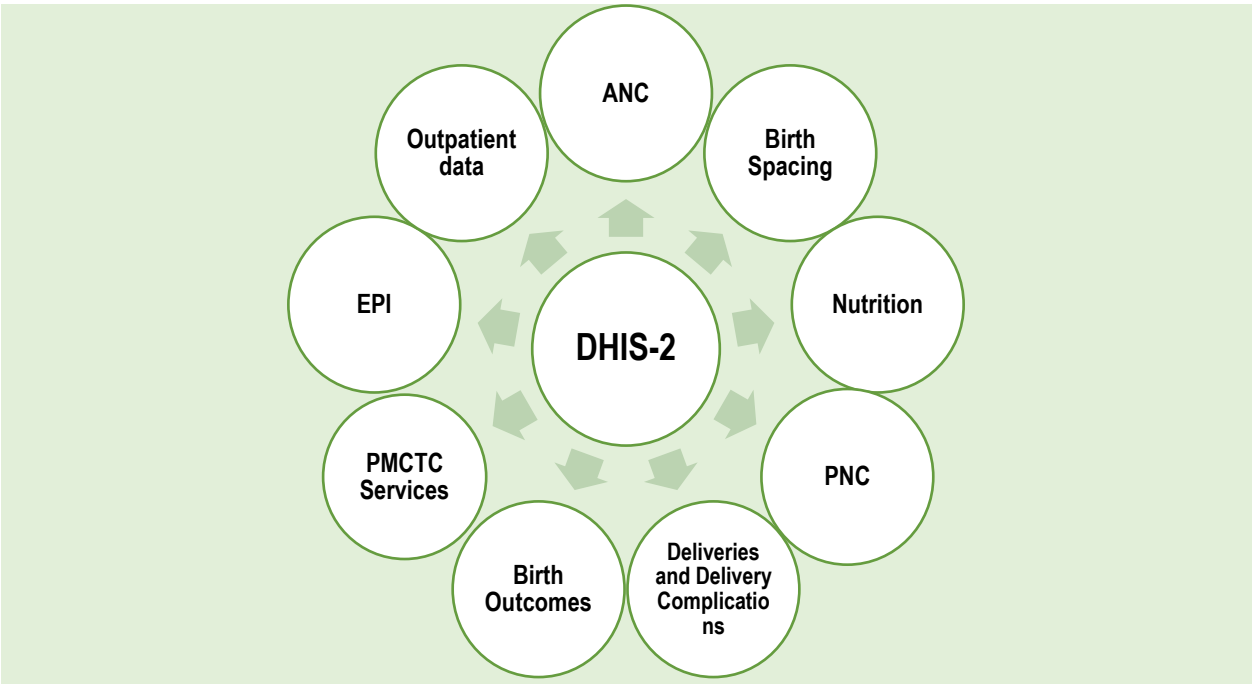
- The leadership and management capacity of health facility managers and their support staff
- A meaningful pursuit of the prescribed service quality framework to improve and standardize service provision at all levels
- Adhering to the ethics and code of conduct set out for the health workforce to ensure that no harm of any sort comes to the beneficiaries
- Enforcement of the health professional act to address the Health workforce qualifications, registration and licensing requirements in relation to the services to which they will be assigned
- The services that will be assigned to each level of health care provision
- The roles and responsibilities of each health workforce professional or care provider including programme managers, health professionals and community health workers
- Organization of the services package for the PHUs that are not currently performing these services creating a major gap and inequity in this lifesaving effort of utmost priority
- Reviving the neglected community role and action for promotion and social mobilization by considering the selection of village girls with 8 years of schooling and training and deploying them to serve in their native rural areas. This cadre will be promoting health and nutrition and reducing health inequities with the treatment of minor ailments
- Scaling up services, particularly in the peripheral areas by creating an additional community-based cadre of CBMWs to carry out ANC, identify the risk factors of pregnancy and ensure their timely referral, while assisting normal vaginal deliveries
- Widen the scope of work of different midlevel health professionals to include the basic treatment of childhood illnesses within their ambit
- Task sharing to provide services to the under-served and marginalized populations including IDPs, refugees, prisoners and women or adolescents involved in hazardous occupations
- The delegation of authority between the different levels of care and supervisory framework and monitoring and evaluation (M&E) necessary for sustaining and periodically evaluating the quality of performance of planned activities.
- Establishing a coordination platform for the different PHC interventions while enabling the intersectoral dimensions as well that link the programme to safe water and sanitation, primary education and to the multifaceted aspects of GBV with RMNCAH services.

[21] Koblinsky M, Moyer CA, Calvert C, Campbell J, Campbell OM, Feigl AB, Graham WJ, Hatt L, Hodgins S, Matthews Z, McDougall L. Quality maternity care for every woman, everywhere: a call to action. The Lancet. 2016 Nov 5;388(10057):2307-20.

2.5 Health Information System and Disease Surveillance

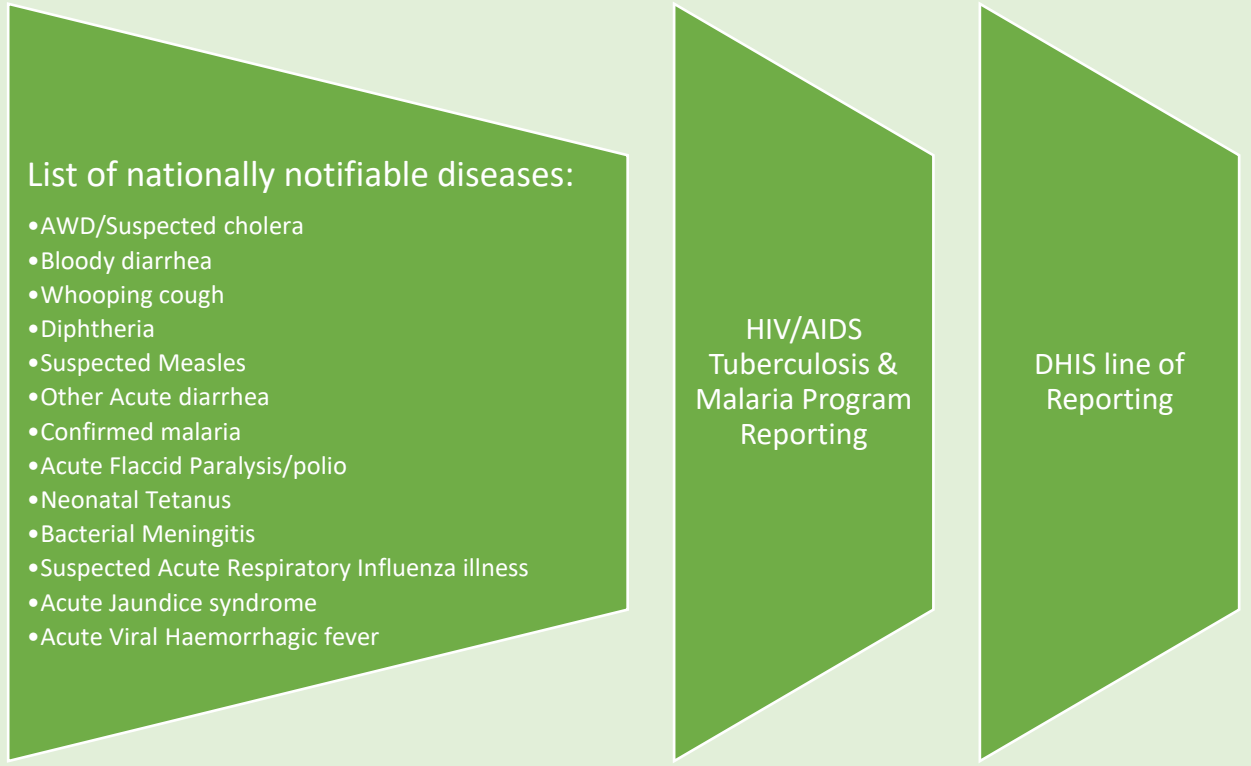
The Somali health data recording and reporting system are carried out using the DHIS-2 implemented in all the health facilities. This electronic recording application is aimed to enable the health management teams to use the information for the sound management of the service delivery systems. The DHS2, with its friendly computation system, will be able to check the validity and reliability of the data entered. Accordingly, the system provides automated routine reports in addition to specifically designed reports for effective planning and management of the different processes of implementation.

