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# REPRODUCTIVE HEALTH

NATIONAL STRATEGY  
& ACTION PLAN  
2010-2015



# REPRODUCTIVE HEALTH

National Strategy & Action Plan 2010-2015

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SOMALIA

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Dr Ingvil Sorbye and Dr Bailah Leigh

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# Preface

Reproductive health is fundamental to individuals, families and the social and economic development of communities and nations<sup>1</sup>. Somalia has been marked by decades of poverty, under-investment, conflict, insecurity, displacements and natural disasters. Reproductive health suffers considerably in such an environment as, more than in any other field of health, progress depends on a comprehensive, functioning health system.

The Joint Needs Assessment of 2006 defined enormous gaps in the response to reproductive health needs. A financing study by The World Bank in 2007 indicated serious under-financing of reproductive health. Various members of the Health Authorities in Somalia have recognised:

- unacceptable levels of unmet need;
- extreme inequities in access to higher levels of curative care;
- slow progress towards redressing problems; and
- under-investment and poorly coordinated actions between UN agencies, international NGOs and local partners.

They have all expressed the belief that development of coherent, focussed strategies to promote better reproductive health is a priority.

WHO and UNFPA held a high-level technical meeting in 2008 where they identified the need for development of a situation analysis and drafting of a strategic framework, plan of action and resuscitation of the reproductive health working group in order to catalyse better reaction to the above-mentioned problems.

During the development of an Essential Package

of Health Services (2008) for Somalia, it was again emphasised that there were enormous gaps in access to and provision of quality reproductive health services. The development of these services was one of the three main strategic thrusts of the EPHS. However, the process itself revealed the need for greater attention and focus to be paid specifically to building consensus around ways forward in addressing reproductive health issues.

When needs are high and ubiquitous and resources and access to the population limited, a decisive and focussed strategy to address maternal and neonatal survival becomes crucial.

The UN agencies (UNFPA, WHO and UNICEF) have collaborated to try to meet this demand. A **situation analysis** was drafted based on a comprehensive review of all published and unpublished literature available to the consultant<sup>2</sup>, after extensive consultation with international and Somali partners.

The **situation analysis** is the first critical step in defining the current state of affairs, what opportunities and challenges must be faced and what choices must be made in order to secure progress. The situation analysis prompted some administrations to request assistance in the formulation of an explicit **national policy** for reproductive health. The policy has been translated into a **strategic framework** and action plan for the immediate future (2010–15). These three documents are all critical components of an overall effort to develop a rational and evidence-based approach to the redress of the appalling suffering, morbidity and mortality faced by women in Somalia today.

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<sup>1</sup> Reproductive health strategy: to accelerate progress towards the attainment of international development goals and targets (WHO, Geneva, 2004).

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<sup>2</sup> Addressing maternal and neonatal survival in Somalia: A situation analysis of Reproductive Health in Somalia by Ingvil Krarup Sorbye, MD (WHO/UNFPA, March 2009).

The strategy presented in this document is intended for a broad audience of governmental actors, professional associations, institutions, non-governmental organizations, donors and other stakeholders within reproductive health. As a strategy it has been designed to be as clear and brief as possible. It does not provide an exhaustive list of reproductive health issues faced

by the Somali people, but seeks to identify key priority areas (i.e. important, and where real gains can be made) within the overall reproductive health agenda, to guide concerted intervention and efforts by all stakeholders over the next five years.

# Acknowledgements

This document is the result of a collaborative process between the Health Authorities in Somalia and the UN agencies – UNFPA, WHO and UNICEF, to define the way ahead for Reproductive Health in Somalia. The process was assisted with finance and support by DFID and the EC.

We would like to acknowledge the contributions of the 2 key consultant authors Dr Ingvil Sorbye and Dr Bailah Leigh.

The authors would like to thank all the Somali health professionals working in Health Authorities, health agencies, training institutes and public and private facilities around the country who actively participated in meetings and discussions to generate a way forward. The issues addressed seemed to strike

a chord with health professionals and respond to a collective felt need for trying to decide what to do to alleviate the suffering and death of their women in the face of such pressing needs and obstacles to action. This document draws heavily on these rounds of consultation – encompassing perspectives from health professionals at all levels and from all parts of Somalia. The task is challenging, resources are limited and so tough decisions need to be made. These decisions necessarily need to reflect reality and so are grounded on the practical experiences of those committed and working in this environment. Without their insights this document would not have been possible.

We sincerely hope this document serves its purpose of increasing focused attention, support and action towards maternal and reproductive health in Somalia.

# Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CHW	Community health Worker
CS	Caesarian Section
DFID	Department for International Development (UK government)
EmOC	Emergency Obstetric Care
EC	European Commission
EPHS	Essential Package of Health Services
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GDP	Gross Domestic Product
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immuno-deficiency Virus
HP	Health Post
HR	Human Resources
ICPD	International Conference on Population and Development
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health (clinics)
MD	Medical Doctor
MDG	Millennium Development Goals
MICS	Multi-Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNH	Maternal and neonatal Health
MoHL	Ministry of Health and Labour
MoH	Ministry of Health
NEZ	North East Zone
NWZ	North West Zone
NGO	Non Governmental Organization
PHC	Primary Health Care
PMTCT	Prevention of Mother To Child Transmission
PNC	Post Natal Care
PPH	Post Partum Haemorrhage
RH	Reproductive Health
SCZ	South Central Zone
SIDA	Swedish international Development Assistance (Swedish government)
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UN	United Nations
UNAIDS	UN agency for HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

# EXECUTIVE SUMMARY

The Somali people have suffered through decades of poverty, under-investment, conflict, insecurity, displacements and natural disasters. Reproductive health suffers considerably in such an environment, as more than in any other field of health, meeting needs depends on a comprehensive, functioning health system.

Recent survey and health information such as the last MICS in 2006 reaffirm the high levels of need of women in Somalia (high fertility and high maternal mortality - MMR 1,400/100,000 live births) and low levels of access to quality services. A recent survey of financing to the health sector indicated disproportionately low levels of investment in reproductive health.

The situation analysis<sup>3</sup> provides a comprehensive and disturbing picture of the status of maternal and reproductive health services in the three zones and the resultant humiliation, suffering and death faced by women on a daily basis. The main needs established in the situation analysis are:

- **High maternal mortality ratios** and the fact that most maternal deaths arise from complications during late pregnancy and childbirth (haemorrhage, prolonged and obstructed labour, eclampsia and infection), imply a strong ethical and practical

imperative for assuring the survival of the mother and her newborn.

- Very high fertility and considerable **unmet needs for birth spacing** imply a pragmatic requirement to focus on expanding access to cheap, safe and effective modern means to empower men and women to take control over major decisions affecting the health and well-being of their families - specifically birth spacing.
- The high prevalence of **traditional practices** and the medical evidence that some of these practices seriously endanger reproductive health, imply the need for increased awareness about the negative health and social consequences of some practices employed today.

These findings drive the choice of three main strategic axes for action. Due to close links between the different aspects of reproductive health, interventions in one area are likely to have a positive impact on other areas (for example the main entry point for developing promotion of healthy families and birth spacing is through maternal neonatal and child health services). The strengthening of existing services can be used as entry points for new interventions, looking for maximum synergy.

3. Addressing Maternal and neonatal survival in Somalia: A Situation Analysis of Reproductive Health in Somalia. Ingvil Krarup Sorbye, MD. WHO/UNFPA March 2009

The three strategic priorities for action, as derived above, include:

Strategic Axis	Overall Objective
<b>I: Making pregnancy and childbirth safer</b>	<i>Accelerate reduction of maternal and neonatal mortality towards achievement of MDGs 4 and 5.</i>
<b>II: Promoting healthy families</b>	<i>Empower men and women to take informed actions for optimum spacing of births to help reduce risks to the lives of women and children and improve the health and welfare of families, communities and the nation.</i>
<b>III: Promoting beneficial and addressing harmful practices</b>	<i>Improve the lifetime health of women and children by raising awareness of beneficial or harmful effects of certain practices connected to reproduction, working towards reduction and eventual elimination of practices that endanger health.</i>

As mentioned, sexual and reproductive health is a unique sub-sector, due to its close association with important and sensitive socio-cultural factors and gender roles which define and prescribe appropriate opportunities and avenues of action. The field is uniquely sensitive and therefore must involve explicit exploration across all areas of activity of some critical cross cutting issues – among them **gender, adolescent health, sexually transmitted infections and HIV/AIDs.**

Most maternal deaths arise from complications during childbirth that can be safely addressed through effective medical intervention. Therefore the availability, accessibility and quality of these services are critical. In the Somali environment, where the health system is fragmented and underperforming, these critical services are hardly available to the majority of the population. They are to all extents and purposes unassisted or subsisting in a “natural state”, unaffected by advances in modern medicine.

Many programmes and actions for improved maternal and reproductive health depend on an overall improvement in functioning of the health system. The \*strategic action plan for Reproductive Health is thus an issue of broader health system reform and development. This strategy paper attempts to flesh out a practical action plan, with core areas of activity to be prioritised to progress along each strategic axis. These action plans will then have to be drawn up into detailed area-specific contextualized plans by the relevant Health Authorities and other implementing actors.

