Country Cooperation Strategy for WHO and Somalia 2021–2025

World Health Organization
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CONTENTS

FOREWORD

The Ministry of Health and Human Services of the Federal Republic of Somalia and the World Health Organization (WHO) are pleased to present the Country Cooperation Strategy for WHO and Somalia 2021–2025.

The Country Cooperation Strategy (CCS) provides the overarching vision and transformational strategic plan of the country office to implement *WHO's Thirteenth General Programme of Work, 2019–23* (GPW 13) in Somalia and defines how WHO would help Somalia attain the Triple Billion targets for healthier populations, universal health coverage, and health emergencies.

The National Development Plan 2020–2024 of the Federal Government of Somalia provides the main driver for actions of the WHO CCS and as such, it is envisioned that the CCS will guide and shape WHO's strategic cooperation, drive measurable impact and will provide a unified approach towards progressing the achievement of the health-related Sustainable Development Goals (SDGs) through leadership, public good and coordinated country support.

The CCS is fully aligned with the strategic priorities of the GPW 13, the National Development Plan 2020–2024, the Roadmap for Universal Health Coverage (2019–2023), the Health Sector Strategic Plan 2017–2021; the Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy (2019–2023), the revised Essential Package of Health Services 2020, the 2030 Agenda for Sustainable Development and the United Nations Sustainable Development Cooperation Framework 2021–2025. The CCS puts further emphasis on coherence and coordination at all levels of WHO in its work with Somalia in order to achieve greater impact on health and well-being in Somalia and to realize the country's SDG priorities.

Building upon Somalia's commitment toward universal health coverage and safeguarding national health security, and considering the current situation – including the impact of the COVID-19 pandemic – this CCS re-emphasizes WHO's mandate to support the country in the foundational elements of health system development, encompassing a focus on strengthening primary health care services to address inequity and improve access to care while also building the resilience of health systems to prepare for, detect and respond to emergencies through strengthening the essential public health functions. The CCS will also support enhancing the leadership and stewardship function of the national and local health authorities to advance public goods for the health and well-being of the Somali people.

The signing of the Country Cooperation Strategy 2021–2025 reaffirms the strength of the relationship between the Government of Somalia and WHO, as part of the wider United Nations system and recognizes and value the specific mandate of WHO to support its Member States in achieving the health-related goals of the SDGs. It underscores the joint commitment to work towards agreed priorities for the greatest impact on and relevance to the people of Somalia.

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ACRONYMS AND ABBREVIATIONS

COVID-19	Coronavirus disease 2019
DALYs	Disability-adjusted life years
EPHS	Essential Package of Health Services
GAP	Global Action Plan for Healthy Lives and Well-being for All
GDP	Gross domestic product
GPW13	WHO's Thirteenth General Programme of Work
IHR	International Health Regulations
IOM	International Organization for Migration
NDP	National Development Plan
PHC	Primary health care
RMNCAH	Reproductive, maternal, neonatal, child and adolescent health
SDGs	Sustainable Development Goals
UHC	Universal health coverage
UN	United Nations
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
WHO	World Health Organization

EXECUTIVE SUMMARY

The *Country Cooperation Strategy for WHO and Somalia 2021–2025* reflects the World Health Organization's (WHO's) vision and strategic framework to guide the Organization's work in Somalia with the overarching aim of promoting health, keeping the country safe, and serving the vulnerable. It responds to the national health and development agenda and identifies a set of agreed joint priorities for WHO's collaboration with Somalia. The Country Cooperation Strategy (CCS) facilitates the implementation of *WHO's Thirteenth General Programme of Work* (GPW13) 2019–2023 with a focus on the country's needs and priorities. The CCS also brings together the strength of WHO support at country, regional and headquarter levels in a coherent manner, in efforts to meet national health goals by demonstrating the measurable impact of the work of WHO in Somalia.

The development of the CCS was guided by review of the National Development Plan 2020–2024, the Roadmap for Universal Health Coverage 2019–2023; the Health Sector Strategic Plan 2017–2021, the Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy (2019–2023), the revised Essential Package of Health Services 2020, the 2030 Agenda for Sustainable Development and the Sustainable Development Goals in Somalia, the United Nations Common Country Analysis 2020, the United Nations Sustainable Development Cooperation Framework 2021–2025, as well as national, regional and global WHO policy frameworks. In addition, key officials of the federal and state ministries of health and partners were consulted extensively during the preparation of the CCS resulting in alignment of the Country Cooperation Strategy 2021–2025 with GPW13, the National Development Plan 2020–2024 and the United Nations Sustainable Development Cooperation Framework 2021–2025.

The strategic agenda for cooperation between Somalia and WHO included in the CCS is based on an analysis of the health and development situation in the country, WHO's current programme of activities, national health priorities and the Organization's work with its health and humanitarian partners and the Somali Government. This analysis was carried out by a CCS working group led by the WHO Representative in Somalia. The CCS provides the strategic plan of the country office to implement the GPW 13 in Somalia and defines how WHO would help Somalia attain the Triple Billion targets for healthier populations, universal health coverage and health emergencies through leadership and by supporting the global public good.

With the overarching aim of meeting the national health development goals of achieving universal health coverage and safeguarding national health security, the CCS aims to help the country progress towards health-related Sustainable Development Goals (SDGs). Both the WHO and the Federal Government of Somalia have mutually agreed on four strategic priorities for this CCS. These four strategic priorities are:

- Strategic priority 1 – Advance UHC by accelerating the PHC-led recovery with a view to supporting the goals of integrated health services.
- Strategic priority 2 – Enhance health security by promoting emergency preparedness, surveillance and response using an all-hazard and one-health approach.
- Strategic priority 3 – Promote healthier populations and well-being using multisectoral approaches to address the social determinants of health and risk factors.
- Strategic priority 4 – Strengthen health governance using the *Global Action Plan for Healthy Lives and Well-being for All* to support joint and collective actions to achieve the health-related SDG goals.

The CCS includes pathways for implementation of the strategy and provides a results framework with indictors to monitor and measure progress in the strategic priorities. The CCS will be implemented during the years 2021–2025. WHO, the Government of Somalia and the United Nations country team will jointly monitor and evaluate its implementation using the CCS country results framework.

SECTION 1. INTRODUCTION

The Country Cooperation Strategy (CCS) is World Health Organizations' (WHO's) strategic framework to guide the Organization's work in and with a country. It responds to the national health and development agenda and identifies a set of agreed joint priorities for collaboration between WHO and the country. The CCS covers areas where the Organization has a comparative advantage to protect, promote and improve health of the population it serves. The CCS facilitates the implementation of *WHO's Thirteenth General Programme of Work* (GPW13) 2019–2023 at the country level with a focus on improving health outcomes and making a measurable impact and delivery of result in accordance with the country's needs, priorities and actions for health.

The Country Cooperation Strategy for WHO and Somalia 2021–2025 reflects the strategic vision and transformational work of the Organization in Somalia supporting the country's goal towards universal health coverage (UHC) and sets out a unified approach to achieving the health-related Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development. The CCS, as such, will shape, guide, align and integrate the work of the Organization for delivery of high-quality normative and technical work for better result and impact at the country level.

The CCS 2021–2025 will continue to be promote health, keep the country safe and serve the vulnerable in line with WHO's Thirteenth General Programme of Work (GPW 13) which aims to deliver healthier populations, UHC and protection from health emergencies and sets out a triple billion target in each of the three strategic priorities. The CCS 2021-2025 also aligns with the WHO Regional Vision 2023: Health for all by all in the Eastern Mediterranean Region by turning the vision into measurable actions at the country level with the aim of contributing to improved health outcome of the population. The CCS 2021-2025 will also leverage on the strong collaboration and partnerships at the country level with other 12 principal agencies of the Global Action Plan for Healthy Lives and Well-being (SDG3 GAP) to accelerate progress on health-related SDG targets and also for other high-value and high-impact health actions.

1.1 Process of CCS development

The overarching aim of the CCS 2021–2025 is to strengthen cooperation between the Ministry of Health and Human Services of the Federal Government of Somalia and WHO in areas of mutually agreed priorities to improve the health of the population in Somalia.

The CCS 2021–2025 was prepared by a CCS working group under the leadership of the WHO Representative in Somalia in dialogue with and the full involvement of the Ministry of Health and Human Services of the Federal Government of Somalia and other health partners and stakeholders. The development of the CCS started with an analysis of the national context and health situation, the national health and development agenda and the partnership environment. The starting point for the analysis was the Somalia National Development Plan (NDP-9), which lays out the country's development priorities for the period 2020 to 2024 and serves as the key overarching planning framework for the Government of Somalia and partners. Several key health sector strategy documents were also analysed, such as the Roadmap for Universal Health Coverage 2019–2023; the Health Sector Strategic Plan 2017–2021; the revised Essential Package of Health Services (EPHS) 2020; the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) in Somalia. In addition, the United Nations Somalia Common Country Analysis 2020, an assessment of the interlinkages and root causes that inhibit the 2030 Agenda for Sustainable Development; and the United Nations Sustainable Development Cooperation Framework 2021–2025 (UNSDCF) were reviewed. The UNDSDCF represents the commitment of the Federal Government of Somalia and the United Nations to

work together to achieve peace, stability and prosperity for all Somalis in support of the 2030 Agenda for Sustainable Development and the SDGs.

Once the national context was analysed, GPW13-related priorities and impact targets were reviewed to ensure that they were aligned with the national health and development agenda. Dialogues were held with the federal and state level ministries of health with the aim of setting the strategic agenda on joint priorities for collaboration and developing an agreed country results framework. Throughout the CCS development process, discussions were held with the WHO country office staff and various departments of the WHO Regional Office and headquarters. The CCS was developed through these consultative processes -first by identifying health priorities in Somalia and then by defining the strategic priorities for WHO's work in Somalia within a framework of five years, with a focus on strengthening the impact on health outcomes and health system development, as well as the linkages between health and other sectors. The CCS is underpinned by commitments that form the basis of cooperation between the Ministry of Health and Human Services of the Federal Government of Somalia and WHO, which are:

- To support the implementation of the WHO GPW13 triple billion targets and progress towards health-related SDGs based on countrywide strategic priorities and the *WHO Global Action Plan for Healthy Lives and Well-being for All* (GAP).
- To translate *WHO's strategy for the Eastern Mediterranean Region, 2020–2023* (*Vision 2023: health for all by all in the Eastern Mediterranean Region*) at the country level within the strategic priorities of the CCS.
- To promote stronger and faster country-level actions to build a resilient health system in the aftermath of coronavirus disease 2019 (COVID-19) aimed at improving both national health security and progress towards UHC.

The CCS, which is a result of this consultative process is the strategic vision of the Organization to implement GPW13 in line with Somalia's national health and development agenda, guides WHO's strategic cooperation and drive impact at the country level, measure impact and track the health-related SDGs (Fig. 1).

The CCS provides a clear results framework for monitoring and evaluation, recognizing the joint responsibility and accountability of WHO and the Government of Somalia to improve the health of the population they serve.

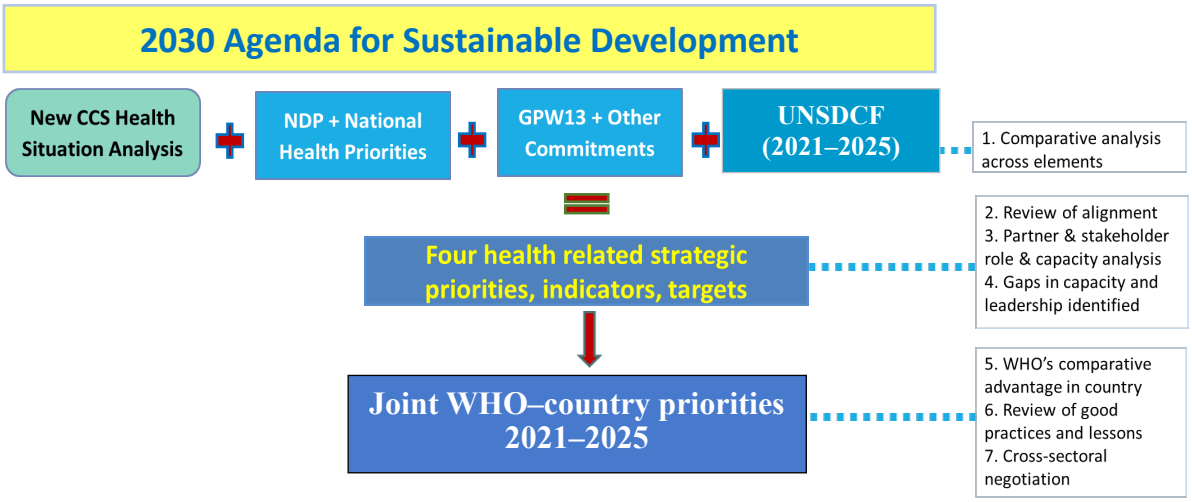

Fig. 1. Process of prioritization for the Country Cooperation Strategy

NDP: National Development Plan; GPW13: Thirteenth Global Programme of Work; UNSDCF: United Nations Sustainable Development Cooperation Framework.

SECTION 2. HEALTH AND DEVELOPMENT IN SOMALIA

2.1 Socioeconomic and demographic situation

Somalia, located in the Horn of Africa, is bordered by Ethiopia to the west, Djibouti to the north-west, the Gulf of Aden to the north, Socotra island (Yemen) and the Indian Ocean to the east, and Kenya to the south-west. Somalia has the longest coastline on Africa's mainland and the terrain is mainly plateaus, plains and highlands. Generally arid and barren, Somalia has two main rivers: the Shabelle and the Juba.

