Somalia
Health Sector Strategic Plan – HSSP III (HSSP) 2022-2026

Intragovernmental Health Sector Coordination
Kismayo-Jubbaland
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Somaliweyn Webpage

Outline of the presentation

- Background
- Broad Aspirations
- Methodology
- Findings
- Features
- Guiding principles
- Strategic Drivers (Main Pillars)
- Monitoring and Evaluation
- Proposed timelines of states operational plan

Background

- Ministry of Health in close collaboration with member states and development partners has made progress in health systems strengthening and delivery of services.
- The EPHS of 2009 has been updated with the lessons learnt in the implementation of HSSP-I (2013-2016) and HSSP-II (2017-2021) together with multiple system reforms being done in the country including the updated national development plan (NDP9) and the roadmap toward UHC.
- The impact of the COVID-19 pandemic and the country response to it have provided critical lessons about the need to strengthen essential public health functions of the FMoH and guide development in the country's health sector.

HSSP III: Broad Aspirations

The Somalia Health Sector Strategic Plan (HSSP-III) will serve as the **overarching strategic framework** for the country:

- To guide each federal member state in developing **state specific operational plans** and implementation.
- To inspire **decision-makers a shared strategic direction for** health system development, toward universal health coverage,
- To **provide coherence** amidst disconnected interventions and siloed programmes and
- To promote the best use of resources to **improve and protect the health of somali population**, a key asset for social and economic development.

Methodology

- Technical Assistance.
- Steering Committee:
- Technical Working Group.
- Desk review
- Consultation
- Key informant interview
- Implementation and Scheduling

Findings

Governance of the health sector

Health Sector Legislation and Regulation:

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

Aid Coordination/ Management:

- There has been an improvement in the donor coordination by the Ministry of Health.
- The MoH takes **the lead in presenting the progress and in discussion** with the partner identified areas/ interventions that need their support and to agree on mechanisms for achieving common goals of implementing the EPHS and health sector priorities.
- the process needs to be **consolidated with regular scheduled meetings and responsibilities**

Emergency Preparedness and Response:

- The present setup, upgraded to **respond to the Covid-19 epidemic**, performs quite well.
- Ways to make it be more durable than its predecessors has been identified through the adoption of Integrated Disease Surveillance and Response (IDSR) which will link to the District Health Information System (DHIS2) platform.
- This will require concerted efforts and **investment to strengthen the routine information system** which is suboptimal in function and provides limited use for decision making.

Management of Health Systems

the current management of the health systems **is weak due to lack of capacity and attrition of personnel.**

The Federal Member states, in addition to the above, require capacity for emergency response, management of human resources and pharmaceuticals, engagement with private sector and other health institutions

Health Information Eco-system

- The health information environment is **quite fragmented** with multiple systems .
- Reports, development plan, review of the health sector in Somalia points to **weaknesses** in the Health Information System.
- A Health Information System Strategic Plan (HISSP) 2018-22 was prepared to **address this gap**, but there is little evidence of its implementation. The plan provided clearly outlines targets and strategies; however, the scope of the plan **appears to be quite ambitious.** Lack of financing continues to be a major reason for its non-implementation.
- The MoH through the health sector coordination mechanism shall promote a **single reporting system** using the data generated by the DHIS2 to avoid duplication of information and compatibility of the data sets.
- Information flows from logistics management system are very weak.

Human Resources for Health (HRH)

- The quality of the current health workforce and consequently the quality-of-service delivery **remains to be a major challenge**
- There are a lot **of informal health care providers** which also require attention.
- The HRH problems can be classified in two major areas;
  - Available workers, category/ skillset, and distribution and
  - Quality of trainings for the production of relevant cadres.

Health Institutions (Health service delivery system)

- Health systems are inherently very complex due to the different specialties and levels of skills involved which require **their own specific supporting environment**.
- In the private sector facilities 46% of hospitals and 74% of clinics are either **individually or group owned**.
- The government and donor partners are mostly focused on provision of **primary health care services in line with the EPHS including relevant primary curative care.**

Health Financing

- The government share in health expenditure **has increased from 7.8% in 2018 to 12.2% in 2020.**
- A majority of the development assistance **to Somalia is off budget which requires coordination to achieve ef**ficient use of available resources
- the greatest obstacle cited by **Somali women aged** 15 – 49. 65% of women cite **lack of financial access as the main barrier**.
- The **high rate of OOP m**eans households often have to deplete savings, sell their assets (14% of the households) or borrow money.
- The rate of seeking health care is lowest for **the nomadic population** where only 10% of households identified that they had someone who was ill and 68% out of these did not seek care.

