The Somali Investment Case for Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition 2021 - 2026

Presentation objectives

- Provide a overview of the priorities and key interventions in draft Somali Investment Case (IC) to facilitate discussions, solicit feedback and agree on next steps to finalise the IC

Presentation overview

1. Objectives, background and process to developing the IC
2. Review of identified health systems and delivery bottleneck analysis
3. Review of IC priorities and key interventions
4. Next steps and timelines to finalise the IC

1. Objectives, background and process

Background

- Somalia became a GFF country in 2019, building on momentum within the Government and the health sector to address Somalia's pressing health challenges
- As part of the GFF process, countries develop an investment case (IC) as the main instrument to support transformational changes by identifying priority reforms that can unlock and accelerate efforts to deliver a prioritized package of services within existing resources
- Ministries of Health and Finance, partners and the private sector align their financing behind the priorities outlined in the IC

Why an Investment Case?

An IC is different but aligned to the national strategic plan

Create shared understanding by collectively identifying bottlenecks, reforms, and financing to accelerate progress in women's, children's, and adolescent's health

Increase focus by prioritizing Reproductive Maternal Neonatal Child Adolescent Health and Nutrition (RMNCAH-N) services through EPHS, 1-5 key health system reforms and Domestic Resource Mobilization and Utilization (DRUM) Strategy to be implemented with available resources

Reduce fragmentation by aligning financing to IC priorities

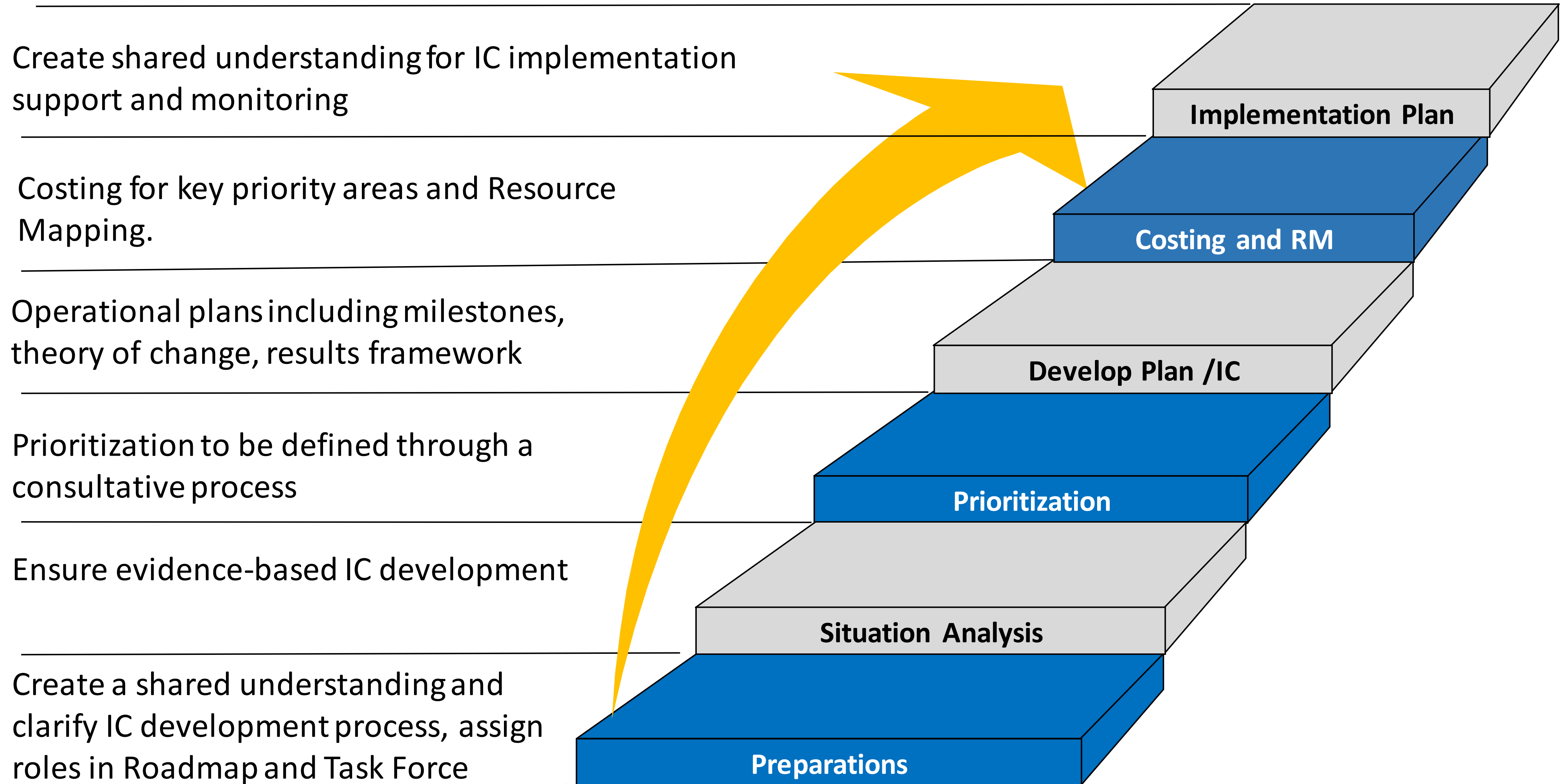
Increase funding for IC priorities by jointly advocating for new financing, particularly from domestic resources, and linking IC priorities to national budget and planning process