In particular, there are major improvements required in financial and human resources (availability and use) and the organisation of services and referral between levels of health services.

***The core message has to be that there is an agenda for action even within the current constraints and with the low resources available.***

# 1

# INTRODUCTION AND OVERVIEW

## 1.1 Introduction to Somalia

### 1.1.1 Geography and people

The Somali Republic covers a combined area of 637,661 km<sup>2</sup> bordering Djibouti, Kenya and Ethiopia, with its coastline facing the Gulf of Aden and the Indian Ocean.

The people of Somalia all speak dialects of Somali, all are Muslims and they are culturally highly homogeneous. Somali society is divided into clans and sub-clans that structure and order social and economic life and provide security. The clan structure is in partial competition with the modern state. There are minority Somalia and Bantu groups that do not fall into any of the clans.

The last population census was in 1975. Given the years of war and displacement there are no accurate estimates of population size and distribution, but a number of estimates have been developed for planning purposes. An independent consultancy<sup>4</sup> validated the UNDP's figures as the best likely set of population figures for Somalia based on an array of different projections and household surveys. In 2006, the UNDP estimated the population of Somalia to be 7.73 million. Roughly 70% of this population live in the South Central Zone of Somalia and the remaining 30% in Somaliland and Puntland. The population has a large proportion of

young<sup>5</sup> with 57% of the population under the age of 20 and 20% under the age of 5<sup>6</sup>.

Thirty-four percent (34%) of the population is estimated to be urban, and 66% rural<sup>7</sup>, although urbanisation is increasing rapidly due to conflict, environmental degradation and diaspora remittance flows, and may already be much higher in some regions. There are massive numbers of Somalis in the diaspora, with over one million Somalis residing in the USA, Canada, the UK, Netherlands and Scandinavian countries, as well as in neighbouring Kenya.

Major climatic factors include a year-round hot climate, seasonal monsoon winds and irregular rainfall, with recurring droughts and floods in the southern riverine areas. The northern zones are arid, while the southern areas tend to be more fertile and vegetated.

### 1.1.2 Political and Administrative Structures

Somalia gained independence in 1960, formed through the voluntary union of liberated British and Italian Somali colonial territories. Despite this act of politically optimistic centralisation, Somalia has not had a central state authority since the collapse of the Siad Barre regime in 1991.

4. Review of various population estimates for Somaliland, Puntland and South-Central Somalia. Ben Jarabi, September 2007.

5. With attendant problems of poor sexual and reproductive health practices, low educational attainment, low employment, dissatisfaction and high rates of mobilisation into militia and high rates of mental disturbance and sexual violence.

6. Socio-Economic survey 2002. Somalia. The World Bank and UNDP  
7. Socio-Economic survey 2002. Somalia. The World Bank and UNDP

In 1991 the North-West region declared the independent state of Somaliland, which has not been recognised as independent by the majority of other countries. Nevertheless, Somaliland enjoys relative peace and security and is de facto administered from its capital, Hargeisa.

In 1998 the North-East declared itself as the autonomous region of Puntland. Puntland has not sought separate statehood but declared its intention to participate in any Somali reconciliation and reconstruction process. Since 1998 Puntland has also been de facto governed by its own administration based in its capital, Garowe.

The South Central Zone of Somalia remains locked in intermittent political conflict and violence. There have been attempts to set up other independent statelets in the central and southern areas, but these currently do not exist<sup>8</sup>. There have also been attempts to establish central regimes (with international backing); this process is ongoing but has met with considerable resistance no matter what formulation the centralising project has taken. Nevertheless, even in the south and central areas there are authorities and some application of norms and customary laws.

### 1.1.3 Socio-Economic Situation

On a per capita basis, Somalia is extremely poor. Somalia was unranked in the recent Human Development Index due to lack of reliable data, but it is clear that Somalia is at the bottom of the league table in terms of wellbeing for its people. Extreme poverty is estimated to be extremely high in Somalia at 43%, with large disparities between urban and rural populations (23% urban vs. 53% rural)<sup>9</sup>.

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8. In 2002 South Western Somalia declared itself autonomous (Bay, Bakool, Middle Juba, Gedo, Lower Shabelle, Lower Juba) but internal fighting weakened the union and it was never able to assert itself. However it remains crucial as a power base to the formation of the Transitional Federal Government (TFG).