Figure 5: District Health Information System Reporting on RMNCAH



The current CDS is being carried out through a unified data collection process for the 12 sicknesses included in the list of nationally notifiable diseases with polio surveillance being promoted more intensively. Moreover, the CDS related to HIV/AIDS, tuberculosis and malaria are reported through their respective programmes. DHIS is another routine data collection process whose information helps understand the seasonal epidemiological trends of these notifiable diseases. Most of the diseases targeted by the CDS are strongly linked to RMNCAH, making CDS a successful investment case towards maternal, neonatal and child survival. However, the CDS channels are weakly coordinated, given their parallel processes which impinge on the epidemic preparedness and response planning in terms of medical and diagnostic supplies and vaccines. The CDS programme is further compounded by the weak health infrastructure and shortage of qualified health workforce. Figure 6 below illustrates the three CDS data collection sources that need to be coordinated through integrated training, data collection, analyses, and reporting system.

Figure 6: Communicable Disease Surveillance: The Three Channels of reporting



2.6 Essential medicines

During the past few years, many training courses were held on essential medicines. Efforts were also made in establishing medical storage facilities in several parts of the country, including training of new staff. Access to vaccines and essential medicines, particularly in the areas of tuberculosis and malaria, has been improved. An essential medicines' list covering both primary health care and hospital level, and a curriculum on the rational use of drugs at the primary health care level have been compiled. It is expected that the new edition of the manual of standard treatment guidelines and training manual on rational management and use of medicines at the primary health care level will further improve the optimal guidance to Somali health professionals. The development of this highly essential reference manual and the upcoming establishment of the National Medicines Regulatory Authority are expected to complement each other in improving the management and rational use of essential medicines across the health system.

2.7 Health Financing

A key challenge being faced by the Somali health services system is the low level of domestic public sector health financing and the high level of out-of-pocket spending on health with catastrophic expenditures experienced by the vulnerable population groups. The development partners predominantly fund the health sector through a tangible number of INGOs contracted out to provide health services in assigned geographical locations. In this regard, the aid funds received by the health sector in 2017, 2018 and 2019 were estimated at the US $ 116.8 million, 108.6 million and 137 million, respectively, as reported by the Somali Federal Ministry of Planning and International Development and the World Bank. Although the financing level of the health sector was relatively sustained, the phasing out of the flexible and predictable approach of the JHNP has led to faltering coordination which could most likely lead to systemic misalignment between the different interventions, fragmentation and inefficiency in resource allocation, duplication and

adverse impact on quality, cost and result outcomes. The grossly inadequate domestic financing for the health sector often results in high out of pocket expenditure that can lead to catastrophic health spending on RMNCAH care making households fall below the poverty line. These risks reflect the need for synchronization mechanisms to be established to ensure greater programmatic cohesion and better communication in the overall implementation process.

2.8 The nexus between humanitarian and developmental health services: the RMNCAH Perspective

The Challenge of integrating RMNCAH services at all levels of care provision: The fragile Somali health system is assisted by several UN organizations, development partners and a large number of INGOs who support the delivery of health services in various geographical areas. The health development programmatic interventions and humanitarian health and nutrition interventions are coordinated with the Somali health authorities across the health system. In emergencies, the cluster approach is applied to bring the national authorities and humanitarian partners together for better coordination of the set operational plans. The RMNCAH interventions fall into this coordination domain, supplemented by a reproductive health working group that contributes to and monitors the implementation process. As both development and humanitarian health services are operational in the country and responding to the population health needs, the existing active health cluster and its regional corresponding branches should closely coordinate the RMNCAH humanitarian activities in the health sector development process and their integration be progressively considered.

3 VISION, MISSION AND GUIDING PRINCIPLES

3.1 Vision	***All Somali woman of childbearing age, newborns, children and adolescents in every urban or rural setting realize their rights and enjoy the highest attainable standards of health and wellbeing***
3.2 Mission	***Promote and provide quality RMNCAH services to all women, neonates, young children and adolescents to achieve better health outcomes and reduce all preventable maternal and child deaths***

3.3 Guiding Principles

The MNCAH guiding principles that are listed below do reflect the vision, mission and the concepts and values that guide the programme which include the following:

- Equity (including access and affordability)
- Efficiency (cost-effectiveness)
- Universality
- Sustainability (financial and political/humanitarian development nexus, multi-sectoral)
- People-centered (culturally sensitive, commitment, ethical, quality, collaborative)
- Transparency
- Accountability
- Human rights'-based approach
- Country ownership (government led with community engagement)

Within the challenging Somali legacy of MNCAH care, it is important that care for mothers, newborns and children is not only easily available and accessible but also of good quality, as enunciated in the latest global initiatives such as the strategies towards EPMM, ENAP, and RMNCAH care**.**

4 THE SOMALI RMNCAH STRATEGIC PLAN ORIENTATION

4.1 Addressing critical MNCAH lifesaving domains

The Strategic plan / Investment case underscores the importance of the early detection of high-risk pregnancies and their timely referral. The Strategic plan will also aim at ensuring the availability of fully functional BEmONC services and access to the lifesaving Comprehensive Emergency Obstetric Care Services (CEmONC) that secure the availability of safe blood transfusion and Cesarean operations in case of need. The Strategic plan endorses the MNCAH continuum of care concept across the life course and through the effective use of the health system referral chain. The Strategic plan will call upon the national health authorities and partners to improve the availability of essential commodities, supplies, and medicines for maternal, newborn and child care. This Strategic plan also emphasizes the promotion of Maternal and Perinatal Deaths and Surveillance Response (MPDSR) as a routine practice to augment the performance and quality of maternal and child health care services. The Strategic plan will encompass the essential newborn care programme including care for the low birth weight and preterm infants, by ensuring that all deliveries are assisted by trained health workers, promptly accessing the lifesaving newborn resuscitation through the provision of the required minimum medical supplies and equipment. The Strategic plan also highlights the implementation of the IMNCI best practices across the health system to reduce and even eliminate the fragmentation of child care.

This Strategic plan has a major focus on bridging the health inequities between the urban and rural populations by actively training middle school cleared rural women on community-based health services. The following two cadres are envisaged for this function:

i. The first cadre is the tested cadre of CBFHWs "*Marwo Caafimaad*" who are trained to provide a comprehensive package of PHC services to the rural populations of their catchment area villages with a major focus on RMNCAH. The CBFHWs will be trained to provide basic treatment of childhood illnesses.
ii. Community-based CBMWs: Replacing the untrained TBAs, who are currently attending to 60% of the deliveries with community-based CBMWs, each of whom will be serving a catchment population of 2000, equivalent to the catchment areas of two CBFHWs. The CBMWs will assist the normal deliveries, as well as to identify family maternity support homes located close to the BEmONC and CEmONC facilities that are readily accessible for their potential use in the case of a referral.

These community-based health workers are horizontally linked and expected to exchange information about ANC services, and work on the early diagnosis of high-risk pregnancies and expedite their timely referral.

These two-community based outreach health cadres are expected to particularly address the RMNCAH needs of the six million Somali rural and nomadic population that are currently suffering from poor coverage and limited access to lifesaving care. These community embedded health workers will also promote birth spacing and meaningfully contribute to HSS by integrating

MNCAH services into PHC, leading to the attainment of the service coverage goal in the march towards UHC.

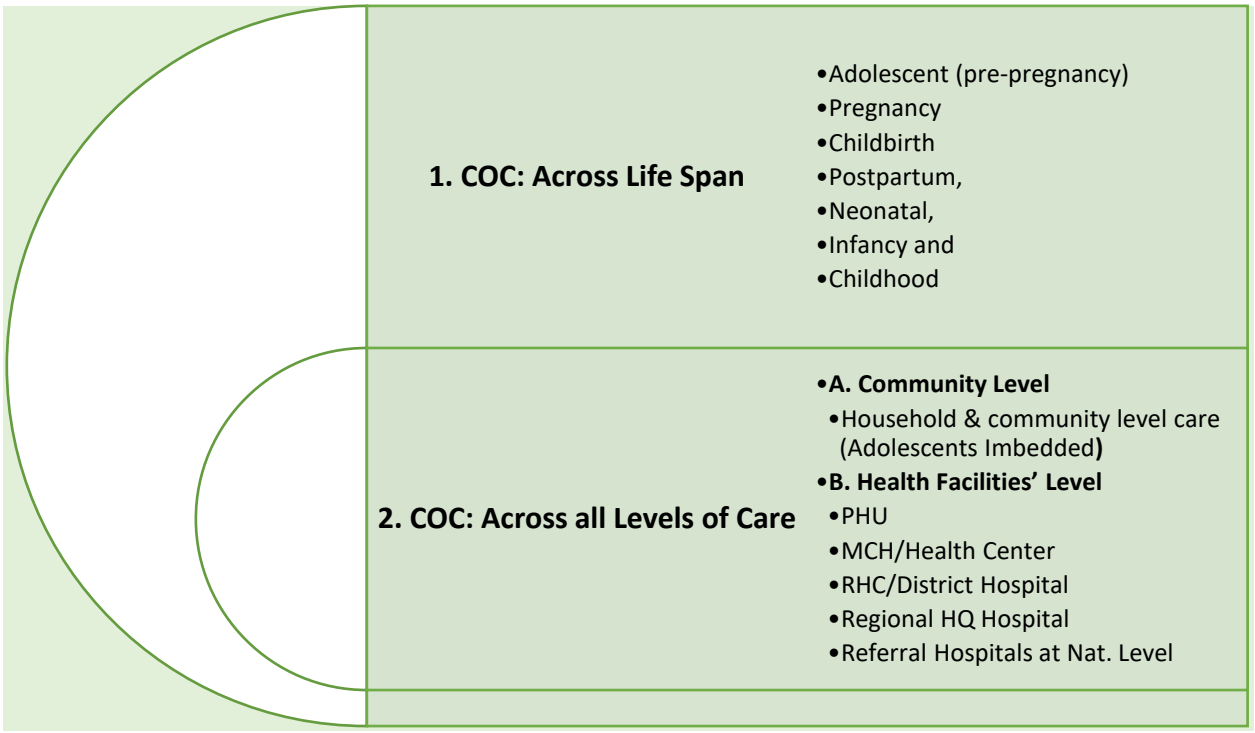
4.2 The service coverage and its quality

