Ministry of Health and Human Services
Federal Republic of Somalia

SOMALI ROADMAP TOWARDS UNIVERSAL HEALTH COVERAGE 2019-23

November 2018

World Health Organization

From the People of Japan

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Federal Republic of Somalia

SOMALI

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Somali Roadmap towards
Universal Health Coverage (2019-23)

Produced by:
Ministry of Health, Federal Republic of Somalia (FRS) and
State Ministries of Health

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MESSAGE FROM FEDERAL MINISTER OF HEALTH

Ensuring that all Somali people can access the health services they need – without facing financial hardship – is key to improving the well-being of Somali people. However, universal health coverage (UHC) is more than that: it is an investment in human capital and a foundational driver of inclusive and sustainable economic growth and development. It is a way to support Somali people so they can reach their full potential and fulfil their aspirations.

Progress towards UHC is a continuous process that changes in response to shifting demographic, epidemiological and technological trends, as well as people's expectations. The goal of the service coverage dimension of UHC is that people in need of promotive, preventive, curative, rehabilitative or palliative health services receive them, and that the services received are of sufficient quality to achieve potential health gains.

A UHC service coverage index – a single indicator computed from tracer indicators of coverage of essential services – was developed to monitor SDG indicator 3.8.1 by the World Bank and WHO. The UHC service coverage index is straightforward to calculate, and can be computed with available country, state and regional level data, which allows for government-led monitoring of UHC progress.

Unfortunately, UHC for Somalia is having the lowest UHC index in the world, indicating that only 22 percent of Somali people have access to essential services. This is unacceptable. Similarly, one of the proxy indicator used for estimating UHC index is International Health Regulations (IHR) index, which is also very low. IHR index indicate that only 6 percent of Somali people are protected from health emergencies and high threat infectious hazards. In other words, majority of Somali people are having a high risk to their lives and that preparations to tackle health hazards are very weak.

Together, we have to tackle these challenges through maximum possible efforts within available resources and through effective coordination. We have to introduce new reforms in the health sector, which are based on scientific evidence and are considered best practices to deliver results in a cost effective way.

Finally, we need to implement the strategic choices and regularly monitor the progress towards achieving health related sustainable development goals and more significantly the UHC index.

I am thankful to all those who participated and deliberated in the consultations to produce the roadmap. I am grateful especially to Somali health authorities from all ministries, CSOs, WHO, UNICEF, UNFPA and donor agencies.

I am especially thankful to Dr. Abdullahi Hashi, Director General (Health) for his leadership role in developing the roadmap. I hope we will soon re-activate the UHC/ health sector coordination mechanism, which is critical for the implementing of the roadmap for UHC.

I appreciate very much the support from Dr. Ghulam Rabbani Popal, WHO Representative and the Government of Japan for providing timely technical assistance in this regard. Now, we need to work in a more coordinated way in our quest to achieve the UHC and SDGs.

Dr. Fawziya Abikar Nur
Minister of Health and Human Services
Federal Republic of Somalia

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BOD	Burden of Disease
CVD	Cardio Vascular Diseases
CSO	Civil Society Organization
DALYs	Disability Adjusted Life Years
DCP3	Disease Control Priorities – Edition 3
EC	European Commission
EIP	Early Inter-sectoral Prevention Policies
EPHS	Essential Package of Health Services
EUHC	Essential Universal Health Coverage
FRS	Federal Republic of Somalia
GDP	Gross Domestic Product
GNI	Gross National Income
GPW	General Programme of Work
HCS	Health Consortium for Somali people
HIV	Human Immuno-Deficiency Virus
HPP	Highest Priority Package
HPV	Human Papilloma Virus
HSSS	Health System Strengthening
IP	Inter-sectoral Prevention Policies
IHR	International Health Regulations
JHNP	Joint Health & Nutrition Programme
MCH	Maternal and Child Health
MoH	Ministry of Health
OECD	Organization of Economic Cooperation and Development
OOP	Out of Pocket
SDGs	Sustainable Development Goals
SARA	Service Availability and Readiness Assessment
STI	Sexually Transmitted Infections
TB	Tuberculosis
THE	Total Health Expenditure
TICAD 6	6th Tokyo International Conference on African Development
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WASH	Water, Sanitation & Hygiene
WB	World Bank
WHO	World Health Organization
UHC	Universal Health Coverage.

SOMALI ROADMAP TOWARDS UNIVERSAL HEALTH COVERAGE

EXECUTIVE SUMMARY

The Somali Roadmap towards Universal Health Coverage (UHC) reflects the medium-term vision of the Ministry of Health, Federal Republic of Somalia (FRS) and defines a strategic framework for making progress in the health sector of Somalia over the period 2019-23. The Roadmap aims to bring together the strengths of Somali people, Federal government, State Ministries of Health, Regional health system, private health sector, UN agencies and development partners in a coherent manner to address the challenges and move towards achieving UHC.

This Roadmap is the result of analysis of the health and development situation; it was carried out by a UHC working group representing the federal ministry of health (MoH), state level ministries of health, WHO, UNICEF, UNFPA, civil society organizations (CSO) and donor community. Somali Health Policy was a major guiding document along with National Development Plans. In addition to individual meetings with stakeholders, four workshops were held in November 2018 for the preparation of the roadmap.

Despite challenges, the country currently has improved political, security, economic and social situation compared to the status a decade ago. High political commitment to health and generous financial support from the donor community has resulted in gradual improvement in access to health care and health outcomes. Somalia has shown some recent achievements in health with improving maternal and child health. However, still Somalia has one of the lowest UHC index (of only 22) in the world. The country is committed to augment the progress including taking responsibility for health and ensuring social security for those in need.

Key challenges to the health system include delayed demographic and epidemiological transition, limited health sector investment, challenges related to social determinants of health and changing behaviours and lifestyles, demand for better quality package of health care services, strengthening of health system and ensuring the country has the right competencies towards international health regulations. Based on identified challenges and considering national and international commitments, the UHC working group has prioritized maximizing efforts to achieving the health related Sustainable Development Goals (SDGs) by campaigning universal health and focusing on country-level impact through a 'multi-sectoral approach' to addressing health issues.

Considering the strategic priorities in the Somali Health Policy, the National Development Plan, the 2030 agenda for sustainable development, the 2017 Tokyo declaration of Global UHC Forum and the thirteenth General Programme of Work (GPW) endorsed in the World Health Assembly in May 2018, the Somali Roadmap towards UHC (2019-23) is structured around three strategic priorities to ensure healthy lives and well-being for all at all ages: 1) advancing universal health coverage, 2) addressing health emergencies and 3) promoting healthier populations.

The three strategic goals of the MoH and the roadmap for the period 2019-23 are:

1: **2.4 million** more Somali people will be benefitting from universal health coverage

2: **1.6 million** more Somali people will be better protected from health emergencies

3: **1.6 million** more Somali people will be enjoying better health and well-being

Strategic outcomes to achieve the goals were prioritized in a series of workshops and consultations in November 2018, with high level participation of stakeholders and are as following:

1.1: Improved access to quality essential health services

1.2: Reduced number of people suffering financial hardships

1.3: Improved availability of essential medicines, vaccines, diagnostics and devices for primary health care

2.1: Country health emergency preparedness and response to high threat infectious hazards strengthened

3.1: Determinants of health addressed leaving no one behind, reduced risk factors through multi-sectoral approaches and ensuring health and wellbeing through Health in all policies

Organizational outcomes of the Somali MoHs for the period will be:

A: Strengthened country capacity in data and innovations

B: Strengthened leadership, governance and advocacy for health

C: Improved financial, human, administrative resources management towards transparency, efficient use of resources and effective delivery of results

The strategic priorities will be supported by three strategic shifts, i.e. driving impact towards making progress on health related SDGs and UHC index; focusing on the delivery of updated essential package of health service based on global public goods; and stepping up leadership and effective coordination with all stakeholders in the sector.

While producing the Somali roadmap towards UHC, the UHC working group under the leadership of Director General (Health) - FRS, was able to demonstrate progress on the three strategic shifts, i.e.:

- Localization of the health related SDGs was completed at Somalia level by setting baselines, milestones and targets, along with identifying data needs and gaps. It was agreed that State level localization of the health related SDGs will be done around April 2020 - soon after availability of the Demographic Health Survey (DHS) results. At the same time, UHC index will be estimated for all states and regions to monitor progress on UHC.
- The UHC working group also completed that review of Somali EPHS based on Disease Control Priorities – 3 and prioritized interventions for future Somali EPHS in order to make progress on UHC. Further a plan of action was developed to update the Somali EPHS considering prioritized interventions.
- Preliminary discussions were held among the ministries of health on stepping up the leadership role of Somali health authorities and reactivate the health sector coordination mechanism at the start of the year 2019 along with regular activities related to Joint Annual Review (JAR) & Planning exercises and monitoring of the same.