In 2006 the regional authority of Jubaland claimed autonomy.  
9. Unicef 2001

Somalia is a semi-arid country with only 2% arable land (mostly along rivers in the south). Animal husbandry is the most important sector, with livestock accounting for 40% of GDP. The long coastline and multiple borders mean that Somalia has long been an important trading zone with cross-border trade as well as international import/export through various ports. Roughly 65-80% of annual exports are livestock and animal products (other key export commodities are bananas, fish and some minerals).

The large, well-organised and informed Somalia diaspora repatriate significant remittances and, to a very considerable extent, Somalis (especially urban communities) subsist on these remittances. Remittances have been used to invest in a flourishing private sector in Somalia, including private health care services. However, these investments are not aggregated nor under control of central authorities, are not distributed according to need and so are not strategically focussed, efficient or egalitarian.

The status of educational attainment in the country is very low. Only 20% of the population is estimated to be literate, with major urban-rural differences (urban 35%, rural 11%)<sup>10</sup>. More recent data<sup>11</sup> indicate that literacy rates have improved among women aged 15–24 years; 25% of women aged 15–24 are literate (44% in urban areas, 10% in rural areas, but only 4% among nomadic populations).

Somalia is unable to provide an educated pool from which to create and staff modern institutions of state. Subsequently, the outlook for the provision of comprehensive public health and other services is poor. If a meaningful central state re-emerges, a massive shortage of trained manpower will exist in the country.

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10. Socio-Economic Survey 2002. Somalia. UNDP, World Bank.  
11. MICS 2006

“The Somali youth have lost an opportunity to acquire the skills needed to rebuild institutions and industries and to compete regionally”<sup>12</sup>.

## 1.2 Reproductive health overview - Somalia

### 1.2.1 General health system characteristics

Somalis have suffered from poverty, under-development, conflict, natural disasters and internal displacements for decades, and the country has been without an effective central government for almost a generation. The health system has suffered considerably and, of all areas of health, reproductive health is uniquely dependant on overall health system adequacy and functioning to progress.

The Somali health system is characterized by insufficient, inequitable, fragmented and highly privatized services, with low levels of central governance or management. Consequently, a large segment of the population is without access to basic health services and with complete absence of some higher level services in many regions.

**Governance and stewardship:** In the South Central Zone (SCZ) the state has been unable to construct enduring public welfare institutions with the ability to project authority. In Somaliland and to a lesser extent Puntland, there has been the formation of more or less stable government institutions with specific construction of institutions for public health administration and a public health workforce. However, the public administrations have no overall plan for sector reform and development, a limited and patchy policy framework, limited capacity and legitimacy to govern the health sector and limited roles in coordinating and leading health stakeholders. There is ineffective

regulatory framework and enforcement capacity to ensure adequate regulation and public protection.

**Health financing:** Overall, there is a lack of financing for health services. The northern administrations in Somaliland and Puntland commit roughly 3% of their annual budgets to health but relative and absolute amounts are extremely low (less than US\$ 1 million per year in each case). In the SCZ there has been no public budget and no public financial commitment to health. In all three zones the health system is heavily dependent on private out-of-pocket expenditure, charitable donations and international assistance from traditional institutional donors – none of which are dependable sources<sup>13</sup>. Total amounts remain far short of what is required and funding is not targeted to strategic priorities, nor focused or predictable. Reproductive health financing in particular has been neglected for many years, as the current trend of vertically organized and disease-specific programmes does not favour progress in maternal and reproductive health which is dependent on access to quality services provided through a tiered and effective health system.

**Human resources:** There is a grave shortage of qualified professional health workers (and professionals in reproductive health specifically), especially of qualified midwives. The majority of those professionals that do exist are clustered in major urban conurbations. In rural areas public services are reliant on auxiliary staff, most of whom are inadequately trained for their job and for whom salaries are extremely low (which will not attract professionals). In urban areas health staff is also poorly and irregularly remunerated and hence commit limited time to their public duties. Urban professional staff has opportunities for private employment and business and so, even in urban areas, access to qualified health

12 Little P. (\*date) Somalia: Economy Without State. African Issues Series. James Curry Oxford.

13 Capobianco E, Naidu V. (2008). A review of health sector aid financing to Somalia (2000–2006). The World Bank (WB Working Paper No. 142), Washington, DC.

professionals is only available to those who can afford to pay relatively large sums of money.

Training of new health staff is limited to production of general medical doctors and nurses. There is little systematic production of other essential health cadres such as midwives, community midwives, sanitarians and pharmacists, or health system management professionals. For those who are newly-trained, few systems are in place for planned deployment within the public system, and there is a lack of mechanisms for retention.

