Humanitarian-development-peace nexus for health profile

SOMALIA

October 2020

World Health Organization
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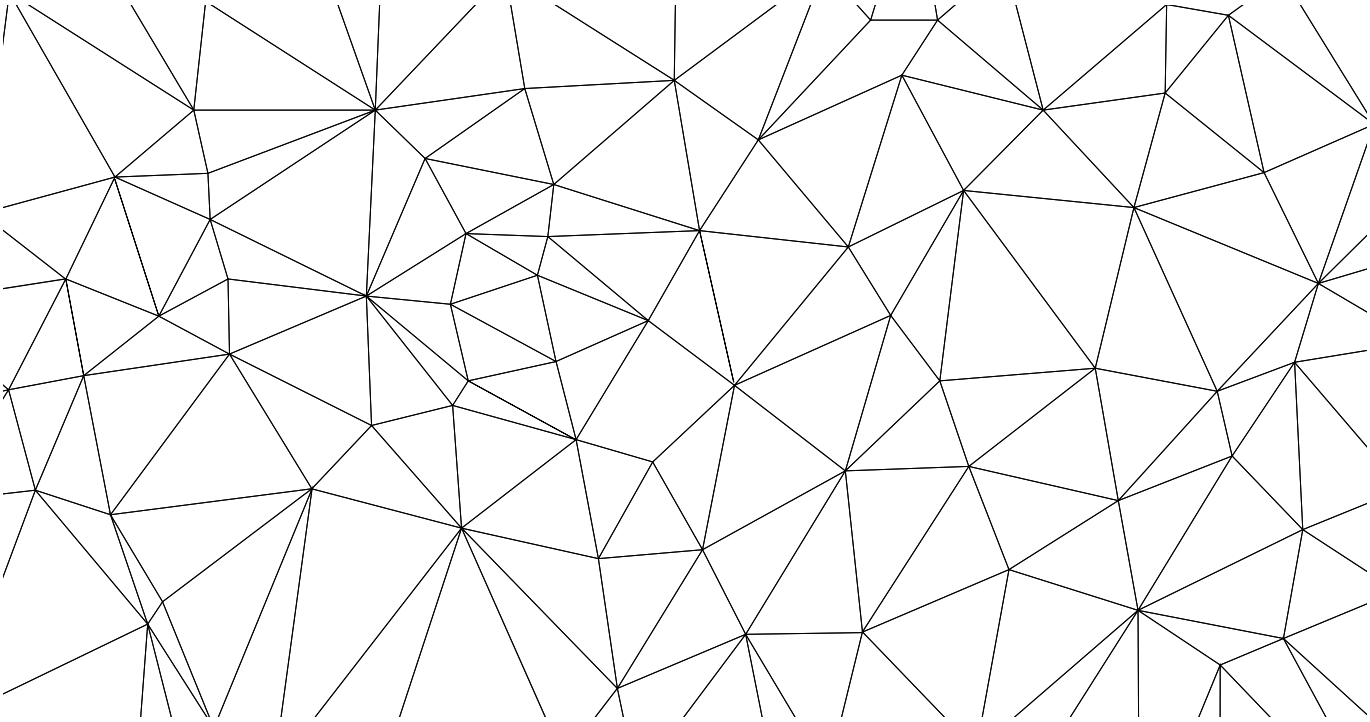

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Abbreviations

COVID-19	Coronavirus disease 2019
DHIS2	District Health Information System
EPHS	Essential package of health services
FGS	Federal Government of Somalia
HDPNx	Humanitarian-development-peace nexus
HeRAMS	Health Resources and Services Availability Monitoring System
HNO	Humanitarian needs overview
HRP	Humanitarian response plan
IDP	Internally displaced persons
NDP9	National Development Plan 9 2020–2024
NGO	Nongovernmental organization
NPS	New Partnership for Somalia
OCHA	Office for the Coordination of Humanitarian Affairs
PHC	Primary health care
SHINE	Somali Health and Nutrition Programme
UHC	Universal health coverage
UNSF	United Nations Strategic Framework
WHO	World Health Organization

Executive summary

THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX) is a framework for coherent joint planning and implementation towards shared priorities between humanitarian, development and peacebuilding actors. Although the HDPNx approach is not new, the question remains of how to operationalize it. This profile aims to provide a foundational understanding of progress the current HDPNx for health in Somalia by detailing the overview of the crisis, public health status/health system and current HDPNx operationalization.

Despite the advances made in promoting stability, Somalia's political landscape remains extremely challenging, due to factors such as high levels of insecurity, exacerbated by the continuing activities of non-state actors, weak capacity of state institutions and human resources and high prevalence of poverty. Clannism, which is at the core of the deep political divisions, continues to play a central role in perpetuating political instability in Somalia. In addition to the complex political environment, much of the recent, recurrent humanitarian need has been linked to climatic shocks. As most Somalis depend on agriculture, forestry and fisheries, climate-related changes significantly affect the lives of the Somali population.