The Strategic plan will make intensive efforts for addressing the complications of pregnancy and childbirth, neonatal and child health complication that constitute a leading cause of death and disability among women of reproductive age. Henceforth, an urgent focus on the minimum acceptable quality standards will be pursued to ensure the embedding of safe and effective care within the MNCAH services network delivered at the facilities providing BEmONC, CEmONC, ENC and child health services. In the strategic framework, it will be critical to ensure that all the envisaged tools are guided by the appropriate standards, accepted by the health authorities and adapted to the local context, to make their implementation more effective.

5 RMNCAH PRIORITIZED STRATEGIC AREAS

The priority strategic areas have been designed to cover a wide range of dimensions that enhance the coverage and quality of care and reduce the high maternal, neonatal and child mortality rates and ensure the health of adolescents across the country. They will also bring about a continuum of care that will combine the RMNCAH high impact interventions that can improve home care practices and health care services. The RMNCAH strategic areas will become an integral part of the country's basic essential package of health services (EPHS). The prioritized RMNCAH strategic areas include: i) Maternal health, ii) Newborn health, iii) Child health, iv) Reproductive health, v) adolescent health and vi) cross-cutting issues. These areas will be addressed in the framework of the continuum of care that will focus on universal coverage and integrated care. Figure 7 below illustrates the continuum of care dimensions across the life span and through the referral network of the different levels of care provision.

Figure 7: Continuity of care (COC) across the life course and across the different levels of care provision facilities



The priority RMNCAH Strategic Areas are outlined below:

5.1 Strategic Area 1: Maternal Health

To reduce maternal mortality and improve the quality of maternal care at every level of the health system, the following strategies are being considered:

5.1.1 The Antenatal Care Strategic plan

To improve and scale up the quality and utilization of ANC services, it is essential to train nurses and midwives to be deployed in health facilities and CBMWs to serve in the PHUs and at the community level, while ensuring that the requisite equipment and logistics are available. ANC services are aimed at reducing the risk of stillbirths and pregnancy complications, by screening high-risk pregnant women and ensuring their timely referral to secondary/tertiary health facilities for safe delivery and enabling optimal health outcomes both for mothers and their newborns.

ANC Strategic Objective: To Strengthen ANC to improve and scale up the quality of maternal and perinatal health outcomes. The latter is achieved through the delivery of the following preventive and care provision strategic interventions outlined below:

- Community mobilization and awareness creation through frontline health workers to ensure that every pregnant woman receives at least 8 antenatal contacts starting with the onset of pregnancy
- Establishment of maternity waiting homes located in the vicinity of CEmONC facilities, where women from the remote rural communities can reside during the last weeks of pregnancy while they await the planned referral support.
- Conduct routine MUAC screening at community level and primary healthcare facilities for all pregnant women to assess their nutrition status and identify malnourished women among ANC seeking mothers, enabling efforts to stabilize their nutritional status.
- Screening maternal illnesses through laboratory investigations and preventing anemia with iron and folic acid while addressing other micronutrient deficiencies
- Detecting the high-risk women for pre-eclampsia and managing eclampsia by following the standard protocols using Magnesium Sulphate and managing hypertension
- Provision of tetanus toxoid immunization routinely to all pregnant women and promote birth spacing through counseling at ANC visits.
- Screening for and managing HIV and providing antivirals when indicated and preventing malaria with insecticide-treated nets and managing diagnosed cases with the appropriate antimalarial therapy
- Providing antibiotics for preterm pre-labor rupture of membranes and corticosteroids to prevent respiratory distress syndrome in newborns
- Screening for the prevention and management of sexually transmitted infections such as HIV, hepatitis B and syphilis

5.1.2 The Strategic plan of Increasing Skilled Attendance at Birth

To target the reduction of the high maternal and neonatal mortality, this Strategic plan aims to ensure that every delivery is assisted by a skilled birth attendant (SBA) within the community or in the health facilities, with the availability of Basic EmONC facilities at an accessible location.

The midlevel health workers are found to be highly effective in the delivery of RMNCAH services.[22]

Skilled Birth Attendance Strategic Objective: To promote and encourage every childbirth to be assisted by SBA at the health facility level and by a trained CBMWs for remote communities and ensure the timely access to BEmONC services.

The above outlined strategic objective will be attained through the following interventions:

- Encouraging mothers to seek facility-based delivery, providing the necessary emotional support by explaining the procedures to pursue. observing privacy and confidentiality and addressing any perceived medication adverse birth outcomes
- Training the frontline health care providers to effectively communicate and create a respectful working environment that generates a positive experience among the care-seeking mothers and improves quality. In this regard, the shortage of health workers will be addressed.
- Organizing cross-sectoral activities for the delivery of BEmONC services in a socially and culturally friendly environment and on refresher training activities on the Integrated Management of Pregnancy and Childbirth (IMPAC) guidelines and tools with the implementation of supportive supervision.
- Ensuring the availability of adequate equipment, and medicines' supply stock.
- Allowing the presence of a companion of choice for all women during labor and childbirth, to provide the needed confidence and provide a sustained communication with the SBA and mother in labor, as this will raise mothers' trust and decision to choose to deliver in a facility.
- Periodically update the BEmONC guidelines and Information, Education and Communication (IEC) materials and translating them into the local language for wider dissemination and use across the health system.
- Ensuring the proper use of the partogram during labor, applying the established standard guidelines for managing complications and providing on-the-job training for obstetric caregivers.
- Deploying community midwives or trained CBMWs at the most peripheral care providing level, the PHUs, to bring RMNCAH services closer to the rural communities.

5.1.3 The Strategic plan of Establishing CEmONC Services

CEmONC centers combine the BEmONC care services plus the specific CEmONC capacities of performing cesarean section deliveries and applying the set standards for safe blood transfusion, which is vital for maternal and neonatal survival. These high impact RMNCAH referral facilities need to have the required geographical access and equitable distribution.

CEmONC Strategic Objective: To improve access to CEmONC services for pregnant women and newborns experiencing fatal complications that include postpartum hemorrhage, pre-eclampsia/eclampsia and, birth asphyxia and prevent and manage these effectively

The above outlined strategic objective will be attained through the following strategic interventions:

[22] World Health Organization. Mid-Level health workers: a review of the evidence. http://www.searo.who.int/entity/health_situation_trends/mid_level_health_workers.pdf 2017.

- Expanding the CEmONC facilities to at least 60 that are geographically and equitably distributed across the health system covering all the regions and the neediest districts, with a complete range of services that include the availability of safe blood transfusion and the ability to perform Cesarean section operations
- Ensuring the rehabilitation or construction of CEmONC facilities complying with the WHO set minimum standard of establishing one fully functional CEmONC for every four BEmONC, collectively serving a population of 500,000 as is currently pursued by the Somali health system needing to be sustained.
- Introducing the cash voucher system in identified hard-to-reach areas' health facilities to scale up and incentivize the demand for facility-based delivery and postnatal care services and avoid catastrophic costs.
- Building the capacity of EmONC and IMNCI staff at country level on Essential Newborn Care
- Training physicians on CEmONC courses including neonatal intensive care for 9 months in the different teaching hospitals to expand the health system referral support capacity and improve the quality of service delivery
- Training physicians and/or allied health professionals on anesthesia and neonatal nursing for 9 months aiming at complete teams to perform CEmONC.
- Integrating the cesarean section skills into the CEmONC training programme
- Reviewing and updating the CEmONC guidelines and developing MPDSR and ensuring their subsequent implementation

5.1.4 The Strategic plan for Post-Natal Care Including Birth Spacing

During the post-natal period starting soon after childbirth, both the women and their newborns will need to be closely monitored, given the potential risk of post-partum hemorrhage in the mother and the respiration, temperature, breastfeeding aspects of the newborn, while promoting birth spacing.

