UNICEF Somalia
Health Strategy Note
2018-2020

1. Introduction

The UNICEF Somalia Health Programme will focus on foundational programming (health system strengthening) given the fragile context, pre-famine, drought and pockets of continuing insecurity caused by the Al Shabaab group. It will seek to address the zonal, regional and district disparity reduction and equity gaps which are the greatest threats to reducing child and maternal mortality and morbidity. These efforts will be sine qua non for Somalia achieving the Sustainable Development Goals (SDGs) 3. The key issues for children and women remain vaccine preventable diseases besides the major five common childhood illnesses – diarrhoea, pneumonia, malaria, malnutrition and new-born conditions – prematurity and birth asphyxia. Maternal mortality ratio has remained one of the highest in the region and globally at 732 per 100,000 livebirths; and have been attributed to direct causes related to obstetric complications of pregnancy, labour and delivery, and the post-partum periods. The strategy is built on the strengths of the previous country programme, which saw successes in the interruption of polio (last new case reported in 2014); the roll-out of an essential package of Reproductive Maternal Neonatal Child Adolescent Health (herein RMNCAH) services for up to 5.7 million Somalis (of which 20 per cent are children) and a subsequent very low and slow rate of reduction in the under-five mortality rate of 0.6 per year. However, a significant reduction of the malaria prevalence from 22 to 2.8 enabled Somalia to meet the Millennium Development Goal (MDG) goal target for Malaria. The UNICEF vision for 2018-2020 offers a revitalised approach to supporting to the health sector in Somalia to ensure that all children’s right to health are realised. There will be a greater focus on building the resilience of mothers, caregivers and their communities to promote health seeking behaviour and increase demand for services; while at the same time developing the institutional and managerial capacity of the Somali Health Authorities (SHA) and core components of the health system that would help managers both lead and effectively manage the country programme.

Despite gains made in the health sector during the MDG era, there are stark disparities in health outcomes amongst Somali children based upon their exposure to violence and insecurity, their gender and ethnic group, and the stability of their community or clan structure. While child health outcomes have generally improved, addressing these great inequities amongst children, especially inaccessible areas remains a UNICEF Priority. Given the unique access constraints in some parts of the country, UNICEF health strive to provide tailored essential packages of interventions, designed to meet the needs of different communities, especially the socially excluded; those with unique vulnerabilities such as nomadic children; and those displaced by conflict. The programme also provides a sharpened focus on meeting the specific needs of mothers and new-born children through improved neonatal care systems and services while continuing services for adolescents specifically for HIV and AIDS control and prevention. Communication for Development (C4D) initiatives will be fully integrated with WASH, nutrition and child protection efforts to ensure continuity of advocacy and social behaviour change for child survival and wellbeing. Similarly, a woman’s chance of dying from pregnancy and childbirth in Somalia is 1 in 22. Although many of these deaths are preventable, the coverage and quality of health care services in Somalia continue to fail women and children. Presently, about 56 per cent of health facilities offer basic emergency obstetric care; but only 40 per cent of deliveries are attended by skilled birth attendants. This shows the close relationship between the well-being of the mother and the child, and justifies the need to
integrate maternal, new-born and child health interventions. During 2018-2020, the health sector has a unique responsibility, because it has the greatest reach to children and their families during critical time periods that affect child development. The first window of opportunity is during pregnancy, birth, and in early childhood, the first 1000 days, when essential interventions for health, nutrition, and psychosocial development have a great impact. Core messaging around Early Childhood Development (ECD) practices will also feature as an integral part of health promotion.

The Strategy proposes different implementation options based upon resource availability. The programme is designed to be able to quickly scale up to respond to emergencies with an emergency ‘development light’ approach that can be utilised to deliver services in hard-to-reach areas, through key established partnerships with implementing partners. Resilience of communities will be built up using C4D socioecological model of change and strategies. Natural and man-made emergencies will be responded to urgently considering the responsibilities outlined in the Core Commitment for Children, thus focusing mainly on women and children. Provision of emergency first aid, basic health services, immunization, appropriate care during pregnancy and delivery will be provided using the adopted essential package of health services (EPHS). Key partners include the Federal Ministry of Health, as well as the health authorities in newer Federal Member States, Puntland and Somaliland. Implementation partners include International and local NGOs, CBOs as well UN partners WHO, UNFPA and WFP. Established development partnerships for health are expected to continue with a number of donors and UNICEF national committees.