Furthermore, Somalia is currently experiencing the "triple threat" of the COVID-19 pandemic, the most severe desert locust upsurge in recent decades and seasonal floods as a result of heavy Gu rains. At this time, less than 20% of health facilities have the necessary equipment and supplies to manage epidemics. The COVID-19 pandemic is creating unprecedented health, economic and social effects in the country.

Growing consensus for the HDPNx approach can be seen in Somalia. For example, the United Nations Strategic Framework for Somalia 2017–2020 highlights the HDPNx as one of its approaches to building partnerships and fulfilling the UN's commitment to supporting Somalia's National Development Plan. To further support a HDPNx approach, the United Nations Strategic Framework's priorities and outcomes are aligned with the 2030 Agenda for Sustainable Development, the Sustainable Development Goals and Somalia's Humanitarian Response Plan. Additionally, a high-level delegation from WHO visited Somalia in January 2020 to assess the current situation of primary health care and to provide recommendations for strengthening primary care, moving towards achieving universal health coverage.

At the government level, the Federal Ministry of Health, with support from sector partners, is presently reviewing the sector coordination structure to form national and state-level coordination mechanisms that will work to ensure coherent delivery of health services and reduction in duplication. The aim is to support partners on joint planning and implementation of sector programmes.

From a programme perspective, the Department of International Development-funded programmes, Somali Health and Nutrition Programme 2016–2021 and Somalia Humanitarian and Resilience Programme, aim to combine relief and resilience-building activities.

Finally, peace must be central to the HDPNx process, in order to prevent the constant regression of development and to reduce needs over time. In Somalia, communities living in conflict areas are severely impacted by armed violence, with civilians shouldering most of the burden through death and injury, destruction of property, taxation, land grabbing, destruction of livelihoods and restricted freedom of movement. At the same time, humanitarian interventions and health activities are frequently impacted due to insecurity. Integrated approaches, which both address health needs and promote peacebuilding, are critical, as in the case of a WHO-led collaboration working to improve psychosocial support and mental health care for conflict-affected youth, enabling them to engage in promoting social cohesion rather than the negative practices which contribute to conflict. Peace is therefore central to achieving humanitarian and development goals in Somalia.

The groundwork for the HDPNx has been paved in Somalia and different actors have begun to build on this foundation. However, there is recognition that further improvements must be made to formally articulate and align HDPNx for health efforts. The following are potential opportunities for advancing implementation of HDPNx for health in Somalia:

- strengthening existing health coordination mechanisms;
- conducting joint, comprehensive health system assessments;
- defining health sector development objectives and identifying HDPNx for health collective outcomes;
- shifting towards multi-year planning and financing;
- bolstering monitoring and evaluation mechanisms;
- creating HDPNx-related resource and financing records; and
- mainstreaming conflict analysis and peacebuilding prioritization.

1. Introduction

THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX), as a new way of working, is a framework for coherent, joined-up planning and implementation of shared priorities between humanitarian, development and peacebuilding actors in emergency settings. Advancing the HDPNx in a given country requires a shared, foundational understanding of the current progress to be established. However, finding such a resource can be challenging, perpetuating low understanding, planning and operationalization. The HDPNx for health country profiles aim to address this need through a health lens by providing an overview of health-related nexus efforts, as well as of opportunities for the advancement of humanitarian and development collaboration and health as a bridge to peace in countries affected by protracted emergencies in the Eastern Mediterranean Region of the World Health Organization (WHO).

While stakeholders agree that the HDPNx approach is useful, the question remains of how to operationalize it. As HDPNx operationalization remains nascent, many cross-cutting humanitarian, development and peacebuilding activities have not been formally labelled or conceptualized as HDPNx, although the collaborations between humanitarian, development and peacebuilding actors do exist. Therefore, criteria were needed in order to evaluate whether or not an activity should be considered HDPNx work. In this profile, the following criteria were used: health-related, cross-cutting activities that contribute to identified objectives of at least two of the following fields: i) humanitarian; ii) development; and iii) peacebuilding. One caveat to these criteria is that different countries have varying degrees and sequences of HDPNx development. Therefore, when developing profiles the criteria can and should be tailored to be country/context-specific.

The development of the *Health-development-peace nexus for health profile: Somalia* is a joint initiative by the Somalia Country Office of WHO and the WHO Regional Office for the Eastern Mediterranean, through its Health Systems in Emergencies Lab (HSEL) in the Department of Universal Health Coverage/Health Systems, in collaboration with the Department of Health Emergencies and Department of Healthier Populations, as well as relevant programmes in WHO headquarters.

2. Overview of crisis

Political conflict

In the aftermath of the 1977–1978 war with Ethiopia, rebellions throughout Somalia led to the eventual collapse of the government in 1991. This collapse resulted in continuous power struggles between clans, leading to a civil war, and ultimately to a serious humanitarian crisis in Somalia. In the same year, Somaliland declared unilateral independence, resulting in its de facto separation from Somalia. A few years later, in 1998, the Puntland region declared autonomy, creating the first of the self-defined Somali Federal States (*1*).