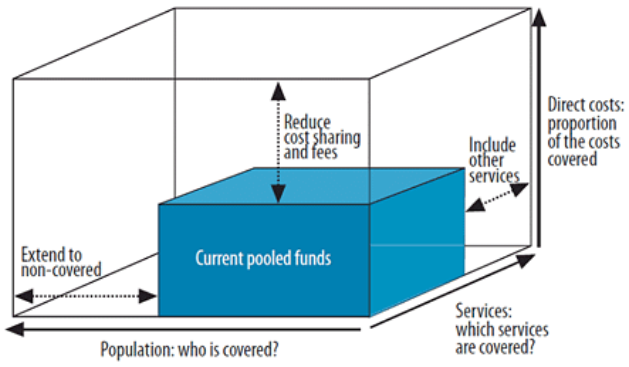
INTRODUCTION

As part of the 6th Tokyo International Conference on African Development (TICAD VI), African countries and international partners endorsed the Framework for Action for UHC in Africa1, which was reiterated at the Global Universal Health Coverage (UHC) Forum held in Tokyo in December 2017 ensuing Tokyo Declaration. The latter also stressed the need to build resilient health systems.

In the context of the above, the Government of Japan decided to enhance implementation of the Framework for Action for UHC in Africa and the related declarations. In an effort to enhance UHC for the Somali people and given the contextual similarities between the three neighbouring African countries; namely, Kenya, Somalia and Sudan, a seminar was held in April 2018 to share experiences and learn from the progress reached by these countries.

The April 2018 seminar became the starting point for the development of Somali roadmap towards UHC as the Somali health authorities made firm commitment to take strategic actions in the sector for speedy progress towards UHC, while considering other national and global commitments.

Universal Health Coverage (UHC) is based on the principle that all individuals and communities have equitable access to their needed health care, in good quality, without suffering financial hardship. A set of policy choices about benefits and their rationing are among the critical decisions in the reform of health financing systems towards universal coverage. Choices need to be made about proceeding along each of the three dimensions, in many combinations, in a way that best fits their objectives as well as the financial, organizational and political contexts. The three dimensions are: i) which services are covered and which needs to be included; ii) covered population and extension to non-covered; iii) reducing cost sharing and fees.



Three dimensions to consider when moving towards universal coverage

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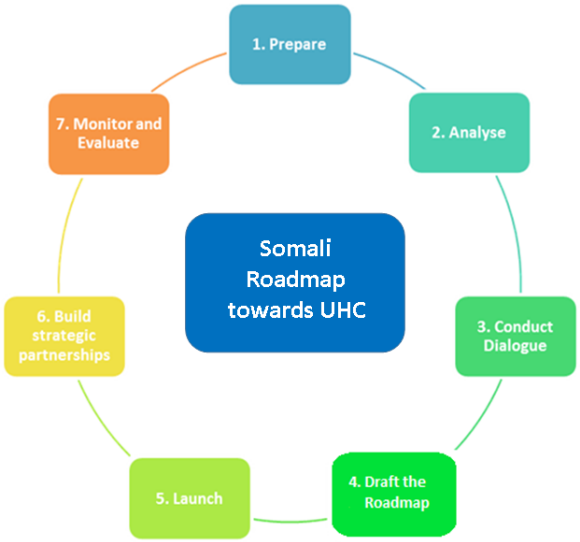
The 2030 Agenda for Sustainable Development has given impetus to Universal Health Coverage (UHC) as an overarching target to guide health systems transformations to achieve the health-specific and health-related Sustainable Development Goals (SDGs) targets.[2] Specifically, SDG 3.8 calls for achieving universal health coverage, through access to quality essential health care services for all including financial risk protection.

[1] http://www.who.int/health_financing/documents/uhc-africa-action-framework/en/

[2]: Kieny MP, Bekedam H, Dovlo D, Fitzgerald J, Jarno Habicht, Harrison G, et al. Strengthening health systems for universal health coverage and sustainable development. Bull World Health Organ 2017; 95:537–539.

Process

After the April 2014 seminar on UHC, the MoH decided to develop a roadmap towards UHC, with the support of Government of Japan, WHO and other partners. A UHC working group under the leadership of DG (Health) was formed to carry out preliminary analytical work, followed by the development of Somali roadmap towards UHC for the period 2019-23, through an inclusive consultative process.



Analytical work included contextual analysis, examination of the burden of disease (BOD) data for Somalia, review of health related SDGs indicators for Somalia and response of the Somali health system. In addition to identify key challenges in the health sector of Somalia, the analysis also helped the UHC working group to localize health related SDGs in the Somali context and to carry out a detailed review of Somali essential package of health services (EPHS 2009) based on the Disease Control Priorities-3 recommendations.[3,4]

In addition to individual meetings with stakeholders, a series of four workshops were organized to develop consensus, set baselines, milestones & targets and explore a set of strategic choices to define the roadmap towards UHC in Somalia.

Once there is consensus on the roadmap (2019-23), next steps would be the launching of the same, building strategic partnerships with all development agencies and partners and regular joint annual review and planning exercises under the leadership of Somali health authorities. An evaluation of the implementation of the roadmap in 2023, will lead to the development of next phase of UHC roadmap.

HEALTH AND DEVELOPMENT SITUATION

Political, Social and Macroeconomic Context

Somalia, officially the Federal Republic of Somalia (FRS), is a sovereign state with its territory located in the Horn of Africa, is bordered by Ethiopia to the west, Djibouti to the northwest, the Gulf of Aden to the north, the Guardafui Channel, Scotra island (Yemen) and Indian Ocean to the east, and Kenya to the southwest. Somalia has the longest coastline on Africa's mainland and its terrain consists mainly of plateaus, plains and highlands. Climatically, hot conditions prevail year-round, with periodic monsoon winds and irregular rainfall.

[3] University of Washington, DCP secretariat: http://dcp-3.org/
[4] Dean T Jamison, Ala Alwan*, Charles N Mock*, et al, Lancet 2018; Universal health coverage and inter-sectoral action for health: key messages from Disease Control Priorities, 3rd edition

Area wise, Somalia spans 637,657 square kilometres. Population of Somalia based on the Population Estimation Survey of Somalia (PESS) in 2014 was 12,325,508. Projected population in 2018 is approximately 14.1 million (including 300K refuges returned from Kenya in 2018) thus having a very low population density of 22.1 persons per square kilometres. Assuming the current population growth rate of 2.9 percent, it is expected that population of Somalia will increase to 15.8 million in 2023 and more than 19.8 million in 2030.

According to the PESS results, 42.6 percent of people live in urban areas, 22.5 percent in rural areas, 25.9 percent are nomadic while 9 percent are internally displaced people (IDP). Urbanization is increasing rapidly with complex migration and in migration.

Politically, Somalia is a federal parliamentary representative democratic republic government with President as the head of state. Prime Minister is the head of the government appointed by the president with consent of parliament. Somaliland is located in north-west while Puntland is located in the north-east. States in the Southern areas are Galmudug, Hirshabelle, South-West and Jubaland. Banadir is the capital region with Mogadishu as the capital city. Under the state, administrative areas are called regions where local government system is working and is more mature in north where there is more peace and stability. The state is running its business through a provisional constitution agreed in 2012, while review for a new constitution is in process by the parliament.

Somalis constitute the largest ethnic group in Somalia, at approximately 85 percent of the nation's inhabitants. They are organized into clan groupings, which are important social units; clan membership plays a central part in Somali culture and politics. Clan-families, once functionally unimportant, became increasingly significant as political rallying points.. Somalia has often been referred to as a "Nation of Poets" and a "Nation of Bards" and have a story-telling tradition. Somalis also have a rich musical heritage centred on traditional Somali folklore.

Somalia is among the least developed countries in the world with a GDP of US$ 7.3 billion in 2017, GDP per capita at US$ 499 and a poverty headcount rate of more than 51 percent in 2016. The economy is highly dependent on imports which account for 2/3rd

of the GDP, mainly financed by remittances and international aid. Seventy percent of Somalis engaged in agro-pastoralism, pastoralism, agriculture and charcoal production.

