Global Alliance for Vaccine and Immunization -

# Health System Strengthening

Support for

# SOMALIS

# Strategic Plan 2011-15

**Draft - December 2011**

**World Health Organization, Somalia**
**and**
**United Nations' Children Fund, Somalia**

# Foreword

The direct and indirect consequences of poverty and conflict in the developing world last long. Conflict impacts on the most vulnerable people, making long-term development impossible. Fighting poverty among those caught in wars and conflict, is central to help end global poverty.

It is surely no coincidence that no conflict affected country is close to achieving Millennium Development Goals (MDGs). Nor is it a coincidence that majority of countries furthest from reaching the MDGs are in the midst of or emerging from a violent conflict. The challenges faced by these countries are immense:

> Child mortality is five times more than middle income countries and almost twice that of low income countries
>
> One in three people living in conflict affected states is undernourished; this proportion is twice as high as in other developing countries

Conflict leads to migration of workforce especially of those who are the brightest and the best one. But their flight, from conflict-affected areas, which already lack human capital, is one of the biggest barriers to development.

Somalis are no exception to this tragedy. Poor Somali people lose out twice over: once because they are poor and once because of the insecurity and conflict that define their every waking moment. Natural disasters aggravate the status further.

No country has achieved lasting peace and development without a basic functioning state that is, without a system to guarantee rights, resolve issues, and address inequalities. Building an accountable state means putting the development at the very heart of its response, especially in delivering basic services like healthcare, food security, education and clean water.

The development process is no easy or quick feat. Building things up takes much longer than pulling them down. We must look for fresh ways of drawing together all the development and humanitarian tools at the disposal of Somali people. The need for greater cooperation among Somali Health Authorities, Donors, UN agencies, Private Sector, Implementing Partners, Health Staff and Communities is one of them. An 'integrated approach' that brings all stakeholders together from the beginning to the end, from planning and execution through to the evaluation of our interventions is the logical approach. To get the best outcomes we must make sure that the development case is part of our decisions for the poor Somali people.

Right now, the “Health System Strengthening” approach gives us the perfect opportunity to go further in a coordinated response to conflict, poverty and poor health. As we approach close to the end date of the MDGs, there can be no better time for remembering that our ultimate goal is to ensure that Somali people - and

especially the poor - have access to the health care and other services that they so desperately need.

We committed to a road map while agreeing to the Country Cooperation Strategy (CCS) for the period 2011-14, as an interim health sector strategy and now we endorse this Strategic Plan for Health System Strengthening as a practical approach to achieve health sector objectives.

The responses identified are based on an understanding of the specific political, economic, technical, social and cultural factors that determine health status. The interventions detailed in the strategic plan aims to prioritize and adapt what is proven effective, with what is viable in the context. Mindful of the importance of using limited resources to the greatest efficiency, the strategy focuses on investing in the areas most likely to achieve maximum impact. As such, interventions are targeted mainly at women, girls and children as the critical window of opportunity through health system approach.

The choice is ours to move forward with confidence, focusing on the poor and vulnerable Somali, working across the three Health Authorities and beyond in a spirit of true partnership making our land a safer and more prosperous place for a healthy generation to come.

Hussein Muhumed Mohamed
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**Marthe Everard**
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**Health Sector Coordination Office**

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# Abbreviations

| | |
|---|---|
| ARI | Acute Respiratory Infection |
| BCC | Behaviour Change Communication |
| B/L | Bilateral Organizations |
| BoD | Burden of Disease |
| CCS | Country Cooperation Strategy |
| CHD | Child Health Days |
| CHW | Community Health Worker |
| CMW | Community Midwife |
| DALYs | Disability Adjusted Life Years |
| DFID | UK's Department for International Development |
| DMO | District Medical Officer |
| DPO | District Polio Officer |
| EC | European Community |
| EmOC | Emergency Obstetric Care |
| EPHS | Essential Package of Health Services |
| EPI | Expanded Programme of Immunization |
| FGM | Female Genital Mutilation |
| FHW | Community based Female Health Worker |
| GAVI | Global Alliance for Vaccine and Immunization |
| GDP | Gross Domestic Production |
| GFTAM | Global Fund against Tuberculosis, AIDS and Malaria |
| GNU | Government of National Unity |
| HAB | Health Advisory Board |
| HMIS | Health Management Information System |
| HR | Human Resource |
| HSAT | Health System Analysis Team |
| HSC | Health Sector Committee |
| HSS | Health System Strengthening |
| HSWG | Health System Working Group |
| HSCO | Health Sector Coordination Office |
| IC | Italian Cooperation |
| IDPs | Internally Displaced Persons |
| IDSR | Integrated Disease Surveillance and Response |
| IEC | Information, Education and Communication |
| INGO | International Non Governmental Organizations |
| LAM | Lactational Amenorrhea method |
| MCH | Mother and Child Health |

| | |
|---|---|
| MDGs | Millennium Development Goals |
| MICS | Multi Indicator Cluster Survey |
| M/L | Multilateral Organizations |
| MMR | Maternal Mortality Ratio |
| MNCH | Maternal Newborn and Child Health |
| NGO | Non Government Organization |
| OR | Operational Research |
| PEI | Polio Eradication Initiative |
| PHC | Primary Health Care |
| RDP | Reconstruction and Development Plan |
| RMO | Regional Medical Officer |
| SIDA | Swiss International Development Assistance |
| TB DOTS | Tuberculosis Directly Observed Treatment |
| TB | Tuberculosis |
| TFG | Transitional Federal Government |
| UN | United Nations |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| V&A | Voice and Accountability |
| WB | World Bank |
| WHO | World Health Organization |
| WMO | Women Medical Officer |
| ZHCF | Zonal Health Coordination Forum |

# Map


DJIBOUTI
Djibouti
Ásayita
Saylac
Dikhil
GULF OF ADEN
Caluula
Breeda
Bandar Murcaayo
Boosaaso
(Bender Cassim)
Butyaalo
Qandala
Bargaal
Karin
Xiis
Maydh
Laasqoray
Hurdiyo
AWDAL
Baki
Bullaxaar
Berbera
Ceerigaabo (Erigavo)
BARI
Xaafuun
Iskushuban
SANAAG
WOQOOYI
GALBEED
Burco
(Burao)
Garadag
Qardho
Dudo
Bandarbeyla
Diré Dawa
Boorama
Togwajaale
Hargeysa
Nazrêt
Hárer
Jijiga
Oodweyne
Kiridh
Xudun
Taxeex
TOGDHEER
SOOL
Buuhoodle
Laascaanood
Garoowe
NUGAAL
Gori Rit
Eyl
Degeh Bur
ETHIOPIA
Werdêr
K'ebri Dahar
Megalo
Imi
Godê
Shilabo
Berdaale
Xamure
Beyra
Seemade
Gaalkacyo (Galcaio)
Garacad
MUDUG
War Galoh
Baxdo
Mirsaale
Hilalaya
Mereer-Gur
Dhuusamarreeb
(Dusa Marreb)
Hargele
GALGUDUUD
Hobyo
Ferfer
Ceel Huur
Beledweyne
Ceel Buur
Xarardheere
BAKOOL
HIRAAN
Derri
Dolo Bay
Xuddur
(Oddur)
Tayeeglow
Buulobarde
Ceeldheere
INDIAN OCEAN
Luuq
KENYA
Garbahaarrey
Baydhabo
(Baidoa)
SHABELLE
DHEXE
GEDO
Mahadday
Weyn
Cadale
El Beru Hagia
Buurhakaba
Wanlaweyn
Jawhar (Giohar)
BAY
Diinsoor
Baardheere
Balcad
Afgooye
Muqdisho (Mogadishu)
BANADIR
Qoryooley
Wajir
JUBA
DHEXE
SHABELLE
HOOSE
Marka (Merca)
Haaway
Baraawe
Bu'aale
Afmadow
Jilib
Bilis Qooqaani
Jamaame
JUBA
HOOSE
Kismaayo (Chisimayu)
Buur Gaabo
SOMALIA
SOMALIA
National capital
Regional capital
Town, village
Airport
International boundary
Regional boundary
Main road
Track
Railroad
0 50 100 150 200 km
0 50 100 mi
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
Garsen
Lamu
42°
44°
46°
48°
50°
12°
10°
8°
6°
4°
2°
0°
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January 2007
Department of Peacekeeping Operations
Cartographic Section

# … Vision ….

*To reduce the high levels of mortality and morbidity, especially among women and children, through:*

*(i) the development of an equitable, effective and efficient package of health services which are available, accessible, and of reasonable quality, especially in rural areas and*

*(ii) the development of the capacity to deliver the necessary services, with improvements in the availability, accessibility, and quality of health services especially in rural areas.*

……National Reconstruction and Development Plan (RDP) 2008

# Introduction

This Health System Strengthening (HSS) strategic plan has been developed to contribute to the achievement of the vision of **National Reconstruction and Development Plan (RDP-2008)** "reducing the high levels of mortality and morbidity, especially among women and children, through: (i) the development of an equitable, effective and efficient package of health services which are available, accessible, and of reasonable quality, especially in rural areas; and (ii) the development of the capacity to deliver the necessary services, with improvements in the availability, accessibility, and quality of health services especially in rural areas".

The Health Authorities agreed to **Country Cooperation Strategy (CCS 2010-14)** as an interim health sector strategy for Somalia, essential to achieve the vision and sets the road map for health system strengthening.

To ensure coherent implementation, a joint proposal for Health System Strengthening (HSS) was submitted to the Global Alliance for Vaccine & Immunization (GAVI) Secretariat in May 2009. It was approved in May 2010 and confirmation of approval was communicated in September 2010.

The World Health Organization (WHO), Somalia organized a mission of the GAVI-HSS support for Somalis from 18 to 30 October 2010 with an objective to agree on a common line of action and accordingly to produce a strategic plan to translate GAVI-HSS approved proposal into action.

In 2010, the mission visited Somaliland and Puntland, where UNICEF and UNFPA through their field staff joined the mission in meetings with the government's officials and other stakeholders. Meetings were also held with the officials from South and Central Somalia and with different stakeholders based in Nairobi such as UNICEF, UNFPA, bilateral & multilateral donors and health partners (INGOs and local NGOs) to comprehend the context, to review the status, to highlight issues & challenges, to develop consensus on a framework for health system strengthening and to plan for the implementation of GAVI HSS project. The mission had the opportunity to interact (including group work) with the Somali Health System Working Group (HSWG) to generate useful ideas for the development of strategies and to develop consensus on the operational issues related to GAVI HSS implementation.

The draft plan was produced at the end of mission but was not finalised due to delays in signing of the Grant Agreement. The Aide Memoire of the HSS grant was signed on 26 May 2011 followed by signing of the Grant Agreement on 29 September 2011. The draft plan was again reviewed in December 2011 before getting its endorsement from the Health Sector Coordination Committee.

The expected **impact of the GAVI-HSS support for Somalis**, in partnership with the stakeholders, is the "Better health of Somalis and progress towards the health related MDGs" whereas the **outcome** is "to improve access, availability, consumption and quality of essential low cost maternal and child health services in selected areas of Somaliland, Puntland and South & Central Somalia".

Health systems should improve the health status of individuals, families and communities, defend the population against what threatens its health; protect people against the financial

consequences of ill-health; provide equitable access to people-centred care and make it possible for people to participate in decisions affecting their health and health system.[1] Since 1991, conflict, disaster and statelessness have had a profound effect on the Somali health system in all areas. The impact of weak governance has resulted in a generation without adequate access to social services and the collapse of public institutions for health and welfare. Current public health infrastructure is small, concentrated in secure areas, mainly in towns, and dilapidated, because of war destructions or lack of maintenance. The health workforce is small, under-skilled and ageing, often engaged in dual - public and private - practice, forced to work in an insecure and demotivating environment. The collapse of the pre-war public health system has encouraged the emergence of a vibrant but unregulated private health sector and a variety of relief and vertical projects, run by donors, NGOs and UN agencies. The quality of services is often poor, resulting in a waste of both donors and household resources and providing a low impact on the health outcomes.

Somali health status, particularly maternal and child health outcomes have not shown any improvement since 1990 and at this stage it seems unlikely that Somalia will be able to achieve the health Millennium Development Goals (MDGs) targets. Every year, 69,000 Somali children[2] and 4,800 mothers[3] die because of the weak health system, compared to 8,428 Somali people who died because of conflict during 2004-07. Few recent improvements in health outputs are unevenly distributed in the three zones, with many regions "lagging" in health service provision and system performance. However, there are some success stories, which include good progress towards achieving Tuberculosis MDG targets, interruption in polio transmission (Somalia being Polio free for more than four years) and significant improvement in EPI coverage. In addition, innovative approaches like Child Health Days (CHDs) have been successfully implemented to ensure that the population receives essential life saving interventions.

The GAVI-HSS Strategic Plan adopts the overall strategic direction for the Somali health sector as determined in the CCS (2010-14). It also incorporates the health sector priorities of the RDP (2008) and other strategies designed to achieve the health related MDG targets of 2015. The priority areas under the programme contributing to the overall health system have been formulated into **four outputs**. These are:

**Output 1:** Improved availability and utilization of immunization and other essential maternal and child health services based on the Essential Package of Health Services (EPHS).

**Output 2:** Improved access to rural communities to basic essential preventive, promotive and curative health services through community based Female Health Workers (FHWs).

**Output 3:** Improved awareness and demand for immunization and other essential quality maternal and child health services through a comprehensive and sustained campaign of behavioral change communication.

**Output 4:** Evidence (on utilization, impact and cost of services) to generate appropriate and affordable health care delivery models for maximization of efficiency health essential services.

[1] World Health Organization
[2] : Levels and Trends in Child Mortality, Report 2010, Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation
[3] : Trends in Maternal Mortality 1990 to 2008; Estimates developed by WHO, UNICEF, UNFPA and The World Bank

The strategic plan is based on an approach for improvement in access to quality primary health care services, including: increasing resources (financial, human, material) so as to address the issues on supply side of health services; developing stronger partnerships with the community by bridging the gap through community based Female Health Worker (FHW); improving demand side of health services through a comprehensive behaviour change communication strategy; and finally strengthening evidence based decision making process through effective monitoring, supervision and regulatory roles at facility, district and regional levels.

There are plans for a review of the three Health Authorities and their role focusing more on stewardship and regulation of health service provision which could include innovations. Aligning private not for profit sector with the public sector plans is also being considered, which would go towards taking benefit of synergies and avoiding duplications to the maximum extent.

The Somali healthcare delivery system includes; both state and non-state provision, and for profit and not for profit health service providers. The three tiers of government (Zonal, Regional and District) have different roles essentially following a policy-provider division with the Somali and Zonal level responsible for policy development and monitoring, and the Regions and the Districts responsible for the implementation. These responsibilities are badly affected because of security and poor economic conditions and majority of health care system is working through implementing partners with funding from donors, UN and other philanthropic mechanisms.

## Strategic plan development

### *1. Strategy Development Team*

The GAVI- HSS proposal was developed with involvement of all major stakeholders. The process was led by WHO. After the approval of proposal in September 2010, WHO launched a mission in October 2010 to have further consultation with stakeholders on how to operationalise this proposal into action. In order to support the work, a consultant was contracted by the WHO to work closely with the three UN agencies, the Somali Health System Working Group and three Somali Health Authorities.

### *2. Major Activities*

Initially the activities of the mission were focused on defining a ‘conceptual framework’ for Somali health system strengthening based on a strategic review of the health sector in Somalia, brief analysis of the current health sector context and donor landscape, including government and donors’ policies/ plans, fiscal situation, constraints and security challenges. This framework was developed not only for the operationalisation of GAVI-HSS proposal but also for all other health system strengthening interventions, thus promoting better coordination and effective use of available scarce resources.