After decades of continued conflict and instability, 2012 saw the establishment of Somalia's first formal parliament since 1991 and the adoption of the federal Provisional Constitution. In 2017, the Federal Government was established, in addition to peaceful elections, transition of presidential power and establishment of a bicameral federal parliament (*2*). With these advancements, Somalia entered a new period in which longer-term peace could be feasible. Presently, the Federal member states include Hirshabelle, Jubbaland, South West State, Galmudug and Puntland. The status of Banadir (i.e. the Mogadishu area) has yet to be decided, and Somaliland continues to consider itself an independent state, seeking international recognition of its sovereignty from Somalia (*1*).

Today, conflict between Somaliland and Puntland to control the northern Somali regions of Sool and Sanaag continue. Furthermore, clannism, which is at the core of the deep political divisions, continues to play a central role in perpetuating political instability in Somalia. Clans continuously contest the current and future distribution of resources and power. Clan-related conflicts are mainly recorded in areas where pastoralist communities reside, due to competition for scarce resources like water and pasture, or in areas where farmers clash with nomads over farmland (*1*). Galgaduud and Hiraan remain the regions most affected by prolonged clan conflicts (*3*).

Although advances have been made in promoting peace and stability, Somalia's political landscape remains extremely challenging due to the following factors:

- high levels of insecurity exacerbated by the continuing activities of non-state actors, large stocks of weapons held by the civilian population, and limited law enforcement mechanisms;
- weak capacity of state institutions and human resources;
- high prevalence of poverty; and
- high unemployment, especially among youth (*1*).

The security situation in Somalia continues to be a challenge for health actors. An estimated 2 million people are living in hard-to-reach, conflict-affected areas, primarily in the southern and central regions of Somalia (*3*). Accessibility to these areas is greatly hindered by the presence of non-state armed actors, active conflict and insecurity, in addition to limited infrastructure. This has resulted in the reduction in presence of humanitarian partners as well as difficulty in the delivery of assistance (*3*). Additionally, people living in areas controlled by non-state actors remain largely out of reach, as they have very limited ability to move to safer areas where humanitarian and development health actors are currently responding. The enduring nature and impact of the conflict has generated a complex set of political and social grievances that remain a threat to the country's stability.

Climate shocks

In addition to Somalia's complex political environment, much of the recent, recurrent humanitarian needs have been linked to climatic shocks. As most Somalis depend on agriculture, forestry and fisheries, climate-related changes that may lead to disrupting weather phenomena such as droughts and floods, significantly affect the lives of the Somali population (*3*). As livestock and agriculture form the basis of the population's livelihoods and with two-thirds of the country's population living in rural areas, the country is highly vulnerable to the current and future impact of extreme climate conditions.

Most recently, the humanitarian situation in Somalia remains fragile due to the impact of the prolonged

2016–2017 drought, poor 2018 Deyr rains (October–December), unusually hot and dry conditions during the 2019 Jilaal season (December–March), and erratic and abnormal performance of 2019 Gu rains (April–June).

The effect of decades-long, enduring conflict and violence compounded by recurrent climate-related shocks have created urgent health-related humanitarian and development needs in Somalia.

Impact of the COVID-19 pandemic

Currently, Somalia is experiencing the "triple threat" of the COVID-19 pandemic, the most severe desert locust upsurge in recent decades and seasonal floods as a result of heavy Gu rains (*4*). The COVID-19 pandemic is creating unprecedented health, economic and social effects. For example, COVID-19-related movement restrictions have created disruptions in domestic supply chains, affecting the availability and cost of basic goods, further reducing the purchasing power of many Somalis. Since the first confirmed case of COVID-19 in Mogadishu on 16 March 2020, the number of confirmed cases has risen to 3864, with 99 associated deaths, as of 16 October 2020. Of imminent concern is the spread of COVID-19 in settlements of internally displaced persons (IDP). Somalia has 2.6 million IDPs, including more than 632 000 people displaced in 2020 alone (*4*).

3. Public health status and health system

Prolonged civil unrest and violent conflict in some parts of the country continue to perpetuate insecurity and instability across the country. Of the total 3.1 million people in need of health services, 1.4 million non-IDPs and 1 million IDPs are considered in need of urgent support through maternal health care, treatment for outbreak of communicable diseases and clinical support for health complications for children under 5 (*3*). Somalia has the highest rate of under-5 infant mortality, sixth highest rate of maternal mortality, and second highest rate of neonatal mortality in the world (*5*). Malnutrition in Somalia has proven to be a generational issue for adolescent girls, as poor nutrition and subsequent poor health carries over from adolescence, through pregnancy, to the child. Poor environmental conditions, limited access to water and insufficient sanitation facilities drive increased levels of malnutrition and outbreaks across the country. Somalia continues to experience outbreaks of measles, diarrheal disease and vaccine-derived polio, as well as malaria. In addition, harsh conditions, violence and displacement subject the population, especially IDPs, to psychological distress resulting in social and mental health problems (*3*). In 2016, Somalia scored a six out of 100 on the Health Emergency Preparedness Index, which measures a country's capacity to prevent, detect and respond to global health security threats. In the context of COVID-19, less than 20% of health facilities have the necessary equipment and supplies to manage epidemics (*4*). As health services and activities have been adjusted to target COVID-19 and flood response, many previously planned health activities have been reduced or suspended, negatively affecting the delivery of essential health services.