In 2012, the country adopted the constitution of Somalia. The establishment of a federal structure has strengthened federal and state-level institutions, resulting in a total of six Federal Member States. Newly formed states in the central and southern areas are Galmudug, Hirshabelle, South West State and Jubaland. Established earlier, Puntland in the north-east is an integral part of Somalia. Located in the north-west of the country, Somaliland has a different level of autonomy in the political system. Benadir is the capital region of Somalia with Mogadishu as the capital city. In each state, administrative areas are called regions and districts.

Somalia is continuing its recovery from decades of conflict, civil unrest and protracted humanitarian crises, underdevelopment and political instability. The country has been making significant progress on its path to peace, stability and sustainable development since the formation of a new federal government in 2012. The establishment of a nascent federal structure, strengthened federal and state-level institutions, improved public sector management have allowed peaceful transition of power through electoral processes. These developments have helped consolidate political gains, increase economic growth and deepen the accountability of the state to its citizens.

Somalia is one of the countries in the world most vulnerable to climate change and it has experienced a wide range of natural and human-induced disasters due to its unique geographical, physiographical and strategic setting. In the past decade, Somalia has suffered catastrophic natural disasters that have caused widespread loss of life, livelihood and assets. A famine in 2010–2012 and a prolonged drought in 2016–2018 resulted in many deaths and long-term large-scale population displacement. Moreover, rapid urbanization, including a rise in squatter settlements, have increased the vulnerability of marginalized people living in run-down environments. As a result, health emergencies and disease outbreaks are common in the urban areas. Multiple concurrent crises – COVID-19, locusts, flooding and drought – continue to disrupt Somalia's economic recovery. Climate change will continue to multiply risks, causing displacement, conflict, exacerbation of water and food insecurity, and fragility unless it is effectively embedded into the country's overall management of risk-reduction and resilience-building efforts.

Although, some security gains have been made in the past decade in Somalia, substantial areas of the country, particularly in south and central Somalia, are still under the control of armed militia groups, with some locations difficult for humanitarian agencies to access.

The decades of conflict, violence and climatic shocks have also led to economic marginalization and social exclusion of young people who make up about 70% of the population, as well as other vulnerable groups, such as women and children and internally displaced people (IDPs). The country's estimated 2.6 million IDPs are consistently identified as among the poorest groups in the country. These people have been displaced within the country as a result of recurrent climatic shocks and insecurity in the country. The violence, conflict and political instability are still driving poverty in Somalia, and the resultant health inequities and protracted and continued displacements have left an estimated 5.2 million people in need of humanitarian assistance.

Somalia is among the poorest countries in the world with a nominal gross domestic product (GDP) per capita of US$ 335. Nearly 70% of the population live on less than US$ 1.9 per day. Already limited resources have been impacted by a high population growth rate and a reduced economic growth rate due to the COVID-19 pandemic, floods and a locust infestation. In 2020, Somalia's economy decreased by an estimated 0.4%, from an annual economic growth rate of 2.8% between 2016 and 2020. This was better than the anticipated 1.5% reduction. Higher aid flows, fiscal measures to support businesses, social protection measures to support vulnerable populations and higher-than-expected remittances mitigated the situation. The economy of the country is highly dependent on foreign aid, both humanitarian and development aid, and diaspora remittances making it hard for the Government to increase domestic investment in health, education and other social sectors. In 2019, the country's GDP was US$ 4.9 billion. Somalia received about US$ 1.9 billion in official development assistance, with roughly equal amounts of humanitarian and development aid. Somalia's extensive diaspora send about US$ 1.4 billion a year, nearly one third of GDP. In March 2020, Somalia qualified for the Heavily Indebted Poor Countries (HICP) Initiative Decision Point, with debt-relief and access to financing from the International Development Association (IDA) and other international financing institutions. Somalia's economy relies largely on agriculture and livestock, accounting for 70% of GDP. Livestock alone accounts for about 60% of GDP and over 90% of export earnings. Other main products include fish, charcoal, bananas, sugar, sorghum and corn. Small-scale enterprises are emerging.

Somalia has a population of about 15.7 million as of December 2018 and around 54% of the population lives in urban areas. It is estimated that 46% of the population is under 15 years of age and 75% is under 30 years. Half of the population is composed of people aged between 15 and 59 years. The birth rate is high, at around 37–40 births per 1000 population, leading to a high population growth rate of 3%. If this trend continues, the population will double every 24 years. Nomads constitute about one fourth of the population. Seven out of 10 Somali women aged 15–49 identify themselves as nomadic. The high fertility rate at 6.9 children per woman has resulted in an average household size of 6.2 people. About one third of all households have foster or orphaned children.

Youth unemployment is high at around 20%. Somalia has one of the world's lowest enrolment rates for primary school – only 30% of children are in school and only 40% of these are girls. In rural areas, only 18% of children attend school. Only 16% of the population has completed primary school and 7% secondary school. Schools are mainly privately run. Less than half (45%) of Somalia's population has access to improved water sources. The prevalence of open defecation in rural areas is estimated as 56% and poor hygiene and sanitation practices, coupled with recurring floods, are major causes of diseases and deaths.

The Federal Government of Somalia has a low capacity to mobilize tax revenue, due to a weak tax collection system, political instability and a predominantly informal sector. With limited revenue, health is not a priority. Government expenditure on health (as a percentage of GDP) was estimated to be 1.3% in 2020 while government health expenditure as a percentage of total health expenditure (at 2017 prices) was estimated to be less than US$ 1 in 2020. The public expenditure for the defence sector was 29% in 2020.

There is no recent Human Development Index, but in 2012 it was 0.285, ranking Somalia 165th of 170 countries. The Gender Inequality Index was 0.776 (a score of 1 denotes complete inequality), placing Somalia in the fourth worst position globally. Gender inequality is a persistent societal problem in Somalia, perpetuated primarily by cultural norms and traditions.

2.2 Health situation

Somalia is in the initial stages of an epidemiological transition, characterized by declining maternal, infant and child mortality and increasing life expectancy at birth. Life expectancy at birth for both sexes has increased since the 1990s but is still lower than the Sub-Saharan Africa average of 61.3 years. Life expectancy at birth is 56.5 years, lower for males (55.7) than females (59.1).

2.2.1 Burden of disease[1]

Somalia continues to face a double burden of communicable diseases and maternal, neonatal and nutritional conditions and noncommunicable diseases owing to epidemiological and demographic transition. Though Somalia's disability burden of communicable, maternal, neonatal and nutritional diseases in 2019, measured in terms of age-standardized DALY, was 53% of all DALYs lost, showing a decline from its level of 64% in 2000, which was driven mostly by improvements in infectious disease control, the disability burden of noncommunicable diseases, which was 29% of all DALYs lost in 2000 increased to 38% in 2019 (Fig. 2) owing to an increase in high systolic blood pressure and high fasting plasma glucose and cholesterol between 2000 and 2019. With increasing life expectancy, noncommunicable diseases, such as cardiovascular diseases, diabetes and cancer, are expected to become increasingly significant public health problems in Somalia. The share of disability burden of injuries, on the other hand also increased from 6.23% in 2000 to 8.6% in 2019 owing to substantial increase in conflict, terror and road traffic accidents observed between 2000 and 2019.

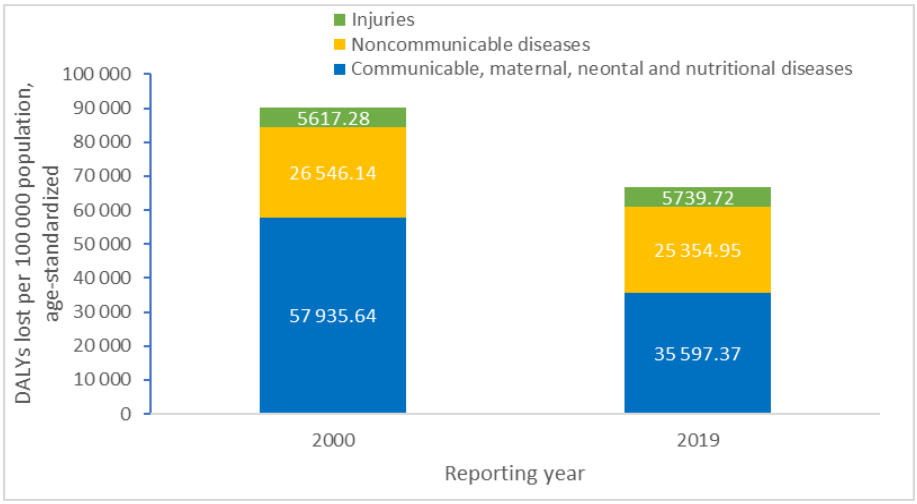

Fig. 2 Burden of disease by cause, disability-adjusted life years (DALYs), age standardized and both sexes, Somalia 2000 and 2019

DALYs: disability-adjusted life years. Rate in 2000: 90 099.06 DALYs per 100 000 (76 754.06-103 543.86); Rate in 2019: 66 692 DALYs per 100 000 (55 231.90-81 850.41)

Source: Global Burden of Disease. Seattle, WA: Institute for Health Metrics and Evaluation; 2019 (http://www.healthdata.org/gbd/2019).

[1] Sources of data: 1) GBD results tool. Institute for Health Metrics and Evaluation; 2019 (http://ghdx.healthdata.org/gbd-results-tool?params=gbd-api-2019-permalink/2e9f7d3e121f5797a110c1317a3a6b2d). 2) Disability-adjusted life years (DALYs). World Health Organization; 2021 (https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158). 3) Raising the importance of postnatal care. World Health Organization; 2015 (https://www.who.int/activities/raising-the-importance-of-postnatal-care). 4) State of inequality: reproductive, maternal, newborn and child health. World Health Organization; 2015 (https://apps.who.int/iris/handle/10665/164590). 5) Somalia. UNICEF data; 2021 (https://data.unicef.org/country/som/).

Analysis of estimates of burden of disease data for Somalia available from the Global Burden of Disease 2019 shows that the leading causes of death in Somalia in 2019 were communicable diseases, including tuberculosis (TB), lower respiratory infections, diarrhoeal diseases and noncommunicable diseases such as stroke and ischaemic heart disease, all of which are largely preventable and avoidable. The analysis of leading causes of deaths and disability shows that mortality from communicable diseases decreased between 2000 and 2019 (measles, diarrhoeal diseases and TB) but these are still the leading causes of death and disability in Somalia (age-standardized mortality rate of 761.53 per 100 000 population). However, mortality from noncommunicable disease (ischaemic diseases) increased (age-standardized mortality rate for noncommunicable disease was 738.4 per 100 000 population in 2019). In 2019, communicable diseases and maternal, neonatal and nutritional disorders were responsible for 47% of all deaths, down from 57.5% in 2000 while noncommunicable diseases contributed to 45.6% of all deaths in 2019 up from 36.6% in 2000. Injuries, on the other hand caused 7.35% of all deaths in 2019 (age-standardized mortality rate of 119.10 per 100 000 population in 2019), up from 5.74% in 2000. The leading causes of disability in 2019 were also communicable diseases such as TB, lower respiratory infection, diarrhoeal diseases and neonatal disorders and noncommunicable diseases such as stroke and ischaemic heart disease. Road injuries were also among the 10 leading causes of disability in Somalia in 2019.

Fig. 3 shows the 10 leading causes of death and disability for 2019 for both sexes, and Table 1 shows the leading causes of death and disability for 2000 and 2019 for both females and males.

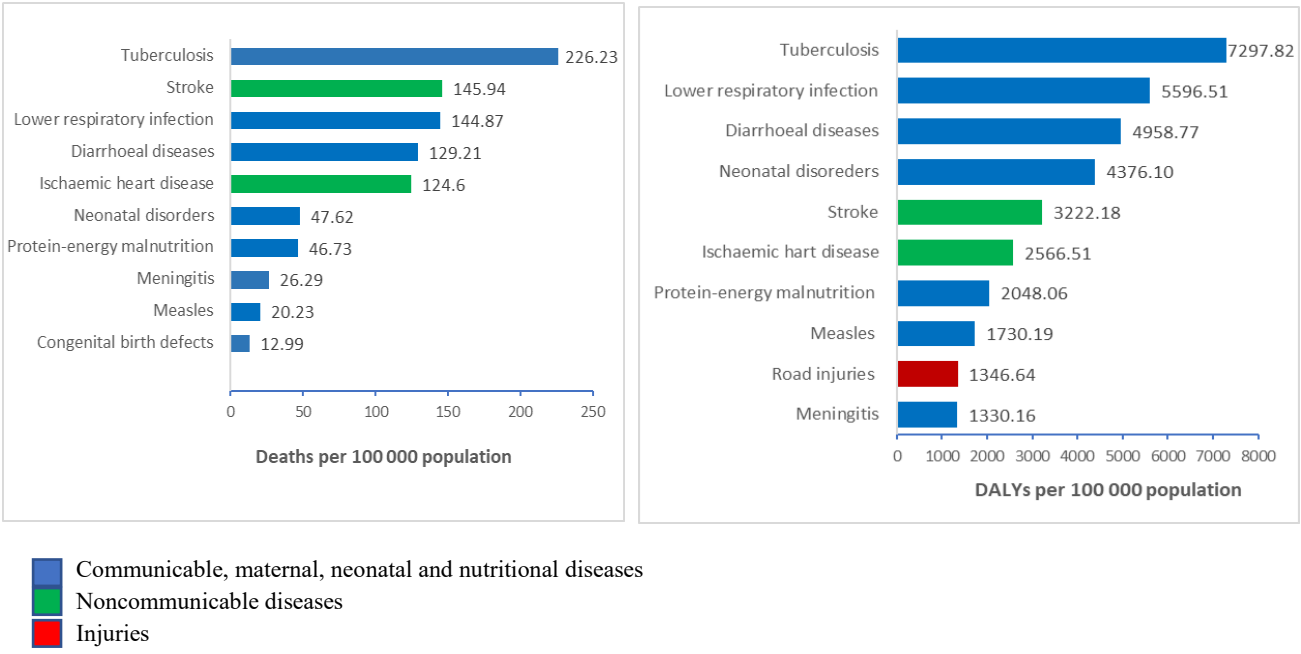

Fig. 3. Top 10 causes of death and disability-adjusted life years (DALYs) (per 100 000 population), age-standardized and both sexes, Somalia, 2019

Source: Global Burden of Disease. Seattle, WA: Institute for Health Metrics and Evaluation; 2019 (http://www.healthdata.org/gbd/2019).