Consultations were held from 16 to 30 October 2010 in Nairobi, Somaliland and Puntland and were attended by representatives of all major stakeholders from the public and non-government sectors including; health authorities, bilateral and multilateral donors, service providers, civil society at all levels: communities, health centers, regional and zonal. The purpose was to identify challenges faced by the health sector and to provide input into the development of initiatives to achieve targets. Two consultations with Somali HSWG were

held to generate ideas and issues related to conceptual framework and GAVI-HSS strategic plan. Key informant interviews were conducted with implementing partners and those managing health programmes and hospitals.

The mission report was shared with the stakeholders and feedback was used to develop the draft strategic plan. However, finalization of the strategic plan was postponed due to delay in signing of the Grant Agreement with GAVI secretariat. The Aide Memoire of the HSS grant was agreed on 26 May 2011, followed by signing of the Grant Agreement on 29 September 2011. The draft plan was again reviewed in December 2011 before getting its endorsement from the Health Sector Coordination Committee.

The starting date of the HSS Programme is 1 September 2011 and this will end on 31 December 2015.

## *3. Strategic Plan*

The Strategic Plan adopts a systematic approach to define the road map.

**Part 1** of this strategic plan outlines the context and issues of health outcome and the programme.

**Part 2** proposes a framework for Somali health system strengthening and the way forward.

**Part 3** identifies impact, outcome and key outputs of the programme to ensure improved health status.

**Part 4** gives the details of strategic priorities of GAVI-HSS Programme (2011-15) aligned with the conceptual framework.

**Part 5** provides implementation, monitoring and governance mechanisms.

**Part 6** gives the details of financing arrangement.

**Annexes**: The annexes provide additional information about GAVI-HSS logical framework (LFW), Activities Plan and Essential Package of Health Services (EPHS) details at the community level.

While an attempt is made to encompass issues related to the implementation of GAVI-HSS proposal and strategies related to the health sector as a whole, it is recognized that the acceptance of the strategic plan by the private, non-government sector will be voluntary. Therefore the strategic plan focuses on areas that the government can influence and on how it can coordinate its efforts with the private and non-government sector.

# Part 1. Context and Issues

Conflict, disasters and statelessness in Somalia have had profound effects on the health care system in all areas, and resulted in extremely grim situation of Maternal and Child Health. Since the collapse of the central government in 1991 and the descent into civil war, there have been many efforts to restore a central government in Somalia, but there are powerful internal forces and regional dynamics that resulted into a state of chaos. The impact of lack of governance has resulted in a generation without adequate access to social services and the collapse of public institutions for health and welfare. Despite the success of some business sectors, Somalia is marred with widespread social and economic problems and a dire lack of public institutions.

In 1991, the North West region declared an independent Republic of Somaliland and made good efforts to revive the public sector structure. Somaliland, twice affected by civil strife (1992 and 1994–96), in recent years acquired a remarkable level of peace and stability: local elections and presidential elections were held.

In 1998, the North-East declared itself the autonomous Puntland State of Somalia where administrative structure and infrastructure need strengthening, with capacity to enhance revenue. In 2010 elections were held in Somaliland and Puntland under the auspices of United Nations (UN) and the new political leadership took control of the two zones peacefully.

The South & Central Somalia remains locked in intermittent conflict and violence. There had been an international recognized entity 'The Transitional Federal Government' (TFG) that continued functioning from 2004-2009 and it has recently been replaced by the 'Government of National Unity' (GNU). The new entity is trying its best to establish jurisdiction in Mogadishu while facing tremendous resistance from opposing factions.

### *1. Demography*

The population of the whole of Somalia is estimated to be 8.5 million, but the last census was carried out in the 1970s. Somalia is the lowest population density country in Africa (the lowest population density area on earth).

The geography ranges form riverine and relatively densely wooded areas in the south to extremely marginal near desert zones in the North. The terrain is inhospitable and infrastructural development is minimal. Rural populations are spread out and hard to reach.

### *2. Poverty profile*

Somalia's GDP is estimated at $2.5bn, with a growth rate of 2.6% (roughly US$320 per capita – Economist Intelligence Unit 2008). Remittances by the Diaspora, estimated at US$1 billion per year, are regarded as one of the pillars of the economy, and essential to the survival of large portions of the population. The economy is mainly based on livestock, fishing and agriculture accounting for 65% of export earnings. Somalia is a net deficit basic food production country and has to import 60% of basic food needs. Somalia is experiencing its worst humanitarian crisis since 1993. The war, combined with the economic shocks of increased global food and fuel prices and the collapse of the Somali shilling, has created unprecedented levels of poverty.

Extreme poverty in Somalia is estimated to be 43% (less than $1 a day) and 73% (less than $2 a day). Large disparities in poverty (less than $1 a day) noted between the urban population at 23% and the rural and nomadic populations at 53%. UNDP's 2000 Human Development Report ranked Somalia lowest in all health indicators except life expectancy. As a result, it was noted that "most Somalis spend most of their time trying to stay alive and keep their families alive" (UN, 2005).

### 3. Gender

Women in Somali society have an increasingly strong role to play in raising children, managing the household *and* earning income. Nevertheless, the male head of household has significant decisional powers over use of time and resources. While women exercise greater power of decision over health seeking behavior for children – family elders and husband exercise greater authority over decisions to access health care for women during complication. In general women have far lower levels of education and lower access and utilization of health services – and rural women are the most disadvantaged.

### 4. Illiteracy

Demand for higher quality healthcare increases with education. Adult literacy is only 25% with gender parity index of 0.8 for primary school and 0.5 for secondary school. A quarter of Somali women age 15-24 are literate. Women living in urban areas are four and a half times more likely to be able to read than women living in rural areas (MICS-2006).

### 5. Drinking Water and Sanitation

Water borne diseases are a huge problem for the population. Only twenty-nine percent of the Somali population has access to an improved source of drinking water. People from households in urban areas and where the household head has had some form of formal education are more likely to use an appropriate water treatment method than others. On average it takes one hour and twelve minutes to go to the source of drinking water, get the water and then return. In two thirds of households an adult women bears the responsibility for collecting water. Half of the Somali population is living without any type of toilet facilities. Just over three quarters of Somalis living in urban areas are using a sanitary means of excreta disposal compared to 13 percent of people living in rural areas (MICS-2006).

In MICS 2006, 21 percent of children under age five had diarrhea at some time in the two weeks before the survey. Around one in five children who had diarrhea were treated with some kind of oral re-hydration therapy (ORT), whereas just under 80 percent of children with diarrhea did not receive any type of treatment at all. Comparatively, 15 percent of children under the age of five years showed symptoms of Acute Respiratory Infection (ARI).

### 6. Internally Displaced Persons (IDPs)

Insurgency with militants stepping up their activities has led to mass movement of people especially from S&C Somalia, and has been further worsened by a series of natural disasters. Major disasters included several droughts (in Sool/Sanag and in Bay/ Bakool), regular floods (in the Shabelle and Juba regions), and the 2004 tsunami (in Puntland). In 2005/6 failure of the autumn rains caused 1.7 million people to be in dire need, while 400,000 internally displaced people required assistance and protection. In 2008, the most severe drought in two decades affected approximately 3.3 million Somalis, triggering a major humanitarian response. Recently, Somalia has been hit by the worst drought in 2010. All the

above natural events generated mass movement of people, caused major blows to the local economy and increased the needs of the affected population.

### *7. Damage due to conflict*

Somaliland is placed in the "gradual improvement" zone, which is characterized by the presence of some government reform, but entrenched systems where change is often difficult and slow. Puntland is placed in the "post-conflict transition" zone which is characterized by the conclusion of peace and renewed international engagement; while South-Central Somalia is in between the "post-conflict transition" and the "prolonged crisis" (World Bank, 2007).

As a consequence of the prolonged civil strife the health sector is fragmented and provides limited services to the Somali population. The public health care network is small. It mostly relies on national and international NGOs that tend to be concentrated in towns and in secure areas. Direct provision of services by the health authorities is marginal. Private health care outlets have proliferated throughout the country and are now estimated to be in the thousands, with large variations in their size, services offered, staff qualifications and performance.

## Programme Context

### *1. Multi Sectoral Issues affecting Health*

- Poverty and inequity resulting in a high burden of disease and/or barriers to accessing health care services. The burden of disease (BoD) is mainly attributable to communicable diseases and under-nutrition. Maternal and peri-natal conditions along with injuries make up another major portion of the burden.

- The Health Authorities, Donors and Civil Society Organisations have been facing multiple challenges due to the security situation. They have to respond to the manmade and natural disasters, maintaining routine services and providing services to the IDPs.

- Poor economy of the country further adds to the complexity. There is a wide variation amongst regions in terms of availability of resources, disease prevalence, gender inequality and illiteracy.

- Under-nutrition is a major issue, partially tackled through humanitarian interventions. Although the entire population is at risk of under-nutrition, children under the age of five years, adolescent girls and pregnant and lactating women are the most vulnerable. There are alarming rates of acute malnutrition and chronic malnutrition throughout the country with some variations by zone and livelihood system. The MICS (2006) found that exclusive breastfeeding levels are very low as only 9 percent of Somali children age 0-6 months are exclusively breastfed.

- There is a high prevalence of water borne diseases.

- Eight percent of women age 15-49 years were married by the time they were 15, the proportion increases to 46 percent by the time women are 18. In thirty-one

percent of these marriages the husband is ten years older than the woman. Twenty-three percent of currently married women are married to men who are in a polygamous union.

- The communication network is important for access to health facilities and in particular for emergencies. The communication infrastructure is in poor or bad condition.

### *2. Women and children's health status – among the worst in the world*

According to the latest estimates of the UN interagency group, 69,000 Somali children and 4,800 mothers are dying every year because of the poor health status and weak health system. UNICEF's 2006 multiple indicator cluster survey, showed very slow improvement in the maternal, infant and under 5 mortality, and conversely very low levels of vaccination coverage.

- The Maternal Mortality Ratio (MMR) varies in different estimates to between 1044 and 1600 per 100,000 live births, amongst the highest in the world. The main direct causes of maternal mortality are haemorrhage, prolonged and obstructed labour, eclampsia and Infection. Female Genital Mutilation (FGM) is experienced by majority of Somali women with some declining trend and this is thought to contribute to a high incidence of haemorrhage and obstructed labour.

- A total of 22,400 deliveries were recorded as being assisted in S&C Somalia in 2007 (less than 6,000 in facilities); 3,700 deliveries were recorded as being assisted in Puntland (less than 1,500 in facilities); and almost 12,000 deliveries were recorded as being assisted in Somaliland (less than 2,200 in facilities).

- Family planning utilization is very low and is not rising fast enough to achieve MDG goals and the fertility rate is between 6.2 and 6.7. There are no substantial differences in fertility by zone; rural women have on average just one more child than urban women by the end of their childbearing years. Fifteen percent of married women age 15-49 are using a method of family planning. One percent of women using a method of family planning are using a modern method. The most commonly used modern method is the pill, although usage is extremely low. The most popular non modern method is the lactational amenorrhea method (LAM).

- The infant mortality rate is 109 per 1,000 live births and under-five mortality is 180 deaths per 1,000 live births in 2008[4]. This means that one in every 9 Somali children dies before reaching age one, while one in every 5 does not survive to the fifth birthday. Neonatal mortality in the most recent period is 41 per 1000 live births[5].

- The top three morbidities reported in clinics by UNICEF in 2011 are acute respiratory tract infection (including pneumonia), diarrhoea and intestinal parasites. Despite the low rates of routine measles vaccination, UNICEF & WHO carried out a national measles campaign in 2006/7 and since then very few cases have been reported. However, with the drought and famine in 2011, an increase

[4] Level & Trends in Child Mortality, estimates by UN Interagency Group, 2010.
[5] MICS 2006

of suspected measles cases was noted in almost all regions of Somalia. Malaria is common in certain regions, such as Lower Shabelle, Gedo and Bay where it accounts for 55% of cases in clinics.[6]

### 3. *Insufficient provision of primary health care services.*

- There is low coverage and poor quality of antenatal and postnatal care. Only one in four pregnant women attends antenatal care at least once. About 90% of women deliver at home, receive no postnatal care after delivery and newborn care is neglected.[7] Most MCHs are not equipped to do deliveries despite many having trained midwives. Consultation rates for children and adults are very low, with people over 5 years visiting a health facility once every 10 years, and children under 5 visiting once every 5 years.[8] This indicates poor quality service and low demand. This is a reason why most patients consult the private provider (pharmacies) rather than going to their local facility.

- Service delivery occurs via a network of poorly supported maternal and child health centers and health posts. UNICEF currently distributes drugs, vaccines and other supplies to majority of MCHs and health posts. Majority of health posts are rarely supervised and are run by unskilled volunteers with poor monitoring and evidence on utilization of health posts.

- The supplies are delivered through a complex network of partners, consisting of government authorities, international and local NGOs and community based organizations. There are many partners and their programmes varying from support to one facility at a village level, to supporting dozens of facilities within a region in an attempt to develop a regional health system. Facilities are not standardized and have different operating levels, staffing and degrees of support.

**Table 1: Numbers of Health Posts and Maternal & Child Health centres:**

| Zone | No. of Health Posts | No. of Maternal and Child Health centers |
|---|---|---|
| Somaliland | 160 | 83 |
| Puntland | 120 | 47 |
| South & Central Somalia | 264 | 130 |
| **Total** | **544** | **260** |

Source: UNICEF Somalia, 2011.

- The quality of services needs to continue to improve to have an impact on health status, whereas Primary health care facilities need to be functioning for successful referral. There is little known about what the community's priorities are in primary health care services.

### 4. *Shortages of qualified human resource*

The health workforce is small, under-skilled and ageing, often engaged in dual - public and private - practice, forced to work in an insecure and demotivating

[6] Snow R, Okiro E & Noor A; Estimating the morbidity and mortality burden due to P. falciparum in Somalia. 2007 KEMRI
[7] WHO/ UNFPA Maternal, reproductive and neonatal health strategy; April 2009
[8] UNICEF HMIS report 2007.

environment. The health sector suffers severely from the lack of skilled staff, structural fragmentation, insufficient salaries and almost non-existent supervision and management. There is no budget to recruit newly trained staff: consequently they go to the private sector or overseas. Since there are no proper structures and procedures, there is no human resource development policy or plan, no job descriptions, no in-service training and no mechanism for performance assessment.

Health care training institutions do not have accreditation systems and standardized curricula. The shortage of qualified and competent teachers is a key concern. The average health work force ratios are very low: three physicians per 100,000 people and 11 nurses per 100,000 people. There is an acute shortage of midwives, with a total of 282 midwives and a ratio of three midwives per 100,000 people.

### Table 2: Human Resources for Health:

| Health Workforce | S&C Somalia | Somaliland | | | Puntland | | | Grand Total |
|---|---|---|---|---|---|---|---|---|
| | **Total** | Public | Private | **Total** | Public | Private | **Total** | |
| Doctors | **94** | 43 | 42 | **85** | 32 | 42 | **74** | **253** |
| Pharmacists | **4** | - | - | **-** | 14 | 3 | **17** | **21** |
| Nurses | **189** | 240 | 96 | **336** | 128 | 208 | **336** | **995** |
| Midwives | **10** | 44 | 15 | **59** | 29 | 18 | **47** | **282** |
| Auxiliaries/ Technicians | **333** | 462 | 242 | **704** | 160 | 215 | **375** | **1512** |
| **TOTAL** | **630** | 1241 | 243 | **1184** | 363 | 486 | **849** | **3110** |

Source: Zonal Ministries of Health 2007

### *5. Poor prescribing and dispensing practices*

It appears that there is short interaction time between the patient and their health worker, overuse of antibiotics, polypharmacy, poor communications between patient and dispensing personal, and inadequate and faulty dispensing techniques. However, more evidence is required to understand the context.