Service delivery

Currently, Somalia has the lowest levels of access to needed health services globally. WHO and World Bank Group's joint Universal Health Coverage Monitoring Report 2017 gave Somalia a service coverage index of 22, the lowest value held by any country in the report (*6*). Many factors have been contributing to the low functionality, accessibility and availability of the health system, including: i) shortage of facilities and lack of adequate service delivery models fit for nomadic, IDPs and urban poor populations; ii) unregulated private health sector; and iii) presence of non-state armed actors, hindering the ability for health actors to delivery services to certain populations (*5*).

At this time, the health system in Somalia consists of approximately 106 hospitals/referral health centers and over 1000 maternal and child health/health centers (*7*). However, Somalia has less than 40% of its target of two health facilities per 10 000 people, where 23% of non-displaced and 35% of IDPs do not have access to a health care facility (*3*). Somalia's private health care system continues to grow but remains unregulated. The private health care system includes general practitioners and specialists based in a private clinic or hospital, as well as a vast network of pharmacies with only a few certified pharmacists in the country. In addition to the private sector, nongovernmental organizations (NGOs) are the main service providers, mostly working as implementing partners of humanitarian and/or development health programmes (*7*).The Federal Government of Somalia (FGS) – with support from health sector partners including NGOs, UN and donors – launched the essential package of health services (EPHS) in 2013 and has since been trying to scale up its delivery across different parts of the country (*8*). However, the current EPHS is limited in coverage, with fragmented implementation modalities and inequitable access. The main aim of the EPHS is to reduce preventable mortality and morbidity while increasing access and utilization of primary health services among vulnerable populations. Monitoring of the implementation of the updated EPHS need to be strengthened.

Health workforce

The number of skilled workers in the country are below the WHO's minimum threshold for health

worker-to-population ratio, with two health care workers per 100 000 people, compared to the global standard of 4.28 per 10 000 (*4*). In particular, there is a severe shortage of female doctors and midwives or traditional birth attendants, both in terms of number and level of medical training (*3*). In addition to health workforce shortage, there is inequity in access, distribution and skill mix. The core health worker-to-population ratio ranges from 0.34 to 4.45 core health workers per 1 000 citizens (*5*).

Health information systems

Over the past decade, there has been an increased uptake of the District Health Information System (DHIS2) in Somalia. Additionally, most hospitals and health facilities supported by the EPHS delivery programme are reporting via DHIS2. However uptake in peripheral health centres and health units is still very low (*9*).

In Somaliland, public hospitals are reporting through DHIS2 and most health centres (and many peripheral health centres) are reporting using paper templates, where the data is subsequently uploaded to district and regional offices. In 2019, there was an increase from 120 to 250 health facilities reporting data in DHIS2 in Somaliland. Of the reporting facilities, Somaliland Ministry of Health reported a 97% reporting rate from January to November 2019 (*9*).

Although there have been improvements in health information systems, regular monitoring and enforcement of standards needs to be enhanced. In addition, a major obstacle is that information from areas controlled by non-state actors is difficult to collect and verify.

Essential medicines

In Somalia, facility service readiness was found to be 39%, with only 15% of facilities having essential medicines available (*9*). Factors such as a lack of national procurement, supply chain management and regulatory systems have led to an abundance of substandard/falsified medicines. At the same time, the pharmaceutical sector in Somalia remains largely unregulated and run by the private sector (*5*).

Health financing

Somalia is currently experiencing inadequate, unpredictable and unsustainable level of financing, with a high share of out-of-pocket spending on health. Although there is currently no information available on financial protection, 70% of the Somali population live below the poverty line (*5*). In 2015, WHO estimated that the annual per capita public spending on health (including donor financing) was between US$ 10–12 (*7*).

Leadership and governance

Since 2012, Somalia has been a federalized country with a federal government and five member states and Somaliland. The Federal Ministry of Health, based in the capital of Mogadishu, oversees overall policy setting, legislation, coordination and resource mobilization while state-based ministries of health ensure provision and further decentralization of service delivery. One of the main challenges is a lack of clarity as to the definition of roles and responsibilities between health authorities at the Federal and state levels, affecting the smooth operations of health sector programmes. Another major challenge is the limited institutional capacity to steer and provide stewardship for the health sector programmes and partners.

Outside of the government, the Health Cluster is a platform for coordinating health actors, mainly comprising of those providing humanitarian services. There are over 120 partners within the Health Cluster – national and international NGOs, UN agencies and civil society organizations. Currently, the Health Cluster has a number of working groups. The most active in the HDPNx is the Reproductive Health Working Group, which began in the Health Cluster but is primarily involved in development – with links back to the Health Cluster through acute response action, planning, and links to the gender-based violence subcluster. Furthermore, the Mental Health and Psychosocial Support Working Group, co-chaired by the Protection Cluster, is working on 4W mapping of Mental Health and Psychosocial Support activities and supporting standardization of interventions and training.