Table 1. Top 10 causes of death and DALYs (per 100 000 population) for females and males, age-standardized, Somalia, 2000 and 2019

Cause of death	Deaths (per 100 000)				Cause of DALYs	DALYs (per 100 000)			
	2000		2019			2000		2019	
	Females	Males	Females	Males		Females	Males	Females	Males
Tuberculosis	220.33	396.81	177.82	290.84	Tuberculosis	7 385.03	12 964.06	5 600.05	9 216.29
Stroke	135.75	175.82	135.64	159.09	Lower respiratory infections	6 622.50	9 927.66	4 804.70	6 503.35
Diarrhoeal diseases	306.41	242.64	126.98	128.80	Diarrhoeal diseases	10 792.48	9 851.39	4 610.51	5 265.64
Lower respiratory infections	146.48	224.92	125.06	173.14	Neonatal disorders	4 386.64	5 230.52	3 838.02	4 885.47
Ischaemic heart disease	85.20	141.33	104.52	151.13	Stroke	3119.09	4122.86	2928.93	3579.96
Neonatal disorders	48.64	58.11	41.52	53.40	Ischaemic heart disease	1620.08	3196.32	1943.96	3347.37
Protein–energy malnutrition	65.79	99.31	39.49	57.56	Protein–energy malnutrition	3279.49	4345.26	1787.09	2355.54
Meningitis	28.25	30.51	25.25	27.25	Measles	6326.63	6019.23	1789.73	1673.69
Measles	73.99	70.41	20.93	19.56	Road injuries	813.63	2222.14	733.03	1204.07
Congenital birth defects	11.13	14.52	11.35	14.55	Meningitis	1467.06	1582.99	1273.13	1387.27

DALYs: disability-adjusted life years.
Note: Ordered according to female rates in 2019.

Source: Global Burden of Disease. Seattle, WA: Institute for Health Metrics and Evaluation; 2019 (http://www.healthdata.org/gbd/2019).

The gender disaggregation of causes of deaths and DALYs shows persisting disparities between females and males for neonatal disorders and protein–energy malnutrition between 2000 and 2019. DALYs also declined between 2000 and 2019 for the leading 10 causes of disability, although less so for neonatal disorders, congenital birth defects and meningitis.

Data for 2019 also show that there are still pronounced disparities in mortality in Somalia by age: mortality rates are disproportionately higher among infants within the first six days of their lives compared with all other age groups. For example, in Somalia in 2019, early neonatal mortality rates were 95 419.26 for females and 130 528.66 for males while for adult females and males (aged 15–49 years) these were 356.09 and 509.12 per 100 000 population, respectively.

2.2.2 Maternal health

Maternal and child mortality rates in Somalia are among the highest in the world. Frequent and close births leave women more susceptible to pregnancy-related risks, diseases, disability and malnutrition. Although Somalia's maternal mortality continues to decline, it is still high, at 829 per 100 000 live births, well above the Sub-Saharan average of 542. The leading causes of maternal mortality are postpartum haemorrhage, pre-eclampsia/eclampsia,

obstructed labour and sepsis. Several factors contribute to this situation, including limited involvement of skilled birth attendants, inadequate access to maternal health or delivery services, high fertility rates, low uptake of family planning and female genital mutilation/cutting (FGM/C). Nearly all women in Somalia have undergone FGM.

Though the number of births attended by skilled birth attendants have increased in recent years, only one third of births are attended by skilled birth attendants. Only one fifth of deliveries take place in health facilities. The 2016 health facility assessment survey, SARA, found that comprehensive emergency obstetric and newborn care services were only offered in 37% of hospitals and 1% of health facilities. Urban areas were more likely to offer such services.

Maternal and reproductive health care, such as antenatal and postnatal care, not only remains low in but has not reached all women equally. Only one in three Somali women aged 15–49 received one antenatal care (ANC) visit during pregnancy, and only one in four women had the desired four ANC visits. Women in rural and nomadic areas tend to have more children than women in urban areas, and they are less likely to have access to ANC and postnatal care services. Only 9% of women in rural areas received at least four ANC visits with trained provider, compared with 49% in urban areas. ANC coverage was only 12% among women in the lowest income quintile, compared with 56% in the highest income quintile. In 2019 in Somalia, 10.5% of women aged 15–49 years received postnatal care within two days of giving birth. But again, women from the highest income quintile were about eight times more likely to receive postnatal care than those in the lowest quintile. The rate of contraceptive use in Somalia is one of the lowest in the world. Most Somali women consider six or more children to be the ideal family size.

2.2.3 Child health

Somalia's neonatal mortality rate has declined since the 1990s but is still among the highest in the world. Between 1990 and 2015, Somalia's neonatal mortality rate remained around 45 deaths per 1000 live births. In 2019, the neonatal mortality rate had declined to 37 deaths per 1000 live births, which is higher than the Sub-Saharan African average of 27 per 1000 live births. The main causes of neonatal mortality include birth asphyxia and trauma, prematurity and sepsis. Lack of adequate health services is a contributing factor.

The child mortality rate in Somalia is also among the highest in the world. One in seven Somali children dies before they turn five. From 1990 to 2005, child mortality hardly improved at all. Currently, the under-five mortality rate is 117 per 1000 live births, which is higher than the Sub-Saharan average of 76 deaths per 1000 per live births. Child mortality is higher among boys than girls at 123 and 111 per 1000 live births, respectively. The infant mortality rate is estimated at 74 per 1000 live births, while the average Sub-Saharan African infant mortality rate is 52 per 1000 live births. Mortality among infants is highest within the first six days of their lives.

Pneumonia, diarrhoeal diseases, measles, TB, malaria, respiratory infections, malnutrition and neonatal disorders are the leading causes contributing to the high infant and child mortality. Health-seeking behaviour and access to health services may influence child mortality as well. Care-seeking for children under five years with diarrhoeal symptoms increased between 2006 and 2019 among children living in both urban and rural areas. In 2006, 2.8% of children under 5 years living in rural areas and 9.0% of those living in urban areas received care for diarrhoeal symptoms. In 2019, the rate had increased to 52.2% and 59.9%, respectively. Approximately 27% of all Somali children under five are stunted (short for their age), compared with the Sub-Saharan Africa average of 33%. An estimated 23% of children under five are underweight (thin for their age), and 12% are wasted (thin for their height)

2.2.4 Adolescent health

The probability of dying among children aged 5–14 is 25 per 1000 live births, while in Sub-Saharan Africa the average is 17. Also, youth aged 15–24 face a higher probability of dying in Somalia than in Sub-Saharan Africa: 43 per 1000 live births compared to 23.

The Somali Health and Demographic Study 2020 indicated that 12% of Somali girls aged 15–19 had already given birth to a child and that 2% of them were pregnant with their first child. Among nomadic girls the figure was even higher; 19% of them were already mothers or pregnant with their first child, while the proportion in urban areas was 11%. Girls without education were more likely to have had a child or be pregnant than girls with education: 19% compared with 2%. From the poorest household 20% of the girls had started childbearing, compared with 9% of girls in the wealthiest households. Somali adolescent girls aged 10–19 are at risk of child marriage, early pregnancy, FGM and mental health issues, particularly among internally displaced persons. Limited educational opportunities for girls may also influence the situation.

2.2.5 Migrant and refugee health

Somali migration patterns are complex. There are about 30 000 refugees and asylum seekers in the country, mainly from Ethiopia and Yemen. About 765 000 Somalis live as new or long-term refugees outside the country, while 130 000 refugees have returned to Somalia since December 2014. With 2.9 million people estimated to be internally displaced, Somalia has one of the highest numbers of internally displaced persons (IDPs) in the world. Many of these IDPs have left rural areas and moved to urban centres in search of work opportunities and humanitarian assistance. The increased displacement has added to the already high number of forced evictions of IDPs and the urban poor from the main towns. IDPs are identified as the most vulnerable people in the population, as they are chronically more food insecure and have limited access to basic health care services, such as vaccinations, treatment for infectious diseases, psychosocial support and safe maternity care, and safe drinking-water and sanitation to prevent the spread of waterborne diseases.

According to UNHCR's projections for 2022, the total number of refugees and asylum seekers will stand at 30 800 and refugee returnees from neighbouring countries at over 132 000. Refugee returnees are particularly vulnerable to the consequences of insecurity, conflict, drought, and floods, as well as COVID-19, and therefore need humanitarian support.

The United Nations Office for the Coordination of Humanitarian (OCHA) Affairs projects that a total of six million vulnerable non-displaced people will need humanitarian assistance in 2022. As with IDPs, their needs are driven by pre-existing vulnerabilities, as well as several recurring shocks.

2.2.6 Persons with disabilities

Persons with disabilities have been identified as a particularly marginalized and at-risk group within Somali society as a result of the numerous attitudinal, environmental and institutional barriers they face. Statistics on the number and situation of people with disabilities in Somalia is lacking. Most estimates suggest that it is likely to be higher than the global estimate of 15% as a result of the long period of conflict, poverty and lack of access to health care. One study in Somaliland found that as many as 42% of households had at least one member with a disability. Lack of data on disability in Somalia has contributed to limited awareness of disability issues among policy-makers, services providers and the general public. There is no specific national policy framework regarding persons with disabilities. Somalia has not ratified the United Nations Convention on the Rights of Persons with Disabilities.

2.2.7 Mental health

Globally, the mental health burden affects about 10% of the population while in humanitarian settings it is about one in five persons. Somalia is considered as one of the countries with the highest burden of a mental health disorder with one in every three persons being estimated to be living with some form of mental health disorder. Years of conflict and the effects of climate shocks have contributed to widespread psychosocial trauma and social deprivation with devastating consequences on people's mental health. Mental health disorder is among the top 13 leading causes of disability adjusted life years (DALYs) in Somalia (272.9 DALYs per 100 000 population) and about 2.1% of all DALYs in Somalia are attributed to mental health and substance abuse. The age-standardized suicide mortality rate of Somalia is also one of the highest in the world at 14.66 per 100 000 population. Yet, most persons with mental health issues do not receive the treatment they need. Somalia has negligible mental health services and nearly non-existent community mental health services.

2.3 Social determinants of health

The health status of the Somali people varies depends on their educational and income levels, geographic location, migration status and gender. Health disparities across geographic areas and socioeconomic groups are wide. Several factors pose risks to the health of the Somali people, including unsafe water and sanitation, air pollution, high blood pressure and malnutrition. The health impact of factors also vary across socioeconomic groups, although data are largely lacking.

Education and income levels not only determine the health status, but also influence health-seeking behaviour and use of health services. For example, uptake of ANC services and delivery in hospitals vary depending on educational level and wealth, with educated and wealthier women more likely to use these services. Health-seeking behaviour varies between low-income and high-income households. Households in the lowest wealth quantile are less likely to seek care when ill than households in the highest wealth quantile. Only 9.7% of women from lowest wealth quantile have skilled birth attendants at delivery, compared with 64.1% from the highest quantile.

Financial access hamper nomadic and rural households from seeking care. Health outcomes are worse in rural and nomadic areas, where women tend to have more children than women in urban areas and are less likely to have access to ANC and postnatal care. There are also differences between nomadic, rural and urban populations when it comes to child immunization. Immunization coverage is less than 1% of nomadic communities, 14% in rural areas and 19% in urban areas.

The Global Burden of Disease Study 2019 showed that the leading risk factors for death and disability were unsafe water and sanitation, air pollution, high blood pressure and malnutrition. Table 2 summarizes deaths and disability in 2000 and 2019 caused by these four leading risk factors, shown as a percentage of total mortality and DALYs. From 2000 to 2019, the contribution of unsafe water, sanitation and handwashing, and child and maternal malnutrition to mortality and disability declined, while the contribution of air pollution and high systolic blood pressure increased.

More specifically, the reduction in malnutrition has contributed to some of the decline in mortality and disability caused by communicable, maternal, neonatal and nutritional diseases. Malnutrition and overweight are important health concerns and jeopardize the growth and development of children and young people. Nearly 65% of DALYs due to diarrhoeal diseases and 71.10% of DALYs due to lower respiratory infections can be attributed to child and maternal malnutrition. Similarly, 62% of DALYs and 60% of deaths caused by ischaemic heart disease and 23.1% of diabetes can be attributed to dietary risks.