### *6. Weak Referral system*

The absence of a proper referral system contributes to underutilization of primary healthcare facilities resulting in high unit costs. Self-referral to hospitals is very common. The weak organizational and functional linkages between the district health system and the hospitals, contributes to the lack of integration between primary and secondary level health services.

### Table 3: Number of Referral Hospitals:

| Zones | District Hospitals | Referral Hospitals |
|---|---|---|
| Somaliland | 8 | 1 |
| Puntland | 4 | 1 |
| South Central | 15 | 5 |
| **TOTAL** | **27** | **7** |

Source: UNICEF Somalia, 2008

### 7. In-sufficient Emergency services

There are only a small number of functional ambulances available, often without trained staff. There is a lack of capacity both at zonal and regional level hospitals to respond to emergencies, epidemics and disasters in appropriate manner.

### 8. High Out of pocket expenditure

There is high out of pocket expenditures for health care and a low level of social protection. Household out of pocket spending remains the main source for financing healthcare. With the high percentage of people below the poverty line, the high potential cost of healthcare and the high level of out-of-pocket spending on health often leads to denied access to healthcare services or catastrophic incidents that leave families and households completely impoverished.

### 9. Poor Coordination

One of the major challenges for the implementation of not only GAVI-HSS programme but also for all other HSS interventions is the lack of effective coordination mechanism among different stakeholders. The expectation of stakeholders varies and mechanism of Health Sector Committee Reforms, although agreed, needs to be fully functional, particularly at the zonal level. However, in 2011 coordination has improved considerably with increased participation of the health authorities in various strategic meetings facilitated by the Health Sector Coordination Office.

The local authorities are still facing humanitarian crises and lack a clear long-term development vision and effective governance mechanisms. There is a need for cost effective service provision interventions at community and primary health care level. The focus on hospitals may significantly increase the recurrent cost with relatively fewer benefits considering accessibility issues and scarcity of financial and workforce resources.

Donors, with some variation, are mostly interested in those projects which are cost-effective, can deliver quick results and have low fiduciary risks. However, donors need to work in a more coordinated way through the existing and agreed coordination mechanisms for all health sector interventions.

There is also disconnection between donors funded humanitarian and development interventions and there is a need for harmonization and better linkages between health sector and health cluster coordination mechanisms in order to avoid duplication of efforts and resources.

Implementing partners especially INGOs are facing security issues in some areas. However, they are able to show positive results even in the high-risk areas especially in South and Central Somalia.

Performance of some of the local NGOs was considered good as they have more acceptability of local authorities and communities and face relatively few security challenges.

# Part 2. The Framework for Somali Health System Strengthening

**Country Cooperation Strategy (2010-14)** provide a base and direction for the health system strengthening and the strategy was agreed by the three Health Authorities as an interim health sector strategy, essential to achieve the vision with main focus on the following strategic areas:

- Priority Health Programmes: Communicable Disease Control; TB, Malaria and HIV; Maternal, Newborn and Child health; EPI and Nutrition.
- Health System Development: HR Development, Governance and Leadership, District Health System, Medical Products, Health Information, and Health Care Financing.
- Coordination and Partnership
- Determinants of Health: Environmental Health, Health Equity, Health Promotion.
- Emergency Preparedness and Response

Of the three political zones, only the Somaliland government has made some investment in the health system in recent years. Under Lot 3 funding support to the health sector in Somalia, the EC championed health system development. Some positive developments in the health system strengthening are:

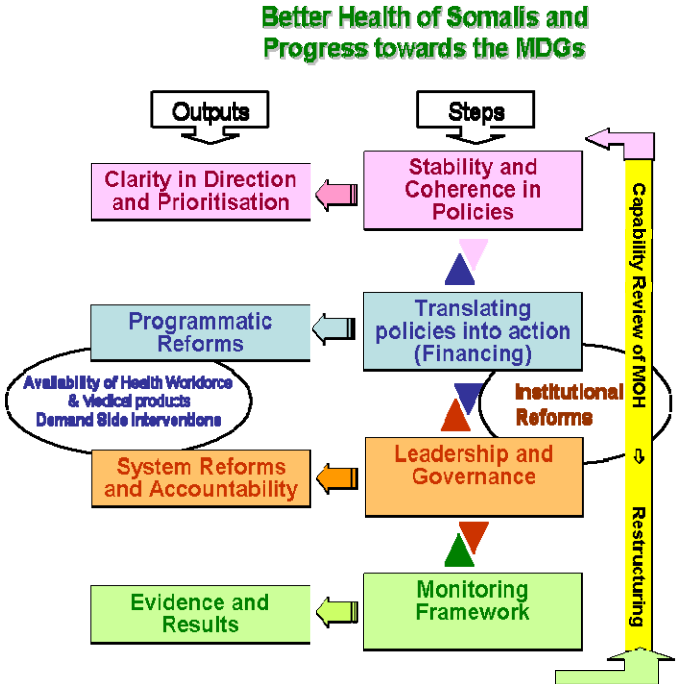
1. The creation of an Essential Package of Health Services for all 3 zones, now adopted and a reference point for all partners. This standardizes the activities that should take place at each level of the service, and directs health authorities, health workers and health partners on how to achieve rapid improvements in quality of service and care.
2. The policy environment improved, with the creation of a reproductive health situational analysis, strategy and policy for rapidly tackling the very high maternal and newborn mortality.
3. A Human Resource management strategy and policy for Somaliland that could potentially be developed in the other two zones. This helps tackle the greatest single challenge to increasing performance which is in reforming the workforce.
4. Rationalization of drug provision, with a redesign of UNICEF drug kits
5. Development of Joint Nutrition Strategy and Draft Child Health Strategy with WHO support.
6. Interruption of polio virus transmission and good progress on TB case detection and cure rates are because of significant investment in health system strengthening. GF malaria has given funds for the National Health Management Information System to be established, which is now collecting monthly data from hospitals across all three zones.

However, Somali health status, particularly maternal and child health outcomes have not shown any significant improvement since 1990 and at this stage it is unlikely that Somalia will be able to achieve the health Millennium Development Goals (MDG) targets.

A typical standard approach to aid instrument is being applied in Somalia, emphasizing on availability of low levels of funding, mainly disbursed through NGO and humanitarian projects, short-term commitments, use of technical assistance as a way to persuade governments to improve policies and limited donor coordination with an argument of weak government leadership. On the other hand there is no doubt about weak public systems, imposing risks to direct donor financing.

The support for Somali health system strengthening (HSS) through Global Fund, GAVI and bilateral funding provides an opportunity to establish together a 'strategic framework' for policy prioritization, implementation and opening the way for donors to align with programmes and later on with budget allocations and policy objectives. Considering the realities on the ground, the following '**conceptual framework**' was proposed to the stakeholders involved in the Somali health sector.

### Figure 1: Framework for Somali Health System Strengthening




With donors and UN support, a number of policy/ strategic documents have been produced over the last few years, but these strategies have not resulted in a 'single social health policy' and have not been used effectively to drive resource allocations for the health sector. However, these policy and strategic documents have a number of potential strengths which include:

- Government ownership and modalities for policy implementation, strategic and operational planning, including explicitly linking of resource allocations (and capabilities of the Health Authorities)
- Strengthened implementation monitoring mechanisms, including the establishment of Health System Analysis Team (HSAT).

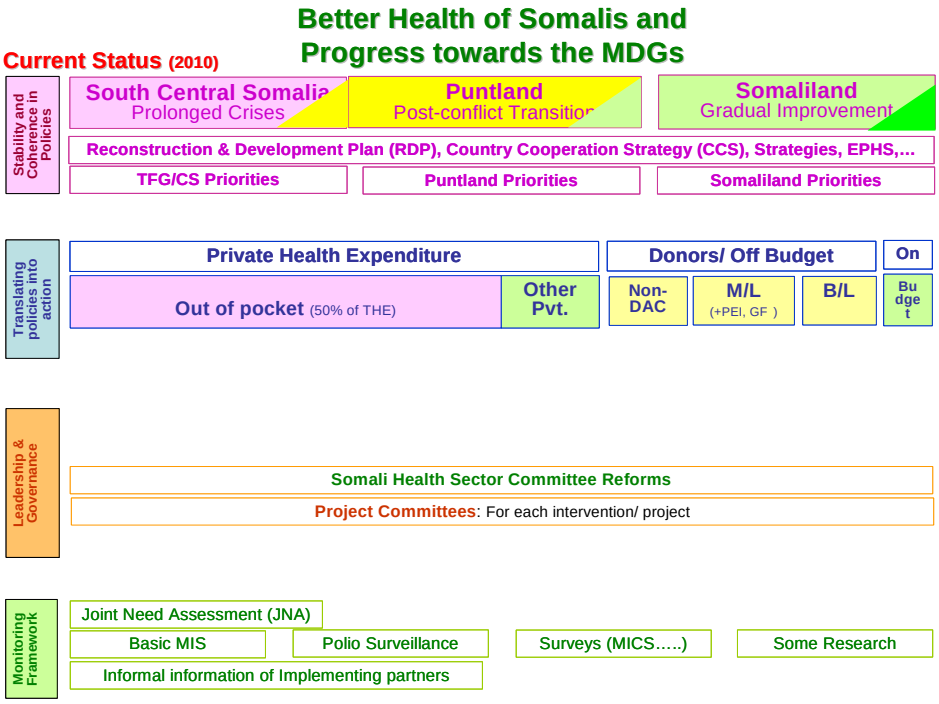
- Plans for reinvigorated governance mechanisms for implementation oversight through agreed Somali Health Sector Committee reforms.

These strategic documents, particularly the Country Cooperation Strategy (CCS) for Somalia (2010-2014) - agreed and endorsed by the three Health Authorities as an interim health sector strategy - provide an entry point not only for effective implementation of priorities but may also provide valuable opportunities for increased harmonization of donor programmes, which mainly consist of off-budget project/ humanitarian assistance.

# Current Status

The current status of this framework for Somali health system strengthening and ultimately better health status of Somalis is shown in the figure 2.

### Figure 2: Current Status of Somali Health System Strengthening Framework




# The Way Forward

The future steps required for Somali health system strengthening and ultimately better health status of Somalis are shown in the figure 3 and 4.

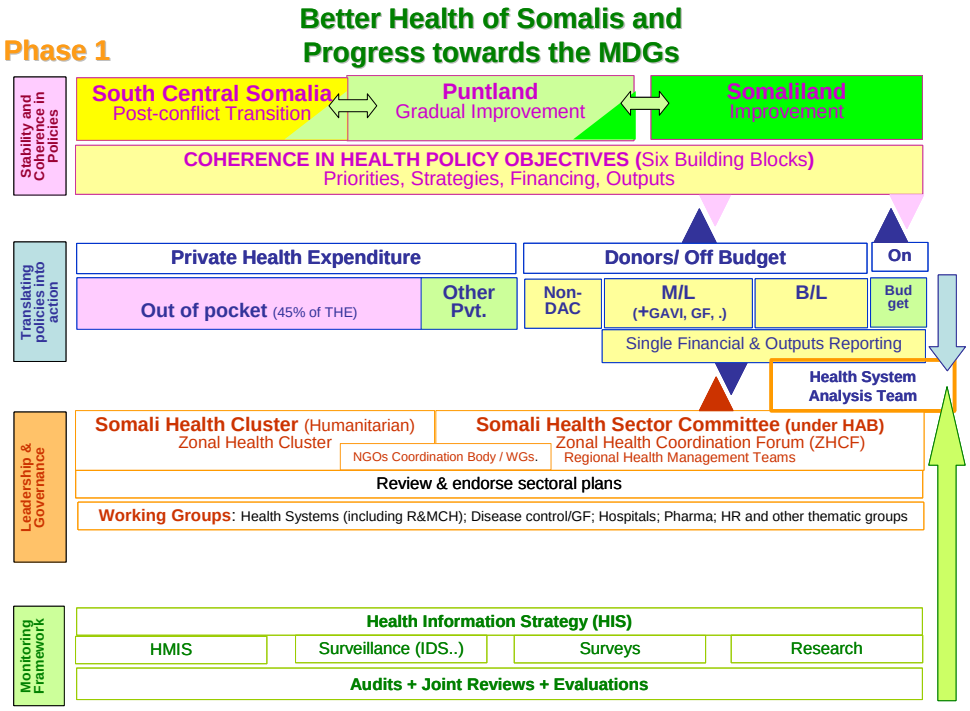
1. It is assumed that political stability and peace building measures in the country will bring more clarity in policy priorities. Through effective coordination, **Coherence** among policy and strategic documents should be the starting point of the reform process. The approach of WHO's 'six building blocks' provide a useful framework for setting policy priorities. Moreover, clarity in policy objectives can be used to allocate and prioritize all current and future investments (including on budget and off budget) in the health sector.

- Policy should clearly define policy priorities, strategies, funding requirement, expected outputs and roles and responsibilities under each policy objective.
- Governance mechanisms should be able to convert these policy objectives into annual and long-term development and humanitarian plans.
- With the same policy objectives, the regional health authorities should develop their health strategic and operational plans.

2. For **translating policies into action**, humanitarian and development assistance should be used, aligned with policy objectives. Importance of reducing out-of-pocket health expenditure should not be ignored. Abolishing user charges at the district/ primary health care facilities can be another starting point for the reforms, which will improve accessibility of the poor to the health services.

3. To ensure effective **governance mechanisms**, the reinvigoration of the Somali Health Sector Committee (under Health Advisory Board-HAB),and activation of Zonal Health Coordination Forums with representation from health authorities, civil society and development partners are critical to oversee progress, align off budget investments and to agree on future policy implementation priorities. The importance of Health Cluster approach for humanitarian assistance will remain high, considering prolonged conflict in some areas and high probability of disasters e.g. floods and droughts. Coordination among NGOs and their representation in the governance mechanism will ensure effective implementation of projects and mutual accountability.

## Figure 3: Phase I for Somali Health System Strengthening




4. Further to streamline strategic review/ direction, the mechanism of Working groups and Task forces needs to be made functional and more systematic – with relatively few number of members but meeting regularly – to keep focus on strategic priorities.

Information sharing at the Zonal and Somali levels is very important to have clarity on issues, developing consensus and decision making process.