2. Prioritised issues and areas

The Somali people have some of the worst health indicators in the world, with women and children most affected. Despite modest improvements in maternal and child mortality rates1 in the last five years, inequities amongst communities meant that some children and mothers are disproportionately exposed to otherwise avoidable and treatable diseases. Geography, clan hierarchy, livelihood vulnerability, internal displacement, gender, exposure to shocks and conflict-related stresses have resulted in communities having different levels of access to affordable RMNCH services; variances in community exposure to health promotion; and gross variances in local health authorities’ capacity to provide duty of care.

UNICEF’s comparative advantages include 25 years supporting the health system in Somalia, established partnerships with close to a hundred implementing partners, able to deploy and deliver services in the most challenging and conflict areas, a well-established, efficient and responsive supply chain system across the country including international standard warehouses and the cold chain.

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Service Delivery. At the end of the current Country Programme, one third (about 3.6 million) of the Somali population will have access to an integrated ‘Essential Package of Health Services’ (EPHS) which focuses on RMNACH, HIV and Malaria. As a result of UNICEF’s integrated EPHS approach, targeted EPI campaigns, and emergency/humanitarian assistance; key indicators for child, maternal and adolescent health show a consistent positive trajectory, which with continued investment should be maintained.

Despite these positive gains, the EPHS has only been available to one third of the Somali population. Deprivation analysis for health reveals that Nomadic children, IDPs, urban poor and children living in ongoing conflict areas have either not had access to the same level of service quality, or had no access to health services at all. These communities are also particularly vulnerable to shocks and stresses such as drought and conflict, which significantly worsen health deprivations for the most vulnerable. In addition, a systematic approach to new-born care in Somalia has been severely lacking. Somalia continues to have one of the highest Neonatal Mortality Rates in the world. With an NNMR of 40 per 1000 lb in 2015, at least 18,000 children die before their first month birthday.

UNICEF remains committed to the Government-championed EPHS but recognises that this must be delivered in tandem with a less development-heavy approach to ensure that the most vulnerable children and mothers in hard-to-reach or high-risk communities receive a minimum package of lifesaving vaccinations, and RMNCAH services. UNICEF’s global expertise in new-born care, delivered alongside development partners UNFPA and WHO, will support strengthened government capacity to safeguard the first 28 days of a baby’s life.

The EPHS contains 10 different health ‘components’. Reflecting the funding available for the sector, and UNICEF’s comparative advantage in maternal and child health, the programme will focus only on RMNCAH services and outpatient care, at the community level. Services for adolescents will focus on HIV prevention and response, as well as reproductive health, with other aspects of adolescent health (e.g. mental health) being out of scope for the country programme from an affordability perspective.

Demand for services. There is generally a low level of awareness on issues related to maternal and child mortality across Somalia. Gender dynamics and other social norms are influencing factors which act as a barrier to access for women and children. Somali women are often better informed than men on maternal and child health issues, but their behavioural preferences and choice to access services comes secondary to the preferences of their husbands and elder women (grandmothers). Men in the family often dictate whether a child can be vaccinated,

- 48% children of 0-11m were immunised for measles in 2015, compared to 32% in 2008; (WHO-UNICEF JRF, 2015)
- 52% of children 0-11m received 1st dose of DPT vaccination compared to 40% in 2006 (WHO-UNICEF JRF, 2015)
- 11% increase (From 22% to 33%) in skilled birth attendance in 2015, compared to 2014. (UNICEF, 2016)
- Malaria prevalence reduced from 22% in 2009, to 2.8% in 2014
- 0.9% young pregnant women infected with HIV in 2009; compared to 0.2% in 2014 (HMIS, 2015)

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2 New-born health in Humanitarian Settings field guide.
what birth spacing practices can be used and whether women can access life-saving obstetric care during birthing complications. Community-based communication approaches, coupled with radio and mass media campaigns have been successful in influencing behaviour⁴.

Since the creation of the Government’s C4D Strategy for Somalia, and the supporting UNICEF Somalia C4D Strategy, the government is increasingly taking a leadership role in coordinating health promotion. From 2017 onwards the UK Government, traditionally the largest development donor to the sector, will largely use the private sector modalities to deliver specific district level social behaviour change campaigns to increase demand for service delivery. In this new context, UNICEF’s comparative advantage lies with its Social Mobilization Network (SM Net) approach, successfully piloted and scaled up in Puntland after the 2013 Polio Outbreak. SM Net is unique in its focus and highly cost effective, using community mobilisers within hard-to-reach communities, alongside mass media and religious leaders to improve and sustain service utilization. The approach has enjoyed many successes including a reduction in the proportion of unimmunised children in nomadic communities from over 40 per cent in 2014 to less than 15 per cent in 2016. The new Country Programme will scale up this effective approach, targeting communities where demand for services is low; and sustain significant gains made from improving health seeking behaviour especially immunization coverage and use of RMNCH services. Working with the WASH, CP and Nutrition programmes we will develop integrated and comprehensive messaging on child survival and wellbeing, UNICEF will also continue to strengthen the capacity of Ministry of Health Behaviour Change staff to enable them to lead social BCC programming by 2020.