Table 2. Four leading risk factors for attributable deaths and disability, by sex, Somalia, 2000 and 2019

Risk factor	2000		2019	
	Females	Males	Females	Males
Unsafe water, sanitation and handwashing				
Mortality	18.39	11.85	10.72	8.66
DALYs	14.65	11.90	9.22	8.84
Child and maternal malnutrition				
Mortality	14.58	12.75	10.01	9.01
DALYs	25.85	23.65	19.09	17.58
Air pollution				
Mortality	14.04	16.24	16.99	17.72
DALYs	11.02	13.67	12.48	14.16
High systolic blood pressure				
Mortality	10.60	9.31	14.63	12.27
DALYs	4.99	5.36	6.99	7.15

DALYs: disability-adjusted life years.
Values are the percentage of total mortality and DALYs.
Source: Global Burden of Disease. Seattle, WA: Institute for Health Metrics and Evaluation; 2019 (http://www.healthdata.org/gbd/2019).

Indoor air pollution results from the burning of solid fuels such as crop waste, dung, charcoal and coal for cooking and heating in households. Burning these fuels produces particulate matter, which is a major health risk, particularly for respiratory diseases. Air pollution from solid fuels is one of the leading risk factors for death and disability in Somalia, causing 280 deaths per 100 000 population (17.29% of all deaths) and 8897.82 DALYs lost per 100 000 population (13.33% of all DALYs) in 2019.

Ambient air pollution causes death and disability related to respiratory conditions and TB, maternal and neonatal disorders, cardiovascular disease, chronic obstructive pulmonary disease and kidney diseases. It causes 63.01% of DALYs lost and 61.79% of deaths from lower respiratory infections. In addition, 84.80% of DALYs and 87.16% of mortality due to chronic obstructive pulmonary disease, and 45.43% of DALYs and 42.06% of deaths caused by ischaemic heart disease are attributable to air pollution.

About 13.1% of the adult male population used tobacco daily in 2015; the figure for females was 1.6%. It is estimated that every year more than 3800 die from tobacco-caused diseases in Somalia. While tobacco use is limited in Somalia, there is widespread use of *khat*, a psychoactive substance indigenous to East Africa and the Arabian Peninsula. In the past chewing *khat* was a regulated social norm and commonly consumed by adult men. Consumption patterns have changed and increased addiction is being seen in women and youth. There is scant information on the prevalence of substance abuse in Somalia. However, there is a growing urgency to address problems such as mental health and physical disorders related to *khat* usage. There is also evidence of increased use of opioids, cocaine, amphetamine and cannabis in recent years.

2.4 Health system

2.4.1 Health infrastructure

There are four different levels of health facilities in the country that are involved in the delivery of essential health services. These include primary health care (PHC) units located at the rural areas and is most frequently visited health infrastructure, health centres at the sub-district level, referral health centres at the district level and regional hospitals at the regional capitals. According to recent data, there were in 2019, a total of 661 operational health facilities in the country. A survey conducted in 2016 showed that the density of health facilities was 1.69 per 10 000 population, which can be broken down to 0.76 public facilities and 0.93 private facilities per 10 000 population meaning that most health services are delivered by the private sector.

2.4.2 Universal health coverage

Somalia has the lowest universal health coverage (UHC) index in the world at 27 out of 100 indicating that in 2019 only 27% of the population had access to essential health services without facing financial hardship. This is considerably lower than the Sub-Saharan Africa average of 42 and well below the global average of 60.3. Somalia's health system is considered the second most fragile in the world, according to the 2019 Global Health Security Index. The Government of Somalia has demonstrated its commitment to improving PHC as a means to advance towards UHC and achieve the health-related SDGs through designing and developing a set of basic and standardized package of health services called the Essential Package of Health Services (EPHS 2020), which will be rolled out across different levels of care in a uniform manner.

The country faces many different challenges to improving access to and efficiency and quality of care across the health sector. Low expenditure on health, shortage of skilled and trained health workers, security problems and weak institutional systems are the main challenges (Table 3).

Table 3. Key health system data, Somalia

Indicator	Value	Year
Health facilities		
Health facility density per 10 000 population	1.69 (0.76 public and 0.93 private)	2016–2018
Hospital beds per 10 000 population	8.7	2019
Health workforce		
Essential health workforce per 1000 population	0.11	2019
Psychiatrists per 100 000 population	< 0.05	2017
Health expenditure		
Per capita total health expenditure in US$	6	2017
Per capita government health expenditure (excluding official development assistance) in US$	1	2017
Per capita development assistance for health in US$	3	2017
Government health expenditure (% of total health expenditure)	< 1	2017
Out-of-pocket per capita health expenditure in US$	2	2017
Out-of-pocket health expenses (health expenses paid by households as a percentage of their income)	48	2017

Sources: Health and well-being profile of the Eastern Mediterranean Region: an overview of the health situation in the Region and its countries in 2019. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2020 (https://applications.emro.who.int/docs/9789290223399-eng.pdf). Monitoring health and health system performance in the Eastern Mediterranean Region: core indicators and indicators on the health-related Sustainable Development Goals 2020. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2021 (https://applications.emro.who.int/docs/WHOEMHST246E-eng.pdf?ua=1). IHME. Somalia. Seattle, WA: Institute for Health Metrics and Evaluation; 2019 (http://www.healthdata.org/somalia).

The gaps in health service delivery are widespread. Health facility density in Somalia varies across the regions. For the country as a whole health facility density is 1.69 facilities per 10 000 population. Distance to health facilities is a major barrier to accessing health services. Geographic access is especially challenging for nomadic and rural populations. Long distances to health facilities may delay health seeking or make it completely unable to access services due to high transportation costs or insecurity.

Somalia's public health facilities are not only limited in reach, but also when it comes to function. Facilities are often inadequately equipped to deliver health services. The 2016 service availability and readiness assessment (SARA) survey identified a total of 1074 public health facilities, but only 799 were operational. Only 28% of facilities had the ability to deliver ANC services; only 32% had the capacity to deliver child health services; and less than 5% could screen for and treat TB, diabetes and cervical cancer.

Private for-profit health providers are the largest health service providers across Somalia, providing up to 40% of health services. The private sector provides pharmacies, clinics, hospitals, laboratory services, mental health care services and dental care, mainly in urban areas. Traditional healers are also widely used health service providers. The supervision, regulation and coordination of the private sector is limited. There are significant gaps in the quality of private health services and the quality of medicines and health technology. The private sector has traditionally operated in isolation from the public health sector.

Utilization of both outpatient and in-patient services remains Low. There are several barriers to health care. About 65% of women 15–49 years old report that cost is a major constraint to accessing health care, 62% say distance to health facilities and 42% cited the need for permission from the household head.

2.4.3 Immunization coverage and services

Somalia's routine immunization coverage has increased substantially since 2015. Nationally, the administrative coverage of pentavalent 3 vaccine increased to 73% in 2020 from 45% in 2015, while the immunization coverage for the measles 1 vaccine increased to 70% in 2020 from 41% in 2015. However, the 2020 WHO/UNICEF immunization coverage estimates of both DTP and measles 1 are considerably lower, 42% and 46% respectively. Children in urban settings are more likely to be vaccinated compared to those children whose mothers are uneducated and are from rural areas.

The Expanded Programme on Immunization, which has existed in the country since 1978, is delivered mainly through over 600 fixed health facilities spread across the country, and through outreach and mobile services that are implemented on a small scale depending on the availability of funds and human resources. Routine vaccination programmes face several challenges such as insecurity, lack of available funds to support community outreach immunization services and insufficient health work force. One of the effects of COVID-19 in the country has been a drop in routine immunization coverage.

The country remains free of wild poliovirus. The last wild polio outbreak in Somalia started in April 2013 after an importation and 194 cases were reported that year. The epidemic was effectively controlled and, since 2015, no new wild poliovirus case has been reported in Somalia. Despite achieving polio-free status, Somalia has had sustained circulation of vaccine-derived polioviruses since November 2017 when the first circulating vaccine-derived polio virus (cVDPV) was detected in an environmental sample. Since then, and because of low routine immunization coverage, the country has continued to report both type 2 (cVDPD2) and type 3 (cVDPV3) circulating vaccine-derived poliovirus outbreaks with international spread. In February 2021, WHO declared Somalia's outbreak of cVDPV3 had

been successfully stopped, with no international spread. The country is expected to introduce and roll out a type 2 novel oral polio vaccine (nOPV2) nationwide to stop cVDP2 outbreaks.

2.4.4 Human resources for health

Somalia faces a severe shortage of health workers who are inequitably distributed across the country. The training of health workers varies as there are no set standards for their qualifications. The number of core health care workers (general practitioners, specialist medical doctors, non-physician clinicians, nursing professionals and midwives) per 10 000 population was estimated at 4.28 in 2016, well below the Sub-Saharan Africa average of 13.3. In rural and inaccessible areas regions, availability of qualified health workers drops even lower. There is also a significant number of untrained health workers, working alongside formally trained health workers.

Despite policies being in place, such as the Human Resource Policy 2016–2021, and the Midwifery Deployment and Retention Policy 2019, the retention of health workers in the sector continues to be a challenge. Some reasons include limited remuneration, professional advancement and on-the-job-training. As there is no comprehensive human resources information system, it is difficult to track health workers and conduct work force planning.

2.4.5 Essential medicines and supplies

The Somali National Medicine Supply Chain Master Plan of 2015 summarized the major challenges of the national supply chain as poor quality, distribution inefficiencies, security problems in transportation within the country, poor drug management practice in health facilities and unwanted or unsolicited product donations. High level of donor involvement in the health service delivery has also resulted in parallel donor supply chains with varying capacity in the states. Supply chain functions at health facility level is carried out by mainly nurses and doctors, as pharmacists and pharmacy technicians are in short supply. Reforms are currently under way.

2.4.6 Antimicrobial resistance

Antimicrobial resistance, including multidrug-resistant tuberculosis, is an emerging health challenge. Several factors contribute to antimicrobial resistance including misleading advertisements, self-medication, unqualified practitioners and the lack of a fully functional medicines regulatory authority. Antibiotics tend to be overprescribed in public health facilities; 61% of patients are prescribed antibiotics when visiting a public health facility. Over-the-counter medicines, particularly antibiotics, are commonly available. About one third of medicines, including antibiotics, are bought without prescription at private pharmacies. The country has recently developed a national action plan for antimicrobial resistance and has enrolled in the Global Antimicrobial Resistance and Use Surveillance System (GLASS).

2.4.7 Health information and surveillance systems

Somalia's health management information and disease surveillance systems are fragmented with gaps in both the availability of reliable and timely information, and the use of actionable data. The Somali Government at federal and member state levels has committed to using the District Health Information System 2 (DHIS2) for managing its health information system. Data are reported by health centres, but data tend to be used at the higher levels of the system, with limited flow of data being used at health facility level. Numerous partners are supporting the health management information system development, affecting the development of strong coherent systems. Efforts are under way to harmonize partner support for HMIS.

Communicable disease control surveillance is carried out for 15 nationally notifiable diseases via the Early Warning Alert and Response Network system (EWARN). In 2020, COVID-19 was included among the reported priority health conditions. EWARN covers about 690 health facilities detecting, verifying and investigating alerts on priority health conditions, providing feedback on disease trends through a weekly bulletin. However, communicable disease surveillance for HIV/AIDS and TB is reported through their respective programmes.

2.4.8 Health emergency preparedness and response

The COVID-19 pandemic has further strained the fragile health system in the country and has negatively affected the delivery and continuity of essential health care services. There is concern that many the country's modest health gains may be reversed. Furthermore, some projections suggest that the life-saving vaccination coverage, which is already very low, may drop by 20%, facility-based health service delivery may decrease by 4% and childhood deaths may increase by 13%.

The joint external evaluation undertaken in 2016 assessed the country's core capacities of the International Health Regulations (IHR 2005) and found large gaps in the country's capacities to prevent, detect and comprehensively respond to public health threats, including antimicrobial resistance and medical waste management. Somalia's 2018 IHR capacity and health emergency preparedness index, a measure of IHR core capacity, was 31 out of 100 (at level 1 out of a maximum level 5). The Global Health Security Index in 2019 for Somalia was 16.6 out of 100 indicating that the country's capacity to prevent, detect and respond to emerging and expanding health threats such as COVID-19 was very low. The Ministry of Health and Human Services of the Federal Government of Somalia, in collaboration with WHO, has finalized the National Action Plan for Health Security, which is a roadmap for the country to build the required core capacities for IHR.

2.4.9 COVID-19

The first laboratory-confirmed cases of COVID-19 was detected in Somalia on 16 March 2020. Since then, the country has reported 23 154 laboratory-confirmed cases of COVID-19. The case-fatality rate was 5.7% from mid-March 2020 to the end of November 2021.

While cases surged during the initial phase of the outbreak in April–May 2020, the progression of cases did not continue as was observed in Sub-Saharan countries. One of the possible reasons for this, apart from the limitations in the surveillance system, was that the country had no testing capacity for COVID-19 at the time the outbreak started. The country established it testing capacity by late April 2020 across the federal member states and cases of COVID-19 were seen to grow. During February–March 2021, the country saw another surge of COVID-19 cases.