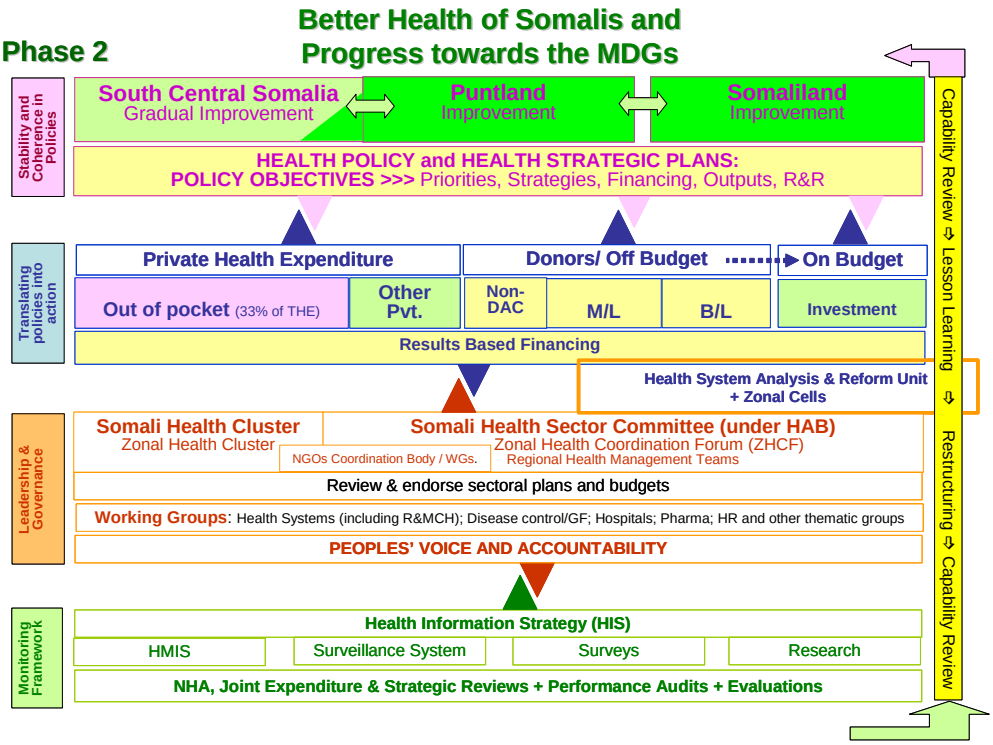
5. Strengthening of peoples' voice and accountability (V&A) processes should not be ignored and a separate V&A strategy should be developed – with a major focus on enhancing peoples' voice and oversight on achieving policy objectives. From the role of parliament to the community participation in health sector interventions, all possible options should be explored. This may bring more trust of the people towards the public sector and thus more political stability.

6. The concept of Health System Analysis Team (HSAT) in developing a **policy monitoring framework** and regularly producing "annual financial and outputs reports" could become the basis for long-term reforms in the Somali health sector and results based financing. Gradually this unit should be converted into a Health System Analysis and Reform Unit.

7. This may also have major implications for harmonizing and aligning development partner's inputs. All development partners should consider aligning their plans with the agreed policy objectives and gradually efforts should be made to bring 'off budget' investments to 'on budget' investment, which will also demand major cross-government budgeting, fiduciary, governance and transparency reforms.

8. Technical Assistance (TA) should be available on long term basis for **capability reviews and structural/ institutional reforms** in the health sector while considering needs to implement agreed policy objectives. TA would ensure that each programme and institution within MOH has the requisite capabilities to fulfill its share of the overall national policy agenda.

## Figure 4: Phase II for Somali Health System Strengthening



# Part 3. Impact, Outcome and Outputs

The GAVI-HSS Programme does not cover all aspects of the "Conceptual Framework" but makes an effort to contribute to the key strategic areas of the framework and its alignment with agreed strategic objectives and mechanisms for effective service provision, coordination and governance. The GAVI-HSS Programme will attempt to avoid creating any vertical mechanism and will generate evidence to scale up its interventions at large scale in future.

## Impact

**"Better health of Somalis and progress towards the health related MDGs".**

By 2015, the GAVI-HSS Programme will contribute to the reduction in child and maternal morbidity and mortality from vaccine preventable and other serious and easily avoidable/ treatable diseases by providing support to the lowest tiers of the public health system and communities in order to improve access, availability, consumption and quality of essential low cost maternal and child health services.

## Outcome

**"To improve access, availability, consumption and quality of essential low cost maternal and child health services in selected areas of the three Somali Zones".**

The Programme will achieve its outcomes by:

- Improving utilization of MCH/ Health Centers and by bridging the gap between the community and health services through community based FHWs;
- Addressing health problems and needs of the community, providing promotive, preventive, limited curative care services to which the population covered by the programme has effective access;
- Expanding the access to Maternal and Child health (MCH) including birth spacing services in urban slums and rural areas; and contributing to the community service delivery of existing health care interventions like control of diarrhea diseases, management of respiratory infections, promotion of EPI, Malaria and Tuberculosis control and Nutrition;
- Ensuring that these services reach women, girls, children, the underserved and the poor, especially in the urban slums and rural areas;
- Bringing about community participation through creation of awareness, changing of attitudes, organization and mobilization of support; and
- Generating evidence to ascertain the effectiveness of health system strengthening interventions but also for evidence based decision making.

The Programme aims to:

1. Strengthen 40 out of total approximately 250 MCH/HC meeting core essential package of health services (EPHS) standards in the three zones by 2013.
2. Deploy 200 community based Female Health Workers by end 2013 in the catchment areas of these MCH/HC.
3. Expand services by 2015 into areas that are more disadvantaged and covered by the Programme.
4. Increase its health impact in communities by 2015 through:
    - Improving Immunization coverage among children;
    - Improving coverage of Tetanus Toxoid;
    - Increasing the number of children who are exclusively breastfed;
    - Decreasing infant and child mortality due to common causes (diarrhoea, pneumonia, under nutrition etc) through early diagnosis and referral;
    - Improving antenatal, natal and post natal care and referral of complicated cases;
    - Promoting deliveries by skilled birth attendants and birth spacing;
    - Improving hygiene and sanitation in the served areas through increasing awareness using BCC interventions.

# Outputs

There are four specific outputs of the GAVI-HSS Programme:

**Output 1:** To improve availability and utilization of immunization and other essential maternal and child health services by 2015 - by strengthening and supporting selected MCH/ Health centers based on the Essential Package of Health Services (EPHS).

**Output 2:** To improve the access of rural communities to immunization and other basic but essential preventive, promotive and curative health services through support to: Health posts and CHWs; and introducing on a pilot basis a new cadre of Community- based Female Health Workers (FHWs) providing mainly preventive services to a defined catchment population.

**Output 3:** To improve awareness and demand for immunization and other essential quality maternal and child health services through a comprehensive and sustained campaign of behavioral change communication.

**Output 4:** To provide evidence (on utilization, impact and cost of services) in order to generate appropriate, equitable and affordable health care delivery models for maximum efficiency and equity of immunization and other essential services, through managing a programme of operational/ health system research.

# Key Performance Indicators & Means of Verification

Please refer to the Logical Framework at **Annex A**.

# Assumptions

Key assumptions are:

- Political stability and improvement in security situation
- Economic growth
- Availability and improved predictability of donors' assistance
- Increased government financing in health
- Improved literacy and education levels
- Improved coordination among stakeholders

# Part 4. Strategic Directions

## Introduction

The strategic directions for the GAVI-HSS over the period 2011 to 2015 emerged out of the priorities defined in the Country Cooperation Strategy. The directions mentioned below are those, which will contribute to the strengthening of health system and services and are critical to achieve results.

The whole Somali population needs improved provision of health services. However, the GAVI-HSS must target those who are poor and relatively underserved. This approach will be challenging as in general, the underserved live in rural areas, and it is difficult to provide public services to such areas. Yet these are the people who have the fewest options available to them, and for whom the consequences of illness and death are perhaps the greatest. However, the population living in urban slums areas may not have much different health issues and consequences of illness, especially in a scenario when health services have been disrupted for quite long time because of conflict and disasters.

There are three major challenges for the Somali GAVI-HSS Programme in providing good quality services to such communities.

Firstly, the gaps in health facilities where community based FHWs will be trained at and also for her to refer patients/ clients.

Secondly, there may be difficulties in finding women who meets the educational criteria for recruitment in some geographical areas.

Thirdly, the costs and therefore difficulties of ensuring regular supplies and supervision are likely to be greater than elsewhere.

The provision of quality services to the FHWs' patients/ clients must also be ensured in order to maximize the impact of these services on the health outcomes. In particular, priorities are:

contribution of FHWs to improve immunization coverage, reducing communicable diseases and under-nutrition, and improving availability of RMCH services;

promoting greater gender equity in the provision of health services, and

creating mass awareness in public health issues.

In providing these services it is important to establish linkages and create synergies with strategies and activities of other health system strengthening interventions including Global Fund and other donors' projects.

One important factor would be to focus on improving the quality of the inputs, the FHWs knowledge and motivation to provide this service and to ensure that she has the necessary supplies to carry out her work. The second is to ensure that there is good quality supportive supervision and monitoring occurring and that the poor performance is dealt with.

# Key Strategic Directions

## 1. Strengthening of selected MCH/Health Centers to deliver EPHS

The Somali Essential Package of Health Services (EPHS) is to be implemented across 4 levels of service provision, each with a standardized service profile, and each supported by a standardized set of management and support components:

- primary health unit (PHU)/ health post
- health centre (HC)/ MCH centre
- referral health centre (RHC)
- hospital (H)

The Programme will assist the Somalis Health Authorities to upgrade 40 MCH centers to the level of Health Centers (HC) in the three zones. The health centre is the key unit of the essential package at which all six core programmes (Reproductive, Maternal & Newborn Health; Child health; Communicable disease surveillance and control, including WATSAN promotion; First aid and care of critically ill and injured; Treatment of common illness; and HIV, STIs and TB) are carried out. It is the first level at which obstetric services are provided including ANC and facility based delivery with qualified midwives.

The minimum number of staff is a qualified midwife, qualified nurse, and a qualified auxiliary nurse and community midwife. Along with maternity beds there are a minimum of 6 beds for 24 hour observation of sick patients. A Primary Health Officer is a qualified nurse responsible for Nutritional and EPI activities in the health centre as well outreach services in the community. A District Health Committee is involved in the management of health centre with the health team, and they are involved in raising funds at community level. No user fees should be charged at health centre level to improve accessibility to essential health services. Health centers have refrigerators to guarantee the cold chain. Additional programmes (Management of chronic disease; Mental health; Dental Health; and Eye health) may not be operational at health centre level in the first two phases.

### KEY PERFORMANCE INDICATORS:

- % of intervention MCH/ Health centres implementing core EPHS standards
- % of intervention MCH/ Health centres providing facility based and outreach immunization services
- % of intervention MCH/ Health centres visited by regional supervisors at least 4 times in the last year using checklist

### ISSUES:

1. Selection of appropriate MCH/ Health Centers
2. Implementation of EPHS
3. Selection of implementing partners
4. Role of health authorities
5. Effective supervision
6. Standardized training
7. Timely procurement and supply of equipment, vaccines and supplies

## STRATEGIES:

**Selection of Health Centers:** Functional regional/district health system and especially functional health centre/ MCH centre plays a key role in the success of community level health interventions. Realizing this, selection of functional HC/MCH is the first major prerequisite for the implementation and success of the programme. The approach would be to select health facilities which may not meet all Essential Package of Health Services (EPHS) standards but should be able to provide essential minimum support to the community level interventions. The following criteria was agreed to identify 40 Somali MCH/HC (13 in Somaliland, 12 in Puntland and 15 in South & Central Somalia) which will be strengthened to meet core EPHS standards:

a) MCH/HC should be functional, with at least one female skilled health care provider preferably two or more;
b) MCH/HC with minimum of 3 rooms, one of which could be used as a training room for FHWs;
c) MCH/HC to be selected from a District with reasonably dense population; settled; and preferably rural or urban slum;
d) MCH/HC in a District with a 'Tertiary hospital' or in a District with 'better socio-economic status' should not be selected, as the population already have some access to services. District (urban) with majority of population living in peri-urban/ slums areas may be prioritized;
e) MCH/HC in a District with a functional Global Fund intervention should be preferred;
f) MCH/HC in a Region with a functional public health structure/ authority;
g) MCH/HC in a Region with relatively better accessibility to ensure regular supervision.

A cluster approach should be adopted to select MCH/HC in few districts and regions rather than dispersing interventions sites throughout the country which may lead to management and supervision difficulties.

**Role of Health Posts:** According to EPHS, Health Posts (HP) are to be upgraded to function as Primary Health Unit (PHU). The issue was raised whether such PHU could be selected as intervention health units. However, it was not clear that how much time it would take to upgrade these health posts and whether required funds and skilled staff are available for such intervention. Therefore, the HSS Programme will select only MCH/HC meeting the agreed criteria in this phase and later on criteria may be revised by the Health Sector Committee(HSC) considering status of up gradation of HPs to PHUs and whether these units are able to support community level interventions or not.

Through GAVI-HSS Programme, 80 health posts in the catchment areas of 40 MCH/HC will be strengthened during this phase.

**Implementation of EPHS:** The implementation of EPHS (which has been endorsed by all stakeholders) may be ambitious to fully implement at this stage. However, all efforts should be made to reach close to the core standards in 40 MCH/HCs, with a mechanism of monitoring these standards.

**Standardization of Terms of Reference with implementing partners working at MCH/HC level:** It was observed that a variety of TORs are being used by donors and UN agencies to contract out/ manage Health Centers to the implementing partners. The TORs in

the contract with NGOs will be revised and standardized not only to manage MCH/HC in line with EPHS but also by inclusion of management of out reach component.

**Selection of Implementing Partners:** A transparent process for the selection of implementing partners to manage intervention MCH/HC should be adopted with involvement of local health authorities. Preference should be given to the NGOs:

- working at the Zonal level and below, with presence of staff on the ground;
- having previous experience of managing MCH/HC centers;
- having experience of implementing community level interventions;
- good working relationships with local health authorities and communities;
- preferably those NGOs which have comparatively less accessibility issues; and
- NGOs having sound financial, procurement and M&E mechanisms.

However, most facilities might already be functioning with support from UNICEF and so might only need to align.

**Realistic incentives and the linkage with performance:** A strategy on standardized salary support/ incentives for health staff was developed with EC support, agreed by all partners but not implemented uniformly by all. The approach should be to implement the recommendation of the report however, for the interim period, there is a need to develop consensus on realistic incentives particularly for the MCH/HC and supervisory staff. UNICEF will work with Health Sector Coordination Office to develop consensus on realistic salary support/ incentive and to link these incentives with performance at all levels.

**Role of health authorities:** Currently governance mechanisms are weak and there is a need to enhance the role of health authorities in decision making process, regulation, assuring quality of services, supervision and monitoring of health services and programmes. Donors will play a key role in building their capacity on these issues particularly at the macro level.

**Training curriculum:** A number of training curricula/ materials already exist and there is no need to develop new curricula/ training manuals for trainings under GAVI-HSS Programme. Existing training curricula/ training manuals will be adopted to meet the needs of EPHS at MCH/HC level and get these endorsed by the HSC and the health authorities.

**Procurement and Supplies:** Timely availability of equipments, supplies and printing material is critical to achieve positive outputs from the programme. It is recommended that UNICEF should develop annual procurement and supply chain plan in consultation with WHO and health authorities.

### ACTIONS:

- The Zonal Health Coordination Forums (ZHCF) will identify and communicate 40 MCH/HC (13 in Somaliland, 12 in Puntland and 15 in SC Somalia) to WHO and Unicef in order to conduct baseline and start implementation of activities. After agreement on 40 MCH/HC, 80 health posts in the catchment areas of the same MCH/HCs will be selected for strengthening through GAVI-HSS support.

- Meet the core standards in 40 MCH/HCs, with a mechanism of monitoring these standards.

- WHO and UNICEF will revise the TORs for contracting out/ managing MCH/HCs and will get these endorsed by HSWG and HSC.
- Link realistic incentives/ salary support with good performance at all levels.
- Contract out selected MCH/HCs through a transparent process with involvement of health authorities.
- Standardized training curriculum and manuals to be agreed, approved and used to train staff of MCH/HCs.
- Development of annual procurement plan in consultation with stakeholders.