4. HDPNx operationalization

In the context of COVID-19, there is rising consensus that "longer-term thinking for investment and integration of interventions" is needed (*10*). This section highlights the health activities pertinent to operationalization of the HDPNx for health in Somalia as of today, while putting into perspective the wider scope of HDPNx conceptualization and operationalization in the country.

Coordination mechanism

The United Nations Strategic Framework (UNSF) for Somalia 2017–2020 emphasizes the "importance of envisioning a longer-term development perspective for Somalia," making sure to align the UNSF and its results framework with the 2030 Agenda for Sustainable Development and the Sustainable Development Goals (*10*). Due to Somalia's recurrent humanitarian crises, several outputs under the Strategic Priorities of the UNSF 2017–2020 complement Somalia's Humanitarian Response Plan (HRP) by focusing on "underlying and structural drivers of man-made and natural humanitarian crises and strengthening linkages between humanitarian early recovery and resilience activities" (*10*). In addition, the UNSF specifically highlights the HDPNx as one of its approaches to building partnerships and fulfilling "the UN's collective commitment to support Somalia's humanitarian, development, political and security priorities as outlined in the Somalia National Development Plan" (*10*). The UNSF emphasizes the importance of close collaboration with the in-country UN system, the Government of Somalia, Somali civil society and international partners.

The FGS has specifically emphasized the importance of the HDPNx and in the National Development Plan 9, 2020-2024 (NDP9) highlighted that "during conflict and in its aftermath, humanitarian and peace interventions, often delivered by international partners, dominate. But this must transition to building national capacity if sustainable development is to be a reality" (*11*).

The New Partnership for Somalia (NPS) was adopted at the London Somalia Conference May 2017 by the FGS and international community (*12*). The NPS regulated the relationship between Somalia and its international partners, providing the guiding framework for how to work together under Somali leadership to implement the NDP9. The NPS commits Somalia to a set of reforms that focus on economic recovery, security and governance, in return for sustained international support. A key element to the NPS is that "gender equity and equality is crucial to building peace, improving health and wellbeing, and promoting sustainable economic growth" (*12*). Accountability for addressing cross-cutting issues such as gender equality and human rights is a central focus in delivering the NDP9 and therefore, the NPS (*12*).

Joint assessment

Although humanitarian and development actors have conducted most assessments separately thus far, there have been considerations of the needs of the other. On the humanitarian side, the Joint Multi Cluster Needs Assessment in 2018, conducted by REACH in partnership with the Office for the Coordination of Humanitarian Affairs (OCHA), aimed to provide "integrated and harmonized information sources that support both the immediate and long-term response" (*13*). REACH worked in the framework of the Assessment Working Group, co-led by OCHA in partnership with the Inter-Cluster Coordination Group and the cluster leads, to plan and execute the assessment. Though health was not a primary focus of the analysis, the assessment included some aspects of health, mostly related to health care access (*13*). The Somalia Humanitarian Needs Overview (HNO) 2020 is another example of a recent assessment to inform strategic response planning (*3*).

On the development side, the UN Strategic Assessment, which served as the basis for the UN Strategic Framework 2017–2020, examined "a broad spectrum of areas related to the UN's role and scope of work in Somalia, including

political, security sector, socioeconomic development, state capacity and service delivery, gender, human rights, UN security, footprint and posture, and internal coherence" (*10*). This assessment included collaboration with government (federal and regional), national UN staff, civil society and other key stakeholders/partners such as in-country Security Council member states and African Union Mission in Somalia (*10*).

A few joint HDPNx analyses have also taken place in Somalia. Primary examples are the Somalia Drought Impact and Needs Assessment and the Recovery and Resilience Framework. These initiatives were led by the Government of Somalia and supported by the World Bank, the UN and the European Union to "reduce the country's vulnerability to climate shocks, strengthen resilience, and significantly reduce the future risk of famine" (*14*). However, these analyses have not been further developed or implemented in the health sector.

Most recently and relevant to health, a Service Disruptions and Reallocation of Resources Survey during COVID-19 was conducted. This survey was distributed to Somalia health partners by Somalia Health Cluster to gauge the disruptions and constrains brought on by COVID-19 (*15*).

Another example of a health-related analysis with a HDPNx approach can be seen in the high-level delegation from WHO headquarters and the Regional Office for the Eastern Mediterranean to Somalia in January 2020. The delegation assessed the current situation of primary health care (PHC) and provided recommendations for strengthening PHC, moving towards achieving universal health coverage (UHC). The mission resulted in a set of recommendations on improving PHC for UHC, including operationalizing the HDPNx and developing health systems resilience.

Additionally, WHO Somalia conducted a study on Operationalizing the Humanitarian Development Nexus for Health and Nutrition in December 2019. This report synthesized the HDPNx approach that was taking place in Somalia and presented key recommendations for further operationalizing the nexus.