Somali health authorities are continuing to take action to contain the spread of COVID-19. However, limited testing capacities, fragility in the health system and weakness in the surveillance system mean that most of the cases reported officially represent only the "tip of the iceberg". The fragility, vulnerability and conflict-affected context of the country make the situation unpredictable.

Current COVID-19 vaccine uptake in the country is seemingly poor – less than 10% of the population had been fully vaccinated by the end of December 2021. The economic and humanitarian consequences of the COVID-19 pandemic in 2020–2021 have been significant with worsening economic, business, education and livelihood outcomes.

2.4.10 Health financing

Due to the Government's low tax revenue mobilization system, Somalia is highly dependent on foreign and private health financing. Since comprehensive health financing data are lacking, the Institute of Health Metric Evaluation (IHME) has estimated that the total per capita spending on health in 2018 was US$ 7; with US$ 3 from out-of-pocket spending; US$ 2 from government spending; and US$ 2 from development assistance for health. Private health insurance was basically non-existent.

High out-of-pocket payments mean that households use their savings, sell assets (livestock) or borrow money to pay for health services, exposing themselves to financial risks. Almost half of all households report using their own income to pay for health services.

Funding of health services is fragmented. Development assistance is only partly channelled through the government systems, making prioritization, co-ordination, efficiency and accountability difficult. As a result, the federal MoH has a partial role in decision-making on resource use.

2.4.11 Governance and health sector stewardship

After decades of conflict and state collapse, the health sector is largely unregulated. This include pharmaceuticals and health services, as well as supply, registration and licensing of health workers. The Federal Ministry of Health and Human Services is in the process of developing its role as the steward of the health sector with policy, coordination and regulatory and standard setting.

The government health sector coordination capacity is weak, partly because the federal Ministry of Health is in the process of developing its role and capacity, but also because of fragmentation in both country and donor financing and interventions. Intergovernmental coordination in the health sector is emerging, reflecting political complexity and the nascent state of federalism.

SECTION 3. PARTNERSHIP ENVIRONMENT

3.1 Main health and development partners in Somalia

WHO is the main health partner of the Ministry of Health and Human Services of the Federal Government of Somalia and also works closely with other United Nations agencies in the country such as the Food and Agriculture Organization of the United Nations (FAO), International Organization for Migration (IOM), United Nations Children Fund (UNICEF), United Nations Development Programme, United Nations High Commission for Refugees, United Nations Office for the Coordination of Humanitarian Affairs (UN OCHA), United Nations Population Fund (UNFPA) and the World Food Programme (WFP).

Together, these agencies support the work of the health ministry in a harmonized manner. WHO is working closely with UNFPA on youth and women's health and with UNICEF on early childhood development and nutrition. In addition, WHO is working with the IOM and UNICEF on mental health and peace, and with the WFP for inclusion of health in its social safety net/protection programme. WHO is also collaborating with FAO on combating antimicrobial resistance and also on a one-health approach for protecting human and veterinary health.

The Federal Ministry of Health and Human Services is actively engaged in strengthening collaboration with bilateral partners, health and development partners and the private sector, a priority highlighted in the National Development Plan 2020–2024. Somalia is a member of the African Union and also the regional Intergovernmental Authority on Development and collaborates closely with member countries of both organizations on health issues. The

country also has good technical relations with United Nations agencies and bilateral partners as the country is mostly dependent on aid for its developmental work.

WHO also collaborates with other institutions, including those in the private sector, to support the national health agenda. The collaboration with academia and professional associations is expanding, not only to support national health priorities but also to support research and curriculum development in medicine and nursing training and provide opportunities for postgraduate training. Somalia's health sector is not necessarily always underfunded; rather, a lack of coordination, competition and a disjointed approach have led to fragmentation and duplication of work. The WHO country office is playing a convening role to bring together all United Nations agencies and partners for a common purpose and goal to better serve and address the needs of the health sector of Somalia. It will continue to promote, support and advance joint and collaborative actions by United Nations agencies that can contribute effectively to improved health outcomes, especially in relation to the SDGs. WHO's strong engagement in the health sector offers a unique opportunity to harness the power and strength of the United Nations and principal agencies who are signatory to the *Global Action Plan on Healthy Lives and Well-being For All* (GAP) in Somalia to support positive health outcomes and systematically track and monitor the SDG 3 goals and PHC-led recovery following COVID-19.

Throughout the CCS implementation, WHO will continue to build partnerships with existing and new donors, and ensure all contributions are in line with government priorities and needs and consistent with Somalia's humanitarian response plans, emergency response plans (e.g. COVID-19, floods and drought) and the present CCS, which also advances the health-related goals of the SDGs and the triple billion targets of WHO.

3.2 Health sector coordination

Health sector coordination in Somalia has been undertaken through many different channels, including, but not limited to: the Pillar 7 Working Group, a government-led multisectoral coordination forum for health, which brings together the federal Government, all federal member states, United Nations agencies, donors and other development partners; and a WHO-led, integrated humanitarian health response mechanism, called the Health Cluster, which coordinates the humanitarian health response over 120 partners across Somalia through regular meetings, continuous updates, needs assessments and responses to service provision gaps. The humanitarian health partners directly provide health services in conjunction with the health authorities and respond to humanitarian and public health emergencies to improve the health outcomes of affected populations through timely, predictable, appropriate and effective coordinated health action. By doing so, these humanitarian health partners, which are mostly local nongovernmental organizations, fill the gaps in human resources, supplies and equipment in the health sector. In addition, by organizing outreach services which augment the capacity of fixed facilities, these organization enable health providers to serve marginalized, nomadic and hard-to-reach communities with integrated health, nutrition, and water, sanitation and hygiene services. Furthermore, community engagement is critical to improving health services and disease prevention, especially among women and girls. Recently, WHO, the World Bank and the Global Financing Facility, have worked to roll out the EPHS 2020, which is a key strategy to improve health services and also ensure sustainable and predictable funding for the health sector.

WHO Somalia will continue to strengthen partnerships with all relevant health actors and will work to forge new partnerships. The Organization recognizes that greater and lasting impact can only be achieved by working together with others, whereby each partner is able to utilize and benefit from the strengths of one another. Furthermore, WHO Somalia will continue to work in close partnership with the Ministry of Health and Human Services to ensure government commitment to, and ownership of, the health activities undertaken.

3.3 Collaboration with the United Nations system at country level

The UNSDCF 2021–2025 for Somalia aims to facilitate better integration of United Nations activities in efforts to achieve the SDGs. The strategic priorities of the Somalia CCS are fully aligned with the UNSDCF 2021–2025 for Somalia. WHO will monitor the progress of implementation of health-related SDGs under this framework. In addition, together with other United Nations agencies, WHO will help monitor progress in the fourth strategic priority of UNSCDF – social development – and all its outcomes.

3.4 Global Action Plan for Healthy Lives and Well-being for All – SDG coordination

The Global Action Plan brings together 12 multilateral health, development and humanitarian agencies[2] to more effectively support and coordinate countries to accelerate progress towards the health-related SDGs. The plan will enable agencies to better align work, reduce inefficiencies and provide more streamlined, strategic and longer term developmental support within the international health commitments made at the United Nations high-level meeting on UHC and the Astana Conference on Primary Health Care. WHO's strong relations with SDG 3 GAP partners (especially GAVI - the Vaccine Alliance, the Global Financing Facility, the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNDP, UNFPA, UNICEF, UN Women, World Bank and WFP) at senior and operational levels will allow the agency to bring together these partners and the health authorities to support the PHC-led recovery of the health system using innovative approaches. Joint actions and collaboration between the SDG 3 GAP partners. This could also encourage bilateral donors to finance the PHC-led health system recovery, which is founded on equity and social protection, and promotes the humanitarian-development-peace nexus in the country.

SECTION 4. WHO COLLABORATION WITH SOMALIA

WHO has been working in Somalia since 1960 when its country office was established in Hargeisa (Somaliland). Currently, its country office is based in Mogadishu, the capital city of Somalia. The WHO country office coordinates its activities from four strategic locations: the main country office in Mogadishu and its three sub-offices in Garowe (in Puntland), Baidoa (in South West state) and Hargeisa (in Somaliland).

The work of the WHO country office for Somalia is focused on improving the health outcomes and health status of the population of Somalia, especially the underserved communities (Fig. 4). This work involves planning, strategizing and implementing an integrated set of interventions that reduce health inequities, promote healthy well-being and improve the quality and coverage of and access to health care services. WHO's country programmes are fully aligned with the triple billion targets of the GPW13 and the health-related SDGs in support of 2030 Agenda for Sustainable Development.

A country functional review was conducted by the Regional Office and updated in July 2019 which reviewed the organogram, human resources plan, financial implementation, management structure and proposed recommendations to cover strategic areas. Increased staffing capacity at the country office to support the priority areas of work of WHO is being considered.

[2] The 12 multilateral agencies that have committed to the GAP SDG 3 initiative are: Gavi - the Vaccine Alliance, Global Financing Facility, Global Fund to Fight AIDS, Tuberculosis and Malaria, Joint United Nations Programme on HIV and AIDS, United Nations Development Programme, UNFPA, UNICEF, Unitaid, UN Women, WFP, WHO and the World Bank.

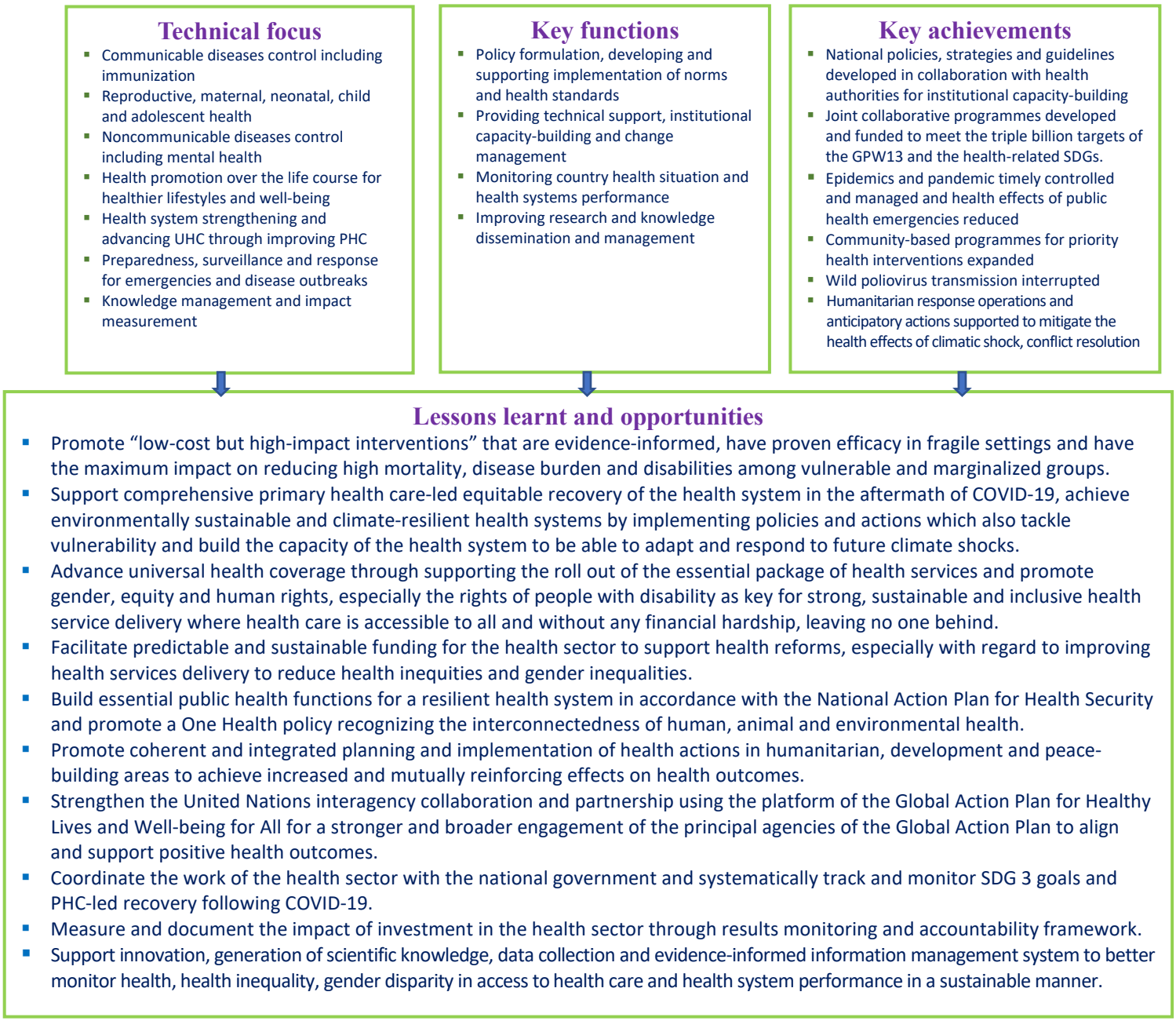

Fig. 4. Collaboration between Somalia and WHO: technical focus, key functions and key achievements

4.1 Somalia's contribution in the health agenda

Somalia has been playing an increasingly important role in contributing to global and regional health agendas. Somali ministers of health actively contribute to the World Health Assembly, WHO Regional Committee for the Eastern Mediterranean and other regional and global forums. Many Somali health experts have worked and are working in WHO at regional and global levels.