# 2. Deployment of a new cadre of community based Female Health Workers (FHWs)

This component is based on a new Somali programmatic and health system reform with a concept of bridging the gap between the Health Services and Communities by providing integrated primary health care services through a community based Female Health Worker at the doorsteps of communities. FHW is expected to deliver services to her own community that contributes to the improved delivery of number of other priority development health programmes. This component is not expected to operate as a stand-alone organization. It relies on the involvement of Zonal Health Authorities, the Regional/ District Health Office, functional health facilities, implementing partners, private sector (for referrals) and the successful operation of other health programmes.

### Figure 5: Expected contribution of FHWs to other Somali Health Programmes

| *Health Programmes* | Expected Contribution of FHWs |
|---|---|
| *EPI* | Mobilization and Vaccination |
| *Maternal, Newborn and Child Health* | Antenatal; screening of pregnant women to identify risk; help access skilled birth attendant; tetanus toxoid immunization; postnatal care; care of newborn; prevention and management of childhood illness; child health promotion; adolescent health; information, education and communication (IEC) for birth spacing; and referral of patients and clients |
| *Nutrition* | Nutrition counseling; screening of children, adolescent girls and women for malnutrition; micronutrient supplementation; and referral |
| *TB, Malaria, HIV, other common ailments, Mental Health, and Environmental Health* | Health education and promotion; Administration of DOTs; Initial treatment of malaria; and referral |
| *Others* | Community organization; school health activities; raising community awareness; and participation in humanitarian activities |

This component aims for a measurable reduction in the burden of diseases especially among vulnerable segments of the population – women and children. There is a need to be consistent in defining procedures and meeting criteria/standards of the component. One example is that FHWs should be resident and providing services to their own communities.

The FHW intervention will be supported by strengthening of other Programmes and health care services. For example, the posting of skilled health staff in health centers will support

the training of FHWs; improved management and supply of medicines in the core health services should support the referral function of the FHWs and their own activities, etc.

The development and functioning of the FHW intervention is also dependent on the capabilities of public health managers and implementing partners. WHO will responsible for management and supervision of this component working closely with Regional/ District health office and the implementing partners whereas recruitment, training, supervision and logistic support will be ensured through the MCH/ HC (including FHW supervisor).

It is estimated that approximately 8,000 FHWs will be required to cover the targeted Somali population. However, the intervention will start with only 200 FHWs in phase I, with a strong research component to prove its effectiveness in the Somali context. Positive evidence along with availability of required resources will determine the scaling up of this intervention in future.

### KEY PERFORMANCE INDICATORS:

- % of FHWs (Total target: 200 FHWs) trained and deployed in their communities
- % FHWs fulfil the Programme selection criteria
- % of deployed FHWs carrying out at least 5-7 visits per day
- % of deployed FHWs with regular supply of essentials kit items (no stock out of ORS, antibiotic, iron/folic acid tablet, paracetamol and anti-helmintic in the previous month)
- % of FHWs regularly supervised by their supervisors

### ISSUES:

- Non availability of suitable candidates for selection as FHWs in the hard to reach areas
- Low female literacy rate
- Socio cultural barriers in selection of FHWs
- Shortage of resources to cover all the rural areas of the country

### STRATEGIES:

**Selection Criteria for FHWs and their Supervisors:** The first major task under this component would be the selection of community based Female Health Workers (FHWs) and their supervisors. The following criteria will be followed for the two cadres:

Criteria for selection of FHW:

i. Female, preferably married
ii. Resident of the community to serve
iii. Education: 8 grade pass or more
iv. Age: 20-45 years at the time of selection (Minimum age may be 18 years in case she is married)
v. Preference:
    - Endorsed and respected by the community
    - Health sector work experience, (e.g experience of working in Child Health Days, National Immunization Days, Measles campaign etc)
vi. Test (reading, writing and numerical) / documented evidence that she can write in Somali language and do simple calculations

There is a risk that a literate woman may not be available in some communities. However, it was agreed not to relax the selection criteria in phase –I. FHW will be responsible to serve her own community where she is permanent resident and will serve a population of 600-1000 (in this phase) consisting of approximately 100-160 households. After completing the basic training, she will register all households and will visit 5-7 households every day. Her own house will be labeled as a 'Health House' but she will not be a static health care provider.

Criteria for dismissal of FHW:

- Violation of the selection criteria
- Continuous poor performance assessed through supervisory checklist

Criteria for selection of FHWs' supervisor:

i. Female, preferably married
ii. Resident of the district to serve
iii. Education: Minimum 12 class pass or above
iv. Age: 22-45 years at the time of selection
v. Preference:
    - Endorsed and respected by the district community
    - Health sector work experience (nurse, midwife)
vi. Test (including mathematics) / evidence that she can read, write and do simple calculation.

One FHW-supervisor will be responsible to supervise 10-15 FHWs in a district/ region where she is a permanent resident. She will be responsible for visiting each FHW twice a month using a supervisory checklist and will be based in a MCH/HC in the same district/ region.

**Selection process of FHWs:** The selection committee of FHW will consist of:

- Incharge of MCH/HC/ trainer of FHW
- Local Community Leader
- Representative from implementing partner
- District Polio Officer

WHO's District Polio Officer (DPO) and the regional health office will issue the offer letter after re-verification of the selection criteria.

It is expected that day to day issues will emerge on the selection and termination of FHWs and their supervisors. WHO in consultation with the Zonal Health Coordination Forum (ZHCF) will resolve such strategic issues about selection, recruitment and termination of FHWs under the agreed criteria.

**Scope of work of FHW:** The scope of work of FHW prioritize Maternal, Newborn and Child health services including immunization, reproductive health, nutrition and control of communicable diseases though provision of promotive, preventive and some selected curative care services. FHW will be trained to work as a vaccinator in her catchment's area through intensive on job training. FHW will be provided with a stipend in recognition of her services. The details on EPHS at the level of 'Health House' are in **Annex C**.

FHW will deliver services to patients and clients, through household visits interacting mainly with mothers and children. She will be an important link for referral of cases to health

facilities and hospitals. FHW will mobilize and organize the community for active participation in health related issues through Health committees and Women groups.

FHW should serve on average 600-1000 people in her community. She is expected to visit 5-7 households per day to provide services 6 days a week. She will also be available to the community to provide services in the case of emergencies. She will work around 4-5 hours a day and nearly eighty percent of her work time will be spent in household visits.

The demands on FHWs' time and services are likely to increase in future. It is therefore necessary to guard against overburdening the FHWs. The involvement of FHWs in new areas will require the approval of the governance mechanism (including Health Authorities, WHO and HSAT) after having completed a detailed study or analysis of the benefits for the community and the health system. Demands on FHWs time need to be defined in terms of safety, FHW capabilities, workloads and remuneration, cost effectiveness of interventions and the ability of the health system to support new services to high quality standards.

**Training of FHWs:** The content of training curriculum will determine the exact duration and nature of training of FHW. However, following approach for the training of FHW is expected to be adopted:

- Initial phase of 3 months intensive class room training with exposure of clinical training in the MCH/HC;
- Second phase of 9 months field (3 weeks) cum class room (1 week) training;
- Third phase of continuing education – on going 1 day per month augmented by different refresher courses (of maximum 15 days/ year);
- FHWs' supervisor will also help FHWs through identification of capacity issues and on the job training/ recommending refresher training.

**Selection of FHWs' Supervisor:** One FHWs' supervisor would be responsible for the supervision of 10-15 FHWs and will visit all FHWs minimum two times in a month. She will carry out supervision activities by using a checklist to assess the performance of FHWs. In case there are few number of FHWs in a region, ZHCF may consider using MCH/HC skilled health care providers to have additional responsibility as FHW supervisor. Such issues should be resolved after allocation of FHWs to the districts/ regions. The selection committee of FHW's supervisor may consist of:

- District Polio Officer
- District Community Representative
- Representative from implementing partner
- Regional Medical Officer

WHO's District Polio Officer (DPO) and the regional health office will issue the offer letter after re-verification of the selection criteria.

**Training of FHWs' Supervisors:** The content of training curriculum will determine the exact duration and nature of training of FHW' supervisor. However, following approaches for the training are expected to be adopted:

- Initial phase of 3 months (13 weeks including 8 weeks for FHW's trainers' manual and 5 weeks for FHS's manual) intensive class room training with exposure of clinical training and supervision skills;

- Second phase of 9 months training - field (3 weeks/ month) cum class room (1 week/ month) training;
- Third phase of refresher training courses (of maximum 15 days/ year);
- Regional/ district supervisors will also help FHWs' supervisors through identification of capacity issues and on the job training/ recommending refresher training.

**Role of Zonal and Regional Health authorities in supervision activities:** The Zonal and Regional health authorities will be responsible for monthly joint supervision activities with WHO staff and implementing partners. WHO will facilitate the process. Zonal health authorities will also organize joint annual review in which different development and implementing partners and health authorities from others zones will participate to review progress and learn lessons.

**FHW- Management Information System (MIS):** Submission of monthly report of field activities to MCH/HC would be one of the responsibilities of FHWs. UNICEF will be responsible to develop community based reporting and recording forms in close consultation with health authorities, WHO and other partners. UNICEF will review the HMIS tools and consider the option for integration of FHW-MIS into HMIS, with involvement of Zonal authorities and WHO.

**Linkages**: Linkages will be developed for close working relationships among FHW, TBA/ Community midwife (CMW) and Health Post with clearly defined roles and responsibilities. Referral linkages will be developed from FHW to TBA/CMW, MCH/HC and referral hospitals based on the needs. Approaches like community transport fund for the referral of emergency cases may be tested.

**ACTIONS:**

- Support Regional/ District Health Offices and Implementing Partners in criteria for selection of FHWs from poor and underserved areas.
- Support health authorities to ensure availability of required staff in selected MCH/HC, according to the set criteria
- Involve clan/ community leaders and NGOs to mobilize and motivate community to encourage girls to work as FHWs
- Develop Zonal training centers to train batches of FHWs' Supervisors
- Encourage more frequent supportive supervision to FHWs and their supervisors
- Create linkages among different community level health workers and with the referral health facilities/ hospitals.
- Delegate capacity to resolve problems to the Regional/ District level - along with holding them accountable for resolution.
- Provide feasible transportation mechanism for supportive supervision activities.
- Ensure regular and appropriate logistics supplies to FHWs so that they can perform their tasks.
- Regular analysis and feed back of monthly reports and other data at every level

# 3. Demand Creation and Behaviour Change Communication

Behaviour Change Communication (BCC) forms an integral component of health system strengthening and should fit into the implementation structures. The communication interventions should aim to strengthen the existing capacities of the health workers for providing multi-level communication services with the purpose to influence health related harmful behaviours of individuals towards adapting state of art health behaviours to gain positive health outcomes.

The objective of BCC strategy would be to establish quality communication health services at all levels of service provision to create meaningful and appropriate linkages between the community and existing health delivery system that would result in:

1. Increased awareness in general public about healthy and risky behaviours

2. Increase in the practice of healthy behaviours in communities

3. Decrease in the practice of prevailing risky behaviours in communities

World wide experience has identified six essential elements as central to the behavior change communication programme. These six elements form the guiding principles in application of BCC strategy.

1. Results – oriented and Service linked

2. Evidence and research based

3. Consumer centered and benefit oriented

4. Multi-channeled with key criterion of any given channel is:

    - Reach - The reach out to the target audience
    - Frequency - The frequency at which the audience will be exposed to the message
    - Appropriateness - The effective is the channel in conveying the message
    - Cost – The cost effectiveness and the ability to scale up

5. Technically high quality

6. Balanced supply and demand

### KEY PERFORMANCE INDICATORS:

- BCC strategy developed based upon formative research
- IEC material developed and distributed
- % of planned school events held to improve awareness on key healthy behaviours
- % of mothers having knowledge about danger signs for childhood illness and pregnancy

## ISSUES:

- Few formative research in a complex setup
- Low capacity on BCC strategy implementation in the Ministries of Health and Implementing Partners
- How to improve community involvement and participation especially during conflict and humanitarian crises
- Availability of right and cost effective communication channels
- Balance between supply and demand for health services
- Effective involvement of opinion leaders, policy makers and communities

## STRATEGIES:

**Formative research**: To develop a comprehensive BCC strategy, formative research activities will be carried out through a) Desk research of available literature on behaviors; b) Review of available Information, education and communication (IEC) material and c) conducting new formative research to identify behaviors at the household level, their determinants, aspects of the behaviors that can be changed, target audiences and potential tools and channels of communication.

**BCC strategy development:** Based on finding of formative research, UNICEF, in consultation with WHO, UNFPA, donors, implementing partners and local authorities will develop a comprehensive BCC strategy and IEC materials with the objective to improve knowledge, attitudes and behaviors of the individuals, families and communities focusing on child and maternal health (including nutrition and immunization) and adolescent health issues.

**Zonal BCC Plans of Action:** UNICEF will develop in consultation with health authorities, WHO and other partners. BCC plan of action for each zone integrated with an M&E plan and with a focus on 'health promotion', 'social mobilization', 'institutional mobilization', 'advocacy' and 'capacity building'. The plan will identify communication approaches including availability of IEC material, Interpersonal communication (IPC), mass media and training. IPC interventions will include formation of support groups of women in the FHWs' communities, functional Health Committees at MCH/HC level and individual counseling in the communities and at the facility level.

**IEC material development**: A variety of IEC material will be developed informed by formative research findings, targeting different audiences especially meeting the needs of FHWs.

**Innovative approaches**: Innovative approaches may include SMS messages, use of poetry, songs, theatre, involvement of FHWs in school health activities and activation of professional associations. Different electronic media options may include BBC Somali radio, and other local channels. Religious scholars, role models, champions and Imams may be involved for disseminating health messages. Coordination with other sectors on nutrition, WATSAN, child protection, environment and child education may be considered to address social determinants of health at various levels.

**ACTIONS:**

- Review and conduct formative research on existing models of community support to understand the context, identify behaviors at the household level, their determinants, aspects of the behaviors that can be changed, target audiences and potential tools and channels of communication.
- Based on evidence develop a BCC strategy and BCC strategic plans for all three zones.
- Development of IEC material on technical issues and Programme introduction.
- Formation and linking the Health Committee and Women Groups to FHWs and other community health workers. Train women health activists to facilitate FHWs in community mobilization and assisting in FHW's tasks.
- Collect success stories and disseminate it for guiding others.
- Ensure participation of health authorities and health staff in BCC activities.
- Conduct reviews on the effectiveness of BCC interventions.

# 4. Operational and Health System Research

Research needs to prepare us to deal with future challenges and opportunities. This means setting aside resources to tackle fast emerging issues but also future 'unknowns' – those issues that could take us by surprise in years to come. Research into health systems has been a neglected area. Four main knowledge gaps are hinderring progress towards the MDGs:

- the ways health services are delivered and organised;
- financial and human resources;
- managing political processes and knowledge; and
- local, regional and global influences.

There is a need to invest in research on health systems to collect and share information about the best ways for strengthening health systems. Research has already shown us what essential health interventions developing countries need. However, we need more evidence to show how more and underserved people can have access to and use services.

There is a need to find more effective ways of reducing maternal and child deaths, and to research what works best in different social and cultural settings. Getting the desired results of health system interventions mean we need to improve the way we manage and learn from our work. This is possible through:

- strengthening research expertise;
- decentralizing some health system research functions;
- highlighting and communicating research results; and
- using evidence to influence policies and practices.

GAVI-HSS programme emphasizes the need for a strong operational research (OR) component to generate the evidence about the effectiveness of interventions along with strengthening research expertise within health authorities.