Collective outcomes

The definition of collective outcomes can ensure that all health actors have a common vision that drives their planning and programming, bridging the spectrum between immediate assistance and long-term development.

In Somalia, the FGS, through the Somalia NDP9, has identified in Pillar 4 (Improved Social and Human Development) that "low levels of education and poor access to other basic public services (such as health, water and sanitation) are leading causes of poverty (*11*). Therefore, these issues were highlighted as government priorities to be addressed in the overall strategy of Human Capital Development. Improving access to health and health outcomes is a vital part of Pillar 4. Specifically, the NDP9 addresses the following: i) institutional oversight and strengthening (e.g. strengthening the Health Management Information System); ii) focusing on most pressing health challenges (e.g. improving maternal and reproductive health); and iii) focusing on the most vulnerable (e.g. focusing on rural citizens, IDPs, and those in newly liberated areas) (*11*). The NDP9 clearly outlines that the government will partner with non-state providers to rehabilitate or construct health clinics and will increase distribution of EPHS (*11*).

Additionally, the Somalia UNSF 2017–2020 has outlined the following five, nexus-style strategic priorities: i) deepening federalism and state-building, supporting conflict resolution and reconciliation, and preparing for universal elections; ii) supporting institutions to improve peace, security, justice, the rule of law and safety of Somalis; iii) strengthening accountability and supporting institutions that protect; iv) strengthening resilience of Somali institutions, society and population; and v) supporting socioeconomic opportunities for Somalis leading to meaningful poverty reduction, access to basic social services and sustainable, inclusive and equitable development (*10*).

Though the Somalia HRP has been updated to reflect the COVID-19 context and response (*5*), the original health cluster objectives under the Somalia 2020 HRP included: i) reduce excess morbidity and mortality due to disease outbreaks driven by climatic shocks and conflict among 1.6 million IDPs and non-displaced by 5%; ii) contribute to improvement in physical and mental wellbeing of the population affected by conflict and displacement among 1.6

million IDPS and non-displaced; including 140 000 people with disabilities; iii) improve equitable access to quality emergency and essential lifesaving health services for the crisis affected population to 1.3 million IDPs and 1.1 million non-displaced host population; and iv) improved case management and referral services for 120 000 survivors of sexual or gender-based violence (*7*). The second and fourth cluster objectives, whose indicator is "proportion of functional health facilities providing mental health support, psychosocial support and physical rehabilitation," can be considered at the nexus of humanitarian and development efforts (*7*).

At the end of 2017, humanitarian and development partners came together and proposed four collective outcomes to reduce needs, risks and vulnerabilities and increase resilience by 2022 (*7*). The collective outcomes are based on the key findings from the 2018 Humanitarian Needs Overview and Drought Impact and Needs Assessment, representing the key areas that require combined humanitarian and development action. Out of the four collective outcomes, collective outcome 3 is the most relevant to health, calling for a 27% increase in the number of vulnerable people with equitable access to inclusive basic social services by 2022 (*7*). This collective outcome not only relates to Sustainable Development Goal 3 (ensure health lives and promote well-being for all at all ages) but also the above-mentioned NDP9 Social and Human Development Pillar Goal, UNSF Outcome 5.1 and HRP strategic objectives 1–4 (*7*).

Joint planning and implementation

The Federal Ministry of Health has recently requested WHO to support the revision and update of the National Health Sector Strategic Plan (HSSP) II 2016–2020. It is expected that the plan will be updated through joint and comprehensive consultation with all sector partners, civil society organizations and government ministries. National and state-level committees will be established to oversee the process and to ensure thorough engagement of all parties. The Federal Ministry of Health, with support from sector partners including WHO, is also reviewing the sector coordination structure to form national and state-level coordination mechanisms that will work to ensure coherent delivery of health services and reduction in duplication. The aim is to support partners on joint planning and implementation of sector programmes.

In addition, one example of a nexus-style initiative is the Somali Health and Nutrition Programme (SHINE) 2016–2021. The United Kingdom Foreign, Commonwealth and Development Office-funded programme aims to "address the high levels of preventable maternal and child deaths among Somali women and children" through delivering across three core areas: i) health service delivery, including provision of the EPHS; ii) health system strengthening through supporting the Somali Health Authorities lead, regulating basic service provision and building core elements of a functional health system; and iii) demand creation through empowering vulnerable populations to overcome barriers to accessing services (*16*).

Another FCDO-funded programme, the Somalia Humanitarian and Resilience Programme, successor to the Multi-Year Humanitarian Programme 2013–2017, combines relief and resilience-building activities to "drive greater system-wide changes" (*17*). Through the Somalia Humanitarian and Resilience Programme, there has been improved collaboration between health and nutrition NGOs.

The COVID-19 pandemic, despite the challenges posed to the health system of Somalia, revealed how short term investments during response phase can feed into longer-term health system strengthening. The examples include the scaling up of oxygen capacity as well as capacity for laboratory testing, which have been done in a way that can be maintained and further developed. There are also other examples of the nexus-style initiatives such as recent developments related to the Integrated Disease Surveillance System as this is critical to both humanitarian and development agendas.