The country has contributed to a number of public health milestones, including the London Somalia Conference 2017, Family Planning 2020 Forum, 2030 Sustainable Development Agenda, UHC Forum, Scaling Up Nutrition and the Astana Declaration 2018.

Somalia is also active in regional forums, especially the Arab League, the African Union (AU) and the Intergovernmental Authority on Development (IGAD) and the Tokyo

International Conference on African Development. Somalia collaborates closely with the Member States of the Region on important health issues.

SECTION 5. STRATEGIC PRIORITIES

The strategic agenda for cooperation between Somalia and the WHO is based on an analysis of the Somali health situation, the present health system, the national health and development agenda, as well as current progress of Somalia in achieving the triple billion targets of WHO's GPW13.[3] It is expected that the CCS will strengthen existing collaboration between WHO and Somalia in order to advance UHC and improve the health of the population and drive the country to accelerate progress towards the health-related SDGs.

While implementing the CCS, the country office will support functional integration of all programmes that WHO supports for greater coherence, synergy and impact. The country office will also support innovation in each of the strategic priority areas and will continue to measure the impact of its work and generate new knowledge and evidence specific for fragile settings.

Four strategic priorities have been set for the CCS of Somalia for 2021–2025 that are drawn from the analysis of trends in each of three triple billion targets of WHO's GPW 13, which indicate:

- until 2025, Somalia is projected to make progress towards UHC with more people covered by health services without experiencing financial hardship;
- while Somalia, up to 2019, has made considerable progress in its timely response to health emergencies with more people protected, a worsening situation is anticipated until 2025 unless the country steadfastly makes progress in building and maintaining IHR core capacities;
- Somalia is anticipated to continue to witness worsening trends in the areas of the healthier population billion target, with less people enjoying better health and well-being.

The Triple Billion Target projections indicate that further efforts are needed. These projections have guided the strategic agenda for cooperation between Somalia and WHO, which are divided into four strategic priorities.

Strategic priority 1 – Advance UHC by accelerating the PHC-led recovery with a view to supporting the goals of integrated health services

- Support implementation of the revised EPHS 2020 (*Damal Caafimaad*) as a way to achieve health for all, by all, using PHC as the road to UHC.
- Develop and implement a strategy for development, recruitment and retention of the health workforce for delivery of the EPHS and to address the acute shortage of health workers in the country.
- Implement key, evidence-informed reproductive, mother and child health interventions (including introducing new vaccines) with proven effectiveness in settings with limited resources.
- Promote health actions and services linking short-term relief with long-term developmental goals that support the humanitarian-development-peace nexus and reinforce the "New Way of Working" for coherent, integrated planning and implementation of actions to achieve collective goals in the transition to peace and health.

[3] Tracking the Triple Billion targets: https://www.who.int/data/triple-billion-dashboard.

- Optimize and invest in community-based health interventions for delivery of preventive, promotive and curative health services as part of improving equitable access to health care for the most vulnerable and marginalized populations.
- Promote innovations in health services, for instance use of solar-powered oxygen delivery system to improve access to medical oxygen for critical care, as well as for electrification of health facilities, introduction of e-Health, etc which will optimize effective functioning of biomedical equipment for delivering integrated health care

Strategic priority 2 – Enhance health security by promoting emergency preparedness, surveillance and response using an all-hazard and One Health approach

- Implement the National Action Plan for Health Security to build and maintain the required IHR core capacities.
- Support the roll-out of an integrated disease surveillance and response system for detection and prevention of disease outbreaks and health security threats in real time.
- Build essential public health functions at the district level to meet the priority public health goals of a resilient health system for health security.
- Support medical counter measures such as uptake and coverage of vaccines and biologicals for effective epidemic and pandemic prevention and control.
- Use the One Health approach to prevent and mitigate health risks at the interface of human, animal and environmental health eco system.
- Promote data innovation and use of information technologies (including use and expansion of e-Health and telemedicine) and support digital transformation for policy-making and managing epidemics and health threats.

Strategic priority 3 – Promote healthier populations and well-being using a multisectoral approach to address the social determinants of health and risk factors

- Promote intersectoral actions for protection of health, and promotion of healthier lifestyles and well-being.
- Address social determinants of health by supporting policies and practices that promote tailored interventions for: high-risk populations; the environment and health, water and sanitation; nutrition; and health literacy.
- Align actions that can improve health over the life course, such as promoting mental health and tobacco control, and strengthening substance abuse and disability programmes.
- Support community-based initiatives and multisectoral partnerships for Health-in-All-Policies focusing on environmental health, noncommunicable diseases and antimicrobial resistance.
- Advocate for inclusion of health in the social protection programme of the marginalized and poor populations.
- Support the development and implementation of policies and actions that contributes to attainment of an environmentally sustainable and climate-resilient health system.

Strategic priority 4 – Strengthen the role of health governance using the Global Action Plan for Health and Well-being to support joint and collective actions to achieve SDG 3 goals

- Facilitate effective coordination between the Government, health-related development partners and nongovernmental organizations for collective health outcomes.
- Put into operation the framework of collaboration for GAP agencies to support PHC-led health services recovery in the aftermath of COVID-19, focusing on reducing service gaps in equity, coverage and access to care.

- Collaborate with other United Nations agencies to monitor progress towards SDG 3 goals within the United Nations Country Team and harness joint actions and ensure alignment and integration to achieving goals within the focus of PHC-led health services.
- Support the development of a health information management system that generates timely, reliable, actionable and disaggregated data to monitor the health situation and health system performance at national and subnational level.

5.1 Country results framework

WHO will jointly monitor and measure progress in each of the strategic priorities over the period of 2021–2025, jointly, with the Government of Somalia and the United Nations Country Team based on the indicators shown in Table 4. This will also form part of the evaluation process of the UNSDCF.

Table 4. Indicators to measure progress in the CCS strategic priorities

Country impact framework indicator	Baseline (year)	Target (2023)	Target (2025)	Disaggregation factors*	Indicator alignment
Priority 1 – Advance UHC: ensure more people benefit from UHC					
UHC Service Coverage Index[a]	27 (2019)	29	31	Geo	GPW, UHC roadmap, EPHS
Maternal mortality ratio (per 100 000 live births)[a]	829 (2017)	800	780	Geo	GPW, NDP, EPHS, UHC roadmap, RMNCAH, UNSDCF
Proportion of births attended by skilled personnel (%)	31.9(2019)	37	40	Geo/SE	GPW, NDP, EPHS, UHC roadmap, RMNCAH,
Under-5 mortality rate (per 1000 live births)[a]	117 (2019)	114	110	Geo/SE/Gen	GPW, NDP, EPHS, UHC roadmap, RMNCAH, UNSDCF
Neonatal mortality rate (per 1000 live births)[a]	37 (2019)	33	30	Geo/SE	GPW, EPHS, UHC roadmap, RMNCAH
Proportion of children < 1 with access to pentavalent 3 vaccines (%)[a]	42 (2019)	> 60	> 70	Geo/SE/Gen	GPW, EPHS, UHC roadmap, UNSDCF
Proportion of women (15–49 years) receiving antenatal care four or more times (%)	24 (2020)	> 30	> 35	Geo/SE	GPW, RMNCAH, EPHS
Proportion of tuberculosis cases that are treated (%)	42 (2019)	> 42.5	> 43	Geo/SE/Gen	GPW, NDP, EPHS, UHC roadmap
Incidence of malaria (per 1000 population a year)	2.15 (2018)	1.10	0.70	Geo	GPW, EPHS, UHC roadmap
Proportion of people living with HIV receiving antiretroviral therapy (%)	29.7 (2018)	48.2	> 50	Geo/Gen	EPHS, UHC roadmap
Essential health workforce density (per 1000 population)	0.11 (2014)	> 1	> 1	Geo/Gen	GPW, NDP, EPHS, UHC roadmap
Proportion of PHC facilities with selected essential medicines available, including NCD medicines (%)	NA	> 50	> 65	Geo	GPW, NDP, EPHS, UHC roadmap
Government health expenditure as per cent of total health expenditure (%)	< 1	> 1	2	–	GPW, EPHS, UHC roadmap

Country impact framework indicator	Baseline (year)	Target (2023)	Target (2025)	Disaggregation factors*	Indicator alignment
Priority 2 – Enhancing health security					
IHR core capacities score[a]	31 (2019)	31.8	> 35	–	GPW, NAPHS, UHC roadmap
Proportion of people in accessible areas covered by integrated disease surveillance and response system (%)	0	> 15	> 40	Geo	GPW, NAPHS, UHC roadmap
Proportion of IHR events detected and responded to in a timely manner (%)	51.7 (2018)	68.3	> 75	Geo	GPW, NAPHS
Proportion of at-risk people vaccinated against epidemic- and pandemic-prone diseases (%)	0	46.5	> 75	Geo	GPW, NAPHS, EPHS, UHC roadmap
Proportion of children under 5 years who are acutely malnourished (%)[a]	17.4 (2017)	< 15		Geo/Gen	GPW, NDP, EPHS, UHC roadmap, UNSDCF
Priority 3 – Promoting healthier population					
Proportion of children aged 0–6 months who are exclusively breastfed (%)	33 (2020)	> 40	53	Geo/SE/Gen	GPW, NDP, EPHS, UHC roadmap
Prevalence of stunting in children under 5 years (%)[a]	27.4 (2020)	26	< 25	Geo/SE/Gen	GPW, NDP, EPHS, UHC roadmap, UNSDCF
Proportion of the population with access to safely managed drinking-water services (%)	52 (2017)	> 55	> 60	Geo	GPW, NDP, UNSDCF
Proportion of the population with access to safely managed sanitation services (%)[a]	38 (2017)	42	> 45	Geo	GPW, NDP, UHC roadmap, UNSDCF
Road traffic mortality rate (per 100 000 population)	27.4	< 25.0	< 23.0	Geo	GPW, NDP, EPHS
Priority 4 – Strengthening health governance					
Statistics/data related to UHC Index available at national, state and regional levels[a]	–	Yes	Yes	Geo	GPW, UHC roadmap
Functioning framework for interagency collaboration and coordination established	–	Yes	Yes	Geo	GPW, EPHS, UHC roadmap
Health included in the social safety net/protection programme	–	Yes	Yes	National	GPW, UHC roadmap

UHC: universal health coverage; Geo: geographical/urban–rural; GPW: Global Programme of Work; EPHS: Essential Package of Health Services; NDP: National Development Plan; RMNCAH: reproductive, maternal, neonatal, child and adolescent health; UNSDCF: United Nations Sustainable Development Cooperation Framework; SE: socioeconomic status/wealth quintile; Gen: gender; NAPHS: National Action Plan for Health Security; NCD: noncommunicable disease; IHR: International Health Regulations.

[a] Mandatory indicators.

Table 5. Budget estimates for the strategic priorities in the Somalia country cooperation strategy, 2021–2025

Strategic priority	Estimated budget required[a] (US$)	Anticipated funding[b] (US$)	Anticipated funding gap[c] (US$)
Strategic priority 1	52 650 000	22 000 000	30 650 000
Strategic priority 2	23 165 000	4 000 000	19 165 000
Strategic priority 3	26 985 000	14 000 000	12 985 000
Strategic priority 4	12 500 000	6 700 000	5 800 000
Total	**115 300 000**	**46 700 000**	**68 600 000**

[a] Budget is based on historical costs.

[b] Based on historical funding and anticipated funding from donors in priority areas.

[c] Estimated budget required – anticipated funding. Funding gap forms the basis for the country plan for resource mobilization.

5.2 Financing the strategic priorities

The proposed CCS financing is closely linked to the WHO Country Support Plan which takes account of the CCS priorities in WHO-led support for country work. The five-year budget estimate is shown in Table 5.

The Ministry of Health and Human Services and WHO will develop a health financing strategy and a joint resource mobilization plan to mobilize resources to support the implementation of the CCS by exploring different funding options. While the WHO country office will continue to leverage on funding received from internal WHO sources to support the implementation of the CCS, specific proposals will be developed to access funding for priority strategic areas of CCS from the bilateral and multilateral donors. To this end, a specific "business case" will be developed (and may be updated on an annual basis, if required) outlining the value of investing on WHO's strategic and high-impact interventions to drive and accelerate the attainment of health-related SDGs, PHC-led equitable recovery from COVID-19 pandemic and advancing UHC in Somalia, as well as safeguarding the country's environment and health security.

SECTION 6. IMPLEMENTATION OF THE CCS

The Country Cooperation Strategy for WHO and Somalia will be launched in 2021 and implementation will start immediately and will continue over the years 2022–2023 and 2024–2025. Implementation of the four strategic priorities will require the engagement by the Ministry of Health and Human Services of the Federal Republic of Somalia, the Ministries of Health of the Federal Member States and WHO at country, regional and headquarter levels, as well as other health partners.

6.1 WHO's key contributions to the four strategic priorities

Table 6 illustrates the contributions that the WHO country office, the Regional Office and the headquarters will make to the four strategic priorities. The table also outlines what success will look like if the CCS is successfully implemented.