Pharmaceuticals and medical devices

- The lack of **reliable data** of large coverage
- The quality of the medicines circulating in such highly **deregulated market is a matter of speculation.**
- Many 'pharmacies' have expanded their scope, offering **rudimentary laboratory and outpatient services**.
- The key actors in the pharmaceutical field are **the importers** and these are: pharmaceutical firms, traders and the logistics chains of international donors.

Major themes

- Somalia has made progress in health sector, **improving in maternal and child care service delivery**, there is an increase in availability of services and service delivery is now more in line with the EPHS package.
- The health structures for the FMOH and the FMS are taking shape and there is some **evidence of recent increased coordination through FMOH.**
- The share of health in the government budget has increased from **7.8% in 2018 to 12.2% in 2020**. and is expected to further improve
- The **private sector has responded to health needs** in a positive manner and has expanded mostly in urban **areas around 60%.**
- The COVID 19 emergency has **provided opportunities for learning lessons on system strengthening and initiatives** for surveillance and disease monitoring.

Important points

- Access remains a major issue, particularly for rural and nomadic populations
- UHC is lowest in the world and estimated **that 22% of Somalis** have access to UHC
- Public sector service provision is severely limited
- There are serious shortages of health worker availability
- Pharma sector is unregulated and supply chain management is an issue
- Urbanization is happening at a rapid pace in Somalia

Features

- HSSP will be a **living document** to be revised every two years along with a review of progress and necessary revisions for the Investment case
- It will provide **overall strategic guidance and policy directions**, the details of implementation and specific strategies will be prepared by the member states.
- The Somalia Investment Case will be **considered as the immediate needs document for the health sector**, the first project under it is in preparation.
- The HSSP III will also propose **longer term investments** for the health sector which may be prioritized in later stages for implementation

Features

- The HSSP will provide **a matrix of policy options** indicating priority and the first year priorities are already established under the Investment Case.
- The FMOH, FMS and technical **experts will review progress annually** and adjust the priorities as per requirement.

Guiding principles

- *Feasibility,*
- *Sustainability*
- *Flexibility*
- *Coherence*
- *Adaptation*
- ***Long-term goals:*** *the Establishment of institutions capacity, structures, and mechanisms that foster equitable, efficient and effective healthcare provision.*

Strategic Drivers

- Boosting healthcare demand,.
- Engaging private healthcare providers,.
- Putting in place performing management systems
- Restructuring the health workforce,.
- Rationalizing the pharmaceutical field,.
- Steering physical investments,

Strategic Driver: Boosting Health Care Demand

- **Policy Options:** Lowering existing barriers
  Respecting cultural norms
  Enhancing demand
  Enhancing Quality of Care

  Feasibility and risks:
  Nomadic population need targeted strategies,
  Information Technology can be used to increase awareness,
  Quality is a long term goal

- **Capacity and Resource requirement**
- **Linkages**

Strategic Driver: Engaging Private Sector

- **Policy Options:** Short term
  - Incentives, franchising, disclosure, accreditation, contracting
- Long term
  - Progressively introducing regulatory controls,
- **Feasibility and risks:** challenging, risk of regulatory capture
- **Capacity and Resource requirement;** requires management and related expertise, needs to be responsive to population needs, regulatory regime will require a longer term commitment
- **Linkages:**

Strategic Driver: Strengthening Management System

Policy Options: Information management,
Aid Management
Emergency preparedness and response
Strengthening local management performance

- **Feasibility and risks:** past attempts have not worked
- **Capacity and Resource requirement;** Funding needs to be ensured, strong commitment from government
- **Linkages:**

Strategic Driver: Restructuring health workforce

- **Policy Options:** improving skills,

➢ addressing HRH imbalances and productively managing the workforce,

➢ Regulation: accreditation of training institutions and certification (or licensing) of health workers

- Feasi**bility and risks:** utilization and distribution of workforce is dependent on programming and incentives,
- Capacity and Resource requirement; production will require longer term investments, ensuring quality requires regulatory effort and utilization will require a functional coordination mechanism
- Linkages:

Strategic Driver: Rationalizing the pharmaceutical field

- **Policy Options:** Regulatory measures including quality control,

  streamline supply chains
- **Feasibility and risks:** regulation of pharma is difficult but highly rewarding, Private laboratories may be used for quality control
- Capacity and Resource requirement;
- Linkages:

Strategic Driver: Steering Physical infrastructure investments

Policy Options: Managing gaps and overlaps in health system, Public private partnerships, infrastructure spending

- **Feasibility and risks:** Slow process, understanding of public, private and hybrid investments,
- **Capacity and Resource requirement;**
- Linkages:

Structure of the Policy Matrix

- The policy options matrix is a multilayered structure:
- Each member state takes guidance from it and develops a comprehensive plan for their area
- The FMoH compiles these plans and adds national level interventions to compile the national planning matrix.

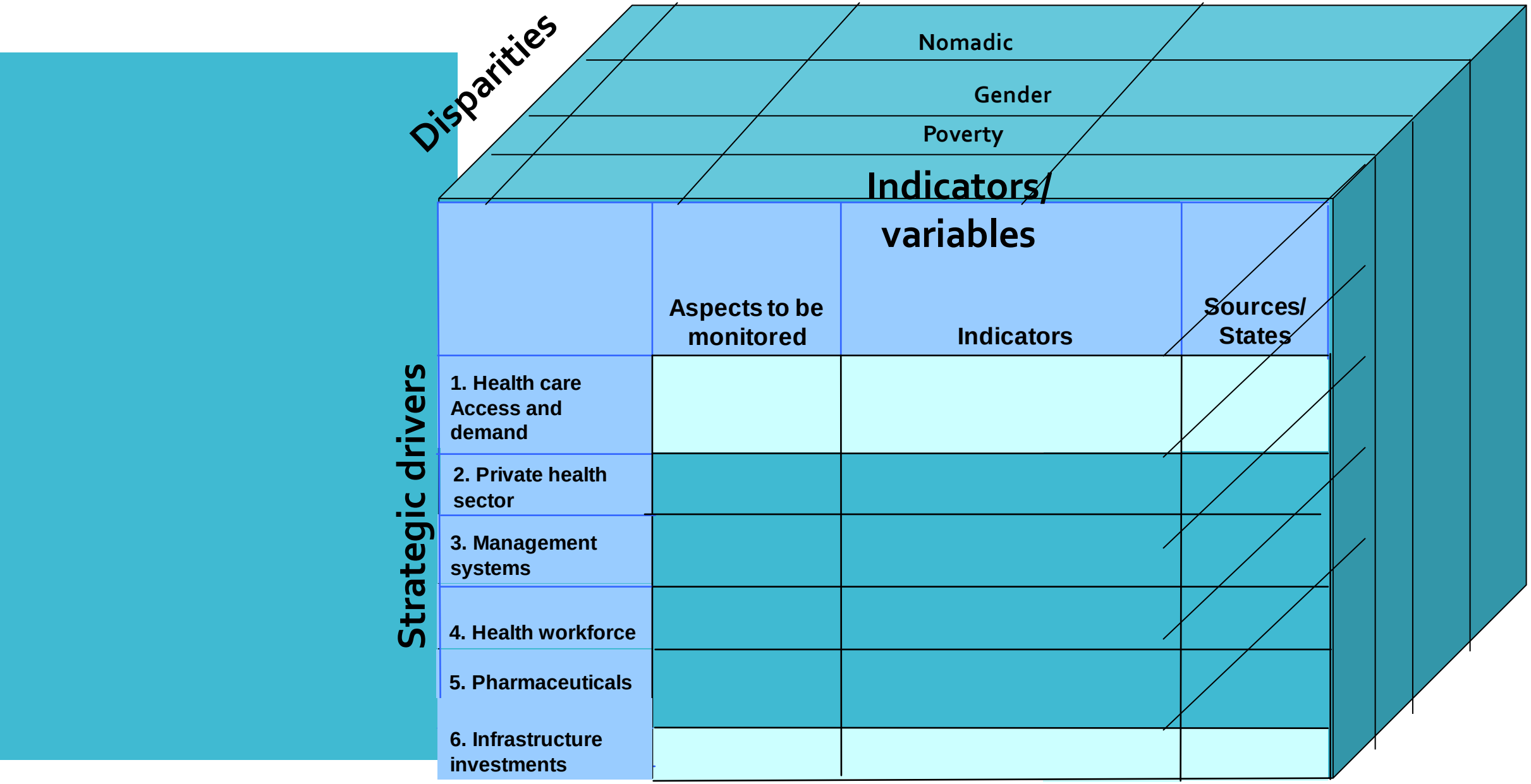
Strategic driver	Policy options (not mutually exclusive)	Feasibility and risks	Capacity & resource requirements	Linkages
2.1.1. Boosting healthcare access and demand	• *Lowering existing barriers*: extending opening hours, reducing the cost incurred by patients, ensuring regular supplies, motivating staff to raise their performance, and improving communication. • Programs addressing *cultural norms* affecting health seeking behaviors. In rural Somalia, *"societal norms may be the main barrier to accessing health care."*[1]. Simply adding facilities and staff will not be sufficient. • Alongside conventional supply-side measures, *innovative approaches* aimed at encouraging demand are needed.	