Over the last two and half decade, internal and external conflict continued, which negatively affected already weak health system in the country, negligible public sector allocation of resources for the social/ health sector, and more difficulties for the partner organizations to implement programmes that support the health sector. The Somali authorities have placed a particular emphasis on security, reconciliation and trust building.

The security gains over the past years are real but remain incomplete and reversible. Significant areas of the country especially Central South remains under the influence of terrorist groups and areas recovered from the insurgency are especially volatile. The authorities being aware of the risk, are in process of establishing several policy frameworks and legislations to help the stabilization process. However, the government structures lack capacity to pursue reconciliation, guarantee basic services, security and justice for the population. The risk of internal & clan conflict also persists.

Health Status

Somalia has made some positive strides over recent years in the social development and in the health of its people – but not all citizens have been able to benefit. The very low level of human development, coupled with other politico-economic and security challenges over last more than two & half decades has resulted in a very weak health system with a number of parallel and fragmented systems, health care structures and crises of health workforce.

The task is further challenging, particularly for those who are poor or vulnerable, women and children, youth, persons with disabilities, people living with diseases, older people, refugees, internally displaced persons and migrants.

Somalia is at the start of epidemiological and demographic transitions. Burden of the communicable, maternal, child and nutritional group, which was more than 72.1 percent (59,416 DALYs lost per 100,000 population) of the total burden of diseases in the year 2000, has gradually gone down to 62.3 percent (36,358 DALYs lost per 100,000 population) in 2017.

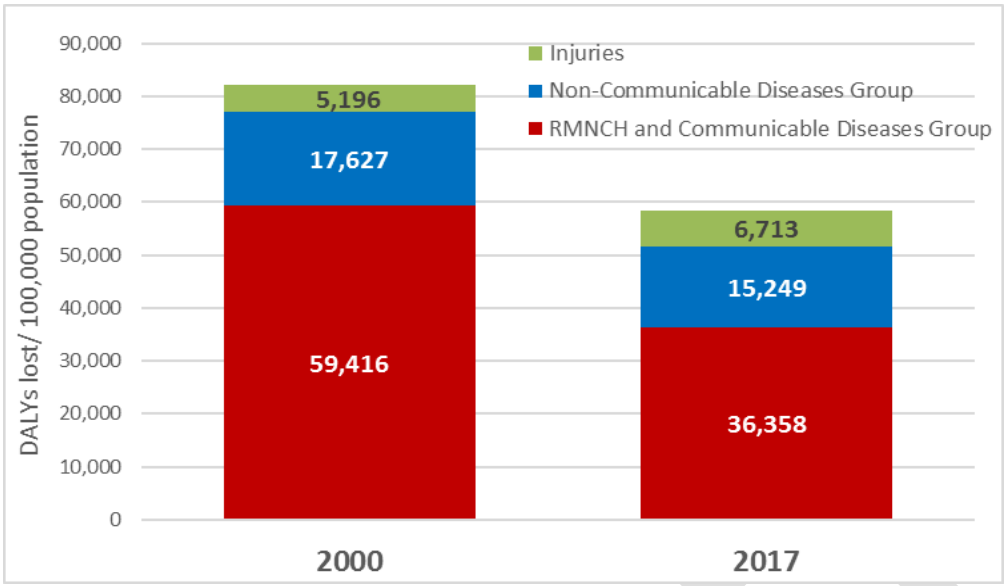
The burden of non-communicable disease group which was 21.5 percent (17,627 DALYs lost per 100,000 population) of the total burden in the year 2000, is having a share of 26.1 percent (15,249 DALYs lost per 100,000 population) in 2017. Note that DALYs lost rate for non-communicable diseases is comparatively less compared to other countries mainly because of low life expectancy whereas burden of non-communicable diseases is more with rising age.

The share of burden of injuries increased from 6.33 percent (5,196 DALYs lost per 100,000 population) to 11.5 percent (6,713 DALYs lost per 100,000 population) over the same period.[5] Major factor for increase in the burden of injuries is not only continued conflict but also increasing burden of road traffic injuries.

The following graph summarizes the changing pattern of the BOD in Somalia from the year 2000 to 2017.

[5] Institute of Health Metrics & Evaluation, 1990-2017; BOD data for Somalia: https://vizhub.healthdata.org/gbd-compare/

Figure 1: Trend in Burden of Disease Rate (DALYs lost/ 100,000 people) in Somalia[5]



There appears to be some improvement in the health status of Somali people. However, when total population is taken into account, the total BOD for Somalia which was 9.99 million DALYs lost in the year 2000 has only reached to a level of 9.85 million DALYs lost in the year 2017, with no significant change in the total burden.

In 2017, the ten top diseases with the highest burden and by cause of death are shown below along with top ten risk factors.

Table 1: Top Ten Health Challenges in Somalia (2017)[5]

Burden of Disease	Cause of Death	Risk
1: Other infectious diseases	1: Respiratory infections & TB	1: Malnutrition
2: Respiratory infections & TB	2: Other infectious diseases	2: Unsafe water & sanitation
3: Maternal and Neonatal	3: Cardiovascular diseases	3: Air pollution
4: Enteric infections	4: Maternal & Neonatal	4: Dietary risks
5: Self harm & violence	5: Enteric infections	5: High systolic BP
6: Cardiovascular diseases	6: Neoplasms	6: High fasting plasma glucose
7: Nutritional deficiencies	7: Self harm & violence	7: Tobacco
8: Other non-communicable	8: Transport injuries	8: Occupational risks
9: HIV&AIDS and STIs	9: HIV&AIDS and STIs	9: Unsafe sex
10: Neoplasms	10: Digestive diseases	10: High body mass index

In 2017, the death rate in Somalia was estimated to be 8.62 deaths per 1,000 population (approximately 145,000 deaths) and 56.2 percent of all deaths were because of RMNCH and communicable diseases group while non-communicable diseases group contributed to 31.9 percent of total deaths and the share of injuries was 11.9 percent.[5]

While death rate in Somali has declined significantly in recent years, the birth rate continues to be very high at around 37-40 per 1,000 population leading to very high population growth rate of 2.9

percent[6]. Life expectancy at birth for both sexes is still very low but has improved gradually to a level of 58.5 years (56.5 years for males and 60.6 years for females) in 2017.[5]

Good health is the foundation of sustainable development. Diseases, high rates of deaths and illnesses hold back well-being and productivity. Somalia's health indicators are improving but the pace of improvement is very slow compared to many developing countries.

Table 2: Trend in Maternal and Child Mortality in Somalia

Indicator	2000	2005	2010	2015
Maternal Mortality Ratio (per 100,000 live birth)	1080	939	820	732
Neonatal Mortality Rate (per 1,000 live birth)	44.5	45.3	43	39.7
Infant Mortality Rate (per 1,000 live births)	105.3	105.3	97.8	85
Under five Mortality Rate (per 1,000 live births)	174	174	160	137

Source: United Nations Interagency (UNICEF, WHO, UNFPA and WB) Estimates for Somalia

A summary of current status of health specific SDG (3) indicators and other health related SDG indicators is shown below for Somalia along with 2030 targets.

Table 3: Baseline and Targets for health SDGs in Somalia[7]

SDG Indicators	Baseline		Data sources	Target 2030	
	2000	2015		Somalia	Global
SDG – 3 Indicators					
3.1.1 Maternal Mortality Ratio (per 100,000 live births)	1080	732	UNIA data	450	<70
3.1.2 Skilled Birth Attendance (%)	NA	33	NDP/ HMIS	55	>90
3.2.1 Under Five Mortality Rate (per 1,000 live births)	174	137	UNIA data	70	<25
3.2.2 Neonatal Mortality Rate (per 1,000 live births)	44.5	40	UNIA data	25	<12
3.3.1 HIV Incidence among adults (per 1,000 uninfected population)	0.3	0.48	UNAIDS WHO	<0.5	≤0.01

[6] World Bank, 2017; https://data.worldbank.org/country/somalia

[7] Following data sources (in addition to consultations) were used to develop the matrix:

1. Somalia National Development Plan 2017-19; Somali Health Policy, Strategic Plans of TB, HIV&AIDS and Malaria, Human Resources for Health Assessment & Policy
2. Multiple Indicator Cluster Surveys, 2006, 2011; Maternal mortality study for Somaliland, 2016 HIV Sentinel Surveillance; 2014 First Malaria Indicator survey of Somali population
3. UNICEF, 2017; JHNP End of Programme Report and HMIS data of Somalia
4. Aid coordination unit, Office of the Prime Minister, 2017; Aid Flows in Somalia; OECD data base for ODA- https://data.oecd.org/oda/net-oda.htm
5. UN (UNICEF, WHO, UNFPA and WB) Interagency estimates for maternal mortality, child mortality and neonatal mortality
6. World Bank and WHO, 2017; Tracking Universal Health Coverage: 2017 Global Monitoring Report
7. WHO, 2016,2017 and 2018; Monitoring Health for the SDGs – World Health Statistics
8. WHO, 2018; Global Health Expenditure Database: http://apps.who.int/nha/database
9. WHO, 2018; Global Information System on Alcohol and Health: http://www.who.int/substance_abuse/activities/gisah/en/
10. World Bank database: https://data.worldbank.org/
11. WHO, Global Burden of Disease estimates 2000-2015: http://www.who.int/healthinfo/global_burden_disease/estimates_country_2000_2015/en/
12. Institute of Health Matrices and Evaluations, 2018; https://vizhub.healthdata.org/gbd-compare/
13. WHO, 2017; IHR Joint External Evaluation (JEE)
14. UNFPA, 2014; Population Estimation Study for Somalia (PESS)

3.3.2 TB Incidence (per 100,000 population)	285	274	WHO	<230	≤54
3.3.3 Malaria Incidence (per 1,000 population at risk)	110	85.5	WHO	<55	<1
3.3.4 Hepatitis B surface antigen (HBsAg) prevalence among children under 5 years old (%)	NA	10.54	WHO	<5	<1
3.3.5 Number of people requiring interventions against neglected tropical diseases	NA	5,016	WHO	<3,000	<1
3.4.1 Probability of dying from cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and 70 (%)	NA	20.2	WHO Global Health Estimates	<20	17
3.4.2 Suicide mortality rate (per 100,000 population)	NA	5.4	WHO Global Health Estimates	<5	≤1
3.5.1 Total alcohol per capita (≥ 15 years of age) consumption (litres of pure alcohol) (%)	NA	0.5	WHO GISAH	0.4	Nil
3.6.1 Road traffic mortality rate (per 100 000 population)	NA	25.4	Global Health Estimates	24	8
3.7.1 Proportion of eligible couples who have their need for family planning satisfied with modern methods (%)	NA	45	WHO/ WB	60	>95
3.7.2 Adolescent birth rate (per 1,000 women aged 15–19 years)	NA	64	WHO	55	≤10
3.8.1 Universal Health Coverage Index (%)	NA	22	WHO/ WB	40	>80
3.8.2 Incidence of catastrophic expenditure (%) at 10% of household total consumption or income	NA	NA	NA	TBD	TBD
3.9.1 Age-standardized mortality rate attributed to household and ambient air pollution (per 100 000 population)	NA	212.8	WHO Global Health Observatory	<200	TBD
3.9.2 Mortality rate attributed to exposure to unsafe WASH services (per 100 000 population)	NA	86.6	WHO, Global Assessment environmental risks	50	TBD
3.9.3 Mortality rate attributed to unintentional poisoning (per 100 000 population)	NA	4.6	Global Health Estimates	3.9	TBD
3.a Age-standardized prevalence of tobacco smoking among persons 15 years and older (%)	NA	NA	WHO	<1	TBD
3.b.1 Measles Vaccine 2 Immunization coverage (%)	-	0	WHO	80	>95
3.b.2 Total net official development assistance to medical research and basic health sectors per capita (US$)	NA	3.52	WHO	TBD	TBD

3.b.3 Proportion of health facilities with essential medicines (%)	NA	NA	NA	>80	100
3.c Skilled health professionals density (per 1,000 population)	NA	0.34	HRH Policy	4.45	>4.45
3.d.1 IHR Index (13 core competencies) (%)	NA	6	WHO-JEE	35	100
Other Health related SDG indicators					
1.a.2 General government health expenditure as % of general government expenditure	-	<1	Global Health Expenditure database	7.5	>7.5
2.2.1 Prevalence of stunting among children < 5 years of age (%)	-	25.3	WHO	<15	TBD
2.2.2 Prevalence of wasting in children < 5 years of age (%)	-	15	WHO	<7	TBD
6.1.1 Proportion of population using improved drinking-water sources (%)	-	NA	NA	60	100
6.2.1 Proportion of population using safely managed sanitation (%)	-	15	WHO	35	100
7.1.2 Proportion of population with primary reliance on clean fuels (%)	-	<5	WHO	20	>95
11.6.2 Annual mean levels of fine particulate matter ($PM_{2.5}$) in urban areas (µg/m**3**)	-	28	Global Assessment	<25	TBD
13.1.1 Average death rate due to natural disasters (per 100,000 population)	-	0.3	Global Health Estimates	<0.3	TBD
16.1.1 Mortality rate due to homicide (per 100,000 population)	-	5.6	Global Health Estimates	<5	TBD
16.1.2 Estimated deaths from major conflicts (per 100,000 population)	-	6th ranked	WHO	Nil	Nil
17.19.2 Completeness (%) of cause-of-death data	-	NA	Global Health Estimates	TBD	TBD

Health System Response

Somalia's public health delivery system functions as an integrated health complex that is administratively managed at the regional level with backstopping from the state ministry. The state attempts to provide healthcare through a three-tiered healthcare delivery system (with some variation among the states) and a range of public health interventions.

The former includes Health Centre/ MCH centre and Referral Health Centre (RHC – with some indoor services), forming the core of the primary healthcare structure. Secondary care including acute, ambulatory and inpatient care is provided through Regional Hospitals, while partial tertiary care is provided by teaching hospitals located only in big cities and most of the patients have no other choice but to visit other countries to access services.

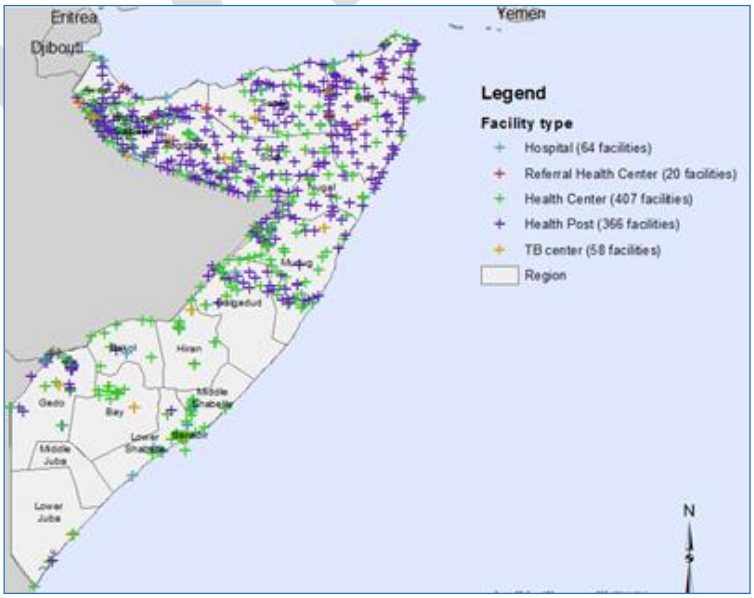
There are also Primary Health Unit/ Health Post, which are community level static health facility with only one staff, mostly selling medicines to the community. A more proper model of community

based female health worker (*Marwo Caafimaad*) is being implemented in selected districts, with proper training and supervision system.

The 2016 Service Availability and Readiness Assessment (SARA) of the Somali health sector was conducted by WHO, as a census of 1074 health facilities identified for inclusion in the survey. Of the 1074 facilities, 106 facilities were found to be non-operational and 169 were non-accessible.