Post-natal Strategic Objective: To promote the provision of safe and effective post-partum health care needs including birth spacing for every mother to protect her health and advance her ability to care for children

Several strategies will be prioritized to ensure safe post-delivery practices across the health system. These will entail the following:

- Establishing or renovating post-natal recovery rooms in health facilities conducting deliveries, that presently lack this essential physical space
- Providing facility-based care for the first 24 hours, while preventing and managing maternal and neonatal complications such as eclampsia, anemia, and/or sepsis, in case of their occurrence
- Provide infant and young child feeding (IYCF) and Kanagroo Maternal care (KMC) routinely
- Ensuring post-natal contact of the mother and newborn with SBA at week one and week 6
- Undertaking an effective health promotion and awareness raising programme on EBF for 6 months for all newborns
- Organizing refresher in-service training courses for qualified midwives and nurses on contraceptives and counseling women on birth spacing as effective measures for lowering maternal mortality and reducing the unmet demand for contraception

- Training of CBMWs and CBFHWs on the promotion and counseling of mothers on birth spacing while monitoring and ensuring a steady supply chain of family planning logistics with a buffer stock of contraceptives in each district and monitoring their effective utilization
- Screening for and providing psychosocial support to women with postnatal depression and other mental health issues during that period

5.2 Strategic Area 2: Newborn Care

The newborn care in the post-natal period in both preterm and term neonates is of critical importance. The SBA both at the facility and community level need to perform neonatal resuscitation and post-resuscitation such as reducing the risk of hypothermia and refer the sick newborn to the nearest neonatal intensive care unit as necessary.

Newborn Care Strategic Objective: To provide the maximum care to the newborn during the post-natal period and effectively manage the preterm, the very low birth weight and sick babies

To effectively respond to the suboptimal care provided to newborns, ENC will be established as a key priority of this strategy for the provision of the critical elements of care. Accordingly, the TOTs that will have the task of building the capacity of health workers caring for sick newborns is a top priority. These units need to be established in the regional hospitals on the immediate term and in the referral health centers on the medium- and long-term perspectives. The health centers assisting delivery need to have the basic training and basic tools to resuscitate the newborn and accelerate referral, as necessary. To provide the desired quality ENC support to the sick newborns, the facilities must possess a regular supply of clean running water; reliable electricity; a cold box or fridge to preserve vaccines, drugs, and blood as well as one or two hygienic corners for hand washing. Provision of essential equipment such as ambu pags, masks, oxygen, suction machine/nasal aspirator, baby incubators, baby scales, sterilizer for basic instruments and the intravenous infusions necessary. Moreover, the ENC unit needs to regularly stock all the key essential medicines and equipment; and initiate EBF within the first hour of birth. Through this strategy, ENC training will be organized for around 400 midwives and nurses to ensure the provision of the necessary quality care for every newborn. The establishment of 18 NICUs will be carried out at regional hospitals offering the minimum essential lifesaving referral support with basic equipment, and trained staff.

In addition, 400 health care providers at health facility & community levels will be trained on KMC for stabilizing low birth weight newborns, with early initiation of breastfeeding and other essential newborn care including promoting hygienic cord removal and skin & eye care. It must be kept in mind that many neonatal deaths take place early mainly due to prematurity, complications of asphyxia, infections or congenital abnormalities warranting urgent remedial measures. The high proportion of low-birth-weight babies also merits immediate action to reduce neonatal deaths as well as preventing complications in future life.

To provide the maximum care to the newborn during the post-natal period and effectively manage the preterm, the very low birth weight, and sick babies the following strategies are to be pursued:

- Ensuring that newborn resuscitation will be regularly performed by the attending SBAs in all health facilities but also by the CBMWs operating in the hard to reach rural communities
- Introducing the KMC for stabilizing low birth weight infants, while providing a hygienic cord and skin care

- Undertaking the early initiation of breastfeeding and feeding support for term and pre-term babies and antibiotic treatment of infections
- Detecting and managing jaundice
- Ensuring effective management for small and sick neonates by establishing Neonatal Intensive Care Units (NICUs) in all the regional hospitals operated by trained staff and equipped with the minimum necessary and affordable biomedical technologies offering the minimum essential lifesaving referral support.

5.3 Strategic Area 3: Child Health

In the framework of the health services delivery, the integrated management of childhood and neonatal illness (IMNCI) is implemented through the Essential Package of Health Services' (EPHS) programme both at facility and community level.

Child Health Strategic Objective: To scale up the coverage and the management of the IMNCI programme across the health system for advancing child survival and improving the quality of care at health facilities and at the community level.

To implement IMNCI and attain the best possible health outcomes the following strategies are being considered:

- Strengthening the child health sections at the federal level and establishing similar units at the State level ministries of health and create a slim but dedicated team supporting the IMNCI planning, implementation, monitoring, and evaluation across the country
- Improving IMNCI skills and capacity of health care professionals, especially those attached to the PHC services' network to provide the appropriate care for sick children and ensure their timely referral to improve health outcomes
- Improving IMNCI family and community health practices with active community participation and expansion of scope of work of Female Health Workers to include basic treatment of childhood illnesses
- Building the health system capacity in terms of IMNCI operational guidelines, equipment, supplies, and access to IMNCI services of the care-seeking children population that include nutrition, i.e., breastfeeding, infant and young children feeding (IYCF) and promoting child immunization and their translation into Somali.

5.4 Strategic Area 4: Adolescent Health

Adolescents are the missing link when addressing reproductive health rights in the Somali health services' system although they constitute a major proportion of the population. Awareness material will be developed on reproductive behaviors, nutrition, negative consequences of risky behaviors including use of drugs such as Khat or tobacco and other harmful social practices.

Adolescent health Strategic objective: To scale up the reproductive health care services and other essential health care needs for adolescents to prevent and manage teenage pregnancies; raise awareness about the adolescents' health risk behaviors and promote healthy behaviors with their active participation

To increase adolescents' access to, and use of health services that respond to their priority health conditions the following strategies are put forward:

- Promoting school-based reproductive health education on birth spacing and delaying marriage
- Preventing risky health behaviors such as tobacco, Khat and use and providing psychosocial support for adolescents' mental health and well-being
- Promoting the management of STI including HIV/AIDS.
- Addressing undernutrition and micronutrient deficiencies through supplementation, while encouraging immunization
- Seeking skilled care during pregnancy, childbirth and post-natal including spacing of pregnancies
- Promoting healthy diet and physical activities through positive adolescents' development with their effective engagement
- Promoting early detection of cervical cancer through the establishment of screening and prevention services in selected hospitals for all women of childbearing age
- Considering the introduction of Human Papilloma Virus (HPV) vaccine to be administered to girls and women aged 9–26 years to prevent cervical cancer
- Provision of adequate sanitary pads to improve menstrual health and personal hygiene
- Training of all health workers on adolescent friendly health services
- Establishing conducive environment to ensure youth friendly services and engage youth in prosocial peer groups activities

5.5 Strategic Area 5: Cross-Cutting Issues

5.5.1 Nutrition

The significant challenge of poor nutritional status in the RMNCAH framework constitutes a huge public health problem that needs to be addressed to effectively reduce the high rates of acute malnutrition, stunting, wasting and low birth weight among the under five years old children, as well as among the malnourished pregnant and lactating mothers.

Nutrition Strategic Objective: To improve the Management of moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) through the RMNCAH Programme interventions. to improve the nutritional status the following interventions are put forward:

- Establishing nutrition stabilization centers in all regional hospitals and main district level referral health centers with the required equipment and supplies
- Training the relevant health staff and community-based health workers on the management of SAM and MAM and focus on exclusive breastfeeding; early infant feeding; integrating community-based care; surveillance and management of severe malnutrition.
- Ensuring compliance with the standard nutrition guidelines to ensure the quality of these services, while identifying and addressing the cultural harmful beliefs and practices that lead to malnutrition
- Prevention and management of micronutrient deficiency such as Iron supplementation particularly for young children and girls

5.5.2 Internally Displace Persons (IDPs)

The protracted humanitarian crises have generated 2.6 million IDPs exposed to critical health conditions drawing on both the weak health services system and humanitarian support.