• Nomadic populations need adapted service delivery models, premised on mobility, flexibility and cultural appropriateness. • Internally displaced population is another major area which requires further effort. • IT applications can greatly contribute to disseminate information, as well as raise access to health services. • *Risks*: • Standardized health services ignore local circumstances. • Health messages inapplicable in real settings do not resonate with people. • The costs borne by distant patients remain high, even with officially free services. • Patients will not travel long distance if healthcare provision are unreliable or deemed substandard	• The training of female health workers must be coupled with local recruitment policies and adequate incentives to deploy them where needed. • Effective communication is built on mutual respect, and recognition of the actual patterns of healthcare provision in each circumstance. • Other providers supplement formal health services: folk healers, traditional birth attendants, community health workers, itinerant traders, nomadic link workers. Supporting these practitioners, rather than competing with them, appears as a realistic option to serve hard-to-reach populations. • Subsidies aimed at making services more affordable, for instance by supplying quality medicines at reduced cost, should be considered.	• Valuable experience has been gained in Somalia about stimulating healthcare demand. See for instance the *Sahan* component of the *Shine* program. • Improved management, by raising workloads at under-used facilities, would provide obvious returns at modest cost. • The decentralized, relevant training of scarce categories, such as midwives, is needed to make a difference.
	• *Enhancing the quality of care* requires protracted efforts on multiple fronts to induce progress.	• The main quality-enhancing interventions under way and in the pipeline should be appraised by independent bodies.	• Software is needed as much as hardware (which usually dominates quality-enhancing projects). • PHC facilities must receive as much support as hospitals (which	• Linked to all the other strategic drivers. For instance, credibly accredited health facilities staffed by skilled workers prescribing affordable,