**Health Systems Strengthening** In order to achieve UNICEF’s mission to ensure that women and children have access to quality government-led public and community services, considerable work is required to strengthen government health systems. UNICEF’s comparative advantage comes from its core mandate of supporting EPI, EPHS and the iCCM strategy which includes the provision of essential medicines and vaccines. UNICEF, through Global Fund resources, has also led on the introduction and adaptation of the district health management information system (DHIS2) to strengthen the current Health Management Information System (HMIS). The supply chain for medicines and vaccines for Somalia is extremely complex and requires investment in terms of capacity strengthening as well as infrastructure to enable government authorities to be able to completely oversee the supply chain by 2020. The strengthening of cold chain and vaccine management through GAVI effective vaccine management EVM tool helps to manage GAVI grants and further improve this component of the health system. In keeping with the Somali health policy, NDP and other key development plans, UNICEF will assist the health authorities to improve capacity to lead in this area of the health sector. UNICEF will assist the Government in its management and oversight of the HMIS and other key aspects of the health system.

**Health Sector investments** 2017 signals the start of a more fragmented approach to development financing for the Health Sector, which is likely to continue into the lifecycle of the new country programme. The sectors’ largest pooled health programme, the Joint Health and Nutrition Programme (JHNP), was phased out in 2016, alongside the existing Health Sector Coordination mechanism. In light of these changes, as well as an overall reduction in development funding in real terms, UNICEF will continue to support EPHS only in specific priority areas, focusing on the hardest to reach nomadic population and socially excluded groups such as the Bantu group. Global Fund and GAVI contributions will be leveraged to

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⁴ UNICEF C4D Strategy
support substantive service delivery components, Health Systems Strengthening and Private Public investment Partnership promotion.

3. Theory of Change

The proposed outcome of the 2018-2020 health programme is expected to create an enabling environment and address bottlenecks that would effectively strengthen health system which would in turn lead to the reduction of preventable new-born, child and maternal deaths and significantly reduced morbidity. Promoting sustained progress toward universal health care coverage and increasingly delivery of quality health services, UNICEF proposes to work closely with the communities and children to have a voice; identifying and promoting essential and strategic partnerships besides the Ministries of Health and NGOs, including the Academia. It will promote and adopt innovative approaches ensuring that the proposed programme outputs are fully aligned to and harmonised with the NDP priorities as set out in the National Development Plan 5, National Health Sector Strategic Plans (2017-2019) and numerous sectoral strategies. UNICEF will leverage, develop joint programmes and through joint programming build a scalable model fit for the Somali context. The implementation will be reviewed during planning, mid-year and end of year work-planning workshops, led by the Ministries of Health. The programme outcome results are aligned to the draft UNICEF Strategic Plan; 'Children Survive and Thrive' goal area; as well Sustainable Development Goal (SDG) 3 on Good Health and Well-being and SDG 10 on Reduced Inequalities.

Achievement of the outcome result is premised upon three components of the bottleneck analysis, which are the enabling environment outputs- budget, policies and government capacity to provide health services; the supply component of access, availability of commodities and human resources; and; demand component that addresses utilization, continued utilization of services and the quality of care.

The theory of change for Health outlines how UNICEF programming will assist the health authorities through increased ownership and leadership, help build or improve their capacity to manage health services using key drivers such as community participation; strategic partnerships; introduction and use of innovation to deliver at scale. Furthermore, UNICEF will use the health system approach and the application of an integrated C4D approaches to sustain and promote issues related to reduction of maternal and child mortality across Somalia through strengthening gender-sensitive communication; better health seeking behaviours and delivery of a minimum care package (EPHS) at scale.