Joint monitoring and evaluation

From the FGS perspective, along with revised National Health Sector Strategic Plan II, the Federal Ministry of Health is planning to develop a monitoring and evaluation framework that will guide and support partners on monitoring and evaluating sector programmes. The NDP9 also highlights improving access to health care as its first strategy. Under this

strategy, the FGS has developed both short-term and medium- to long-term goals. To ensure these approaches are met, an implementation framework has been developed by the FGS that includes joint implementation, cost and priorities and monitoring. Additionally, the Mutual Accountability Framework for Somalia allows for monitoring of commitments from both government and international partners between October 2019 and December 2020. It aims to complement the existing government monitoring efforts in the NDP9. This framework was endorsed at the Somalia Partnership Forum (*18*).

The Health Cluster also continues collecting information via an established cluster reporting and monitoring system (ReportHub) that includes direct reporting from partners on activities and monthly operational reach to target benificiaries of the HRP. An additional monitoring mechanism is the Cluster Coordination Performance Monitoring, a country-led self-assessment where clusters assess their own performance against six core cluster functions in addition to accountability to affected populations. The Cluster Coordination Performance Monitioring allows cluster partners and coordinators to identify strengths and weaknesses as well as agree upon actions towards improvement. Furthermore, the Health Cluster is working on establishing the Health Resources and Services Availability Monitoring System (HeRAMS) to monitor the functionality of health care facilities, which will be valuable for both acute and long-term sytem planning. Additional steps are being taken to improve accountability to the affected population via multi-cluster feedback mechanisms (*19*).

Harmonized resources and financing

In 2019, Somalia received almost US$ 35.3 million for health, amounting to roughly 3.4% of the total financial support to Somalia (US$ 1.03 billion) that year (*20*). The HRP 2020 states that the health sector will require US$ 85 million for its activities. In 2019, the requirement was US$ 93.2 million, of which 24% was funded (US$ 22.4 million).

In relation to the UNSF 2017–2020, it is estimated that the total financial requirement for achieving the five strategic priorities amounts to US$ 2.88 billion. As mentioned in the collective outcomes section, strategic priority 5 is most relevant to health. The funding required for strategic priority 5 is US$ 989.8 million, which is about 34.4% of the total funding required for the UNSF.

The UN Multi-Partner Trust Fund, established in 2015, is the preferred pooled funding mechanism for the UN's support to Somalia. As the UN increasingly focuses on pooled funds and joint programming as preferred modalities for UN country presence, the UN Multi-Partner Trust Fund will likely grow in emphasis and use. It currently has 12 active donors from both development and peacebuilding.

Conflict prevention, peacemaking and peacebuilding

In fragile and conflict-affected countries, "peace-building strategies are necessary to ensuring lasting health gains" (*21*). Conversely, "the health sector can play a significant role in promoting peace by using its competencies, credibility and networks" (*21*). The neutrality of the health sector and health workers can be leveraged to mediate and promote dialogue. The multilateral consultation meeting on Health as a Bridge for Peace, held on 1 November 2019 and cosponsored by Oman and the Government of Switzerland in collaboration with WHO Regional Office for the Eastern Mediterranean, gave WHO the opportunity to share lessons learned from the field with the international community. Health as a Bridge for Peace is an established framework that supports the health workforce in operating in conflict settings while contributing to peacebuilding. It calls for increased partnerships among Member States, UN and non-UN partners and academia to conduct diplomacy, build capacity on the ground and design and implement strategic initiatives linking health interventions with peacebuilding (*22*).

In Somalia, communities living in conflict areas are severely impacted by armed violence. Civilians shoulder most of the burden of the ongoing conflict through death and injury, destruction of property, taxation of communities, land grabbing, destruction of livelihoods, and restrictions in movement. Armed groups, check points or other bureaucratic

roadblocks severely impede and restrict humanitarian activities. Accountability for such violations is limited and disrupted, if not disrespected or inaccessible (*3*). Furthermore, humanitarian interventions and health activities are frequently impacted due to insecurity.

An example of a project aimed at linking health with peacebuilding is the WHO-led development of a training module on Mental Health and Psychosocial Support at Somalia National University. The goal of this project is to "improve access to psychosocial support and mental health services for Somali youth in conflict-prone displacement areas enabling them to actively engage in promoting peacebuilding and social cohesion, rather than resorting to negative practices that contribute to conflict, thus addressing a critical barrier to reconciliation" (*23*).

5. Way forward and recommendations

Although there is consensus among the FGS and HDPNx stakeholders to implement the HDPNx in Somalia, progress on HDPNx implementation has been halted by the dynamic political situation, frequent climate shocks and the COVID-19 pandemic.

The following are proposed recommendations for advancing the HDPNx for health in Somalia:

I. **Strengthen existing health coordination mechanisms.** The first priority is to fortify the existing health sector coordination structure at the national and subnational levels. The Health Cluster should feed into this national coordination structure, in order to ensure better linkages between the humanitarian and development programmes.