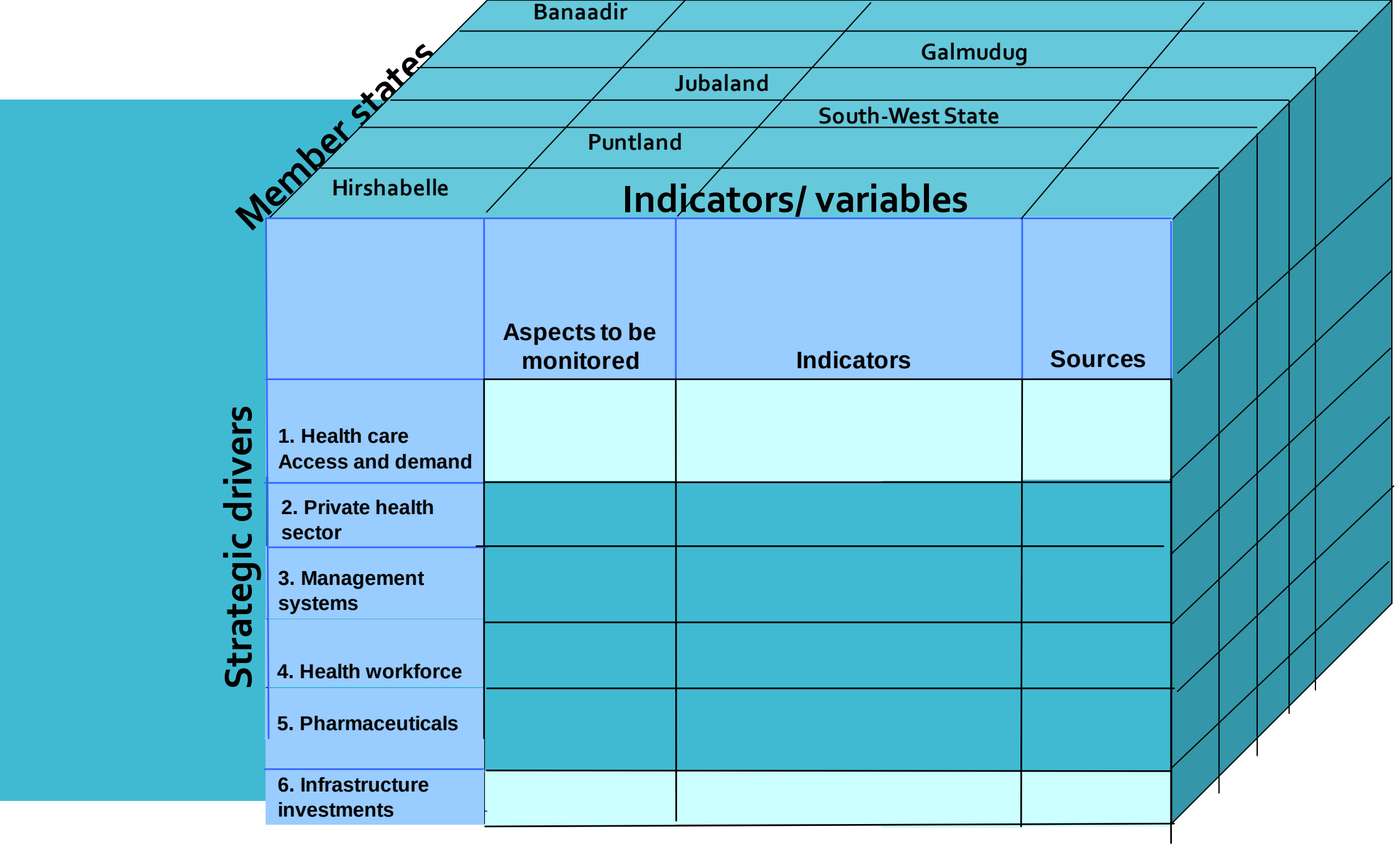
Governance / leadership of the plan

- The plan and its component documents (the GFF-supported Somalia Investment Case for Health sector and the Federal Member States operational plans) **are to be coordinated and managed** by the directorate of planning in the Federal Ministry of Health.
- The state ministries of health will also have a **directorate or section responsible** for the plan and to manage the implementation process.
- The policy and planning department of the Ministry of Health shall be responsible for the **coordination with donors, private sector organizations, NGOs** and federal member states to support the implementation of this strategic plan.
- The Federal Ministry of Health will also assist the member states in development **of individual plans,** mobilize technical expertise both internally or externally, issue **annual progress reports,** hold biannual meetings, coordinate with research institutions and prepare for the revision of the strategic and operational plans if required.

Monitoring and Evaluation

- Adopt a **sector-wide perspective,**
- Promising **innovations studied** on a small scale.
- Different member states might **host different pilots**
- Service uptake needs to be disaggregated by population groups.
- **Trends must be monitored to capture the progress registered** in supplying health services, as well as their uptake.
- The chosen **indicators must be coherent with the strategic drivers,** as well as with realistic timeframes.
- Monitoring and evaluation must also capture developments not encompassed by the strategic plan, but impacting on its implementation, or imposing its revision.
- Healthcare demand, productivity and quality of care, cannot be monitored through routine indicators only. Dedicated surveys may be required.
- Monitoring and evaluation have to be enriched by insights gained by researchers and field


Disparities
Nomadic
Gender
Poverty
Indicators/ variables
Strategic drivers
Aspects to be monitored
Indicators
Sources/ States
1. Health care Access and demand
2. Private health sector
3. Management systems
4. Health workforce
5. Pharmaceuticals
6. Infrastructure investments


Member states
Banaadir
Galmudug
Jubaland
South-West State
Puntland
Hirshabelle
Indicators/ variables
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Proposed timelines of states operational plan

Member State	Responsible Unit	Start of planning process	Estimated end date


Thank you