Improve accountability by setting **achievable targets** that will be jointly monitored and tracked by Country Platform

Guiding principles for the development of the IC

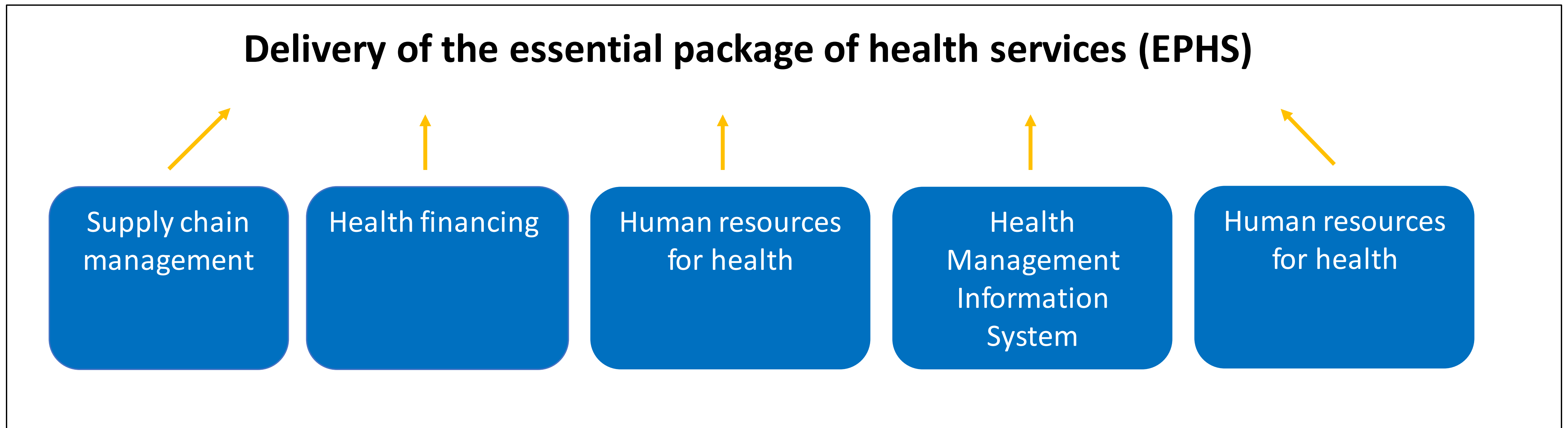
Country-led	Prioritizing	Equity	Data driven & evidence based	No duplication	Minimize new structures
• Collaborative process led by the government	• Prioritizes services and system reforms that can be implemented within available resources	• Focuses on those left behind in terms of socio-economic indicators, gender and other dimensions of equity	• IC priorities are based on sound data and evidence • Includes theories of change and results frameworks with targets	• Situational analysis is used for prioritization and builds on existing analyses and strategies • New analytical work conducted only if needed	• Process should work through existing structures in country and include stakeholders without country presence

IC development process



Somali IC priorities

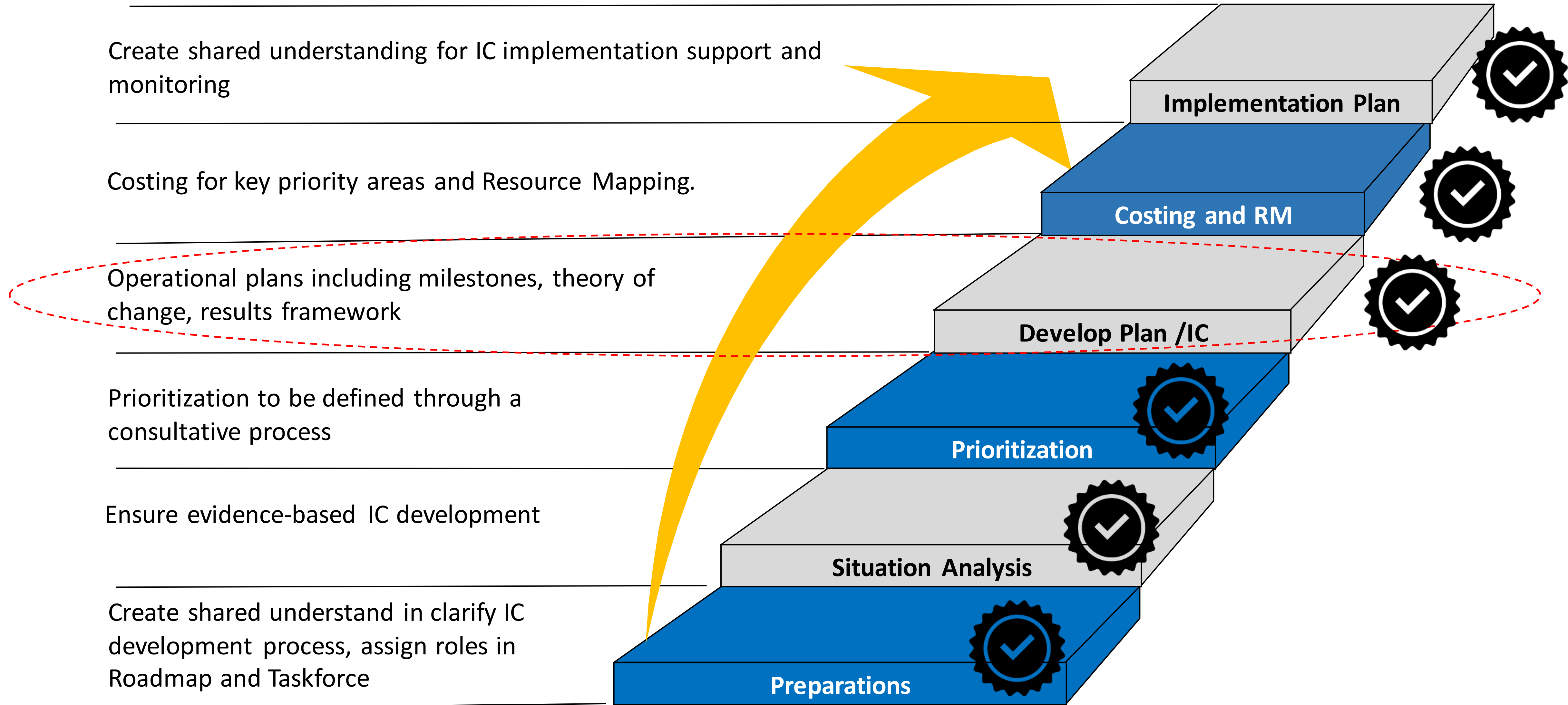
- In October 2019, the Somali health authorities, Federal Members States and partners met in Addis Ababa and agreed on priorities for the IC, and developed a roadmap.
- Key IC priority areas identified are:
  - Improve the coverage of essential services through increasing the reach and availability of EPHS
  - Five health system reforms to improve delivery of DEPHS