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1 The Essential Package of Health Services is the government flagship approach to SD as set out in development literature. The NDPs prioritise comprehensive systems strengthening across all 6 WHO building blocks
2 Including the Somali Community Health Strategy; Communication for Development Strategy
The programmatic risks consideration include adapting to the political instability and changes at all levels; the continuing threats and insecurities posed by the Al-Shabaab group; lack of adequately skilled human resources; the underlying chronic emergency situation and the fragile health system. It would require a long term early recovery and resilience building approach, mainstreaming emergency best adapted to the zonal context.

4. Results Structure and Framework

**Outcome:** By 2020, increased proportions of Somalis, especially mothers and children, have equitable access to and use essential health services in targeted areas.

**Output 1:** By 2020, 75 per cent of health facilities are equipped and 90 per cent of community health workers have skills to provide quality essential health package of primary care services respectively.

The provision of quality health services is the bedrock of UNICEF’s approach to improved Health in Somalia; and this is critical for the achievement of the expected outcome on improved access to, and utilization of, quality services. The Essential Package of Health Services (EPHS) offers the main framework and approach for provision of essential health services for reduction of maternal, new-born and child mortality. UNICEF will work with the Ministries of Health, the donor community, implementing partners and communities to deliver quality and universal access to health services. UNICEF will support provision of EPHS in targeted districts across the country with the aim of sustaining results in low cost and high impact interventions such as immunization, malaria prevention and the promotion of safe and clean delivery services. Recognising the continued need for services in other districts that are not targeted for roll-out of EPHS due to funding or security challenges, UNICEF will leverage and/or support joint programmes that would expand the same as part of geographic and programmatic scalability in these districts. In order to achieve result output the following core strategies will be applied:

- Capacity strengthening of the government institutions and civil society organizations to ensure Government-led health services with full involvement of communities.
- Empowerment through a Communication for development (C4D) and use of Technology for Development (T4D) and other technologies to overcome programme bottlenecks
- Advocacy and resource mobilization– using Evidence generation, policy dialogue and budget analysis
UNICEF will also focus on improving the quality of community-based interventions by strengthening capacity of community owned resource persons or community workers around the use of the integrated community case management (iCCM) combined with technological innovation with traditional approaches for quality improvement. This would include policy development, curriculum adaptation, supportive supervision and on the job training.

A more concerted approach towards enhancing access to quality new-born care services will be initiated with a phased scale-up over the country programme period using a 7 days, 7 weeks and 7 months follow up strategy. This will address the demand and supply side issues that usually hamper timely identification of ‘danger signs’ amongst new-borns; and the health system’s inability at the lower levels of service delivery to manage and refer cases as appropriate timely. UNICEF will build closer relationships with the academia, professional associations such as medical associations and facilitate the introduction of Public Private Investment Partnerships to increasing service delivery as needed.

Natural and man-made emergencies will be responded to urgently considering the responsibilities outlined in the Core Commitment for Children; thus, focusing mainly on women and children. Provision of emergency first aid, basic health services, immunization, appropriate care during pregnancy and delivery will be promoted. The continued strengthening of the capacity of health workers and community resource persons, to deliver services to women and children in emergencies will be enhanced; including the managerial processes.

Funding constraints within the health sector due to changes in the preferred delivery modality for delivery of EPHS by key donors, means that UNICEF-supported EPHS will be limited during 2018-2020. The budget and proposed activities within this strategy note, assume a ‘low cost’ scenario, where UNICEF supports EPHS in a reduced number of key regions. UNICEF’s experience in EPHS from 2012 to 2016 will allow for increasing partnerships and the flexibility of scaling up through funding mechanisms such as the Zakaat, Diaspora initiative while ensuring that core UNICEF accountability for service delivery is clearly articulated.

Output 2: By 2020, the four health system components plans (human resource, HMIS, supply chain and logistics and health financing) for effective and efficient services are in place and functional.

The primary goal for this output is to improve and sustain the quality of care for essential RMNCH services. This output is critical to the horizontal logic and coherence of the Health Strategy by improving the supply component and enabling environment of the service delivery.

The approach will be aimed at three types of recipients: health workers; policy makers; communities; and opinion leaders/community elders, all of whom will be harnessed as agents of change and partners in order to increase resources and demand for health services; as well as to improve health seeking behaviour. Opportunities to collaborate with Water Sanitation and Hygiene (WASH), CP and Nutrition programme deliverables will be fully utilised to ensure...
that communities are engaged and empowered to reinforce positive health social behaviour change communication. It will also provide the opportunity to develop health worker, community, family, and clan leadership capacity on issues relating to Early Child Development.