Table 6. Key contributions to the four strategic priorities

Priority 1 – Advancing UHC

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Support the strengthening of health systems using PHC as foundation to achieving UHC through development and implementation of policies, strategies, legislation and regulatory frameworks for effective health services	• Strengthen the country office's capacity to support, adapt and implement policies and strategies effectively by developing norms and standards	• Develop guidance and give policy support to improve equity, coverage and access to UHC services using PHC as the foundation
• Actively support the implementation and roll out of revised EPHS (2020) through appropriate policy support	• Support adapting global tools (UHC compact) to monitor progress of UHC and track health outcomes	• Generate international best practices and develop guidance to support dialogue and capacity-building for development and implementation of UHC in fragile, conflict-affected and vulnerable settings
• Provide technical support for development of appropriate human resources for integrated service delivery	• Generate evidence using multicountry research or case studies that promote and improve health outcome using a PHC-led recovery following the COVID-19 pandemic in fragile, conflict-affected and vulnerable settings	• Develop evidence-based policies, options, technical and normative standards for health financing, delivery of integrated health services, quality of care and comprehensive PHC
• Support planning and delivery of good quality, safe, people-centred, efficient, equitable and integrated health services across all continuum of care	• Provide platform for advocacy and sharing of policy options, experiences and best practices, and support policies and strategies to end preventable maternal, perinatal and neonatal mortality	• Design and disseminate tools to help strengthen, develop and monitor health and health-system performance
• Promote public–private partnerships to improve access to, and equitable coverage and efficiency of UHC	• Provide technical support for health-facility assessment, health workforce mapping and establishment of a national regulatory authority	• Help mobilize resources for the country office for its work to achieve UHC and service delivery using a PHC approach
• Advocate for and develop strategies to raise adequate public financing for health	• Support the country office for assessment and development of an integrated and standardized health information management system	• Build capacity at the country office to measure the impact of WHO's work
• Support the health authorities to develop appropriate data management system for measuring coverage, inequity and access to health care by different income groups	–	• Support scaling up innovations for health by connecting with innovation funders

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Coordinate with partners to create synergy with and align investments in strategic priorities of the Government and the CCS		
• Strengthen the national regulatory authority to ensure high quality of standards in drug regulation, and pharmaceutical and health technology services	–	–
• Promote rational prescribing, dispensing and use of medicines and other health technologies	–	–
• Develop policies and regulations to ensure availability and affordability of essential medicines and other health technologies through efficient procurement, supply chains and pricing systems	–	–
• Promote links with other countries and organizations for mutual transfer of technologies and skills for the advancement of health	–	–

Success will look like:

- The revised essential package of health services (EPHS 2020) has been rolled out and data show increased overage and equitable distribution of services over time.
- PHC services, including community-based care, integrated into secondary and tertiary level care ensuring continuum of care across all levels of service delivery with demonstrable positive effects on health indicators.
- Interventions on noncommunicable diseases, mental health, communicable disease control, reproductive, mother and child health interventions, immunization and other low-cost, high-impact interventions have been integrated and delivered at the PHC level with visible changes in access, coverage, equity and quality of care.
- Sustainable health-financing strategy in support of a PHC-led recovery of the health system has been developed and a national health account established to monitor out-of-pocket and catastrophic health expenditure.
- Health facility survey using the harmonized health facility assessment tool is done at-least once in every 5 years to review the availability of health facility services, the systems to deliver the services at required standards, and the effectiveness of the services integral to UHC.
- Low cost but high-impact interventions for reproductive, mother, neonatal, child and adolescent health and routine immunization are integrated into community-based care and rapidly scaled up with data showing increased coverage, access and equity.
- The national HIMS has been integrated, standardized and updated to generate standardized data that should facilitate consistent reporting on essential health services and tracer indicators of UHC, and can track progress of health-related indicators of SDG 3 at national and subnational levels.
- Mapping of the existing health workforce has been completed, the projected need in support of UHC and the revised EPHS package has been estimated and a new human resources strategy for health has been developed (especially for community health workers) for delivery of EPHS and for achieving UHC outlining viable options for training, production, deployment and retention of human resources for the health sector.
- A National Pharmaceutical Regulatory Authority has been established and is functioning, which promotes and enforces the implementation of the national medicines policy and rational use of medicines, and improves access to good-quality medicines and health products.

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
Key implementation partners		
• Federal and state ministries of health and other line ministries – health system strengthening coordination • World Bank, multilateral and bilateral donors, and United Nations agencies– health financing for UHC and monitoring of UHC • Public health service providers, nongovernmental organizations, private sector health practitioners and female health workers – service delivery • Somali parliament – monitoring SDGs and access to health as a human right		

EPHS: essential package of health services; RMNCAH: reproductive, maternal, neonatal, child and adolescent health; UHC: universal health coverage; CCS: Country Cooperation Strategy; TRIPS: trade-related aspects of intellectual property rights; PHC: primary health care; WHO: World Health Organization; SDG: Sustainable Development Goal; UN: United Nations.

Priority 2 – Enhancing health security

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Strengthen national IHR core capacities and monitor progress	• Support the country office to run simulation exercises, and mid- and after-action reviews as part of country IHR core capacity assessment and evaluation	• Develop and disseminate a guideline on integrated disease prevention and health care in crises and emergencies
• Develop national capacity to assess risks and vulnerability to health hazards and climate shocks	• Support establishment of national health emergency operation centres, early warning and response systems and public health laboratories with capacity for genome sequencing	• Establish and coordinate expert global networks for forecasting and modelling, pathogen identification and virulence assessment, risk communication and response
• Support development and implementation of national action plan for health security	• Provide technical support for outbreak response and coordination support in emergencies, including in the maintenance of essential health services for affected populations	• Support deployment of Global Outbreak Alert and Response Network teams in the event of declared outbreaks of international concern
• Ensure public health preparedness and operational readiness to manage identified health risks and vulnerabilities at national and subnational levels	• Provide funding and support resource mobilization efforts for implementation of the national action plan for health security and IHR core capacity development	• Monitor and disseminate information on IHR core capacities using information provided in the IHR State Party Self-Assessment Annual Report
• Support implementation of all recommended public health measures in the event of declared public health emergencies in accordance with the IHR	• Provide technical support for implementation of integrated disease surveillance and response systems, hazard and risk mapping, and development and implementation of a One Health framework	• Advocate for funding for implementation of national action plan for health security and IHR core capacities
• Support field investigation, verification and reporting of all IHR events in a timely manner	• Support knowledge generation and evidence synthesis on outbreak detection and response in fragile, conflict-affected and vulnerable settings	–
• Support regulatory measures and preparedness for public health emergencies	–	–

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Support implementation of integrated disease surveillance and response systems and monitor key performance and surveillance indicators	–	–
• Build capacity and strengthen outbreak investigation and response capacity at national and subnational levels	–	–
• Promote the One Health approach for improving surveillance and response capacity at the animal-human interface for zoonotic diseases and health threats from antimicrobial resistance	–	–
• Support and advocate for roll out of a pyramidal model field epidemiology training programme for frontline health workers	–	–
• Support establishment of integrated public health teams for acute health emergencies	–	–
• Ensure resilience of health system through improving essential public health functions at the district level for health security	–	–

Success will look like

- The national action plan for health security for strengthening IHR core capacities has been implemented in all 19 technical areas and progress in each of IHR core capacities documented and validated either through external assessment or through intra-action or after-action reviews.
- An integrated disease surveillance and response system has been implemented at national and subnational levels with early detection of health threats in real time, optimal population coverage and with acceptable performance indicators (such as reporting timeliness and completeness).
- At least 80–90% of vaccination coverage for at-risk groups has been achieved through targeted campaigns in the event of any declared outbreak to stop transmission and sustain interruption.
- National framework for improving essential public health functions has been developed and implemented to strengthen the health system for health security to ensure effective management of health emergencies, while maintaining the continuity of essential health services.
- Health vulnerability assessment, risk analysis and mapping of all hazards with potential to affect public health have been completed and emergency preparedness and response plans for major epidemic threats have been developed and implemented for risk mitigation and vulnerability reduction.
- Vulnerability assessment to ensure environmentally sustainable and climate-resilient health systems has been completed, and policies have been developed which lead to risk reduction and improved capacity of the health systems to adapt and respond to future climate shocks.
- A national framework for One Health has been implemented for surveillance and response to the threat of emerging zoonotic diseases and antimicrobial resistance and for enhanced coordination and collaboration between human health, environmental health and animal health sectors.

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Field epidemiology training programme for frontline health workers has been introduced and pyramidal model training rolled out. • Genomic surveillance has been included in the epidemiological surveillance system at the national level as part of enhanced epidemic and pandemic preparedness and for real-time tracking and response to emerging pathogen with epidemic and pandemic potential. • Transition for polio eradication programme has been completed and the polio network and infrastructure have been successfully retained in the form of integrated public health team for national health security, including to prepare for and avert public health emergencies and contribute to WHO's triple billion targets.		
Key implementation partners		
• Federal and state ministries of health – preparedness • FAO – One Health • United Nations Environment Programme – environmental health • WFP, UNICEF, UNFPA and other partners – delivering essential food, health services and vaccinations in emergencies • World Bank, Islamic Development Bank, African Development Bank, other multilateral and bilateral donors – providing funding to strengthen IHR core capacities		

IHR: International Health Regulations; NAPHS: National Action Plan for Health Security; FAO: Food and Agriculture Organization of the United Nations; UNEP: United Nations Environment Programme; WFP: World Food Programme; UNICEF: United Nations Children's Fund; UNFPA: United Nations Population Fund.

Priority 3 – Promoting a healthier population

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Provide technical support to strengthen national and state capacity to engage in effective multisectoral coordination of interventions for safe and healthier environments	• Establish, support and strengthen partnerships and intersectoral policy platforms among countries and regional partners to tackle environmental, social and occupational determinants of health	• Develop methodologies and tools and generate evidence to support the development of policies, strategies and regulations for prevention and management of environmental and occupational risks and climate change, including in sectors of the economy other than health
• Contribute to country- and city-level implementation of WHO guidelines, tools and methodologies for water, sanitation and health (WASH)	• Provide technical support and training for country office and health ministry staff on health impact assessments of environmental risks	• Support innovative techniques and methods for data collection to monitor progress and impact of WHO interventions for promoting a healthier population
• Support establishment and coordination of cross-sectoral partnership mechanisms on childhood nutrition to promote healthy diets and achieve food security	• Conduct regional and intercountry capacity-building activities for policy and programme development related to road safety, clean air, safer environments, safer health care, food safety and prevention of tobacco and substance use	• Generate evidence and knowledge on "best practices" for interventions and implementation methods to achieve highest impact in fragile, conflict-affected and vulnerable settings
• Engage partners to create synergies between programmes to address social determinants of health	• Provide access to financial, technical and policy support for implementation of activities that lead to healthier populations	• Provide access to financial, technical and policy support for implementation of activities that lead to healthier populations

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Strengthen policies and systems for tackling antimicrobial resistance • Support policies and plans that empower people and communities to share responsibilities to improve health through healthy lifestyles • Support capacity to develop and implement programmes to tackle injuries and violence against women, children and young people, and monitor their implementation • Support the Government to ratify the WHO Framework Convention on Tobacco Control and implement the WHO MPOWER package to reduce tobacco and substance use • Provide technical support for implementation of the mental health global action plan (mhGAP) at the PHC level • Support the Government in using innovative method for collection of data on road safety, mental health and tobacco use • Support community-based initiatives and multisectoral partnerships for HiAP that contribute to healthy lives, safe environments, road safety and climate action, among others	–	–
Success will look like: • Intersectoral and multisectoral coordination mechanism to tackle social determinants of health has been established and is functional at national and subnational levels. • Country capacity has been enhanced to assess health risks from climatic shocks and implement policies, strategies or regulations for the prevention, mitigation and management of the health risks arising from behavioural, environmental, occupational and metabolic risk factors. • Selected interventions to integrate health and nutrition have been implemented at the PHC level that demonstrate visible changes in tackling high levels of malnutrition.		

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• The WHO Framework Convention on Tobacco Control has been ratified by the country leading to access to increased technical and financial support for policy-making. • WHO MPOWER package has been partially implemented to reduce tobacco and substance use rates in the country and minimize the risk of death attributed to tobacco use. • Data are available in the national HIMS and published annually as part of annual health statistics or as a separate mental health annual report on a set of five core indicators that cover mental health policy and law, promotion and prevention programmes, service availability and mental health workforce as defined in the WHO mental health action plan. • mhGAP has been scaled up by integrating mental health services within the PHC and community out-reach services through task shifting of health workers. • A comprehensive strategy has been implemented to ensure access to safe water and safely managed sanitation in all vulnerable communities linking the interventions with safe and healthy living. • Plans for health care waste management and improving water and sanitation services in health facilities have been developed, implemented and interagency support secured for improvement of environmental health in such settings. • Data collection on road safety has been enhanced using innovation and multisectoral collaboration to improve road safety, at least on a pilot scale.		
Key implementation partners		
• Federal and state ministries of health and line ministries – intervention implementation and monitoring • UNFPA – family planning programme and midwife training • UNICEF – infant feeding programmes, WASH and communication • World Bank, multilateral and bilateral donors – providing funding support on UHC and PHC and specifically on RMNCAH and nutrition services, and strengthening the financial management system in the public sector		

WHO: World Health organization; WASH: water, sanitation and hygiene; mhGAP: Mental health gap action programme; PHC: primary health care; UNFPA: United Nations Population Fund; UNICEF: United Nations Children's Fund; UHC: universal; health coverage; RMNCAH: reproductive, maternal, neonatal, child and adolescent health.