IC development process

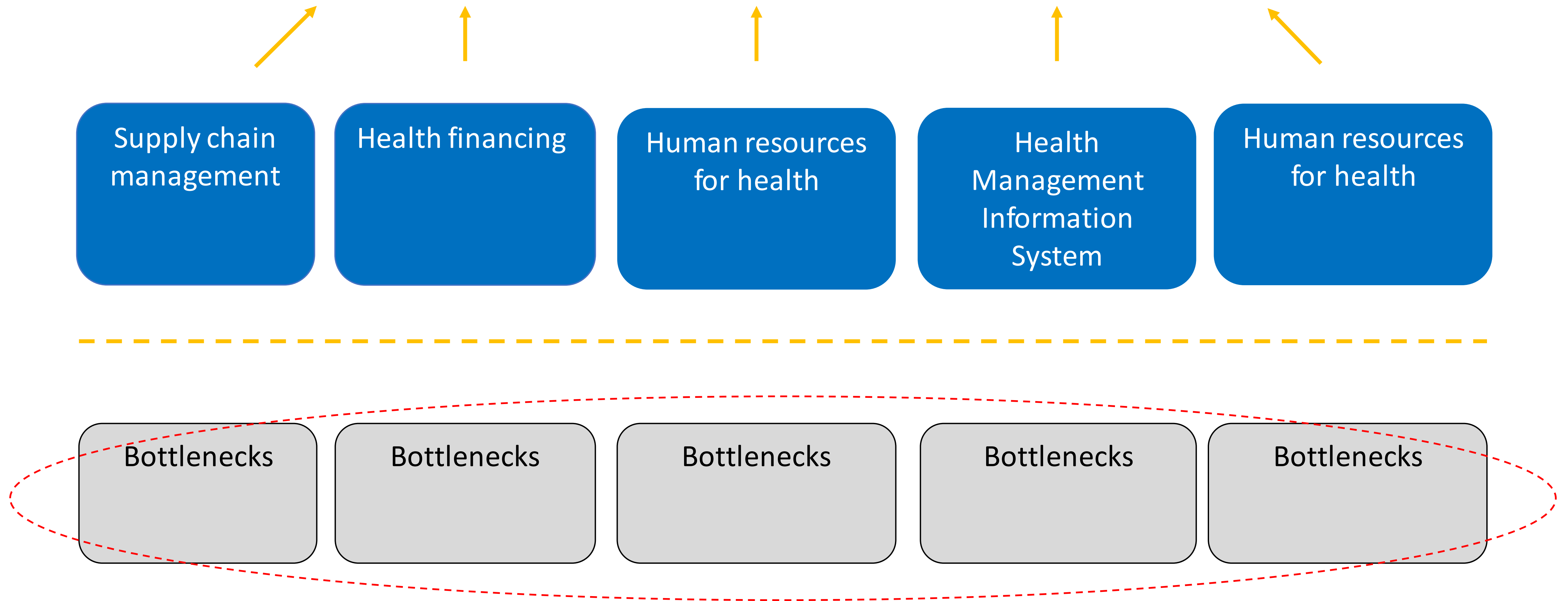
- The development process has been led by the FMoH with support from partners
- In November 2020, a Task Force was established with the objectives of supporting the IC development process, providing technical inputs and participating in a consultatively
  - Chaired by the Director of Planning
  - Made up of around 20 members
    a. FMoH officials
    b. Financiers: GAVI, GF, GCDO, Italian Cooperation, WB and GFF
    c. UN: UNICEF, WHO, UNFPA
    d. Private sector and civil society representatives
  - The Task Force has met regularly, and especially between November 2020 and end March 2021