1. Vaccine, Drug and Equipment Supply and commodity management
2. Financing of health services - Payment of Central Ministry of Health Staff and Facility level Staff salaries
3. Health Management Information System
4. Human resources for health

Qualitative research commissioned by UNICEF and other partners throughout the 2012-2016 Country Programme\(^7\) points to consistent community dynamics and social norms that can promote better health for all:
- Political, clan and religious leaders are key stakeholders influencing health practices
- Religious and community leaders have significant influence on men, who are not only the main decision-makers in the family, but can act as barriers by preventing women and children from accessing life-saving services.
- Poor or substandard Interpersonal Communication skills of health workers have the potential to impact mother’s use of health services
- A deeply engrained and well trusted traditional ‘health’ sector- made up of traditional healers and birth attendants, is still the preferred service provider for most communities- particularly those most at risk (IDPs, Socially excluded groups, conflict areas and Nomads). Addressing demand for this cultural tradition, without alienating or demonizing local culture will require a delicate and integrated approach.

Given these dynamics, a range of strategies will be used to work with communities, families, health workers and opinion leaders including training of health workers, community-led engagement, and innovative mass media messaging to increase interpersonal discussion about health issues within an individual’s social network. Community participation has proven to be critical to sustainable results and will continue to be a priority approach for UNICEF.

The following core strategies will be utilised:

- Strategic Partnerships – engagement of partners, private sector, government and communities
- Effective DHIS2 and Evidence generation and policy through social norms and health practices study
- Innovative Community financing options

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\(^7\) Ali, H & Warsame, a 2014 Knowledge, Attitudes and Practice Survey (KAPS): Mogadishu, Sabawanaag, Las Anod and Hobyo. Mercy-USA for Aid and Development

BBC 2014, Radio for Child Nutrition and Health in Somalia: A mixed-methods impact evaluation; BBC Media Action Research and Learning
Output 3: By 2020, appropriate health policies, strategies, plans and evidence are available for planning and decision making.

Aligned to The Somali Health Policy 2014 priorities; The Somali Health Sector Strategic Plans and the NDP, UNICEF will, in collaboration with its partner UN agencies and development partners, support the development of the Somali Health Authority’s capacity to lead, manage and implement core components of the Health Strategy and plans by 2020.

Four thematic capacity areas are envisaged for investment over the course of the new programme, with the objective of the Ministries of Health taking full leadership by 2020:

1. Evidence generation through conduct of SITAN, DHS, MICS
2. Setting up of Sector wide approach, including MTEF and PERR
3. Costed National Plan as part of Delivering as One - Programme planning and management of HIV/AIDS; Malaria, Immunization and C4D and
4. Programme reviews and evaluation

Milestones will be established in years 3, 4 and 5 to ascertain capacity and readiness to hand over leadership- particularly in the area of vaccine and supply chain management.

Conceived and started at a time when Somalia was emerging from a humanitarian context to a development setting, the UNICEF-managed Joint Health and Nutrition Programme has delivered some critical building blocks upon which a government- run health system can be built. A lesson learned workshop held in May 2016, highlighted the importance of ‘learning by doing’ as a strategy for strengthening government capacity. The following additional implementation modalities will be used:

- Advocacy, Evidence Generation and Policy
- Partnerships
- South/South triangulation and Cooperation

The institutional breadth and depth of UNICEF’s activities within this output will be guided by funding. Regardless of the levels of funds mobilised, capacity strengthening will involve all four thematic areas. However, in the case of low levels of resources being secured, interventions will be limited to the central level ministry of health. In the case that the programme budget is fully funded (high scenario), UNICEF’s approach will be more comprehensive at central, regional and district level.

By 2020, the ministries of health should have fully functional and integrated health programme that includes (a) Malaria Prevention and Control; (b) Immunization; and (c) HIV/AIDS units, supported by endorsed policies, strategies and guidelines. The units should have capacity to plan, manage and monitor all respective activities with minimal technical support from UNICEF. By 2020, the ministries of health should also have fully functional C4D units, tasked with implementing the Somali C4D Strategy and demand-side interventions as set out in the relevant sections of the HSSPs.