IDPs Health Care Strategic Objective: To implement a RMNCAH package of health services integrated into the health system of the host communities to create secure and sustainable conditions of healthy development for the IDPs

To improve the IDPs' access to, and use of health services the following strategic interventions are put forward:

- Ensuring the integration of RMNCAH in the planning for humanitarian emergencies to protect children's and adolescent health following the operational guidelines set out for implementation
- Ensuring the regular provision of RMNCAH services as a key priority of the health sector focusing support on the neediest vulnerable populations
- Developing health situation assessment and monitoring guidelines to regularly follow up and address the health needs of these marginalized IDPs
- Raising community awareness especially the health care seeking behavior of mothers and adolescent girls in relation to RMNCAH and addressing related social determinant and equity
- Improving local public health infrastructures such as PHUs to serve mothers and children who are the most in need and developing durable health solutions to support the longer-term needs of the population
- Establishing strategies aimed at improving the referral support for RMNCAH services

5.5.3 Preventing and Addressing Gender-Based Violence (GBV)

Community awareness will be enhanced for the prevention of GBV, including forced marriages and FGM/cutting, which can often result in long-term psychological and physical manifestations as a result of these traumatic experiences.

GBV Strategic Objective: Prevent and respond to all forms of GBV and work towards the elimination of FGM/Cutting for which the following strategies are to be adopted:

- Addressing GBV as an integral part of the reproductive health services and training imparted to health staff on its clinical management highlighting the need for counseling and psychosocial care
- Establishing geographically distributed stop-GBV centers within the health facilities to provide integrated multisectoral support for health under one roof including access to clinical, psychosocial and legal support
- Eliminating FGM/cutting through advocacy and social mobilization, while working on legislation to make it a punishable offense
- Training health professionals in the prevention and management of GBV
- Establishing geographically distributed forensic labs to handle cases of rape and other forms of GBV in a sensitive and dignified manner that offer post-incident referrals as necessary

5.5.4 Obstetric Fistula

The obstetric fistula (OF) is an abnormal opening between the vagina and bladder and rectum, with continuous leakage of urine and feces. The major underlying factors in the Somali context include the obstructed labor and the lack of access to SBAs; the latter is deteriorated by the high rate of FGM/Cutting of young girls, the child marriage and the sexual abuse and rape of young women.

Obstetric Fistula Strategic Objective: Prevent OF through health promotion and awareness building; develop RMNCAH services of good quality and ensure easy access to fistula diagnosis and repair.

The victims of OF are constantly wet, with damaged vaginal tissue, making sexual activities almost impossible, most of them abandoned by their husbands and with greater exposure to infections. To improve the prevention and the management of OF, the Strategic plan will consider the following action-oriented approach;

- Collecting the available information on the prevalence and incidence of OF in all the regions
- Developing a Strategic plan for prevention, including health promotion, birth spacing and access to SBAs during pregnancy and childbirth
- Establishing sufficiently equipped facilities for repair and postoperative rehabilitation
- Building a well-trained team of health professionals who can effectively deliver an operational plan on the prevention, management, and repair from centers that are geographically distributed across the health system

5.5.5 Health Systems Strengthening to Improve RMNCAH

To successfully implement the RMNCAH Strategic plan, an efficient capacity and performance of the health system in which the Strategic plan is being implemented needs to be ensured.

Health System Strengthening Strategic Objective: To scale up the access and utilization of essential RMNCAH care services through a health system in which all its six pillars are strengthened to improve the health of these vulnerable population groups within the framework of SDGs and universal health coverage. To achieve this the following strategic interventions are necessary;

i. Service Delivery

The set-up of the RMNCAH care service delivery is necessary throughout the lifecycle (adolescence, pregnancy, childbirth, the postnatal period, and childhood) and also between the different levels of the health care service delivery including community-based services at the households. The service delivery components of the health system were comprehensively addressed in the framework of this Strategic plan.

ii. Leadership and governance for RMNCAH activities

The planning and delivery of RMNCAH services across the country, require concerted efforts of coordination and accountability at central, state, regional and district levels in harmony with the established decentralization process[23]. It must also involve all the stakeholders including donors and the national and development implementing partners to improve programme performance outcomes. Each health administrative tier should organize quarterly monitoring and supportive review meetings to share progress, challenges and the key results attained in the preceding quarter. Lessons can also be learned for the practices that worked the best and those that did not do so well or downright failed. The government and its partners must review the situation periodically, with training programme managers and key service providers in leadership and management at all

[23] Somali Health Sector Coordination: Institutional Analysis of Organizational and Governance Arrangements:13th May 2013. Jack Eldon

levels of the service delivery network. The WHO, UNICEF, UNFPA, and other technical partners can routinely provide the needed technical assistance to the health authorities to upgrade the RMNCAH units both at federal and state levels, by bringing all its components under a unified and integrated management structure. This will enable the undertaking of intra-and intersectoral action for better health outcomes and management consolidation.

iii. Health workforce

A well trained RMNCAH health workforce constitutes the backbone of this Strategic plan and is, therefore, critical to this programme's effective implementation. A RMNCAH technical committee would be established to develop the curricula of various cadres of the health workforce. The committee will engage all the care provision levels and health partners in the finalization of the curricula and their dissemination for action. The health sector will also support the production of qualified midwives and nurses through formally accredited training pursued both by the public and private health sectors. CBFHWs and CBMWs will be made available for the hard to reach rural communities, by recruiting rural women with intermediate education who will be deployed after training, with responsibilities to serve their local communities. Advocacy training workshops of short duration will also be organized to enhance the responsiveness of RMNCAH care provision facilities by adopting a people-centered and human rights-based approach. The latter will ensure that patients/clients are managed with dignity and privacy in the environment in which they are being treated. This will be possible by targeting the health professionals that have persevered during the protracted conflicts encountered by the health system but did not have the training they need for this role.

To incentivize work in peripheral locations, hardship allowance will be offered to those serving in remote and hard to reach districts and are active in the delivery of essential RMNCAH services. Furthermore, mentorship and technical supportive supervision for outreach workers will be established to strengthen the capacity of RMNCAH health workers both at the facility level and in rural remote settings. Orientation sessions will also be arranged for newly employed health workers on their RMNCAH roles and responsibilities, while periodic refresher training for the programme staff will be organized to improve their performance capacities. Finally, attention needs to also be directed to the recruitment and deployment of the RMNCAH professionals in the different components of the programme, where their selection to the tasks assigned need to be based on merit and fair competition. Moreover, the shortage of a skilled health workforce in the RMNCAH field demands the creation of a workforce retention strategy that encourages the competent and motivated workforce to stay in their assigned professional roles and assigned locations.

The Two Community-Embedded Programmes

A major component in this Strategic plan will be a focused contribution to bridge the equity gap between the urban and rural populations by actively training middle school pass rural women on two community-based health programmes as follows:

a) The first cadre of CBFHWs are trained to provide a comprehensive package of PHC services to the populations of their catchment area villages with focus on RMNCAH services such as providing ANC, promptly referring the high-risk pregnancies to their catchment areas' health facilities neonatal and child health care, nutrition education through growth monitoring etc. The CBFHWs 'scope of work need to be expanded to include basic treatment of childhood illnesses.
b) Community-based Midwives (CBMWs): The CBMWs will replace the untrained TBAs, who are currently attending to 60% of expected deliveries. At the field level, every trained CBMW will be

serving a catchment area with a population of 2000, equivalent to the catchment areas of two CBFHWs. The CBMWs will assist the normal deliveries, identify high-risk conditions for referral to the BEmONC and CEmONC facilities that are readily accessible for their potential use by these rural population groups.

These community-based health workers are horizontally linked and expected to exchange information about ANC services, and work on the early diagnosis of high-risk pregnancies and expedite their timely referral. These two-community based initiatives will address the Primary health care needs in RMNCAH of the six million rural and nomadic populations that are currently neglected or poorly covered. The Strategic plan will also address birth spacing, for having a great impact on maternal and child health, as well as on the prevention and care of GBV. It will meaningfully contribute to HSS and to the integration of MNCAH services in PHC in the way forward towards UHC. The complementary roles of these trained community-based health workers will become an integral part of the public health system service delivery network.

iv. Health Information System

The DHIS-2 mechanism needs to be implemented across the health system through proper and prompt data collection, analysis, printing, dissemination and be used for decision making. This can only materialize if there is a regular and error-free reporting, making it a truly reliable information tool. It is also essential to identify the priority RMNCAH operational gaps and undertake implementation research to bridge the knowledge gap and generate context-based solutions to the operational challenges encountered during implementation.