IC development process



2. Health systems and delivery bottleneck analysis

Five health system reforms to improve delivery of DEPHS



EPHS delivery bottlenecks

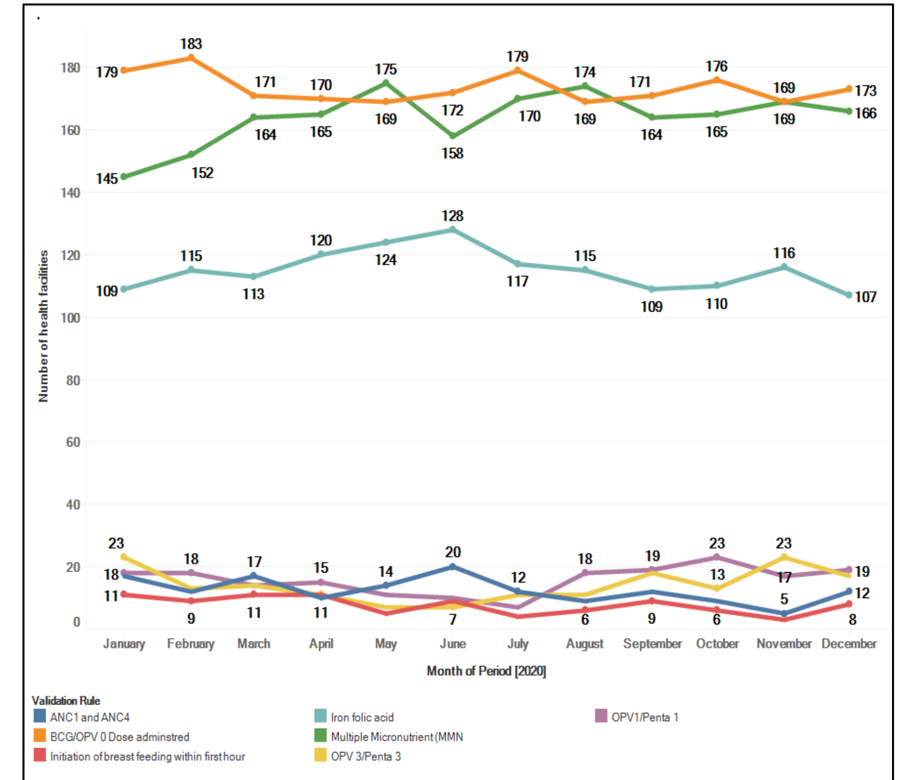
- The 2009 EPHS did not reach the entire population as a result of constraints related to funding and implementation capabilities
  - Statistics published by the WHO in 2017 indicate that the EPHS partially covered around 47 of 89 districts (population of 5.7 million), or 41% of the population.
- The main obstacles confronting the EPHS implementation in Somalia have included
  a. constrained institutional capacity and stewardship role of the MoH
  b. inefficiencies, inadequacies and unsustainability in terms of funding
  c. human resources deficiencies
  d. insufficient and inequitable availability of services
  e. sub-standard service quality
  f. lack of coordination and harmonization among key stakeholders
  g. weak health information system

  Source: Nigel Pearson & Aaron Blaakman, February 2019, Development and Implementation of Somali EPHS 2008-2019

Health information system bottlenecks

- While DHIS2 covers most public facilities, not all regions are covered
- Data quality challenges persist, as indicated by a high number of data errors and outliers
- In the absence of explicit HMIS standards and plans, there exists fragmentation of partner support, creating overlap and gaps
- FGS has limited visibility on who does what within HMIS and there is no functioning coordination mechanism
- Parallel health information systems persist
- No updated, usable HMIS and DHIS2 SOPs
- Substantial HMIS staff capacity gaps and conflicting functions between HMIS positions, particularly between the regional and state levels.
- Because of a lack of clarity in roles, there are conflicting functions between HMIS positions, particularly between the regional and state levels

Figure 1. Data errors for key indicators per month



Source: DHIS2 - check

Health financing bottlenecks

- Health sector is highly dependent on external aid, but the long-term vision will involve significantly increasing domestic resources
- Government health expenditure is highly constrained, little state capacity to mobilize taxes, and the government budget for health is limited
- Budget execution rate remains low
- MoH currently remains highly reliant on external support to provide technical assistance
- Need to build health financing capacity and establish a Health Financing Unit in the FMoH
- At present, ODA is channeled only very partially through government systems, raising issues about prioritization, co-ordination and harmonization
- Concerns about the state's rent-seeking behavior, poor transparency, corruption, and weak PFM

Table 2. Summary of Government Expenditure on Health, 2018-2020 (USD)

Year	Total Govt Expend.	Health Expend.	Health Budget	Health Budget as % Govt Expend.	Health Budget as % GDP
2018	286,066,601	1,168,173	4,393,320	1.5%	0.09%
2019	314,014,117	2,638,841	7,260,440	2.3%	0.15%
2020	494,747,681	6,235,712	9,350,466	1.9%	0.18%

Source: Ministry of Finance, Revenue Explorer; accessed at https://mof.gov.so/fiscal/REVexplorer.html