UNICEF will prioritise supporting and strengthening the MOH Immunization Unit and EPI supply chain system to ensure equitable distribution of safe and potent vaccines and

<table>
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<tr>
<th>UNICEF Core deliverables</th>
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<tr>
<td>Capacity strengthening leading to full leadership of RMNCH, Malaria and HIV programming</td>
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<tr>
<td>Capacity strengthening leading to full management of the supply chain</td>
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<tr>
<td>Capacity strengthening leading to full ownership and management of the HMIS</td>
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availability of cold chain infrastructure at best possible standards in Somalia. The MOH physical capacity and effective management of cold chain and logistic systems will be enhanced by a three-pronged approach: (1) the existing cold chain storage capacity will be expanded or upgraded, (2) MOH cold chain management practices will be improved by sustaining a cold chain management workforce, training technicians and health care providers on vaccine stock management, (3) the EPI vaccine supply chain will be strengthened by supporting and sustaining storage and transportation of vaccines and commodities. GAVI grants managed by UNICEF will be leverage for these.

UNICEF envisages that over the course of five years, assuming that various risk assessment checkpoints are passed, and in line with HACT guidelines, increasing levels of funds will be transferred, via UNICEF, to the Ministries of Health, for direct payment to health workers at EPHS public facilities. This will require adequate risk management measures and the implementation of a regional level payment system which allows for recorded receipt of payment. This learning-by-doing approach will help support the government in its segue to a future Sector Wide Approach (SWAP) scenario, where, in the longer term future, on-budget government generated revenues and a proportion of donor funds can be managed through the ministry of finance and ministry of health systems.

In order to properly oversee the quality and coverage of services, a functioning HMIS is of vital importance for the Somali health sector. UNICEF remains committed to fostering an environment of evidence-based decision making within the sector. UNICEF will work closely with broader sector partners, under the leadership of the ministries to define a roadmap for HMIS and also to build the case for other critical sources of qualitative and quantitative evidence around RMNCH indicators.

The core outline of outcome and outputs is displayed in Annex 1 below. This is complemented by a detailed summary of results, indicators and targets (Annex 2).

Working toward the outcome of ensuring that people, particularly women and young children more equitably access and use quality health services, the outputs are aligned to the new UNSF, and government structure across key programmatic areas.

1. By 2020, 75% of health facilities and 90% community health workers have increased capacity to provide quality maternal, child and new-born health services, including HIV in most vulnerable areas.
2. By 2020, 80% Service providers can provide quality care for children and maternal services; and 95% care givers have increased knowledge and skills to improve health seeking behaviours and home care
3. By 2020, 80% or more of the Health Authorities have the capacity to lead, manage and implement core components of the health system

5. Resource Requirements

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<th>Programme budget (In thousands of United States dollars)</th>
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6. Monitoring outputs and demonstrating UNICEF’s contribution to outcomes

Outcomes will primarily be measured through key national surveys. The expected Demographic household Survey (DHS) in 2017 or early 2018 will serve as baseline data. Disaggregation by geographical area and other social determinants will provide insights into UNICEF contributions in specific regions and towards reducing disparities. Annual health sector review meeting, GAVI Joint Monitoring and the Global AIDS Progress Response Progress Report also provide opportunities from which to track progress and triangulate data. Other surveys supported by partners such as UNFPA and WHO also provide UNICEF with high quality information relevant to UNICEF’s contribution. Partners supported surveys are good opportunities to measure access and quality of health services such as the Essential Life-saving commodities survey and National Emergency Obstetric Care Assessment.

Programme outputs will be measured through a series of coverage and quality indicators already within routine health management information systems and through UNICEF partner reports. There are two areas where current monitoring systems are unable to provide the required data; in tracking retention in HIV services, and in measuring the quality of maternal and new-born care in health facilities.

The main flagship programmes under the health outcome, Global Fund and GAVI will have their own evaluation and monitoring plans in the respective programme for higher intensity monitoring to track and dismantle bottlenecks at both the national and sub-national level. These monitoring efforts will be fed into UNICEF’s overall monitoring dashboard for health and presented to the health sector coordination mechanism. District HIS (DHIS) dashboards and HMIS data will be scaled-up and strengthened for analysis of data and a feedback loop into annual decentralised planning processes and policy dialogue. Analysis of financial bottlenecks will be an additional component monitored through periodic surveys. IBBS is scheduled to be conducted in 2017 which will provide information on baseline data as well as progress of the past implementation to identify lessons learned for better design of intervention. MIS is scheduled for 2017 which will serve as measurement of the Malaria performance and provide evidence based information to continue universal coverage of malaria intervention and moving towards malaria pre-elimination phase.

Changes in behaviour are difficult to assess and monitor regularly and impact tends to be measured by dedicated surveys. UNICEF Somalia recently reorganised the C4D function of the office to strengthen the function of behavioural change across all UNICEF programmes. The results from this approach will be triangulated with data from periodic mixed method surveys to capture both intended and unintended change. At the health systems level, UNICEF has already established a clear role in supporting tracking and advocacy of state budget allocation and providing analysis of budget execution reports. From 2017 onwards UNICEF will work to enable budget tracking by relevant programmatic classifiers.