   When the situation in Somalia allows, there should be a focus on establishing a formal nexus coordination mechanism. The aim of this mechanism is to facilitate coordination and collaboration, effective information management, communication, and harmonization of processes and resources among actors. It is important to note that health is part of a wider ecosystem, and so the success of HDPNx for health depends on the success of HDPNx coordination more generally. Once the nexus coordination mechanism has been established, the next step is the designation of a nexus focal point, followed by the creation of internal nexus structures within actor and stakeholder organizations.

II. **Conduct joint, comprehensive health system assessments.** Many assessments have been conducted from the humanitarian perspective, with consideration of development needs. However, comprehensive health system assessments to advance HDPNx for health in Somalia are lacking (with the exception of the Service Disruptions and Reallocation of Resources Survey). As with the nexus coordination mechanism, the joint assessment can take many different forms. Ideally, it should be conducted in an integrated manner by a coalition of nexus actors, using the same tools and common methodology.

III. **Define health sector development objectives and identify HDPNx for health collective outcomes:** To advance health-related HDPN work in Somalia, collective outcomes such as focusing on the advancement of the EPHS need to be jointly identified, driving planning and programming while bridging the spectrum between immediate assistance and long-term development. The collective outcomes should be based on the results of the joint assessment. Key entry points for health, such as developing a health security plan, should be leveraged. It is important to consider the implementation of other Sustainable Development Goals, as progress towards other targets will have an impact on overall health outcomes.

IV. **Shift towards multiyear strategic planning.** The current HRP is based on a one-year interval, which does not allow enough time for work at the nexus of humanitarian and development efforts. Multiyear strategic planning is needed to ensure both urgent and long-term development needs are addressed. This involves formulating, articulating, and establishing the plan for achieving the agreed collective outcomes, including making decisions about how to mobilize and allocate resources accordingly. The strategic planning should be reflected in the operational plan, leveraging potential entry points (e.g. strengthening EPHS, building on health information systems, advancing district health management, developing a health security plan, etc.) as a means of advancing the HDPNx in Somalia. All partners, including donors, UN agencies, national and international NGOs, and health system representatives, should be included in this process in order to ensure cohesive and collaborative joint planning. Cross-cutting issues such as gender equality and human rights should be integrated in HDPNx programme planning, implementation, and monitoring and evaluation.

It may be challenging for HDPNx actors to come together to develop a shared, multiyear strategy in the midst of the COVID-19 pandemic, in light of the ever-changing and unknowns of the pandemic. However, the effects of COVID-19 will continue to impact vulnerable populations into the future, making it vital to have a sustainable strategy for response, recovery, and resilience-building. In addition, the momentum, solidarity, and achievements that COVID-19 has led to in bringing together humanitarian, development, and non-traditional health actors should be sustained.

V. **Bolster monitoring and evaluation mechanisms.** Regular monitoring of progress should be undertaken to assess the impact of HDPNx for health activities against the collective outcomes. Although there is currently some monitoring and evaluation coordination by NDP9, more robust monitoring and evaluation mechanisms are needed. Simultaneously, HDPNx for health focal points should be assigned to facilitate communication and knowledge management. Systematic collection and archiving of HDPNx-related documents should be conducted. Additionally, due to the dynamic nature of the emergency, the HDPNx for health profile should be updated regularly.

VI. **Create HDPNx-related resource and financing records.** At this time, there are no agreed upon HDPNx funding mechanisms, and discussions surrounding an interagency framework are ongoing. One of the biggest obstacles to coherent planning in Somalia is the absence of a centralized health sector-wide resource tracking mechanism. More precise breakdown of finances is needed to understand the current level of resources allocated to HDPNx for health activities and in turn, to gauge the appropriate short, medium and long-term financing/resources required for furthering HDPNx efforts.

VII. **Mainstream conflict analysis and peacebuilding prioritization.** Closer coordination among humanitarian, development and peacebuilding actors can be achieved by ensuring health-related activities are more inclusive of and informed by peacebuilding activities in the country. The Health as a Bridge for Peace framework is a primary example of an initiative that can be used for defining interventions to advance the HDPNx agenda (*22*). A potential starting point is thorough conflict analysis (*21*). Secondly, the development of a risk management strategy is needed to not only identify and assess risks, but also develop mitigating measures to address these risks. Once completed, the conflict analysis and risk management strategies can inform HDPNx programme design (*21*).

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THE HUMANITARIAN-DEVELOPMENT-PEACE NEXUS (HDPNX) is a new way of working that offers a framework for coherent, joined-up planning and implementation of shared priorities between humanitarian, development and peacebuilding actors in emergency settings. To advance the HDPNx in a given country, a shared foundational understanding of the current situation is needed. However, it can be challenging to find such a resource, perpetuating poor understanding, planning and operationalization. This is one of a series of country profiles that have been developed by WHO to address that need. Each profile provides an overview of health-related nexus efforts in the country, and will be updated regularly.