### KEY PERFORMANCE INDICATORS:

- Monitoring and evaluation mechanisms in place for routine data collection
- No. of health managers trained in operational research
- No of operational research activities carried out

### ISSUES:

- Lack of evidence on the effectiveness of health system interventions in Somali context
- Partially developed health management information system
- Need for a comprehensive disease surveillance system
- Weak research expertise
- How to use evidence in decision making process

## STRATEGIES:

**Baseline and End-line Survey:** UNICEF and WHO will conduct a baseline community survey and a health facility assessment of selected MCH/HC and their catchment population. UNFPA will also participate in this activity especially with a focus on assessing EmOC services. The option to conduct a mid term assessment in 2014 will be explored in addition to end of the project evaluation in 2015-16.

**Operational Research:** The project will promote operational research in the health system. An OR task force will be established along with capacity building activities for health staff in operational research. The Zonal Health Coordination Forum (ZHCF) will propose different topics for the operational research, which will be reviewed and prioritized by the HSWG and will be finally approved by HSC. The operational research task force (including HSAT and WHO) will be responsible for developing/ reviewing ToRs of the operational research and to work as technical committee to review different steps of research activities.

**Joint Annual reviews:** The mechanisms of Joint Annual Reviews for HSS interventions will be established, which may expand later on to cover all health sector interventions. Review findings and recommendations and other evidence generated will be used in annual planning activities.

**HMIS and IDSR:** UNICEF will continue to support the health authorities for further strengthening of HMIS (standardization of tools, improving timeliness, quality of reporting) and incorporating community MIS; whereas WHO may take a lead in developing and implementing integrated disease surveillance and response (IDSR), building on polio and other surveillance activities.

## ACTIONS:

- Finalize TORs and conduct baseline survey and HFA (including EmOC assessment) with endorsement form HSC.
- To operational OR component, finalize TORs of the OR task force and get these endorsed by HSC.
- Conduct OR with strong backup support by HSAT and WHO.

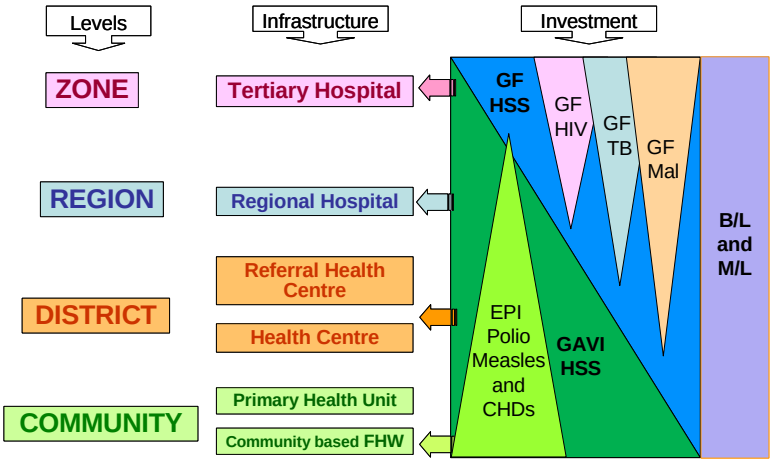
# Part 5. Implementation Mechanisms and Governance

## Linkages

The governance and implementation of the HSS Programme will be based on the principles of "Do No Harm" and to meet expectation of people for better health services and thus contributing to state building. The focus of the GAVI-HSS support to Somalis would be mainly on interventions at the district and community level. It would be critical to develop linkages with other health system strengthening interventions. Another key programmatic intervention is through Global Fund – HSS Programme, which is mainly at the Zonal and Regional Levels with a trickling down effect at the lower levels. Different bilateral donors also have plans to work at various levels of the health system. All HSS programmes should have complementarities and linkages in order to avoid duplication of efforts and resources. Efforts would be made to develop a joint plan for health sector strengthening, which could form the basis for joint review and monitoring activities.

The following diagram suggests the linkages among various HSS interventions and focus at different levels.

**Figure 6: Linkages among different interventions of Somali Health System Strengthening**




## Roles and Responsibilities

Another major challenge for the implementation of not only GAVI-HSS programme but also for all other HSS interventions is the lack of effective coordination mechanism among different stakeholders. The expectation of stakeholders varies and mechanism of Health Sector Committee Reforms, although agreed, still needs to be fully functional, particularly at zonal level.

The health authorities are still facing humanitarian crises and lack a clear long-term development vision to address accessibility and availability of health services issues with scarcity of financial and workforce resources, in addition to the need for effective governance mechanisms.

It is important to have more clarity in the roles of different stakeholders. WHO and UNICEF will lead the implementation of GAVI-HSS Programme in close collaboration with health authorities and other partners. For the implementation of HSS interventions, roles and responsibilities will be as following:

### Table 4: Roles and responsibilities:

| Title / Post | Organization | HSC member | Specific roles and responsibilities of this partner in the GAVI HSS implementation |
|---|---|---|---|
| Director General | MOH | Yes | • Ensure planning, implementation and coordination of Programme at zonal level.<br>• Monitoring and review of progress.<br>• Supportive supervision of activities.<br>• Progress reporting.<br>• Ensure institutional support (including legal framework and access to the Programme for the beneficiaries) for the GAVI Programme from relevant local authorities.<br>• Ensure representation of beneficiaries (patients, communities) in decision making<br>• Promote synergies and coordination with other relevant initiatives.<br>• Promote synergies with NGOs and private sector. |
| Representative | WHO | Yes | • Support overall management, coordination and implementation of the HSS grant in collaboration with health authorities and other partners.<br>• Coordination with allied Programmes and activities in the health sector.<br>• Facilitates the provision of TA required for the implementation of GAVI/ HSS support.<br>• Contracting out of specific functions to NGOs, in consultation with health authorities.<br>• Operational research in collaboration with health authorities, HSAT, UNICEF and other partners. |
| Representative | UNICEF | Yes | • Ensures implementation of specific functions in collaboration with health authorities, WHO and other partners.<br>• Manage procurement and distribution of equipment, drugs and supplies.<br>• Develop implement and monitor BCC strategy and activities.<br>• Conduct baseline and strengthen HMIS and collaboration in Operational research with health authorities, WHO and other partners. |

| | | | |
|---|---|---|---|
| Health Officer at regional and district level | Regional and district level | Yes | • Coordination for Programme related interventions at the regional and district level.<br>• Overall planning, implementation, supervision and monitoring of MCH centers including regular reporting.<br>• Developing referral support and linkages.<br>• Participate in operational research. |
| Health Facilities Incharge | MCH centers | No | • Implementation of GAVI/HSS related activities at the facility and community level.<br>• Training, Monitoring, supervision of health posts staff and FHWs.<br>• Ensure referral services.<br>• Regular reporting. |
| Health Sector Committee (HSC) and its full-time Coordinator | All agencies, Donors and NGO's | Yes | • Reviews and endorses annual plans and any revisions.<br>• Programme review in the quarterly HSC meetings, give update to partners and endorse key strategic actions for the approavl of HAB.<br>• Ensure coordinated intersectoral programmes and activities.<br>• Ensure adherence to the guidelines of HSC and GAVI.<br>• Advocacy and mobilization of complementary resources.<br>• Finalisation and approval of the annual progress report by HAB to be sent to the GAVI secretariat. |
| Implementing Partners | Selected NGOs | Yes | • Implement designated activities under the guidance and supervision of health authorities and GAVI coordinators<br>• Training of MCH centre staff<br>• Training of FHWs and supervisors<br>• Monitoring & supervision in collaboration with health authorities<br>• Regular reporting<br>• Supply and logistics<br>• Data collection for operational research |

# Reporting arrangements

Reports on monitoring of the HSS process and results (according to the outcome and output level indicators) will be an ongoing process. The technical reporting will start at the community level (FHWs and health posts), and will be submitted to the MCH centers on a monthly basis where the reports will be compiled and submitted to the regional health offices. The compiled regional report in consultation with the partners will be sent to the Zonal health authorities where the reports will be compiled, analyzed, used for improving performance and disseminated to all partners and stakeholders on quarterly basis.

An annual progress report on the GAVI/HSS activities will be submitted jointly by implementing partners (Health authorities, WHO, UNICEF) to the HSC Coordinator for synthesis and review of HSC before submission to GAVI.

Selected activities will be contracted out to implementing partners (NGOs). Under the guidance of health authorities, implementing partners will be responsible to assist in:

- Baseline and endline surveys
- Regular reporting via routine HMIS
- Reporting against contractual obligations (utilization, coverage, targets, finances)
- Participation in collection and reporting on monitoring and operational research

# Governance

The Somali Health Authorities and the International Community are determined to make progress in the right direction and for this they agreed to Somali Health Sector Committee Reforms in June 2010. For GAVI-HSS programme the same governance mechanism will be used. Salient features are as following:

**General Principles**

- Membership on the various structures is constituency- based. Each constituency selects its own representatives and alternates and describes the selection process and named individuals in writing to the SSS or equivalent coordination support structure for the record.

- For each structure, a quorum is equal to 50 percent plus one of the total number of members, but with the proviso that at least one member of each constituency must be present for a quorum to be achieved so that decisions can be taken. Underlying this approach is the need for excellent communication between representatives of each constituency and their members, so that the constituency viewpoint is accurately represented in meetings.

- All constituencies should reserve the right to raise concerns regarding decisions to avoid dictatorship by the majority.

The following structures will worked as agreed:

### HEALTH ADVISORY BOARD (HAB)

The Health Advisory Board (HAB) will be a policy forum that brings together senior Heads of Agencies and the Ministries of Health (MoH) to discuss and set overall health policy objectives, strategies and priorities. The HAB will provide guidance and support to the Health Sector Committee and Emergency Health Cluster to further support the implementation of their assigned functions and responsibilities. The HAB will meet on a six-monthly basis and as needed and scope of work will be to:

1. Provide overall guidance, support and oversight to health sector development processes;
2. Review and endorse long-term health sector development policy and strategy;

3. Oversee health funds inside and outside the country and strive for adequate resources to support health sector development;
4. Liaise with donor community on issues related to investment decisions and resource allocations based on principles of integrated; coordinated support to shared priorities of the Government in line with the Paris Declaration;
5. Ensure equitable distribution of resources in the different regions and zones;
6. Ensure alignment and harmonization of sectoral priorities are addressed with funding from Global Health initiatives;
7. Ensure alignment and harmonization between inter-sectoral priorities with available resources;
8. HAB members will work to conclude all discussions on a consensus basis, however if no consensus can be reached at HAB, the decision will be made on quorum of 5 members, with each constituency represented by at least one member. Each constituency will identify at least one alternate in writing.

Membership of the HAB will be limited and each constituency will nominate representatives to the Health Advisory Board, as outlined below:

| | |
|---|---|
| 1. Government (Ministers of Health) | 3 Representatives |
| 2. Donors | 2 Representatives |
| 3. United Nations (UN) | 2 Representatives |
| 4. Non-Governmental Organization (NGO) Consortium | 2 Representatives |
| **Total** | **9 members** |

## HEALTH SECTOR COMMITTEE (HSC):

The HSC is the coordinating health mechanism, including oversight of GFATM (and GAVI) awards and development of new proposals. HSC meetings will attend to the overall Somalia health sector and Global Fund business will be handled in separate expanded HSC meetings. To minimize conflict of interest issues and yet ensure continuity, donors and NGOs will have the same representatives in both meetings. UN and government constituencies may choose to have different representatives within each meeting. Health Sector and Zonal Coordination Meetings will be linked with a common mailing list.

The HSC will provide a coordination platform for Somali Health Authorities as well as development and implementing partners to discuss and develop with Somali authorities technical components; develop comprehensive strategies and health policies taking into account existing country assessments/documents and future in-depth assessments, working with zonal coordination structures and referring draft policies and strategies to the above mentioned Health Advisory Board to review and endorse.

The HSC will meet quarterly and more frequently if needed. Meetings will be scheduled so that Somali participants who are designated representatives to HSC quarterly meetings as well as to HSC Global Fund meetings can make one trip to encompass both meetings.

The scope of work will be to:

1. Support Somali Health Authorities to develop a Health Sector Policy and strategic Framework in consultation with all partners.
2. Support the establishment and capacity development of Zonal Health Coordination structures and increase participation and meaningful engagement of Somali Society at various levels.

3. Ensure effective coordination of the available technical and financial resources and support partners to develop, implement, and monitor Zonal Operational Plans.
4. Provide direction to Working Groups, to ensure that their strategic role is consistent with the overall sector priorities.
5. Advocate and support resource mobilization for the Health Sector by developing evidence-based recommendations on funding priorities for use by donors and government to advocate for additional resources.
6. Monitor and evaluate progress in the implementation of the Somali Health Sector Strategy and make recommendations for revisions.
7. Ensure Health Sector collective learning is preserved, managed, disseminated through the HSC and available to all stakeholders after HSC endorsement.
8. Provide technical review, guidance and recommendations on proposals such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), Sector Wide Approaches (SWAP) etc. to ensure consistency with the Health Sector Strategy Framework and annual work plans in support of National priorities.
9. Undertake decisions on action points referred from Task forces/Working groups and other fora and take responsibility to ensure that action points are implemented by the relevant body.
10. Committee members will work to conclude all discussions on a consensus basis, however if no consensus can be reached at HSC meetings, the issue will be referred to the HAB.
11. A quorum for the Health Sector Committee meetings will comprise eight members with each constituency represented by at least one member. Each constituency will identify at least one alternate in writing.
12. Constituency representatives should call meetings of their groups to feedback information and to enable consultations with their constituencies before and after quarterly meetings.

Membership of the Health Sector Committee will be limited to representatives from the following constituencies:

| | |
|---|---|
| 1. Government (Health Authorities) | 3 Representatives |
| 2. Donors | 3 Representatives |
| 3. UN | 3 Representatives |
| 4. NGO Consortium | 3 Representatives |
| 5. Civil Society | 3 Representatives |
| **Total** | **15 members** |

**Note: Health System Working Group (HSWG) will work at Nairobi level and will present its recommendation to HSC.**

## ZONAL HEALTH COORDINATION FORUMS:

The Zonal Health Coordination Forums will provide information sharing and coordination platform for the health sector stakeholders in Somaliland, Puntland and Central & South Somalia. The Coordination Forums will also facilitate setting standard norms and procedures for the planning, implementation, monitoring and evaluation of health programmes and projects as well as for the delivery of basic health care services in the different zones of the country based on international standards.

Planning Departments of Ministries of Health will be the focal departments that will be responsible for the preparation and follow up of the discussions of the Coordination Forums as well as that of the thematic working groups and related task forces.

The Zonal Health Coordination Forums will meet quarterly and more frequently if required. Meetings will be scheduled in advance of HSC and HSC Global Fund Coordination meetings so action items can be forwarded. Ministry of Health will send an invitation for zonal meetings at least three weeks prior to facilitate Nairobi-level participation.

The scope of work will be to:

1. Formulate Health Sector strategies and policies at zonal levels
2. Identify critical priorities for the health sector development and develop integrated and harmonised annual and quarterly work plans by bringing together into one the individual work plans of the different agencies involved.
3. Facilitate information sharing on health projects/programmes among health sector partners in the field.
4. Ensure equitable allocation and rational use of available resources in a more cost – effective manner at zonal levels.
5. Undertake systematic analysis of the health sector situation at timely intervals to continuously measure the progress of the health sector.
6. Undertake quarterly review against the common priorities and work plans set, identify best practices and challenges as well as lessons learnt and recommend remedial measures to the performance of the sector.
7. Refer reports and recommendations to the health sector committee meetings for further follow up and action.
8. Facilitate the establishment and the functioning of thematic working groups and task forces on specific thematic areas.
9. Ensure the institutionalization of health programmes and projects as well as the capacity development of the national institutions and programmes.
10. Set common management and coordination guidelines for all projects and programmes by ensuring transparency and accountability are preserved among all partners.
11. Ensure participation of other sectors.
12. Zonal coordination forums will take decisions on action points referred from task forces/working groups and other fora and are responsible for ensuring that decisions are implemented.