Over the next two years, UNICEF Somalia is considering conducting an RMNCAH investment case to meet the needs of the new Global Financing Facility. UNICEF will make significant contribution to and make use of the analytical work to be used for priority setting, costing, resource tracking and monitoring of RMNCAH interventions.
ANNEX 1: Results Hierarchy

VISION: By 2030, the most vulnerable children in Somalia will be healthy, in school, protected from harm, and living in resilient communities which access government-led social services.

By 2020, increased proportions of Somalis (especially mothers and children) have equitable access to and use essential services, in UNICEF targeted areas.

1. By 2020, 75 per cent of health facilities are equipped and 90 per cent of community health workers have skills to provide quality essential health package of primary care services respectively.

2. By 2020, the four health system components plans (Human resource, HMIS, Supply chain and logistics and health financing) for effective and efficient services are in place and functional.

3. By 2020, appropriate health policies, strategies, plans and evidence are available for planning and decision making.
### Annex 2: Results Framework

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<th>Key results</th>
<th>Progress indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Means of verification</th>
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<tbody>
<tr>
<td><strong>Sustainable development goals:</strong> SDG 3 Ensure healthy lives and promote well-being for all at all ages</td>
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<td><strong>National Development Plan Priority 2</strong></td>
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<td><strong>UNSF Outcome 6</strong></td>
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<tr>
<td><strong>Programme Outcome</strong></td>
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<tr>
<td>By 2020, increased proportions of Somalis (especially mothers and children) have equitable access to, and use, essential health services in targeted areas.</td>
<td>Proportion of Children &lt; 1 year receiving DTP-containing vaccine at national level</td>
<td>53% (2015)</td>
<td>85%</td>
<td>Routine EPI/HMIS data</td>
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<td></td>
<td>Proportion of population (in targeted districts) that slept under an insecticide treated net the previous night</td>
<td>17% (2015)</td>
<td>70%</td>
<td>MIS Survey conducted every 2 years</td>
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<td></td>
<td>Percentage of adults and children with positive HIV status on treatment 12 months after the initiation of ART</td>
<td>80% (2016)</td>
<td>85%</td>
<td>WHO</td>
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<td></td>
<td>% or proportion of institutional deliveries recorded</td>
<td>18% (2015)</td>
<td>60%</td>
<td>HMIS</td>
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<tr>
<td><strong>Programme Outputs</strong></td>
<td></td>
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<td>By 2020, 75 per cent of health facilities are equipped; and 90 per cent of community health workers have adequate skills to provide quality</td>
<td>Percentage of 47 district Health facilities providing EPHS services</td>
<td>44% (2016)</td>
<td>75%</td>
<td>HMIS/IP reports</td>
</tr>
<tr>
<td><strong>Designated BEmONC facilities that are operational on a 24/7 basis</strong></td>
<td>Designated BEmONC facilities that are operational on a 24/7 basis</td>
<td>135 (2016)</td>
<td>180</td>
<td>HMIS/IP reports</td>
</tr>
<tr>
<td>Number of LLIN distributed to at risk population</td>
<td>Number of LLINs distributed to at risk population</td>
<td>2.1 Million</td>
<td>4.6 million</td>
<td>IPs reports &amp; HMIS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Target</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>53% (2015)</td>
<td>85%</td>
<td>Routine EPI/HMIS data</td>
</tr>
<tr>
<td>17% (2015)</td>
<td>70%</td>
<td>MIS Survey conducted every 2 years</td>
</tr>
<tr>
<td>80% (2016)</td>
<td>85%</td>
<td>WHO</td>
</tr>
<tr>
<td>18% (2015)</td>
<td>60%</td>
<td>HMIS</td>
</tr>
<tr>
<td>44% (2016)</td>
<td>75%</td>
<td>HMIS/IP reports</td>
</tr>
<tr>
<td>135 (2016)</td>
<td>180</td>
<td>HMIS/IP reports</td>
</tr>
<tr>
<td>2.1 Million</td>
<td>4.6 million LLINs distributed (until 2016)</td>
<td>IPs reports &amp; HMIS</td>
</tr>
</tbody>
</table>