Priority 4 – Strengthen health governance

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Improve the governance and oversight functions of the state and local authorities (district level) through capacity injection, exchange visits, fellowship programmes and implementation of regulatory frameworks with a view to ensuring transparency, accountability, efficient use of resources and effective delivery of health services	• Provide technical backstopping for monitoring SDGs at national and subnational levels	• Support implementation of the GAP by coordinating effectively with the GAP principal agencies
• Collaborate with federal and state ministries to improve their health information systems, analytical capacity and monitoring for health risks, social determinants of health and health system performance	• Provide technical support for establishing civil registration and other vital statistics for births, deaths and cause of death	• Support scaling up innovations for health by connecting with innovation funders
• Help strengthen civil registration and other vital statistics system	• Support the country office to gather and analyse data on the impact of WHO at country level	• Provide technical support to the country office to build its capacity for data-driven operational planning, monitoring SDG 3 and GPW 13 indicators and conducting trend analyses

WHO's key contribution		
Country office	**Regional Office**	**Headquarters**
• Support the country to disaggregate data so that progress on gender equality and health equity can be measured	• Develop country-specific advocacy materials and policy briefs and organize policy dialogues on topical interest such as on GAP and SDGs	–
• Improve and develop standards and tools such as routine data, expenditure studies, health facilities assessment and population surveys	• Support the country office in implementing the change agenda to be a more effective and efficient office	–
• Advocate for domestic financial resources by fostering citizen participation and dialogue and by interacting with governments, including parliamentarians, finance ministers and heads of state for health workers, supply chains and health services	• Support the country office to assess and strengthen the national HIMSs to collect disaggregated data to track disease mortality, morbidity, risk factors and health inequities to inform future policy-making	–
• Promote inclusion of health in social protection programme through advocacy and evidence synthesis.	–	–

Success will look like:

- Better coordination and sharing of information among bilateral partners and GAP principal agencies have been established, and data on the health situation, priority needs, gaps in equity, coverage and access to care are available for improved governance by the health ministry, and donor-funded projects have been aligned with the Government's health priorities for positive health outcomes for the population.
- Health has been included in the beneficiaries of the social safety net/social protection programme and measurable health outcomes have been demonstrated among the beneficiaries.
- Implementation of GAP is reflected in the form of joined and collaborative multipartner-funded projects to support progress towards the health-related SDGs, especially in the areas of PHC for UHC and/or other health innovations.
- Regular, reliable and actionable health information and data to monitor progress of SDG 3 goals are available at national and subnational levels and capacity of the health ministry to measure health outcomes and health-sector performance and to track progress of health-related indicators of SDG 3 has been enhanced.
- Civil registration and other vital statistics for births, deaths and cause of death has been established, even on a pilot scale.
- Health innovation to accelerate impact (e.g. in PHC, noncommunicable diseases, mental health) has been scaled up as shown by, for example, increase in PHC centres with solar-powered medical oxygen and lives saved.

Key implementation partners

- Federal and state ministries of health – programme implementation and monitoring
- UN Resident/Humanitarian Coordinator, WHO Regional Office and headquarters – support of the country office

UHC: universal health coverage; WHO: World Health Organization; PHC: primary health care; SDG: Sustainable Development Goal; GAP: Global Action Plan for Healthy Lives and Well-being for All; GPW13: Thirteenth General Programme of Work; UN: United Nations.

6.2 Implementation support

The WHO country office in Somalia will establish a core coordination working group for the CCS comprising staff members from the WHO country and Regional Office and headquarters, as well as personnel from the Ministry of Health and Human Services, as required. This working group will review the implementation of the strategic agenda of the CCS on an annual basis.

The working group will ensure that the strategic priorities continue to be aligned with the national health policy and development agenda of the Federal Government of Somalia. The working group will assess the successes and areas for improvement including suggesting approach and means to assess result, measure effectiveness of the CCS during its implementation, as well as impact of delivery of WHO's work at the country level. The working group will also provide feedback for the mid-term evaluation, which will allow the country office to address any emerging needs and consider adjustments in its results framework before the final evaluation.

6.3 Links between the Country Cooperation Strategy and UNSDCF

The United Nations Sustainable Development Cooperation Framework (UNSDCF) 2021–2025 for Somalia developed in 2020, represents the commitment of the Federal Government of Somalia and the United Nations to work together to achieve peace, stability and prosperity for all Somali people in support of the 2030 Agenda for Sustainable Development and the SDGs.

The strategic priorities outlined in the CCS 2021–2025 of WHO have been fully aligned with the priorities identified in the UNSDCF and the National Development Plan-9. Both the CCS and the UNSDCF serve as the WHO and United Nations accountability framework to the Federal Government of Somalia and the Somali people.

WHO actively participated in the United Nations common country analysis and in the development of the UNSCDF (2021–2025). The UNSDCF has four strategic priorities and the fourth priority is social development, which has four outcomes. The strategic priorities of the CCS mirror the fourth priority of the UNSCDF – social development and all its four outcomes (Table 7).

WHO will develop specific work plans for implementation of the CCS by formulating specific results to be achieved. These workplans will form the basis of agreement between WHO and other UN agencies for implementation of strategic priority four of the UNSDCF.

Table 7. WHO Country Cooperation Strategy 2021–2025: priorities and key alignments with the GPW 13, National Development Plan-9 and the UNSDCF

	Priorities and key alignments			
	Advance UHC	**Enhance health security**	**Promote healthier population**	**Strengthen health governance**
GPW 13 strategic priorities	Strategic priority 1 (UHC) Outcome 1.1, 1.2, 1.3	Strategic priority 2 (health emergencies) Outcome 2.1, 2.2, 2.3	Strategic priority 3 (health and well-being) Outcome 3.1, 3.2, 3.3	Strategic priority 4 (leadership, and focus on global public goods)
NDP 9 (2021–2024)	Expand access to basic health care services of acceptable quality and establish the building blocks of an equitable, effective, efficient, responsive and sustainable health care delivery system. The principle of leaving no one behind and first reaching those farthest behind will be applied.	Enhance capacity for integrated disease surveillance and response, build capacity of the health workforce in epidemiology, establish and put into operation emergency operating and trauma care centres and strengthen diagnostic capacity of public health laboratories	Adopt a Health-in-All-Policies approach, which ensures the health sector interacts with and influences design implementation and monitoring processes of programmes in all health-related sectors	Strengthen the governance, institutional and management capacity of the health sector to deliver efficient and effective health and nutrition programmes and services. Enhance health information, research and evidence generation for policy development and decision-making

	Priorities and key alignments			
	Advance UHC	**Enhance health security**	**Promote healthier population**	**Strengthen health governance**
	Provide equitable, efficient and affordable good- quality essential health services as close to communities and families as possible based on the EPHS and PHC approach			
UNSDF 2021–25	Outcome 4.1. By 2025, more people in Somalia, especially the most vulnerable and marginalized, benefit from equitable and affordable access to Government-led and regulated good-quality basic social services at different state levels	Outcome 4.2. By 2025, the number of people impacted by climate change, natural disasters and environmental degradation is reduced Cover the most urgent emergency and/or crisis-related needs, and humanitarian and life-saving interventions	Outcome 4.3. By 2025, the proportion of vulnerable Somalis with scaled-up and sustained resilience against environmental and conflict-related shocks is increased based on better management of life cycle risk, food security, and better nutrition outcome	Outcome 4.4. By 2025, the capacities of local, national and customary institutions and communities are strengthened to achieve durable solutions and increase the resilience, self-reliance and social cohesion of urban communities affected by displacement

UHC: universal health coverage; GPW 13: Thirteenth Global Programme of Work; NDP: National Development Plan; EPHS: Essential Package of Health Services; PHC: primary health care; UNSDF: United Nations Sustainable Development Cooperation Framework.

SECTION 7. MONITORING AND EVALUATION

The Country Cooperation Strategy (CCS) will be launched in 2021 and implementation will begin immediately and over the 2022–2023 and 2024–2025 biennium. WHO, the Government of Somalia and the United Nations Country Team will jointly monitor and evaluate the implementation and effectiveness of the CCS (Fig. 5) using the CCS results framework. Periodic monitoring of the CCS will be undertaken through review of the biennial workplans, and activities undertaken, as well as through other instruments available such as the review of Mid-Term and End-of-the Biennium Programme Budget evaluation and WHO Country Support Plan. Periodical reviews of the progress through case studies and documentation of progress and success stories will provide inputs for the mid-term and end-term evaluation of the CCS. In 2023, a CCS mid-term evaluation will take place to assess progress towards the health outcomes, using the Country Results Framework indicators as a baseline, together with qualitative impact analysis through examples of successes in the country. The mid-term evaluation will be used to adjust priorities and outcomes based on the changing need in the country, as well as to effectively achieve the desired health outcomes. The final evaluation will be carried out in 2025.

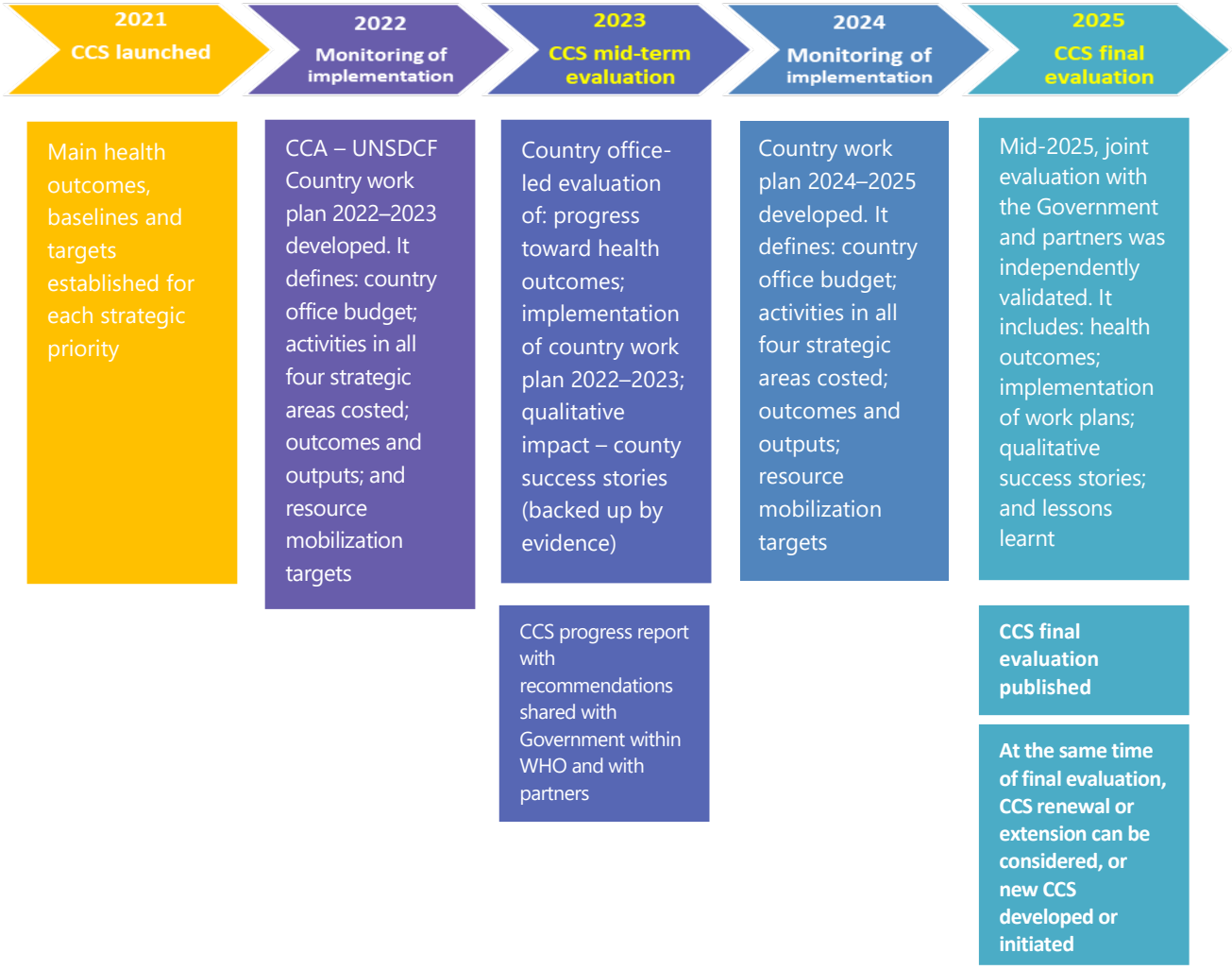

Fig. 5. Country Cooperation Strategy (CCS), 2021–2025: implementation, monitoring and evaluation timeline and activities

CCA: Country common analysis; UNSDCF: United Nations Sustainable Development Cooperation Framework; WHO: World Health Organization.

The WHO Representative will lead the evaluation process, with a CCS working group, which will include staff from across the Organization, as well as government partners and stakeholders. The process will be aligned to the Somalia health sector monitoring and evaluation. The CCS evaluation will have a specific focus on assessing the contribution of the CCS to progress toward the triple billion targets of the GPW13 – globally – and the health-related SDGs in Somalia.

Checklist for evaluation of the CCS

- Measure progress towards the impact targets identified for each strategic priority and therefore the contribution to the triple billion goals.
- Identify achievements and gaps in implementing the CCS strategic agenda.
- Determine the extent to which the CCS strategic priorities influenced progress towards achieving the health-related SDGs.
- Identify the critical success factors and impediments.
- Identify the lessons to be applied to the rest of the CCS cycle and future cycles.