Membership of the Zonal Health Coordination Forums will include:

a. Ministry of Health at central and regional levels
b. Donors involved in health, nutrition, sanitation and HIV AIDS
c. UN agencies involved in health, nutrition, sanitation and HIV AIDS
d. International NGOs (INGOs) involved in health, nutrition, sanitation and HIV AIDS with valid contracts and program Memoranda of Understanding (MoUs) with the government
e. Professional councils and associations
f. Academic health training institutions
g. Private health sector
h. Municipal authorities

**Note: Zonal Health System Working Group will work in each Zone and will present its recommendation to ZHCF.**

**[In addition, WHO and UNICEF will meet on monthly basis to discuss operational issues]**

# Part 6. Financing arrangements

The Aide Memoire agreed on Governing the financial management of GAVI Health Systems Strengthening (HSS) grant as of May 2010 and two separate Grant Agreement between GAVI Secretariat and WHO & UNICEF form the basis for financial arrangements. The period of grant assistance starts from 1 September 2011 and ends on 31 December 2015. A period of up to twelve months shall be allowed after completion of a HSS Programme or after termination of the agreement to liquidate all obligations for activities completed by WHO/ Unicef prior to the date of completion or termination. WHO and Unicef can not enter into new obligations with grant funds after the date of completion of termination.

WHO and UNICEF will manage their own portions of the grant and in accordance with the provisions of the agreement with GAVI. GAVI shall be responsible for the provision of grant funds to WHO and UNICEF as shown below. Other donor support may also augment HSS interventions over the period.

## Funding

| Funding Sources | Allocation per year (US$) | | | | | |
|---|---|---|---|---|---|---|
| | 2011 | 2012 | 2013 | 2014 | 2015 | TOTAL FUNDS |
| **GAVI – HSS (WHO)** | 1,405,509 | 1,461,536 | 1,619,832 | 1,434,152 | 1,417,549 | **$7,338,579** |
| **GAVI – HSS (UNICEF)** | 1,381,282 | 1,015,191 | 603,070 | 583,070 | 622,989 | **$4,205,601** |
| **Other HSS Support** | | | | | | |
| **Donor 1. Global fund – HSS** | 2,999,350 | 3,942,500 | 1,523,050 | 1,079,600 | 1,043,400 | **$10,587,900** (10% reduction) |

## GAVI ALLIANCE TERMS AND CONDITIONS

### CONDITIONS OF PAYMENTS

GAVI will make the grant payment to WHO and UNICEF subject to and conditional on the availability of funds, WHO/UNICEF providing GAVI with relevant reporting, receipt of Annual Performance Reports and necessary GAVI board approvals.

### UTILIZATION OF GRANT AND ACCOUNTING

WHO and UNICEF will take all necessary actions to ensure that all grant funds for the HSS Programme will be used for the sole purpose of fulfilling the activities as agreed. Any significant change in the scope of schedule for activities shall be reviewed and approved in advance by GAVI.

Grant funds will be administered in accordance with the financial regulations and rules and any other applicable rules, procedures and practices of WHO and UNICEF.

WHO and UNICEF will take necessary action to ensure that all grant funds will be used for the sole purpose of fulfilling the agreed activities. Any significant changes in the scope of the activities shall be reviewed and approved in advance.

If GAVI has reason to suspect that grant funds have been used for purposes other than the agreed activities, GAVI may suspend all or part of the grant. GAVI retains its right to terminate its support to WHO/ UNICEF and the government for the activities described in the HSS proposal if misuse of any funds provided by GAVI is confirmed.

## MONITORING PROGRESS

The Health Advisory Board (HAB) and Health Sector Coordination Committee (HSC) is responsible for monitoring performance of the activities and the results to be performed in the HSS Programme. WHO, UNICEF and the government shall jointly report on June 30$^{th}$ and December 30$^{th}$ of each calendar year to the HSC on progress against the activities and related results promised in the HSS Programme.

## FINANCIAL REPORTING AND AUDITS

WHO and UNICEF will include in its Annual Progress Report (APR) annual financial reports and other reports as necessary for which the individual organization will be responsible. The two organizations will submit the reports to the HS Coordination Office for getting approval of HSC and on ward submission of the report to the GAVI. If so requested, WHO and UNICEF will also submit to GAVI annual certified financial statements of account, showing income and expenditure as of 31 December each year with respect to the grant.

## AUDITS AND RECORDS

WHO and UNICEF will conduct financial audits according to its internal and external audit procedures provided for in its financial rules and regulations. WHO and UNICEF will maintain accounting records in accordance with their respective financial rules and regulations.

## TERMINATION

Either party may terminate the agreement giving prior written notice to the other party. As part of the termination of the agreement, the parties will make arrangements regarding the winding up of the agreement including any open issues regarding unspent balances.

## SETTLEMENT OF DISPUTES

Any dispute between the parties arising out of or relating to this agreement that is not settled amicably within a reasonable period of time will be submitted to arbitration at the request of either party. The arbitration will be conducted in accordance with the then current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The language of the arbitration will be English. The place of arbitration will be Geneva. The term “UNCITIAL” shall mean the United Nations Commission on International Trade Laws”

# Annexures:

**Annex A: GAVI HSS Logical Framework (LFW)**

**Annex B: Activity Plan to Operationalise GAVI-HSS Programme**

**Annex C: Competencies of Community Health Workers and Female Health Workers**

# Annex A: Logical Framework (LFW) of GAVI HSS support to Somalis

| **PROJECT NAME** | **GAVI Health System Strengthening support to Somalis** | | | | | |
|---|---|---|---|---|---|---|
| **IMPACT** | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| Better health of Somalis and progress towards the health related MDGs | Under five mortality rate | 145/ 1000 live births (lb) - in 2006<br><br>180/1000 live births in 2008 | | | 125/1000 lb in 2015 | |
| | | **Source** | | | | |
| | | Unicef Multiple Indicator Cluster Survey (MICS)<br>Estimates of UN Interagency Group on Child Mortality 2010 | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | Maternal mortality ratio | 1044/100,000 lb in 2006;<br>1200/ 100,000 lb in 2008; | | | 800/100,000 lb in 2015 | |
| | | **Source** | | | | |
| | | MICS, Trends in Maternal Mortality (WHO, Unicef, UNFPA and WB) | | | | |

| **OUTCOME** | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | **Assumptions** |
|---|---|---|---|---|---|---|
| To improve access, availability, consumption and quality of essential low cost maternal and child health services in selected areas | National DPT3 coverage - disaggregation by gender | 36% in 2006 | 45% in 2013 | 50% in 2014 | 55% in 2015 | Political stability and improvement in security situation<br><br>Economic growth<br><br>Availability and predictability of donors' assistance<br><br>Increased government financing in health |
| | | **Source** | | | | |
| | | MICS | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | % of regions achieving >80% of DPT3 coverage | Nil in 2006 | 15% of regions by 2013 | 25% of regions in 2014 | 30% of regions in 2015 | |
| | | **Source** | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| of the three Somali Zones (Somaliland, Puntland and South &Central Somalia). | | MICS | | | | Improved literacy and education levels<br><br>Improved coordination among stakeholders |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | Measles immunization coverage - disaggregation by gender | 19% in 2006 | 45% in 2013 | 55% in 2014 | 60% in 2015 | |
| | | **Source** | | | | |
| | | MICS | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | ANC coverage (% of women 15-49, one or more during pregnancy) from health facility | 26% in 2006 | 35% in 2013 | 45% in 2014 | 50% in 2015 | |
| | | **Source** | | | | |
| | | MICS | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | Vitamin A supplementation coverage among 6 months to under five children | 24% in 2006 | 45% in 2013 | 54% in 2014 | 60% in 2015 | |
| | | **Source** | | | | |
| | | MICS 2006 | | | | |
| **INPUTS ($)** | **GAVI HSS ($)** | | | | | |
| | **11.544 million** | | | | | |
| **INPUTS (HR)** | **GAVI HSS (FTEs)** | | | | | |
| | 1 HSS<br>3 NPOs - HSS Coordinators<br>1 BCC Coordinator<br>1 Admin/Fin Officer | | | | | |

| **OUTPUT 1** | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | **Assumptions** |
|---|---|---|---|---|---|---|
| Improved availability and utilization of immunization & other essential maternal and child health services based on the Essential Package of Health Services (EPHS). | % MCH/ Health centers providing facility based and outreach immunization services in intervention districts | N/A | >50% in 2013 | >80% in 2014 | >95% in 2015 | Political stability<br><br>Timely availability of supplies and equipments<br><br>Staff availability and retention<br><br>Coordination among partners |
| | | **Source** | | | | |
| | | Baseline survey in 2011, Annual Joint Reviews, End-line survey | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | % of MCH/ Health centers implementing EPHS | N/A | >50% in 2013 | >75% in 2014 | >85% in 2015 | |
| | | **Source** | | | | |
| | | Baseline survey in 2011, Annual Joint Reviews, End-line survey | | | | |
| **IMPACT WEIGHTING** | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| 25% | % of MCH/ Health centers visited at least 4 times in the last year using checklist | N/A | >70% in 2013 | >90% in 2014 | >95% in 2015 | **RISK RATING** |
| | | **Source** | | | | High |
| | | Baseline survey in 2011, Annual Joint Reviews, End-line survey | | | | |

| **OUTPUT 2** | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | **Assumptions** |
|---|---|---|---|---|---|---|
| Improved access to rural communities to basic essential preventive, promotive and curative health services through community based Female Health Workers (FHWs) | % of FHWs trained and deployed in their community | Nil | 50% in 2013 | >80% in 2014 | >90% in 2015 (Total target: 200 FHWs) | Political stability<br><br>Availability of supplies and equiments<br><br>Availability of literate girls<br><br>Community involvement and support<br><br>Coordination among partners |
| | | **Source** | | | | |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | % of deployed FHWs carrying out at least 5-7 visits per day | Nil | 60% in 2013 | >90% in 2014 | >95% in 2015 | |
| | | **Source** | | | | |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | |

| IMPACT WEIGHTING | Indicator | Baseline | Milestone 1 | Milestone 2 | Target (date) | |
|---|---|---|---|---|---|---|
| 35% | % of FHWs with regular supply of essentials kit items (no stock out of ORS, antibiotic, iron/folic acid, paracetamol and anti-helmintic in last month) | Nil | 50% in 2013 | 80% in 2014 | >90% in 2015 | |
| | | **Source** | | | | **RISK RATING** |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | High |

| OUTPUT 3 | Indicator | Baseline | Milestone 1 | Milestone 2 | Target (date) | Assumptions |
|---|---|---|---|---|---|---|
| Improved awareness and demand for immunization and other essential quality maternal and child health services through comprehensive and sustained campaign of behavioural change communication. | IEC material developed and distributed | Nil | BCC strategy developed and 80% of health posts/FHW in the intervention districts are having IEC material in 2013 | 100% of health posts/FHW in the intervention districts are having IEC material in 2014 | 100% of health posts/FHW in the intervention districts having IEC material in 2015 | Political stability<br><br>Effective coordination among partners<br><br>Community involvement |
| | | **Source** | | | | |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | % of planned school events held to improve awareness on key healthy behaviours | Nil | 50% of planned school events in 2013 | 80% of planned school events in 2014 | >90% of planned school events in 2015 | |
| | | **Source** | | | | |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | |

| IMPACT WEIGHTING | Indicator | Baseline | Milestone 1 | Milestone 2 | Target (date) | |
|---|---|---|---|---|---|---|
| 25% | % of mothers having knowledge about danger signs for childhood illness and pregnancy | N/A | 10% of mothers in 2013 | 25% of mothers in 2014 | >30% of mothers by 2015 | |
| | | **Source** | | | | **RISK RATING** |
| | | Baseline Survey, MICS, Supervision reports, Joint Annual Reviews, End-line survey | | | | High |

| OUTPUT 4 | Indicator | Baseline | Milestone 1 | Milestone 2 | Target (date) | Assumptions |
|---|---|---|---|---|---|---|
| Evidence (on utilization, impact and cost of services) to generate appropriate and affordable health care delivery models for maximization of efficiency health essential services | M&E system in place for routine data collection | Nil | 50% of the regions compiling monthly reports by 2013 | 90% of the regions compiling monthly reports in 2014 | >95% of the regions compiling monthly reports in 2015 | Political stability<br><br>Effective governance and coordination mechanisms<br><br>Stakeholders' commitment |
| | | **Source** | | | | |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | |
| | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| | No. of health managers trained in operational research | Nil | 10 health managers in 2012-13 | Cumulative total: 20 in 2014 | Cumulative total: 20 by 2015 | |
| | | **Source** | | | | |
| | | Training record | | | | |
| **IMPACT WEIGHTING** | **Indicator** | **Baseline** | **Milestone 1** | **Milestone 2** | **Target (date)** | |
| 15% | No of operational research activities started | Nil | 3 in 2012 | 8 in 2014 | Total: 8 by 2015 | |
| | | **Source** | | | | **RISK RATING** |
| | | Supervision reports, Joint Annual Reviews, End-line survey | | | | High |

Baseline and Targets to be revised on availability of MICS 2011 results and information from Baseline Survey and Health Facility Assessment

# Annex B: Activity Plan to Operationalise GAVI-HSS Programme

| S.No. | TASK | RESPONSIBLE | Timeline |
|---|---|---|---|
| **Activities related to start of GAVI-HSS Programme, Governance and Coordination:** | | | |
| 1 | Start implementation of GAVI-HSS Programme | WHO, Unicef and Health authorities | 1 September 2011 |
| 2 | Produce final draft Strategic Plan for GAVI HSS support for Somalis | WHO and Unicef | 25 December 2011 |
| 3 | Share the draft GAVI-HSS Strategic and ActivitiesPlan with health authorities and HSWG for their review and comments by 12 January 2012 | Health Sector Coordination Office | 28 Dec 2011 |
| 4 | Meeting of Zonal Health Coordination Forum to review the GAVI HSS Strategic and Activities Plan | Zonal health authorities | Early January 2012 |
| 5 | Finalise GAVI HSS strategic plan and get it approved by HSC/ HAB | Health Sector Coordination Office | February 2012 |
| 7 | Signing of MOUs between WHO and UNICEF | WHO and Unicef | Jan 2012 |
| 8 | Monthly meetings of ZHCF and sharing minutes with HSWG | Health Authorities | 2nd week of every month |
| 9 | Monthly meetings of HSWG and sharing minutes with ZHCF | HSWG secretariat | 3rd week of every month |
| 10 | Meetings of HSC and HAB to review HSS and sectoral progress | Health Sector Coordination Office | HSC - After every 3 months<br>HAB - After every 6 months |
| 11 | Meetings between WHO, UNICEF and UNFPA on operational issues | WHO, UNICEF and UNFPA | On monthly basis |
| 12 | Joint annual review of Health System Strengthening involving all partners | WHO, UNICEF and UNFPA | Oct-Nov every year |