v. Ensure the availability of essential RMNCAH drugs, equipment, and supplies

The RMNCAH Strategic plan will ensure the availability of medicines, equipment, and supplies that are essential for the delivery of the high impact interventions to be implemented at the community level and across the different care provision levels of the health system. The Strategic plan will also strengthen the rational use of drugs through IST and supportive supervision. Guidelines for supplies procurement, management, and rational use practices will also be developed. The latter is aimed to enhance the availability of essential drugs that include the pediatric formulations, as well as the vaccines and their cold chain storage and transportation systems. Likewise, it is essential to achieve the required level of security with all types of RMNCAH commodities and supplies, including the regular provision of contraceptives. Through this process, the community involvement will be strengthened and their care seeking and service utilization facilitated by the establishment of community healthcare resource structures, such as the training of CBFHWs and CBMWs to deliver a package of RMNCAH services for maternal and newborn care, at their household door steps.

vi. Health financing

Despite its visible and gradual progress, the Somali health sector is facing huge challenges in equitably financing its health services at all levels. The sector is predominantly supported through donor funding from bilateral and multilateral international organizations, and through out-of-pocket spending with a very limited contribution from the public treasury. The growing private health sector, though predominantly urban has also become an important source of treatment for RMNCAH related illnesses, where many of these vulnerable population groups seek care. The government, therefore, cannot afford to leave the private sector unregulated. Understandably, a paradigm shift in health financing is critically required by the public health sector on finding innovative financing strategies in the vital area of RMNCAH that incorporates community-based

participation. The costing of the Somali RMNCAH interventions in the prospected five years' period of the Strategic plan will be estimated considering the yearly domestic and international partners' resources made available in the past for the health sector alongside the high impact RMNCAH priorities set out in the strategy to receive the due attention for bridging the existing operational gap. The defined and prioritized strategic objectives in the following matrices were translated into activities that will be costed in close partnership with the senior health leadership representing the public health sector, using the United Nations OneHealth Model costing tool. Efforts will thus be made to ensure that all the 16 key and high impact RMNCAH outlined interventions are considered in the estimated budgetary allocations in close alignment with the envisaged progress of the Essential Package of Health Service' (EPHS) implementation and of the national Health Sector Strategic Plan.

Through this paradigm, there is an inherent need to scale up and diversify domestic financing for the RMNCAH and nutrition interventions on a sustainable basis by working in close cooperation with the different tiers of the government and development partners. Capacity building will also be carried out on fundraising techniques and resource planning with a sharp focus on population health needs as the basis for resource generation. Effective mechanisms also need to be developed for comprehensive resources' utilization through better coordination and pooling of funds. It is self-evident that some of the activities are to be funded through the ongoing support of the Global Fund, with the Strategic plan's goal being to improve the RMNCAH outcomes and end all preventable maternal, neonatal, child and adolescent mortality and morbidity in the country.

The major cost categories of the Strategic plan include a range of high impact interventions such as ANC, BEmONC and CEmONC services; training of RMNCAH health workforce both pre- and in-service training as well as community based female health workers and community based CBMWs; improving the newborn and child health; adolescent health care and health system strengthening activities. The Strategic plan also accounted for the procurement of essential medical supplies and medical equipment, the rehabilitation of health facilities for delivery to increase their utilization, as well as for M&E related cost, A table in MS Excel worksheet reflecting the cost of the different activities is generated for the year-wise implementation of the 5-year MNCAH strategic plan that maybe revisited using the One Health costing model.

5.5.6 The Role of the Private Sector

During the past two and half decades, the public health sector has encountered massive challenges in addressing the population's health needs, and this has led to the expansion and involvement of the private sector in the delivery of health and education services. To ensure the delivery of a need-based, affordable and quality health services, public and private health sectors will have to partner to provide the needed RMNCAH coverage for the different urban and rural population groups. Accordingly, the private sector has to rally behind this Strategic plan, and to its necessary mechanisms of coordination. Private sector facilities will need to be supervised and their health professionals trained on the RMNCAH high impact interventions such as the delivery of the EPI programme, the standardized care for childhood diarrhea with zinc and ORS, and the guidelines of IMNCI that need to be disseminated and applied by the private health sector. The sociocultural barriers that divert the clients from the timely access and utilization of RMNCAH interventions need also to be addressed. Moreover, the establishment of a pediatric essential medicines' list for children adapted to the local morbidity patterns and made available in terms of the type of drugs, strength, dosage formulations and route of administration is necessary and of high priority.

5.5.7 Coordination and integration

The coordination and integration of RMNCAH services need to be enhanced at all levels of service delivery, starting from the reproductive knowledge and skills required at the adolescent age. Coordination is critical among the different stakeholders and partners during the ANC period, at the time of delivery and during the postnatal phase both at facility and community level, linking with the rural grassroots' deployed CBMWs or CBFHWs. Programme coordination efforts are also pursued during child immunization contacts and nutrition promotion and care interventions. The RMNCAH DHIS-2 data collection, analysis, and dissemination are a requirement for quality planning, and service utilization and outcomes. The current fragmentation in the coordination of the programmes that strongly influence the performance and outcomes of RMNCAH, substantiated by the numerous vertical programmes i.e. Malaria; TB; HIV; EPI; Nutrition and the RH cluster need to be linked to the programme. The latter could be achieved by building a coordination and integration platform for greater efficiency and better resource utilization.

Table 10: Somali Health Strategic plan for Maternal, Neonatal, Child and Adolescent Health: Expanding the Coverage of High Impact Interventions with Strong Community Participation and Action.

Strategic Objectives	Interventions/Activities
1. To strengthen ANC to improve and scale up the quality of maternal and perinatal health outcomes	Provide a focused one-day refresher ANC training to 500 nurses, midwives, and their respective auxiliaries and undertake assessments on the availability of essential RMNCAH equipment in all health centers
	Conduct basic ANC related health promotion with 8 ANC contacts for every pregnant woman to become the norm, starting from the first trimester, with birth preparedness advocacy and screening for danger signs around pregnancy both in urban and rural areas
	Conduct MUAC screening for malnutrition among ANC seeking mothers at community and health facility level
	Provide tetanus toxoid, Antihelminth, iron, and folic acid supplementation and diagnose and treat for STIs
	Provide insecticide-impregnated bed/Mosquito nets to all pregnant women and malaria Intermittent preventive and treatment for pregnant women in endemic areas in collaboration with and support by the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM programme)
	Counsel on birth and preparedness for pregnancy-related emergencies Prevent, screen and treat gestational diabetes, pre-eclampsia, and eclampsia Translate, print and disseminate ANC IEC/BCC materials to health facilities and pregnant women along with radio & Television advocacy campaigns
	Provide PMTCT services to ANC clients and treat pregnant women living with HIV with ARV in collaboration with and support from the GFATM programme
	Introduce the Communication for Development (C4D) approach to promote positive health behaviors as an integral part of the RMNCAH strategy through social mobilization and by encouraging dialogue and debate on its high impact objectives and related activities at the community and at the household level i
2. To promote and encourage every childbirth to be assisted by SBA at health facility level and by a trained CBMW for remote communities and ensure the timely access to BEmONC services	Establish/Rehabilitate the infrastructure of 80 BEmONC facilities across the health care system and fully operationalize them
	Support the production of 600 qualified midwives and nurses through formally accredited and standardized training programmes in the public and private health sector
	Organize biannual refresher training activities for 500 midwives, nurses, and auxiliaries on IMPAC guidelines and tools to ensure the effective utilization of BEmONC services
	Review and update the currently available BEmONC guidelines and IEC materials and translate them into the Somali language for their wider dissemination and use
	Focus during labor on the regular and correct use of the partogram to monitor every labor and identify and respond to complications
	Provide EENC interventions' package for every newborn

Strategic Objectives	Interventions/Activities
	Promoting Water, Sanitation and Hygiene (WASH) and hand hygiene as well as the safe segregation and disposal of health care waste in all health care facilities to prevent infection, reduce the risk of antimicrobial resistance and improve the quality of RMNCH services
3. To improve access to CEmONC services for pregnant women and newborns experiencing fatal complications that include postpartum hemorrhage, pre-eclampsia/eclampsia and, birth asphyxia and prevent and manage these effectively	Scale up the coverage with well-functioning CEmONC health facilities reaching out to the target of facility expansion of at least 60 equitably and geographically distributed CEmONC centers across the health system
	Introduce the voucher system for identified hard-to-reach areas selecting 100 health facilities serving these catchment areas to scale up demand for facility-based delivery and postnatal care services
	Review and update the currently available CEmONC guidelines and related IEC materials and translate them into Somali for their practical and broader utilization
	Establish a facility-based maternal death audit by reviewing all maternal deaths that take place at the facility
	Provide ENC interventions package for every newborn
	Organize and launch a 6 months neonatal intensive care training course for 200 CEmONC staff at country level to build the necessary capacity to manage newborn babies who need intensive medical attention conducted by qualified tutors
	Organize at least four CEmONC training courses of 9 months each for 120 physicians to expand the referral support capacity and improve the quality of service delivery integrating the cesarean section skills in this CEmONC training programme
	Develop MPDSR guidelines and pursue their implementation
4. To promote the provision of safe and effective post-partum health care needs including birth spacing for every mother and newborn	Establish/rehabilitate 400 recovery rooms for health facilities conducting delivery but lacking this essential physical space
	Establish valid health promotion and awareness raising programme on EBF for 6 months for all newborns
	Organize refresher training for 500 qualified midwives and nurses on contraceptives and birth spacing
	Train 500 recruited CBMWs on the promotion and counseling of mothers on birth spacing
	Provide care for newborn including referral for sick and small newborn if required
	Procure and distribute birth spacing commodities and monitor the contraceptive stock and its utilization in each district
	Integrate the Somalia Every Newborn Action Plan into the RMNCAH service delivery provision in all public and private health health facilities
5. To provide the maximum care to the newborn during the post-natal period and effectively manage the preterm, the meager birth weight, and sick babies	Conduct Essential Newborn Care Training for 800 doctors, nurses, midwives and community-based health workers to ensure the provision of the necessary quality care for every newborn
	Establish a minimum of 18 NICUs at regional hospitals for lifesaving referral support with the requisite equipment, supplies and trained staff.
	Procure the basic neonatal equipment for conducting newborn resuscitation using bag and mask and ensure a hygienic cord and skin care and PMTCT as necessary