Private sector bottlenecks

- The private sector has thrived and is the largest health service provider across all of Somalia.
- Somalia's private sector offers significant opportunities for quality health services to be delivered at scale across the country, building on existing and extensive reach and infrastructure and which has the potential to play a large contribution towards Somalia's UHC goals and through a "mixed health system".
- There are now significant and important opportunities for the FMoH and FGS to increase their governance of the sector.
- The private sector is faced with a myriad of regulatory gaps that affect the quality of services.
- There are significant gaps in the quality of care, along with widespread concerns from patients and health workers about quality of care – both for health services and the quality of drugs and health technologies.
- The private sector has traditionally operated in isolation from the public sector, primarily because there have been little incentives to work together, and in some cases, interests are incompatible with the implementation of government's agendas.
- Coordination among the different cadres and types of private providers is only nascent and capacity is limited

Human resources for health bottlenecks

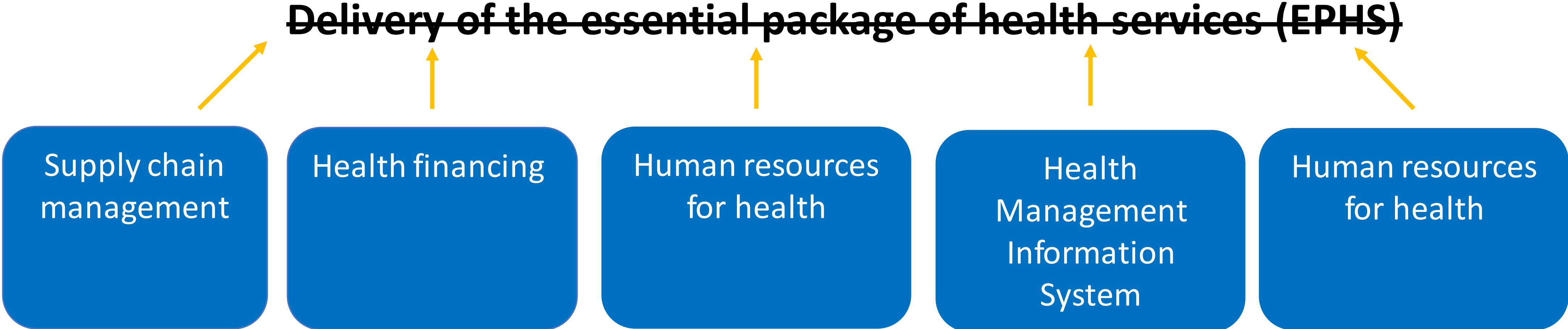
- Somalia's HRH role and function remains highly nascent at all levels of the health system
- Leadership and governance and coordination between the SHAs, financiers and implementing partners remains particularly fragmented, and policies are not adhered to
- Availability and use of HR data remain limited, in part due to lack of a comprehensive HR system such as HRMIS, but also by limited capacity of health workers to report through DHIS2
- There remains a persistent and severe shortage of health workforce – and many who are qualified are not formally employed and retained
- Large differences in the numbers of health workers across Somalia and different levels of the health system
- Workers are often not deployed effectively, utilization remains low, and opportunities to formally integrate trained cadres in the health system remains very limited.
- Harmonized job titles, job descriptions, compensation packages or remuneration pay scales are not in place Coordination between partners supporting HRH remains fragmented.
- The regulation of Somalia's health workforce remains a challenge, including the accreditation and quality of training institutions, the registration of health facilities and regulation of the health workforce

Essential medicine and supply chain bottlenecks

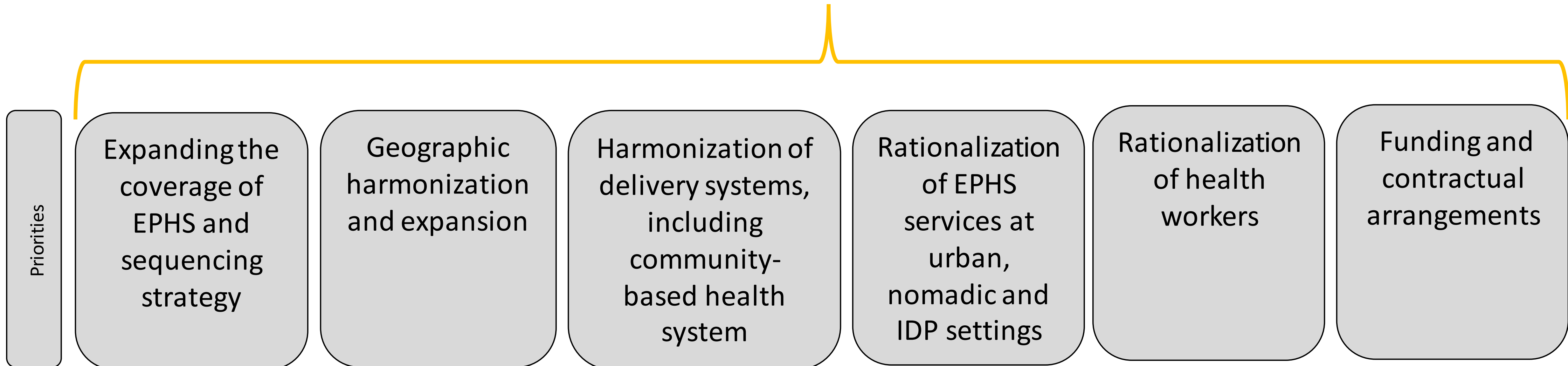
- The supply chain can be characterized as low in maturity and highly fragmented
- There is considerable difference in the way in which supply chain management is organized and controlled
- The medicines supply chain suffers from the twin problems of stock outs and overstocking
- Very high discrepancies exist between health facility records and the information entered into the LMIS as a basis for resupply quantities.
- Long public sector procurement processes can render the supply chain unable to respond quickly to changes in requirements.
- Supply chain infrastructure throughout Somalia is limited in volume and variable in quality.
- The majority of supply chain functions are carried out at facility level by medical personnel
- While regulation of the pharmaceutical sector is universally recognized as a critical area requiring reform, the Master Plan states that the estimates that 80% of medicines consumed by public and private sectors are supplied through private channels which are currently unregulated.