## Activities Implementation Plan 2011-15

| Activity No. | Activities | Responsible UN agency | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|---|
| **Objective 1:** To improve availability and utilization of immunization and other essential maternal & child health services – by strengthening and supporting selected MCH/ Health centers based on Essential Packages of Health Services (EPHS) | | | | | | | |
| Activity 1.1: | Develop list of priority health facilities and conduct survey to identify gaps in 40 MCH centers | WHO | | | | | |
| Activity 1.2: | Rehabilitation of selected MCH centers | UNICEF | | | | | |
| Activity 1.3: | Procurement and supply of essential equipment for MCH services | UNICEF | | | | | |
| Activity 1.4: | Provide comprehensive support for BEmOC in selected MCH centers | UNICEF | | | | | |
| Activity 1.5: | Development / adapt curriculum for training of MCH and EPI staff in supervision, outreach and HMIS | WHO | | | | | |
| Activity 1.6: | Conduct training of MCH and EPI staff (in 40 MCH centers) | WHO | | | | | |
| Activity 1.7: | Develop curriculum for training of all MCH staff in EPI injection safety and vaccine management | WHO | | | | | |
| Activity 1.8: | Training of all MCH centers staff (EPI, injection safety and vaccine management) | WHO | | | | | |
| Activity 1.9: | Renovation of cold chain equipment | UNICEF | | | | | |
| Activity 1.10: | Develop and implement a system of regular EPI outreach from MCH centers to the catchment areas of health posts and FHWs | WHO | | | | | |
| Activity 1.11: | Develop a system for regular supervision for MCH centers from regional and zonal MOH | WHO | | | | | |
| Activity 1.12: | Provide transport support to MOH for supervision of regional offices | WHO | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Activity 1.13: | Provide transport support to regional managers for supervision of MCH centers | WHO | | | | | |
| Activity 1.14: | Provide incentives for EPI outreach and RH staff at MCH centers | WHO | | | | | |
| **Objective 2:** To improve the access of rural communities to immunization and other basic but essential preventive, promotive, and curative health services through support to Health posts and CHWs; and introducing on a pilot basis a new cadre of Female Health Workers providing mainly preventive services to a defined catchment population. | | | | | | | |
| Activity 2.1: | Developing scope of work, incentives and criteria for selection, plan of supervision of FHWs and Health Posts | WHO | | | | | |
| Activity 2.2: | Recruitment of FHWs | WHO | | | | | |
| Activity 2.3: | Development/ adapt curriculum for FHWs and supervisors | WHO | | | | | |
| Activity 2.4: | Training of trainers | WHO | | | | | |
| Activity 2.5: | Training of FHWs | WHO | | | | | |
| Activity 2.6: | Training of supervisors | WHO | | | | | |
| Activity 2.7: | Develop and implement a system of supportive supervision for health posts and FHWs and outreach activities | WHO | | | | | |
| Activity 2.8: | Develop and implement a community based HMIS | UNICEF | | | | | |
| Activity 2.9: | Printing & distribution of HMIS tools | UNICEF | | | | | |
| Activity 2.10: | Procure & distribute, re-supply of FHW kits | UNICEF | | | | | |
| Activity 2.11: | Procure & distribute, re-supply equipment for Health Posts | UNICEF | | | | | |
| Activity 2.12: | Refresher training for FHWs and supervisors | WHO | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Activity 2.14: | Provide incentives to FHWs | WHO | | | | | |
| **Objective 3:** Improved awareness and demand for immunization and other essential quality maternal and child health services through comprehensive and sustained campaign of behavioural change communication. | | | | | | | |
| Activity 3.1: | Formative Research to identify key behavious | UNICEF | | | | | |
| Activity 3.2: | Develop national BCC strategy | UNICEF | | | | | |
| Activity 3.3: | Develop, print & distribute IEC material (MCH/HP) | UNICEF | | | | | |
| Activity 3.4: | Develop video programmes | UNICEF | | | | | |
| Activity 3.5: | Disseminate video messages through cable | UNICEF | | | | | |
| Activity 3.6: | Develop radio programmes | UNICEF | | | | | |
| Activity 3.7: | Disseminate BCC messages through radio | UNICEF | | | | | |
| Activity 3.8: | Increase public awareness through print media | UNICEF | | | | | |
| Activity 3.9: | Organize advocacy/ BCC events for community leaders | UNICEF | | | | | |
| Activity 3.10: | Organize school events on key themes | UNICEF | | | | | |
| Activity 3.11: | Produce and distribute IEC material to private pharmacies | UNICEF | | | | | |
| Activity 3.12: | Produce & distribute IEC material to FHWs & CHWs | UNICEF | | | | | |
| Activity 3.13: | SMS text messages for BCC | UNICEF | | | | | |
| **Objective 4:** To provide evidence (on utilization, impact and cost of services) in order to generate appropriate and affordable health care delivery models for maximization of efficiency health essential services through managing a programme of operational research. | | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Activity 4.1: | Conduct baseline & end line surveys | UNICEF | | | | | |
| Activity 4.2: | Establish and support operational research committee | WHO | | | | | |
| Activity 4.3: | Commission operational research studies | WHO | | | | | |
| Activity 4.4: | Conduct focus group for operational research | UNICEF | | | | | |
| Activity 4.5: | Support data analysis and use | WHO | | | | | |
| Activity 4.6: | Training of MOH managers in operational research | WHO | | | | | |
| Activity 4.7: | Organize study tours for health authorities | WHO | | | | | |
| Activity 4.8: | Technical assistance for operational research | WHO | | | | | |

# Annex C: Competencies of Community Health Workers and Female Health Workers

## Essential Package of Health Services (EPHS) at CHW and FHW Level

| **Suggested key topics for training**<br><br>*(NB each micro module includes practical training, and is completed with practical and written tests of competencies)* | **Key competencies of Community Health Workers (CHWs)**<br><br>**(as proposed in EPHS)** | **Key competencies of Female Health Workers (FHWs)**<br><br>**(as proposed by GAVI HSS)** |
|---|---|---|
| Disease, health, communities, environment, PHC & the health system - core training | – Knowledge of key concepts: can define health & disease; understands ill health, vectors and disease; understands interplay between family, community & cultural beliefs & practices; understands the components of PHC; understands the levels of the health system; understands roles and functions of CHW | – Knowledge of key concepts: can define health & disease; understands ill health, vectors and disease; understands interplay between family, community & cultural beliefs & practices; understands the components of PHC; understands the levels of the health system; understands roles and functions of FHW |
| Community mobilization, behavioural change communication, interpersonal communication – core training | – understands community participation<br>– facilitate a community discussion<br>– master BCC techniques<br>– interpersonal skills gained<br>– able to conduct community sessions for health promotion<br>– can prepare a promotion lesson plan | – understands community organization and participation<br>– Establish health committees and facilitate a community discussion<br>– master BCC techniques<br>– interpersonal skills gained and able to use IEC material<br>– able to conduct home visit for health promotion<br>– can prepare a promotion lesson plan |
| Water & environmental sanitation – hygiene promotion, PHAST & CHAP training & water treatment | – understands how water and food become contaminated<br>– understands the transmission of water borne disease<br>– understands elements of environmental sanitation<br>– advocacy skill for watsan improvements<br>– build an improved latrine<br>– perform emergency chlorination<br>– perform home chlorination and can distribute home treatment sachets | – understands how water and food become contaminated<br>– understands the transmission of water borne disease<br>– understands elements of environmental sanitation<br>– can distribute ORS sachets<br>– communicate key hygiene messages (CHAP & PHAST competent)<br>– can conduct home visit for hygiene & watsan promotion<br>– can treat child with ORS & zinc & advise parents |

| | | |
|---|---|---|
| | – perform safe disposal of medical waste<br>– communicate emergency IEC messages & child health day messages<br>– communicate key hygiene messages (CHAP & PHAST competent)<br>– can conduct community sessions for hygiene & watsan promotion<br>– can treat child with ORS & zinc & advise parent<br>– can advise on safe handling/ preparation of food | – can advise on safe handling/ preparation of food |
| Management of key childhood illness ( fever management, malaria, ARI, diarrhoea, anaemia & worms) and care of newborn | – can advise on anaemia prevention<br>– can give iron/ folate tabs and micronutrients<br>– can advise on diarrhoea prevention & management<br>– can treat child with ORS & zinc & advise parent<br>– can identify & treat pneumonia, tonsillitis & otitis media using IMCI charts<br>– can take temperature and manage fever<br>– can diagnose malaria with RDT<br>– can treat malaria with ACT<br>– can treat malaria with paracetamol or ibuprofen tabs or syrup<br>– can identify & support sick child with measles with Vitamin A, advise on appropriate food and ORS and referral<br>– can advise parent on care of newborn – temperature management, cord care, exclusive breast feeding<br>– can fill in register<br>– can conduct home visit of sick child to advise nutrition and hydration and referral to health post | – can advise on anaemia prevention<br>– can give iron/ folate tabs and micronutrients<br>– can advise on diarrhoea prevention & management<br>– can treat child with ORS & zinc & advise parent<br>– Can treat a child with cough & cold (ARI no pneumonia)<br>– can identify and treat pneumonia<br>– can identify and refer cases of severe pneumonia and very severe disease<br>– can take temperature and manage fever with advice and Paracetamol<br>– can identify & support sick child with measles with Vitamin A, advise on appropriate food and ORS and referral<br>– can advise parent on care of newborn – temperature management, cord care, exclusive breast feeding<br>– can conduct home visit of sick child to advise nutrition and hydration and referral to appropriate health facility |
| Illnesses diagnosed and treated in the PHU – includes simple UTI, thrush, oral candidiasis, conjunctivitis, mild gastritis, mild allergy, simple skin diseases | – can identify and treat skin problems - scabies, fungal skin disease, dermatitis/eczema, chicken pox, simple infection, nappy rash and simple burns<br>– can identify and treat oral and vaginal thrush<br>– can do urine dipstick and treat simple UTI<br>– can identify and treat conjunctivitis and refer other eye diseases<br>– can identify and treat simple gastritis<br>– can treat mild pain<br>– can fill in register | – can identify and treat scabies and advice on prevention<br>– can identify and treat simple conjunctivitis and refer other eye diseases |

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| First aid and simple dressings; accident risk reduction | – can do a simple dressing<br>– can apply antiseptic<br>– can advise on accident risk reduction | – can do a simple dressing<br>– can apply antiseptic<br>– can identify severe injury/ burn and refer |
| Communicable disease surveillance & reporting | – can identify suspicious cases of epidemic potential in community and health post and report to health centre<br>– can advise family on rapid transfer to health centre of suspect case<br>– understands malaria control<br>– can participate in public awareness campaign | – can identify suspicious cases of epidemic potential in community and advise family on rapid transfer to health centre<br>– can participate in public awareness campaign |
| Immunisation | – knows which diseases can be prevented by EPI<br>– can immunize child and mother under supervision<br>– can fill in vaccine card and register | – can promote need for immunization<br>– can register all children and women of reproductive age who needs immunization in her catchment area and update their record<br>– can organize immunization sessions in her community in collaboration with CHW and outreach teams from MCH centers<br>– can immunize children and mothers under supervision |
| Understanding HIV & HIV & STI prevention & TB awareness | – can promote HIV transmission reduction in the community and with individuals<br>– can conduct HIV awareness meeting<br>– knows arguments to reduce stigma<br>– can use educational materials<br>– can promote condom use and distribute condoms<br>– can give abstinence & faithfulness education<br>– can safely dispose of sharps and medical waste<br>– understands single needle & syringe policy<br>– can promote self referral of individuals with symptoms of TB | – can increase awareness and promote HIV transmission reduction with women in the community<br>– can promote preventive measures |
| Mental health and counseling skills | – can talk to person with mental illness and recommend self referral<br>– can help reduce stigma against people with mental illness | – can talk to person with mental illness and recommend referral<br>– can help reduce stigma against people with mental illness |
| Physical disability | – can conduct community meeting in support of people with disability | – |
| Maternal health, menstruation, family planning, reduction of gender based violence | – can advise on appropriate nutrition for pregnant women and on anaemia prevention<br>– can give iron/ folate tabs and micronutrients<br>– can give vit A cap<br>– can provide condoms and explain use<br>– can advise appropriate contraception & and give out oral pills | – can advise on appropriate nutrition for pregnant women and on anaemia prevention<br>– can give iron/ folate tabs and micronutrients<br>– can give Vit A cap<br>– can promote birth spacing and advise appropriate contraception |

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| | – can promote birth spacing<br>– communicate key messages on STI prevention<br>– communicate key message on gender based violence reduction<br>– can conduct home visit of pregnant woman for health promotion<br>– can promote exclusive breast feeding | – communicate key messages on STI prevention<br>– can conduct home visit of pregnant woman for health promotion and follow up on antenatal checkups<br>– Can identify danger signs during pregnancy, delivery, postpartum and advice and refer<br>– Collaborate with local TBAs and community midwives to ensure safe delivery practices<br>– can promote exclusive breast feeding<br>– can advice on care of the newborn and low birth weight babies<br>– can raise awareness about harmful effects of FGM |
| Nutrition promotion – maternal, newborn, infant, child and elderly; Screening and rehabilitation/ supplementary feeding/ Community based management of acute malnutrition; micronutrients | – can define nutritional value of common foods<br>– can carry out MUAC screen<br>– can fill in MUAC info in register/ on card<br>– can assist at OTP clinic<br>– knows key nutrition promotion messages and how to convey them<br>– can give micronutrients and explain their importance<br>– can identify some signs of malnutrition and understands the cause<br>– understands the link between nutrition, growth, development and health<br>– can advise elderly person with poor nutrition<br>– can visit malnourished person at home and promote good nutrition, including appropriate young child feeding & weaning<br>– can promote exclusive breast feeding<br>– can accurately measure, chart and interpret weight and height when assisting at outpatient therapeutic programmes | – can carry out MUAC screen (women and children)<br>– knows key nutrition promotion messages and how to convey them<br>– can give micronutrients and explain their importance<br>– can identify some signs of under-nutrition and understands the cause<br>– understands the link between nutrition, growth, development and health<br>– can visit under-nourished women, girl and child at home and promote good nutrition, including appropriate young child feeding & weaning<br>– can promote exclusive breast feeding |
| Reduction of harmful substance abuse (tobacco, qat, alcohol) | – can promote reduction in use of harmful substances<br>– understands 10 effects of harmful substances | |
| Data collection, HMIS | – can fill in HMIS form for Primary Health Unit<br>– register of births and deaths | – register of births and deaths<br>– Keep immunization records of children and women in her community<br>– Keep records of pregnant women<br>– Submit a monthly report |

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| Management of Primary Health Unit | – can fulfill management tasks for PHU | – |
| Referral systems | – can advise clients to self-refer | – can advise clients to self-refer |
| Essential drug management | – can manage PHU kit – on shelves, monitoring stock, how to administer, how to count, how to put in sachets etc | – manages her supply of medicines and non-drug items in bag and small stock at home |
| Working with community health committees | – knows composition of Community Health Committees and roles | – knows composition of Community Health Committees and roles |
| Raising resources (human, financial and material) in the community for health, water and sanitation improvements, and building, upkeep & maintenance of PHU | – understands importance of diversification of funds for PHU and community improvement programmes.<br>– can mobilize communities to contribute resources to CHC<br>– understands upkeep of buildings | – Promotes contribution to the PHU and community improvement programmes |
| Community mapping | – can make simple map of community | – can make simple map of her community |
| Disaster preparedness, mitigation and response | – understands ways of mitigating hazards<br>– understands health system back up in case of disaster<br>– can communicate rapidly in case of disaster to relevant contacts | – understands health system back up in case of disaster<br>– can communicate rapidly in case of disaster to relevant contacts |
| Practical placements | – Fulfils predetermined tasks as above during placements | – |
| Assessments – oral and written tests, practical procedures tests. Qualifying certificate Code of conduct | – achieves 60% average in oral, written and practical tests/ procedures<br>– receives qualifying certificate<br>– understands limitations of role of CHW<br>– understands code of conduct of CHW | – achieves 60% average in oral and practical tests<br>– receives qualifying certificate<br>– understands limitations of role of FHW<br>– understands code of conduct of FHW |