Strategic Objectives	Interventions/Activities
	Train 400 EmONC health facilities' staff on KMC for stable low birth weight infants with the early initiation of breastfeeding (within the first hour)
6. To scale up the management of common childhood illnesses' programme approach to improve child survival	Establish and strengthen the Child Health Section within Health Ministries to strengthen IMNCI programme planning, implementation, monitoring and evaluation
	Provide Nutrition and Infant and Young Child Feeding (IYCF) practices training to 560 pregnant/WCBA to emerge as champions and peer educators in collaboration with the Nutrition Programme
	Provide routine immunization to all the target children population and periodic vitamin A supplementation, and deworming where appropriate in collaboration with the EPI programme
	Provide IMNCI training to 800 health facility staff across the health system network and community based IMNCI to 200 CBFHWs as champions for their catchment area communities
	Ensure availability of IMNCI guidelines and supplies at all service delivery levels
	Provide comprehensive care for children infected with, or exposed to HIV in collaboration with the GFATM support
	Establish school health services' programme to promote and improve the health of school going children and adolescents
7. To scale up health promotion including reproductive health care services for adolescents and raise awareness about the health risks of early marriage and teenage pregnancies	Develop BCC materials on reproductive behaviors such as nutrition and physical activities and prevent the consumption of tobacco, Khat or drugs and the use of hazardous and harmful substances
	Engage religious and community opinion leaders to promote birth spacing with the involvement of male members at urban and rural level
	Promote school-based reproductive health education among secondary school enrolled teenagers
	Educate families and adolescent girls to delay marriage and promote keeping girls in school to enable them access equal opportunities and realize their full potential through education while helping to preserve menstrual hygiene and seeking reproductive health care from the health system as necessary
	Provide psychosocial support and related services for adolescent mental health and well-being
	Integrate adolescent and youth-friendly health services into the existing public health system
	Organize parent skill training, as appropriate, for managing emotional and behavioral disorders in adolescents including those with unintentional injury or borne to self-harm/ suicide risks
	Provision of adequate sanitary pads to improve menstrual health and personal hygiene
8. To improve the Management of MAM and Severe Acute Malnutrition (SAM) through the RMNCAH Programme interventions	Train 800 facility-based and community health workers and CBMWs and nutrition staff deployed in the health system on the management of CMAM and provide length/height boards and MUAC tapes for growth monitoring of the under-five children. Improve care providers' knowledge on maternal nutrition by providing counselling and promoting a healthy diet through demonstrations on diet diversity and quantity

Strategic Objectives	Interventions/Activities
	Train 400 physicians and nurses on the management of SAM and on integrated management of acute malnutrition (IMAM)
	Establish/Rehabilitate 50 nutrition stabilization wings/centers in regional hospitals and referral health centers
9. IDPs Health Care Strategic Objective: To implement the RMNCAH package of health services integrated into the health system of the host communities to create secure and sustainable conditions of health development for the IDPs	Ensuring the regular provision of RMNCAH services and the needed referral support as a key priority of the health and social agenda of this vulnerable population
	Raising community awareness especially mothers and adolescent girls on positive health-seeking behaviors on RMNCAH and on the related social determinants
	Improving local public health infrastructures such as establishing PHUs to serve mothers and children who are the most in need and developing durable health solutions to support the longer-term needs of the population
10. To prevent and respond to all forms of GBV and work towards the elimination of FGM/Cutting	Promote community awareness for the prevention of GBV as an integral part of the reproductive health services
	Train the health staff of 100 health facilities on GBV clinical management, and psychosocial care and to provide the health care counseling they need
	Organize workshops to establish intersectoral mechanisms for the prevention of harmful practices such as FGM/Cutting and early and forced marriage
	Establish 40 GBV stop centers and scale up the services of existing centers that provide multi-sectoral support under one roof i.e. access to health clinical management, psychosocial support, legal and police services to rape survivors
	Promote the health arguments against FGM/cutting that mandate the enacting of a law prohibiting this harmful practice
	Establish five forensic labs and strengthen existing labs at the national and state level to handle the cases of rape, other forms and manifestations of GBV including FGM
	Promote advocacy and social mobilization for zero tolerance to the FGM practice among the health workforce to avert the medicalization of this practice
11. Prevent Obstetric Fistula through awareness promotion and developing RMNCAH services of good quality and ensuring easy access to fistula diagnosis and repair	Establish four equitably and geographically distributed fistula treatment and repair centers in the health system
	Provide specialized fistula repair training to 30 midwives and doctors preferring females
	Providing treatment and education and raising awareness on the use of SBAs and develop a Strategic plan for the elimination of this condition at the most significant possible scale
12. To improve the governance, leadership and management capacity and accountability of	Establish the coordination and results framework for RMNCAH services at central, state, regional and district level harmonizing the established decentralization process and involving both the national and development partners to improve programme performance outcomes

Strategic Objectives	Interventions/Activities
the RMNCAH programme within the health care system framework	Provide RMNCAH leadership and management training to programme managers and critical service providers at all levels of the service delivery network
	Organize quarterly review meetings at each health tier to share and review progress, challenges and key results attained
	Provide the needed technical assistance to upgrade the RMNCAH unit to a department both at national and state levels, bringing together all its components under a unified and integrated management structure
	Conduct quarterly supportive supervisions and Monitoring of RMNCAH services at all levels of the health system
	Support the procurement, storage and distribution of RMNCAH supplies and commodities
13. To ensure the availability of trained RMNCAH workforce for effective service delivery	Support the production of 600 qualified midwives and nurses through formally accredited training pursued both by the public and private health sector
	Train 500 CBMWs for the hard to reach rural communities by recruiting rural women with intermediate education who once trained will be deployed to serve their local communities
	Organize short advocacy training workshops to enhance the responsiveness of 400 RMNCAH care provision facilities by improving the way client needs are managed, and the environment in which they are treated, targeting the facility level health professionals
	Establish a RMNCAH technical committee to develop the curriculum of the CBMWs and engage all the states and key health partners in its finalization and dissemination for action
	Provide hardship allowances to those serving in remote and hard to reach districts and provide essential RMNCAH services
	Implement integrated RMNCAH outreach services for mentorship and supportive technical supervision for building the capacity of RMNCAH health workers at the facility level and in rural, remote settings
	Organize orientation training for newly employed MNCH health workers on their new roles and responsibilities and periodic refresher training for the programme staff to improve their performance capacities
14. To promote domestic and development partners' financial resources' mobilization for RMNCAH and nutrition interventions	Scale up and diversify domestic resource mobilization for financing the RMNCAH and nutrition interventions in partnership with development partners, bilateral and multilateral organizations and NGOs
	Organize capacity building training activities on effective resource planning and management and design mechanisms targeting population health needs as the basis for resource allocation and develop strategies for domestic and donor resources utilization through better coordination and pooling of funds
15. To attach a high priority focus during humanitarian emergencies on RMNCAH services to reduce the mortality and morbidity of the affected population	Provide MISP on the outset of humanitarian emergencies to 500 RMNCAH staff within the target population
	Procure and deploy the necessary emergency health care kits for effective response
	Establish access to basic and emergency RMNCAH services to IDPs and other vulnerable communities through the provision of mobile health outreach teams

Strategic Objectives	Interventions/Activities
16. To strengthen RMNCAH information systems components in DHIS-2 for evidence-based decision making	Support the collection, analysis, printing, dissemination and use of RMNCAH data for decision making
	Identify the priority RMNCAH operational gaps, and relevant RMNCAH output indicators and undertake implementation research to bridge the knowledge gap and generate context-based solutions to the operational challenges encountered during implementation

RMNCAH M&E Framework

The RMNCAH strategic plan and its implementation will guide the indicators and targets for the M&E processes and results. The different strategic objectives and interventions will be monitored through a set of key indicators during the five years' implementation of the Strategic plan.