3. IC priorities and key interventions

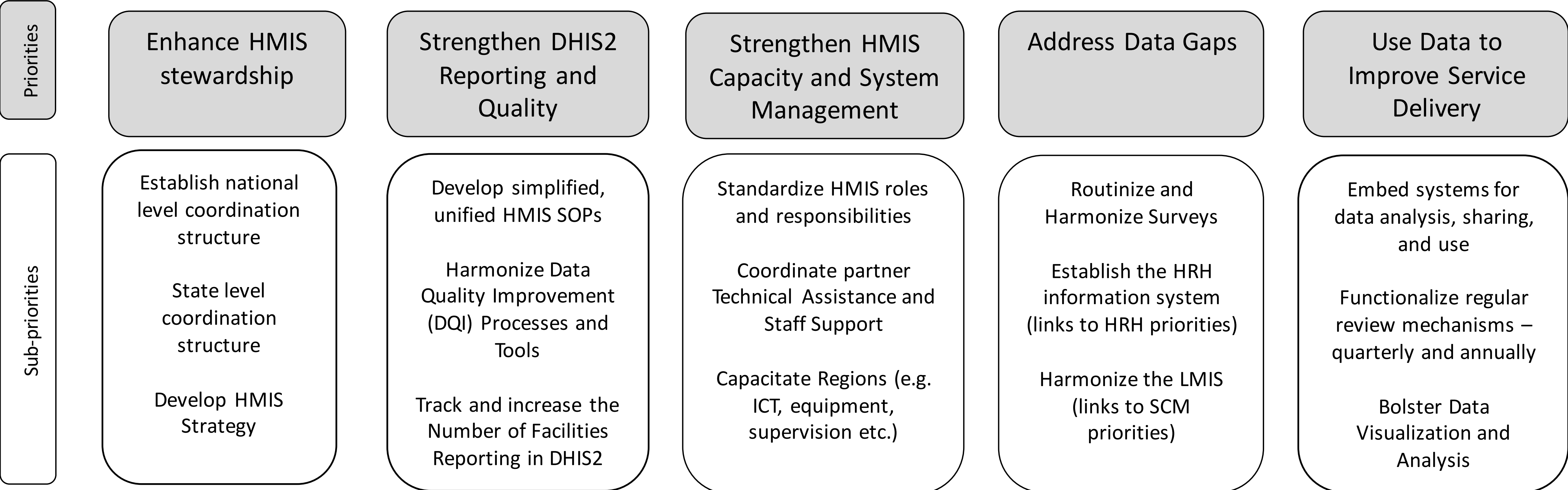
Somali IC priorities



EPHS delivery priorities



Sector reform 1. Improved health information system

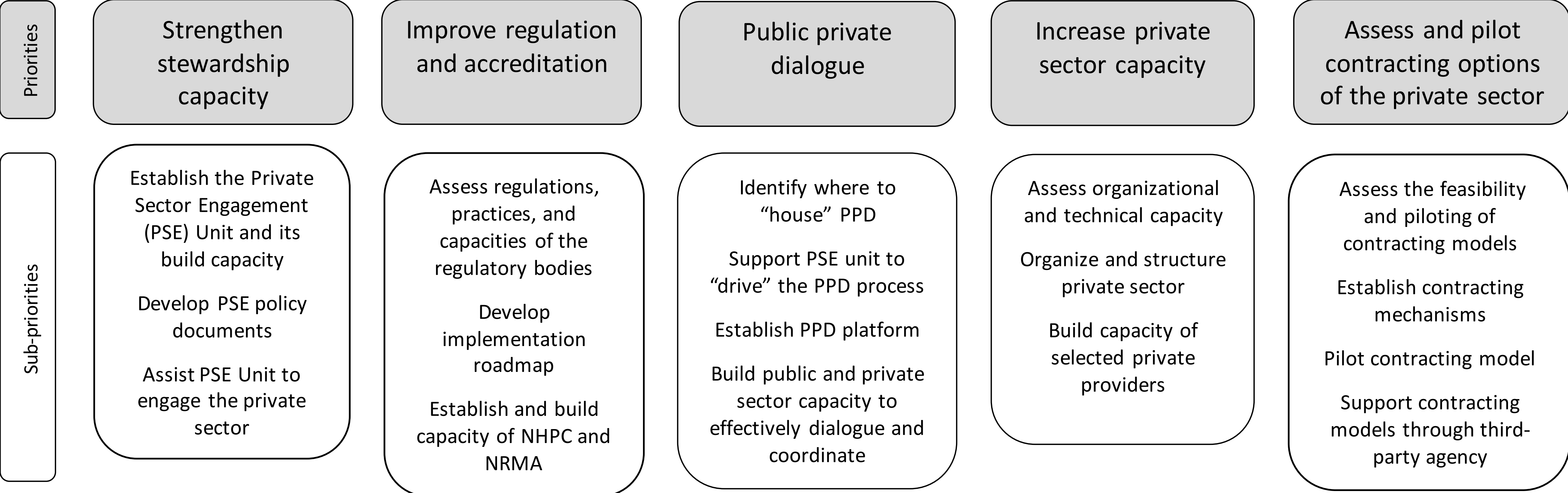


Sector reform 2. Strengthened health financing

Strengthened health financing

	Increase domestic resources	Etablish capacity in the FMoH	Strengthen PFM systems and capacity	Improve data use and transparency	Improve efficiency by prioritizing PHC and frontline health
Sub-priorities	Additional sources of resources Increase the prioritization of health in the budget Explore other revenue sources, from sources such as sin taxes	Establish a Health Financing unit Build capacity of HF unit Institutionalize NHA RMET Health financing strategy HF TWG	Build capacity Support FMoH in planning, budgeting, monitoring, reporting Assess feasibility of creating an online platform to link MOH and MOF systems and software	Establish systems and procedures for routine use of data for decision-making Routine reviews to increase accountability and transparency Strengthen accountability and governance	Salary to frontline staff and FHWs Support FMoH in developing a stewardship and purchasing role to contract out service delivery of EPHS