UNICEF
<table>
<thead>
<tr>
<th>Key results</th>
<th>Progress indicators</th>
<th>Baseline</th>
<th>Target</th>
<th>Means of verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>essential health package of primary care services</td>
<td>Number of crisis-affected people with adequate access to PHC services provided with emergency lifesaving health services in high risk areas</td>
<td>617,953 (2016)</td>
<td>750,000</td>
<td>Monthly SitRep report</td>
</tr>
<tr>
<td>By 2020, the four health system component plans (Human resource, HMIS, Supply chain and logistics and health financing) for effective and efficient services are in place and operational</td>
<td>Number of health workers (including community mobilisers) trained on IPC and integrated C4D package</td>
<td>3,600</td>
<td>7,600</td>
<td>MoH (Training Reports)</td>
</tr>
<tr>
<td></td>
<td>Number of health care workers trained on quality RHMNCH (including HIV) services</td>
<td>EPHS - 400 HIV – 200 Malaria - 533</td>
<td>EPHS – 1000 HIV - 400 Malaria - 2000</td>
<td>IP reports</td>
</tr>
<tr>
<td></td>
<td>Number or proportion of the 47 districts with fully staffed district EPI teams</td>
<td>0</td>
<td>25</td>
<td>Ministry of Health Reports/Country records</td>
</tr>
<tr>
<td></td>
<td>Health services delivery points submitted Health Management Information System reports in all reporting periods during the previous year</td>
<td>65.8% (2015)</td>
<td>90%</td>
<td>HMIS</td>
</tr>
<tr>
<td></td>
<td>Number of child friendly policies and costed strategic plans developed and operational at the Federal level</td>
<td>1 (2016)</td>
<td>3 (</td>
<td>MOH reports</td>
</tr>
<tr>
<td></td>
<td>Number of zonal or regional contingency plans available and operational</td>
<td>0</td>
<td>3 Zonal Contingency plans available and operational</td>
<td>MOH reports</td>
</tr>
<tr>
<td>Key results</td>
<td>Progress indicators</td>
<td>Baseline</td>
<td>Target</td>
<td>Means of verification</td>
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</tr>
<tr>
<td>By 2020, appropriate health policies, strategies, plans and evidence are available for planning and decision making</td>
<td>Number of health sector wide coordination and management system established and functional at the Federal and Zonal levels</td>
<td>1</td>
<td>4</td>
<td>MOH reports</td>
</tr>
</tbody>
</table>
State of the child and mother: Somali women, newborns and children are dying unnecessarily from preventable and treatable illnesses and diseases.

**CHANGE:** By 2020, Somalis, especially mothers and children, enjoy an improved health status as a result of equitable access to and utilization of quality primary health services in targeted areas.

**Output 1: Supply**
- By 2020, 75 percent of 47 district health facilities are equipped; and 90 percent of community health workers have skills to provide quality essential package of primary health services respectively.
- **Core deliverables:**
  i. Skilled health professionals available to provide quality RMNCAH services
  ii. EPHS with a focus on RMNCAH, HIV and Malaria available and access in targeted districts increased
  iii. Essential RMNCAH commodities available

**Output 2: Demand**
- By 2020, the four health system component plans (Human resource, HMIS, Supply chain and Logistics; and health financing) for effective and efficient services are in place and functional.
- **Core deliverables:**
  i. Adequate health and community workers available and well distributed in targeted communities;
  ii. Logistics and supply chain management system in place and operational;
  iii. Quality of RMNCAH data for planning and decision making available at all levels

**Output 3: Enabling Environment**
- By 2020, appropriate health policies, strategies and costed plans are available for planning and decision making.
- **Core deliverables:**
  i. Management capacity and leadership of RMNCH, Malaria and HIV programming enhanced
  ii. Child-friendly policies and protected budget developed
  iii. Costed RMNCH programme available

**Equity and deprivation Analysis (MoRES):**
- Bottlenecks & barriers = compounded deprivations for the vulnerable demographics
  i. Nomadic populations
  ii. Populations displaced by conflict (IDPs)
  iii. Girls
  iv. Adolescents – youth bulge

**UNICEF strategic interventions**

**RISKS**
- Focus on nomadic, pastoral and IDP children with basic primary package of care ensured in 47 targeted districts, including hard to reach communities
- Insecure political high staff turnover

**Assumptions:**
- NDP and HSSPs are adequately funded. High and Consistent Donor funding is maintained and predictable
- 2. Stabilized Ministries management and staffs with capacity to lead
- 3. Harmful norms/practices have less resonance amongst communities and clans
- 4. The economic shocks/droughts/floods/environmental disasters resilience and DRR help development.