Table 4: Number and Types of health facilities in Somalia[8]

	Total number of facilities	Number of non-operational facilities	Number of operational facilities
Somaliland	305	23	282
Hospital	18	2	16
Referral health centre	4	1	3
Health centre	113	1	112
Health post	153	19	134
TB centre	17	0	17
Puntland	247	19	228
Hospital	10	1	9
Referral health centre	6	0	6
Health centre	79	1	78
Health post	141	17	124
TB centre	11	0	11
South Central	522	64	289
Hospital	53	3	33
Referral health centre	0	0	0
Health centre	309	22	193
Health post	116	36	36
TB centre	44	3	27



[8] WHO, 2016; Service Availability and Readiness Assessment (SARA)

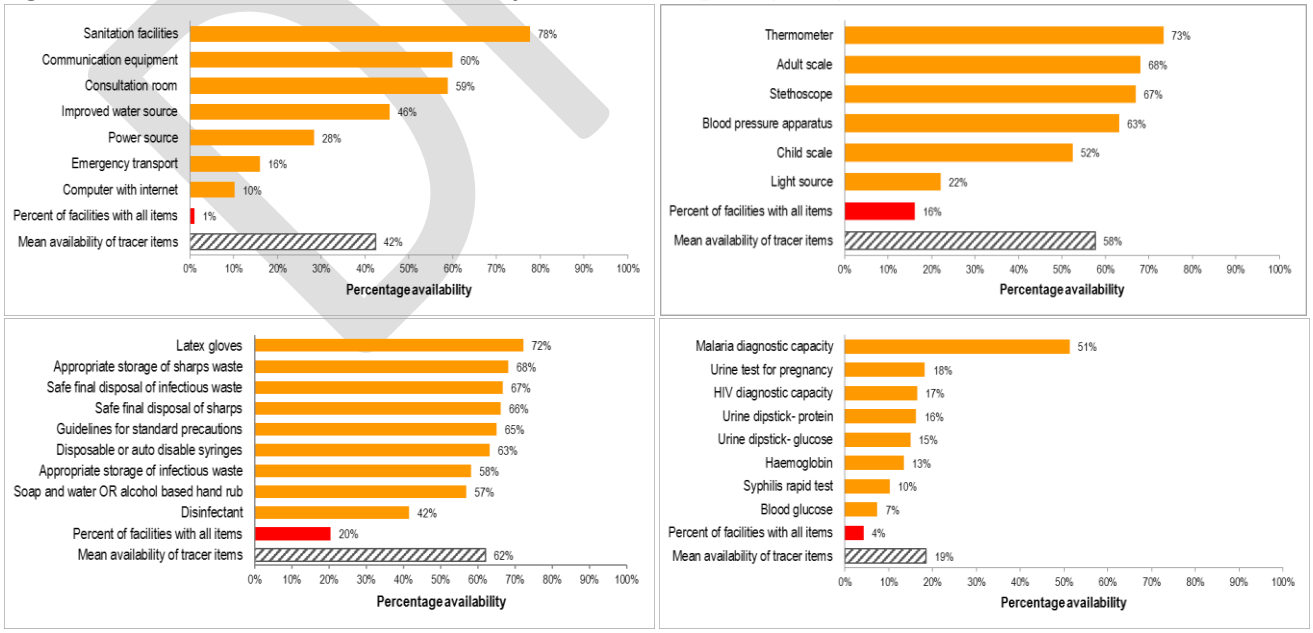
There is less than 1 health facility per 10,000 population (0.76 facilities per 10,000 population) which indicates the country is only 38 percent of achieving the facility density target[9] and is much less in the central south area. A national inpatient bed density of 5.34 indicates the country is 21 percent of achieving the inpatient bed density target[10]. Similarly, the national maternity bed density of 2.55 indicates that the country is 25 percent of achieving the maternity bed density target[11]. Results from the health workforce domain show that nationally there are 4.28 core health workers per 10,000 population indicating that the country is 19 percent of achieving the health workforce density target[12]. In looking at the last domain, health service utilization, indicators demonstrate poor availability and access to health services in Somalia. Nationally, Somalia is 5 percent of achieving the outpatients visit target and 8 percent of achieving the hospital discharge target. When examining the areas of infrastructure, health workforce, and service utilization together, the overall General Service Availability index shows that on average, the country is only 18 percent of the way towards achieving the General Service Availability target.

In the 2016 assessment, a total of 4.28 core health workers per 10,000 population was estimated. Puntland had the highest health workforce density at 5.02, compared to 4.38 per 10,000 population in Somaliland and 4.03 per 10,000 population in South Central. On average, facilities were 19% of the way towards achieving the health workforce density target in the country.

Non-physician clinicians/paramedical professionals represent the largest number of health workers in the country, followed by nursing professionals and community health workers. There were 723 generalist medical doctors in the country while among 148 specialist doctors, a total of 81 obstetricians, 53 anaesthetists, and 46 paediatricians were counted in the country.

The following graphs indicate the readiness of health facilities for provision of health services.

Figure 2: Readiness of health facilities for provision of services (2016)



[9] Facility density target of two health facilities per 10,000 population
[10] Bed density target of 18-25 inpatient beds per 10,000 population
[11] Maternity bed density target of 10 maternity beds per 1,000 pregnant women
[12] Health workforce density target of 23 core health workers per 10,000 population and 45.5 essential health workers per 10,000 population

Figure 3: Status of provision of health services offered (2016)

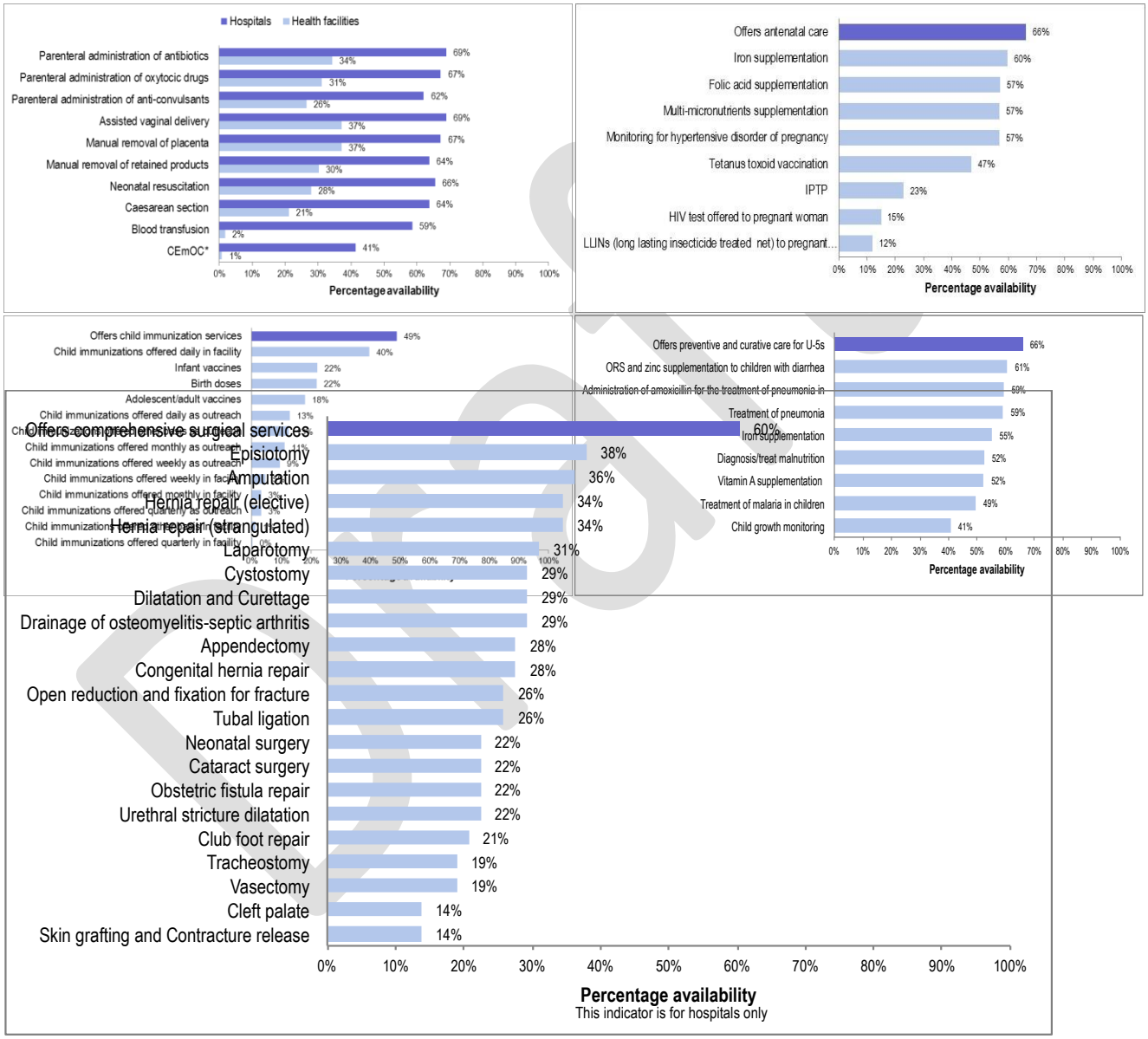


Figure 4: Surgical services offered in Hospitals (2016)