Sector reform 3. Enhanced private sector engagement

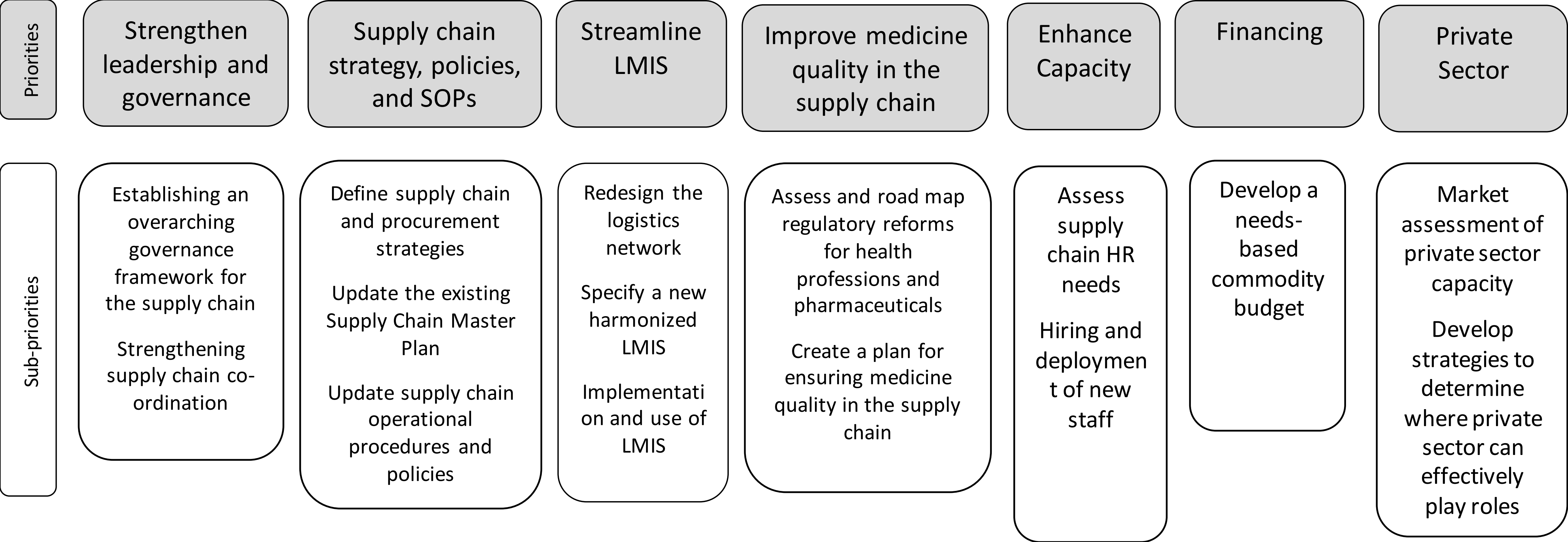


Sector reform 4. Strengthened health workforce to improve the delivery of essential services

Strengthened health workforce

Priorities	Strengthen leadership and governance	Improve availability and use of data	Consolidate and standardize jobs, salaries and posts	Increase numbers of qualified health workers	Improve regulation of the health workforce
Sub-priorities	Strengthen the capacity of the HR Department Establish and support the HR TWG New HR Policy, 2022 – 2027 Harmonize cadres into existing health workforce policies	Support the roll out/scale up of DHIS2 HR reporting Develop HRMIS system Support to improve analysis and use of HR data	Standardize job titles, redefine minimum qualifications and uniform JDs Standardize salary scales and top ups	HR mapping Provide incentives to staff Train more health workers, especially to fill critical gaps Utilize existing cadres of qualified staff (e.g. polio)	Assess and road map regulatory reforms for health professions Support NHPC