Table 11: Selected RMNCAH Indicators and Targets for Programme Monitoring and Evaluation 2019-2023

Strategic Objectives	Interventions	Key indicators	Baseline	Target 2023	Frequency of Measurement	Means of Verification
To improve and scale up the quality and utilization of ANC services	Scale up the ANC coverage among pregnant mothers aiming at eight contacts during each pregnancy	Number of ANC contacts per pregnant mother	1-2 contacts	4+ visits for 50%	Every year	
	Early detection of micronutrients' deficiencies, i.e. Iron & folic acid at community and all BEmONC health facilities for all pregnant women including adolescent girls	Prevalence of anemia among pregnant women	49%	<30%	Every two years	HMIS/DHIS-2
	Improve PMTCT services/ Making the diagnostic supplies and treatment available for HIV, syphilis, & STI	% pregnant women with HIV, Hepatitis B, syphilis and other STIs, adequately treating with ARV prophylaxis among HIV positive pregnant women, prevention of PMTCT and treating eligible women with ARV and following up on their newborns	35%	80%	Every year	HMIS/ DHIS-2
Promote childbirths assisted by SBA both at community and health facility level with timely and full access to BEmONC services	Deploy trained Auxiliary CBMWs at community and qualified midwives at the facility level	Increase the proportion of births attended by SBAs	40%	65%	Every year	HMIS/DHIS-2
		Induce a major reduction in maternal mortality	732	400	Every 2 Years	HMIS/ DHIS

Strategic Objectives	Interventions	Key indicators	Baseline	Target 2023	Frequency of Measurement	Means of Verification
Provide CEmONC services to pregnant women and newborns experiencing fatal complications that include postpartum hemorrhage, pre-eclampsia/eclampsia and, birth asphyxia while preventing and managing these effectively	Establishment of rationally distributed fully functional CEmONC facilities (at least one for every region), introducing resuscitation and newborn care services at community/BEmONC and INBC at CEmONC level	Facilities with Essential Newborn Care service	3	18	Every year	Health facility assessments Reports
	Accelerating the training of CBMWs and CBFHWs for rural areas	Integrated Community Case Management for pneumonia and diarrhoea in 300 rural settings	-	80%	Every year	
	Deploying of CBMWs and CBFHWs at community level and qualified midwives in facilities providing RMNCAH services including the use of Partograph by all to monitor the progress of labor and with skills of basic newborn care & resuscitation capacities	600 CBMWs and CBFHWs trained and deployed back in their rural communities (one CBMW for 2-3 CBFHWs)	-	80%	Every year	DHIS-2
		Deploy at least two qualified midwives at every health facility providing RMNCAH services including PHUs	60%	80%	Every year	DHIS-2
Promote the provision of safe and effective post-partum health care needs for mothers including birth spacing	Providing PNC for mothers and babies within two days of birth	Postnatal care for mothers and newborn within two days of birth	-	>15%	Every two years	HMIS/ DHIS
	Promote advocacies for and involvement of religious leaders and male community members through BCC to support birth spacing using modern contraceptives	Women needs for birth spacing are met with modern contraceptive methods	-	15%	Every year	DHIS-2

Strategic Objectives	Interventions	Key indicators	Baseline	Target 2023	Frequency of Measurement	Means of Verification
	Improve the CPR and reduce unmet need	TFR	6.6	< 5.6	Every two years	Birth registration/Vital registration
Provide the maximum care to the newborn during childbirth and the post-natal period and effectively manage the preterm, the very low birth weight, and sick babies and Promote EBF	Train all BEmONC staff and Community CBMWs on Early Essential Neonatal Care including resuscitation and in promoting the uptake of early initiation breastfeeding and EBF	NMR	40/1000 LB	35	Every two years	HMIS/DHIS-2
		% of coverage of EENC for the B&CEmONC	-	80	Every year	HMIS/DHIS-2
		EBF for six months initiated within the first hour after birth	33%	50%	Every year	HMIS/DHIS-2
Scale up the management of common childhood illnesses' programme approach to improve child survival	Promote the implementation of all the components of IMNCI Strategic plan	Reduce U-5 MR	123/1000 LB	<90	Every two years	HMIS/DHIS-2
		Reduce IMR	85/1000 LB	<70	Every two years	HMIS/DHIS-2
		Proportion of children 12–23 months who received pentavalent-3 immunization	43%	80%	Every year	HMIS/DHIS-2
Improve the Management of MAM and SAM through the RMNCAH programme intervention	Improve the integration outpatient therapy supplementary feeding programme service in health facilities and enhance community screening of malnutrition	Reduce Child Wasting	14%	<10%	Every two years	HMIS/ DHIS-2
		Reduce Stunting	12%	10%	Every two years	HMIS/ DHIS-2
Scale up the reproductive health care services for adolescents	Launching a school health programme to promote life skills and reproductive health awareness and education for adolescents	% of schools with school health programme & life-skills education	0	15%	Every two Years	# school registered of MoE & MOH assessment
Prevent and respond to sexual and other forms of	Develop guidelines for the clinical management on	% of health units that have the protocol for clinical	-	80%		Every 2-3 years through surveys

Strategic Objectives	Interventions	Key indicators	Baseline	Target 2023	Frequency of Measurement	Means of Verification
GBV and work towards the elimination of FGM/Cutting	GBV and establish online GBV training with local mentoring support in all health facilities with trained RMNCAH skilled workforce	management of GBV services and adopted its application				
		Number of RMNCAH providing facilities with staff trained to identify, refer, and care for GBV survivors	-	50%	Every Year	DHIS-2
		Reduce FGM/C prevalence	98%	70%	Every two years	Surveys
Promote awareness building and counseling against early marriage & teen pregnancies	Introduce reproductive health education in school health programmes	Joint MOH and MOE school health taskforce and programme established	-	40% of regions	Every two years	DHIS-2
Improve the governance of the RMNCAH programme through the establishment of central and state level coordination teams effectively assuming collaborative leadership roles in management and implementation	Establish Central and Regional intersectoral RMNCAH coordination Taskforces that mobilize the technical and financial support necessary, led by a similar internal Ministerial taskforce assuming also a secretarial role for the larger Taskforce	Central and Regional level intersectoral RMNCAH coordination Taskforce established	None	80%	Every year	DHIS-2
	Build the capacity of national programme managers	Number of national RMNCAH programme managers trained on programme management skills	0	30%	Every 3 years	Programmes records
Ensure the regular provision and distribution of essential RMNCAH services, supplies and commodities	Consolidate the RMNCAH in All HCs, RHCs and Regional hospitals, and upgrade the RMNCAH staffing in PHUs	Facilities fully performing the assigned RMNCAH services	50%	100%	Every year	DHIS-2
Ensure the availability of trained RMNCAH	Training of qualified Midwives and CBMWs to serve the rural community	SBA delivery at community and health facility level	33%	55%	Every two years	HMIS/DHIS-2

Strategic Objectives	Interventions	Key indicators	Baseline	Target 2023	Frequency of Measurement	Means of Verification
workforce for effective service delivery	Consult the EPHS staffing standards and bridge the existing gap by training and deploying them equitably at district and regional level facilities	Health facilities meeting the staffing plan	<40%	80%	Every two years	HMIS/DHIS-2
Promote domestic and partners' financial resources' mobilization	Earmarked the RMNCAH necessary allocations through domestic and external resources after the necessary advocacy	% of resources allocated to RMNCAH	-	80%	Every two years	National health accounts
Attach a priority focus during humanitarian emergencies on RMNCAH services to reduce the mortality and morbidity of the affected population	Establish regular RMNCAH services within IDP camps and for other disaster-affected vulnerable communities	# of IDP camps with access to RMNCAH services	-	80%	Every years	DHIS-2
	Organize regular outreach visits for supervision and service delivery support	Unified and coordinated health operational plans between the stakeholders	-	40%	Every Year	DHIS-2
Strengthen RMNCAH information system components in DHIS-2 for evidence-based decision making	Introduction & Implementation of logistics management information system (LMIS) in all health facilities/ proper quantification & Forecasting based on the LMIS reports	Facilities with no stock out	-	<50%	Every two years	LMIS
	DHS-2 fully operational and reports on all key RMNCAH indicators	Facilities submitting error-free, regular and comprehensive RMNCAH reports on key indicators	80%	100%	Every Year	DHIS-2