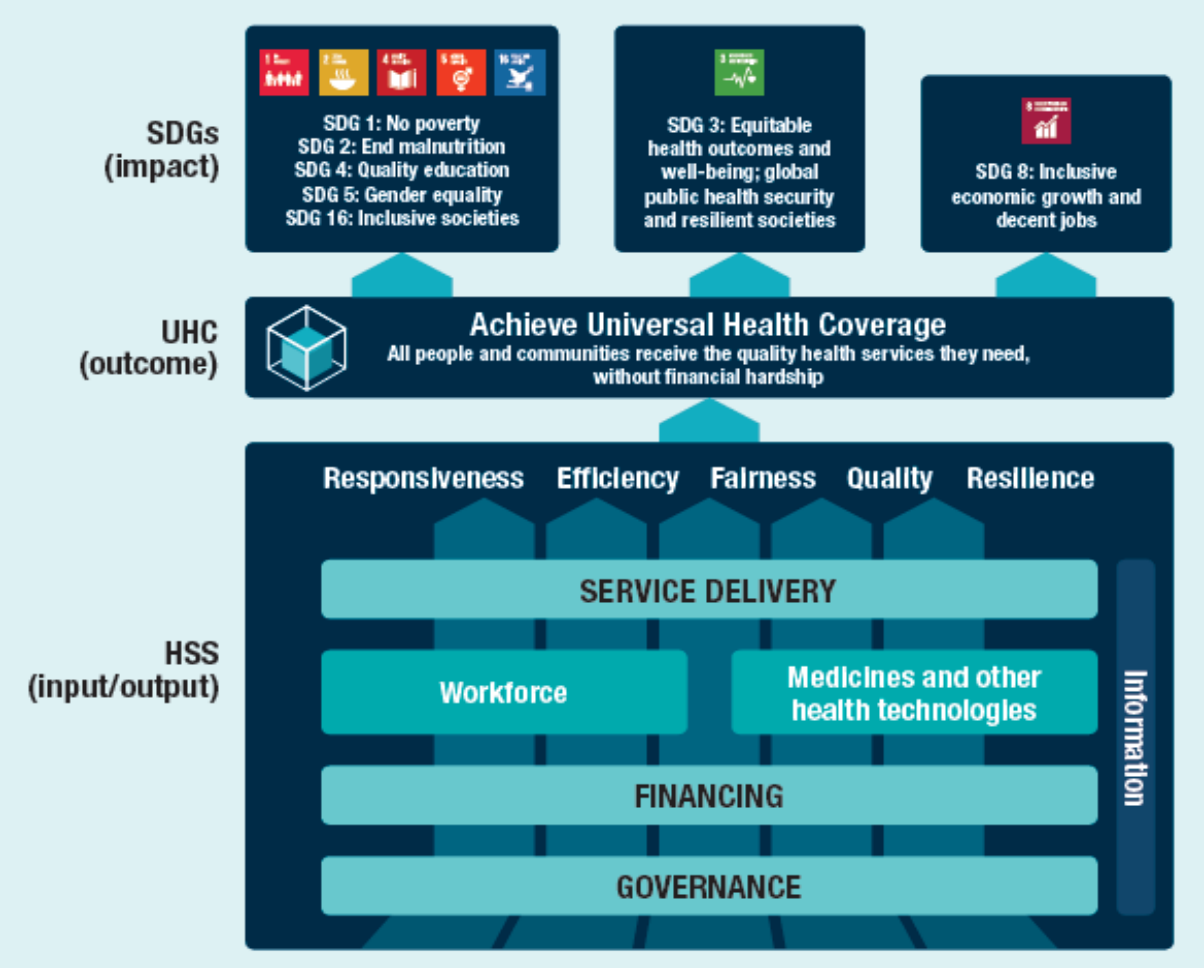
In addition to public sector, there is growing private sector (hospitals, clinics and laboratories) mainly in major cities in addition to a complex network of pharmacies (mostly un-qualified) in all parts of the country. No reliable information is available on the expanse of private sector.

UNIVERSAL HEALTH COVERAGE

Universal health coverage means that all people – irrespective of their living standards - receive the health services they need, including public health services designed to promote better health, prevent illness, and to provide treatment, rehabilitation and palliative care of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship. [13]

Theory of Change

To achieve longer and healthier life expectancy, the health system strengthening (HSS) actions should lead to incremental advancement towards UHC i.e. more and more people and communities receiving the quality essential health services they need, without any financial hardship. Progress on UHC will contribute to SDGs through equitable health outcomes & wellbeing and global public health security and resilient societies.



The UHC service coverage is measured through UHC index, which is a single indicator that is computed based on tracer indicators to monitor coverage of essential health services. Coverage of

[13] WHO and WB, 2017; Tracking Universal Health Coverage: 2017 Global Monitoring Report

essential health services is defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population.

Figure 5: SDG 3.8.1 - Four tracer areas and sixteen tracer indicators to measure UHC index in Somalia (Baseline in 2017)

TRACER AREA	TRACER INDICATOR	Value	Area Score
RMNCH	Family Planning demand satisfied with modern method (%)	45	19.59
	Antenatal Care – 4+ visits (%)	6	
	Child immunization (Penta 3) (%)	42	
	Care-seeking behaviour for child pneumonia (%)	13	
Communicable Diseases	Tuberculosis effective treatment (%)	40	19.59
	HIV treatment (%)	10	
	Insecticide-treated nets for malaria prevention (%)	23	
	At least basic sanitation (%)	16	
Non-communicable Diseases	Normal blood pressure (%)	((67–50)/(100–50))*100 = 34	62.38
	Normal blood sugar / HbAIC (%)	((7.1–5.17)/(7.1–5.1))*100 =96.5	
	Cervical cancer screening among women 30-49 years (%)	NA	
	Tobacco non-smoking (%)	((87–50)/(100–50))*100 =74	
Services Access & Capacity	Hospital beds per 10,000 population against threshold (%)	(8.7/18)*100 = 48.33	9.22
	(Physicians*Psychiatrist*Surgeon) density against threshold (%) (5.56*5*0.71)	((0.05/0.9*100)* (0.05/1*100) * (0.1/14*100))$^{1/3}$ = 2.7	
	Availability of essential medicines in PHC (%)	NA	
	International Health Regulations core capacity index (%)	6	

UHC Index: 22

SDG 3.8.2 captures the financial protection dimension of UHC (use of health services should not lead to financial hardship)

Cost to Deliver UHC

According to one estimate, the requirement for achieving Universal Health Coverage (UHC) is of US$271 per person per year (range 74–984) across country contexts.[14] Somali is very far away even from reaching the lower limit of US$ 74 per capita per year, with a current per capita total health expenditure (THE) of around US$21-24 including US$8-10 as OOP expenditure and only US$13-15 through public sector which is also mainly through budgetary donor support.

[14] Karin Stenberg, Odd Hanssen, Tessa Tan-Torres Edejer et el, Lancet Global Health 2017; Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries

SOMALI ROADMAP TOWARDS UHC (2019-23)

The 'Somali Roadmap towards UHC' sets out the prioritized strategic HSS actions to transform the health sector of Somalia by addressing the challenges, introducing health sector reforms and thus improving the access to essential UHC services to the Somali people. This 'Roadmap' will augment and build upon current health sectoral and sub-sectoral strategies and plans in the country and will support the implementation of critical aspects of SDGs, UHC and International Health Regulations (IHR) agenda in the country.

In addition to consultations with stakeholders, the following key strategic documents were used in the process to develop the roadmap:

1: Somali Health Policy – The Way Forward (2014)
2: National Development Plan/s
3: 13th General Programme of Work – World Health Assembly (2018)
4: Strategic priorities of UN organizations and Development partners
5: Health related SDGs and UHC framework
6: Other National and Sub-national strategic plans

Vision[15]

'The Somali people enjoy the highest attainable standard of health and quality of life and have universal and equitable access to essential quality health services with a priority focus on maternal, neonatal and child health and nutrition, and on the prevention and control of high burden diseases and related risk factors.'

Mission

Promote health – Keep Somalia and the world safe – serve the vulnerable

Overall Goal

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

Core Principles and Values

The following principles and values underpin the priority directions:

- Universal and equitable access to acceptable, affordable, cost-effective, and quality health services with maximum impact on Somali populations' health to ensure the realization of the right to health

[15] Ministry of Health, 2014; Somali Health Policy – The Way Forward

- Protecting especially the poorest people from catastrophic health expenditures
- Effective, transparent and accountable governance and leadership in managing the different components of the health system with decentralized management of health care service delivery
- Building effective collaborative partnerships and coordination mechanisms engaging local community, national and international stakeholders and pursuing the aid effectiveness approaches.