Sector reform 5. Improved essential medicine and supply chain



4. Next steps and timelines to finalise the IC

Create shared understanding for IC implementation support and monitoring

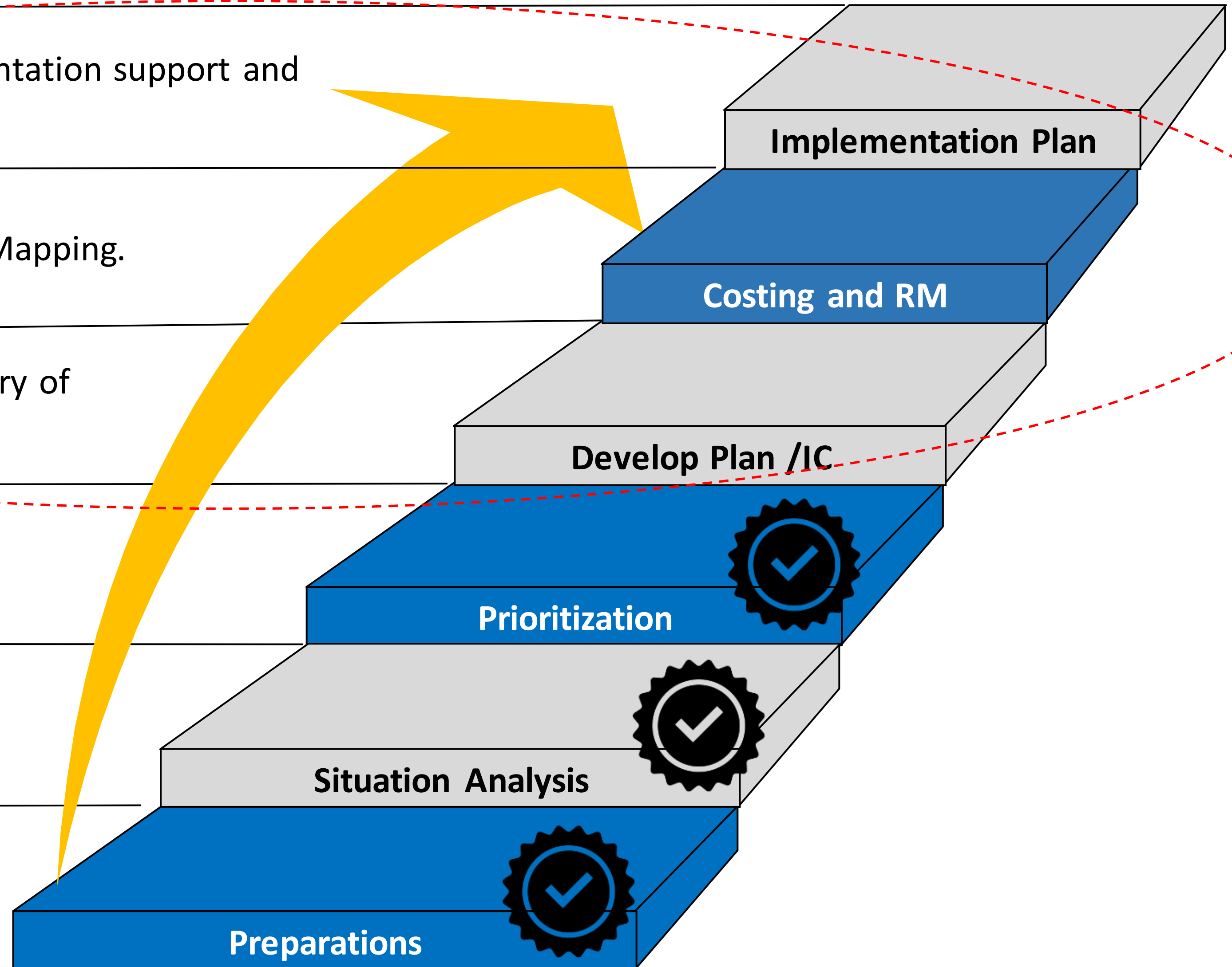
Costing for key priority areas and Resource Mapping.

Operational plans including milestones, theory of change, results framework

Prioritization to be defined through a consultative process

Ensure evidence-based IC development

Create shared understand in clarify IC development process, assign roles in Roadmap and Taskforce



Timelines

Action	By when	Responsible
Comments on draft IC to be shared	Sunday 11th July	FMSs
Final comments on draft IC to be shared	Monday 12th July	Partners
Final consultation meetings to held with FMoH departments and FMSs	Thursday 15th July	Habib Nur, Khamar Abdinur and Rob Wood
Incorporation of consultation feedback into draft 2 of IC	End July	Rob Wood
Consolidation of implementation plans	End July	Rob Wood
Finalisation of Results Framework and ToC	End July	Rob Wood
Draft costing of IC	August	Zina Zarah/World Bank
Sharing of draft costing with FMoH and FMSs	August	Rob Wood
Further prioritization in case of significant financial gaps	August	MoH and partners
Finalization of IC	End August	

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