Strategic Priorities and Goals (for the period 2019-23)

1: Advancing universal health coverage

Somali Goal: 2.4 million more people benefitting from UHC

2: Addressing health emergencies and disease out-breaks

Somali Goal: 1.6 million more people protected from health emergencies

3: Promoting healthier populations

Somali Goal: 1.6 million more people enjoying better health and well-being

Organizational (MoH) Goal: More effective & efficient public health sector

Strategic Outcomes (for the period 2019-23)

The strategic outcomes will ensure implementation of key HSS actions but through health sector reforms will also provide a strong foundation for the next roadmap for speedy progress on health outcomes and UHC index.

1.1: Improved access to quality essential health services

1.2: Reduced number of people suffering financial hardships

1.3: Improved availability of essential medicines, vaccines, diagnostics and devices for PHC

2.1: Health emergency preparedness strengthened and Emergence of high-threat infectious hazards prevented, detected and responded

3.1: Determinants of health addressed leaving no one behind, reduced risks through multi-sectoral approaches and ensuring health in all policies

Organizational Outcomes (for the period 2019-23)

To deliver the strategic outcomes, it is critical that the Ministries of Health and health care delivery system has the right capacities and systems to deliver the results.

A. Strengthened country capacity in data and innovations
B. Strengthened leadership, governance and advocacy for health
C. Improved financial, human, administrative resources management towards transparency, efficient use of resources and effective delivery of results

Outcome 1.1: Improved access to quality essential health services

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Somalia has the lowest UHC index (22) in the world.[13] Review of EPHS based on Disease Control Priorities-3 (DCP3)[16] indicates that overall only 45 (20.5 percent) of the 219 globally recommended essential universal health coverage (EUHC) interventions are being implemented, while Somali EPHS (2009) has only 14 (6.4 percent) of the 219 globally recommended essential health services Somali EPHS (2009) does not have all five platforms for essential services i.e.** ▪ **Community level** ▪ **Health centre** ▪ **First-level hospital** ▪ **Referral hospital and** ▪ **Population based** **Proper community and population platforms are missing; further there is no clear strategic direction on inter-sectoral interventions and people centred service delivery approaches**	1 MoH will revise the EPHS through an inclusive consultative process and with support of development partners. In addition to considering Somali BOD and local health needs, the prioritized interventions under all five platforms of EUHC / DCP3 will be included in EPHS framework, followed by revision of HSS interventions and quality standards with costing exercise. A plan to start early inter-sectoral interventions will also be included in the new EPHS framework for implementation 2 To ensure provision of essential health services at the door-step of community, gaps in the current *'Marwo Caafimaad'* programme will be filled, along with geographical expansion to a reasonable level to generate evidence on its effectiveness in the Somali context 3 Selected inter-sectoral interventions (e.g.	**Impact Level Targets** i. (3.8.1) UHC Index for the country improves from a baseline of 22 percent in 2017 to 33 percent in 2023 (disaggregation by states and regions) ii. (3.1.1) Maternal mortality ratio (per 1,000 live births) reduces from 732 in 2014-15 to 585 in 2023 iii. (3.1.2) Skilled birth attendance improves from 33 percent in 2015 to 44 percent in 2023 (disaggregation by states, regions and wealth quintile) iv. (3.2.1) Under Five Mortality Rate (per 1,000 live births) reduces from 137 in 2014-15 to 100 in 2023 (disaggregation by states, gender) v. (3.2.2) Neonatal Mortality Rate (per 1,000 live births) reduces from 40 in 2014-15 to 31 in 2023

[16] WHO, Nov 2018; Review of Somali EPHS based on Disease Control Priorities-3

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
	introduction of ear-marked 'Sin tax' on khat, fizzy drinks and automobiles with right hand drive etc.) will be explored and advocated for implementation 4 MoH will strengthen strategic partnerships with development partners to scale up the scope of essential services based on revised EPHS soon after revision of EPHS framework 5 'Family practice approach' will be piloted in selected urban districts for provision of essential health services both through the public and private (general practitioners) sector	vi. (3.3.1) HIV Incidence among adults (per 1,000 uninfected population) is controlled at <0.5 vii. (3.3.2) TB Incidence (per 100,000 population) reduces from 274 in 2014-15 to 260 in 2023 viii. (3.3.3) Malaria Incidence (per 1,000 population at risk) reduces from 85.5 in 2014-15 to less than 70 in 2023 ((disaggregation by state and region) ix. (3.3.4) Hepatitis B incidence (per 100,000 population) reduces from 10.5 in 2014-15 to 9 in 2023 (disaggregation by state) x. (3.4.1) Probability of dying from cardiovascular disease, cancer, diabetes, chronic respiratory disease between age 30 and 70 years is maintained at 20.2 percent by 2023 **Coverage/ Process Level Targets** xi. (3.7.1) Proportion of eligible couples who have their need for family planning satisfied with modern methods improves from 45 percent in 2017 to 51 percent in 2023 (disaggregation by state and regions) xii. (3.7.2) Adolescent birth rate (per 1,000 women
▪ **With expansion of scope of EPHS aligned to EUHC, human resources for health may not have the right capacities and skills**	6 Somali HRH Policy and Plans will be reviewed, updated and implemented considering changing context; task shifting will be a priority strategy	
▪ **Burden of disease pattern in Somalia is changing for which disease prevention and control measures needs to be adjusted with changing health technologies and services**	7 Revised EPHS will be comprehensive considering changing disease burden and will prioritize some interventions for prevention of disease which are likely to increase in future	

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Readiness for EPHS were assessed in 2016 but no corrective steps were taken; readiness and quality standards needs to be revised considering changing context**	8 Revised EPHS will redefine standards for different service delivery and system components. Standards will be realistic considering Somali context and may vary for stable and conflict affected areas	aged 15–19 years) reduces from 64 percent in 2014-15 to 61 percent in 2023 (disaggregation by regions) xiii. (3.a) Age-standardized prevalence of tobacco smoking among persons ≥15 years is kept low
▪ **Humanitarian and development interventions overlap with each other with no nexus between the two approaches. Service delivery is very fragmented.**	9 Mechanism for nexus between development and humanitarian funding for health will be developed to avoid duplication of activities and efficient use of available resources. Joint annual review (JAR) and Planning activities will be reactivated	xiv. (3.b.1 and 3.8.1) DPT3/Penta3 Immunization coverage improves from 42 percent in 2014-15 to more than 62 percent in 2023 (disaggregation by state, region, gender) xv. (3.b.1) Measles vaccine 2 introduced in routine immunization in all states by 2023 xvi. (3.b.3) Proportion of primary healthcare facilities with essential medicines improves to more than 45 percent in 2023 (disaggregation by states and regions) xvii. (3.c) Skilled health professionals' density (per 10,000 population) increases from 3.4 in 2015 to 15 in 2023 (disaggregation by states and gender) xviii. (3.d.1) IHR Index (13 core competencies) improves from 6 percent in 2016 to 15 in 2023

Outcome 1.2: Reduced number of people suffering financial hardships

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Very high poverty level in Somalia is also reflected in the estimated out-of-pocket (OOP) expenditure in Somalia, which is surprisingly very low at 38 percent[17] (inability to pay). Many specialized services are not available in the country and people are dependent on financial support from Somali diaspora or other means which lead to catastrophic health expenditure. Alternatively, most of the poor people have no option but to access services from private sector pharmacies which don't have qualified staff**	1 MoH will develop 'Health Financing Strategy' through consultative process 2 Option for piloting health insurance programme in 1-2 refugee settlements will be explored	i. EPHS services are offered without any user charges ii. Pilot testing of Health Insurance Programme is launched by 2023 iii. OOP expenditure does not increase by 2023 iv. More than 65 percent of the population have access to free essential UHC package in 2023
▪ **There is hardly any fiscal space in the public sector to reasonably fund social sector including health (public health expenditure is <1percent of total health expenditure)**	3 Evidence generation and advocacy will be ensured on innovative health financing strategies e.g. Ear-marked Sin Tax on Khat for health	
▪ **Major support in health sector is from development partners and the same is mostly fragmented with poor coherence and**	4 With development partners support, all essential health services will be free of cost, with minimum and regulated user charges on	

[17] Financing Global Health Database, 2017; Data for Somalia

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
coordination	non-essential health services 5 Non-OECD donors from Gulf countries etc. and Somali diaspora will be encouraged to invest in hospitals for which there is huge catastrophic health expenditure especially for the poor 6 Coordination mechanisms with all partners will be strengthened under the leadership of Ministry of Health and Human Services of Federal Government of Somalia and ensuring mutual accountability 7 Social marketing and social franchising intervention will be carefully scaled up for health commodities after a review	
▪ **There are mechanisms for purchasing of services but collection and pooling mechanisms are not properly defined along with high corruption risks**	8 Government will prioritize the payment of salaries to public sector health staff through government channels (ministry of finance); Financial monitoring systems will be strengthened through reforms and third party monitoring 9 Results based contracting of EPHS with third party monitoring mechanism will be explored to ensure more value for money and better delivery of services	

Outcome 1.3: Improved availability of essential medicines, vaccines, diagnostics and devices for primary health care

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Availability of low quality and spurious drugs and technologies in the private sector as a result of poor availability of quality standards in drugs regulation, pharmaceutical and health technology services**	1 With support of development partners, MoH will strengthen and ensure quality standards in drugs regulation, pharmaceutical and health technology services 2 In to the Essential Medicine Policy, Ministry of Health will establish National Pharmacy Regulatory Board (PRB) those will be the central point for pharmaceutical regulatory control following the national drug regulatory act (drafted) 3 Linkages with other countries will be promoted on transfer of health technologies to Somalia	i. (3.b.3) Proportion of primary healthcare facilities with essential medicines improves to more than 45 percent in 2023 (disaggregation by states and regions) ii. Introduction of HPV vaccine with coverage among adolescent increases to 57 percent in 2023 iii. Updated approved list of essential medicines and essential equipment based on revised EPHS for all five platforms available in 2020
▪ **Self-prescription and over use of medicines leading to drug resistance and waste of resources**	4 Action plan will be developed for tackling antimicrobial resistance 5 Capacity building would be a regular activity for promoting rational prescribing, dispensing	

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
	and use of medicines and technologies	
▪ **Timely and uninterrupted supply of medicines, vaccines, commodities and other supplies to EPHS health facilities**	6 Through UN agencies and other partners, availability, affordability of medicines and other health technologies will be ensured for EPHS through efficient procurement, supply chain and pricing system etc.	
▪ **Weak public sector supply and logistic system and dependency on the UN system**	7 Capacity in the public sector will be developed through gradual reforms	

Outcome 2.1: Health emergency preparedness strengthened and Emergence of high-threat infectious hazards prevented, detected and responded

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Somalia has very low level of core capacities (only 6 percent) related to IHR and therefore the majority of Somali people are not protected from health emergencies and high threat infections**	1 In the area of **prevention**, priority would be to strengthen IHR coordination, communication and advocacy 2 In the area of **detection**, workforce development will be the top priority through training in field epidemiology and laboratory training and establishment of three more laboratories to cover different areas in the country (one in Mogadishu is functional); After this, efforts would be made to design	i. (3.d.1) IHR Index (13 competencies) improves from 6 percent in 2016 to 15 percent in 2023 ii. Operational guidelines for disaster management available at national level and core staff trained by 2023

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
	and implement integrated disease surveillance and response programme 3 Academia will be involved in conducting epidemiological studies 4 In the area of **response**, operational readiness will be ensured to manage identified risks and vulnerabilities related to health	
▪ **There is hardly any operational readiness and capacities to manage risks and vulnerabilities**	5 Point of Entry will be strengthened with deployment and capacity development of staff	
▪ **Support services are lacking to deal with public health emergencies and outbreaks**	6 Epidemics will be contained with support of development partners	

Outcome 3.1: Determinants of health addressed leaving no one behind, reduced risks through multi-sectoral approaches and ensuring health in all policies

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Weak inter-sectoral governance and coordination**	1 MoH will strengthen of inter-sectoral governance and coordination – starting from NDP pillar for social sector 2 Health will be highlighted in other relevant sectoral policies and plans 3 After prioritization, Early Inter-sectoral interventions will be included in the EPHS 4 Platforms will be formed to promote networks and evidence generation for key issues related to health e.g. Nutrition, WASH, Social protection etc. 5 Capacity development on good governance and leadership should be benefitted by all sectors / public sector staff	i. Level of wasting and under-nutrition improves over the period ii. All health facilities meet minimum standards for WASH iii. Polio eradicated in Somalia and certified by 2023 iv. Cholera epidemics are efficiently and timely controlled v. More than 50 percent of detected epidemics are contained (Disaggregation by state and regions) vi. Preparatory work for Integrated disease surveillance and response system completed by 2023
▪ **Reaching marginalized and under-served populations for essential health services and addressing issues related to equity and gender**	6 Efforts will be made to reach the marginalized and underserved populations - Action plan for provision of EPHS to nomadic people and refugees' will be developed and implemented 7 Monitoring mechanism will ensure equity and gender issues in health	

Challenges	Priority Strategic Actions (2019-23)	Performance Targets
▪ **Poor people participation in health promotion activities**	8 People's participation and engagement will be enhanced for reducing risk factors through health promotion interventions	

IMPLEMENTING 'THE SOMALI ROADMAP TOWARDS UHC'

The strategic priorities for the period 2019–2023 will require well planned and coordinated support from all stakeholders. MoH (FRS) will lead coordination among health sector partners and draw on expertise from different partners. This approach will lay the foundation for an integrated approach on health systems and health emergencies coordination.

Organizational Outcome A: Strengthened country capacity in data and innovations

- Moh (FGS) will work with development partners to improve the data collection and information production through integrating data systems, and eventually Making MoH information systems as reference system for reporting UHC.

- MoH (FGS) will collaborate with the state MoHs to improve their health information systems, analytical capacity and reporting for UHC – including localization of SDGs at state level in 2019, soon after availability of DHS results
- MoH will work with development partners in developing efficient systems to monitor health risks and determinants; tracking health status and outcomes, and assessing health system performance
- MoH will make efforts to strengthen civil registration and other vital statistics
- Data will be disaggregated so that progress made on gender equality and health equity can be measured
- MoH will work with development partners in developing and using tools such as routine data, expenditure studies and population surveys to enable the country to monitor, evaluate and adapt to meet changing health needs
- Country capacity will be built to track and analyse UHC indicators at national, state and regional levels as part of integrated health information system

Organizational Outcome B: Strengthened leadership, governance and advocacy for health

- All relevant health policies, strategies and sub-sectoral strategies are reviewed and updated on time
- MOH leadership will be stepped up by raising awareness of UHC and highlighting UHC in different meetings and summits
- The message on UHC will be harmonized with the efforts of development partners and will continue to foster collaboration and partnership amongst stakeholders through a broad coalition on UHC
- With support of development partners, domestic investment will be leveraged by fostering citizens' participation, civil society dialogue and by interacting with governments including parliamentarians, finance ministers, and heads of states
- MoHs will advocate for domestic investment in health workers, supply chains, services and information systems that underpin the health sector, and providing evidence of benefits of such investment in developing a thriving health economy

- Efforts will be made to document good public finance and public administration practices that enable the cost-effective use of scarce financial resources

Organizational Outcome C: Improved financial, human, administrative resources management towards transparency, efficient use of resources and effective delivery of results

- Capacity will be developed in the public sector on financial, human, administrative resources management to lead coordination among health sector partners
- Human Resources for Health registry will be established in all ministries for proper HRH planning and monitoring
- Through the implementation of the roadmap, MoH will lay the foundation for a new integrated approach on health systems and health emergencies
- Transparent and efficient use of resources and effective delivery of results will be ensured at all levels
- MoH will provide enabling environment to it's workers by making sure they have rights adhered to their job. E'g Annual leave, health insurance.
- MoH will undertake internal Monitoring and Auditing to ensure the resources are used as planned.

Performance Targets for Organizational Outcomes:

i. A reliable and functional health information system at national, state and regional level with analytical capacity and reporting for UHC
ii. The country has the capacity to analyse burden of disease data for Somalia and use the same for strategic planning
iii. Joint health expenditure report in health is produced annually (through JAR and planning exercise) along with regular donor mapping
iv. A plan for strengthening of civil registration and other vital statistics is developed and implemented
v. Updated health policies, strategies and sub-sectoral strategies developed on time and following comprehensive reviews
vi. Commitment of the government/s, donors, UN agencies and civil society is expressed through investment in UHC and IHR
vii. Universal Health Coverage index is an integral part of the national development plan (NDP 9)
viii. UHC steering group/ Health sector coordination mechanism is fully activated
ix. Parliament regularly monitors progress on SDGs and UHC
x. Evidence generated regularly and used for advocacy purposes
xi. Restructuring of the public health sector at all levels to develop the capacity to lead effective coordination and to ensure provision of right kind of technical support
xii. Introduction of new tools for planning, budgeting and strengthening of systems
xiii. Annual progress report, audit reports are regularly published and shared