The lack of professional staff, including the imbalance in under-production of specific cadres and the lack of managerial functions, means that staff bodies are inadequately organized managed and hence are underperforming. *The reform of the health workforce is a prerequisite for reform and increased performance of the public health sector and the development of effective RH services.*

**Services:** There are roughly 250 Maternal and Child Health centres (MCHs) and 600 Health Posts (HPs) in Somalia. The numbers of public facilities are inadequate for the population served, and the size of the country only exacerbates the distances required to access these few public health facilities. Utilisation rates are estimated as one contact every eight years. Health facilities are irregularly **supplied**, with an inadequate selection of drugs through a kit system (meaning that every month there is wastage and stock-outs). The **Health Information System** is operating at a very low level. Quality of data collected, its transmission and analysis are all major problems slowing down data collection, compilation, completeness and analysis, reducing their influence over decision-making.

### 1.2.2 Reproductive Health Situation<sup>14</sup>

Given high levels of illiteracy and isolation, the level of knowledge about health risks related to pregnancy and childbirth are low and hardly informed by modern medical practices. There is poor demand for, and mistrust of, preventive services such as vaccination and birth spacing. Poverty, illiteracy and the low value placed on women's health, lack of female decision-making power over their own health, and social and cultural norms associated with reproduction adversely affect decisions to seek health care and positive outcomes for mother and child.

Adolescent marriage and early pregnancy are common and associated with higher mortality risks for both the mother and the baby. Frequent and close pregnancies as well as low levels of exclusive breastfeeding and proper complimentary feeding, deplete the nutritional status of mothers and children. Ninety-eight percent of all Somali women have undergone female genital mutilation (FGM) and this practice also contributes to the burden of ill-health among mothers and their newborns.

There are considerable unmet needs in all major fields of reproductive health in Somalia and arguably these are higher than in most other countries due to factors referred to above. Currently available reproductive health information for Somalia shows considerable unmet needs. A maternal mortality ratio of 1,044-1,400/100,000 live births, coupled with a high total fertility rate of 6.2-6.7 translate to a life-time risk of dying of one in 10 women. The perinatal mortality rate is estimated to be 81/1,000 live births.

Only one out of four pregnant women attends antenatal care. For those that do, services are of poor quality

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<sup>14</sup> This section consists mainly of excerpts from the summary of **Addressing Maternal and neonatal survival in Somalia: A Situation Analysis of Reproductive Health in Somalia** By Ingvil Krarup Sorbye. WHO/UNFPA March 2009.

and women hardly receive any useful interventions (constituting a major missed opportunity). Newborn care is neglected, with major missed opportunities to secure immediate improvements in mortality reduction. More than 90% of women deliver at home and more than half are assisted by a traditional birth attendant. The 15% of pregnant women who experience miscarriage have little access to care.

There is poor access to skilled delivery care and emergency obstetric care at almost all locations but rural and nomadic populations particularly, are virtually without access to timely obstetric interventions when needs arise. There is a major lack of facilities able to offer basic emergency obstetric care (BEmOC) and a dire lack of qualified midwives to staff and manage these centres. There are reasonable numbers of centres offering Caesarean section (<1:500,000 pop.), but they are underutilized (overall c-section rate of 0.5%) for managing complicated deliveries and the services are of poor quality, with a high case fatality rate.

Misconceptions with respect to use of modern contraceptives, their safety and efficacy abound among the Somali people. Even so, the need for birth spacing is increasingly recognized by women, especially those living in urban areas. Twenty-six percent of women have unmet needs that would be supported by birth spacing and limiting, yet only one percent of Somali women use a modern method of family planning. Thirteen percent would benefit from some form of lactation amenorrhoea,

given breast-feeding practices. Post-abortion care and medical treatment for victims of sexual and gender based violence and STIs, are not universally available. The special needs of adolescents are presently not being addressed.

The prevalence of HIV/AIDS among pregnant women is 0.9% (i.e. low for the region). Whilst 57% and 71% of women and men respectively have ever heard about AIDS, knowledge of prevention of transmission through the use of condoms was very low. There are currently no national guidelines for Prevention of Mother to Child Transmission (PMTCT) or Highly Active Antiretroviral Therapy (HAART). Coverage for PMTCT is accordingly very low: only 11 pregnant women living with HIV received PMTCT services in 2007, an estimated coverage of 1% (11/940 women).

Barriers to accessing reproductive health care are many<sup>15</sup>. Low levels of literacy and mistrust lead to poor awareness among the population; financial obstacles in the form of ubiquitous user fees; logistic obstacles such as long distances and lack of or expensive transport to health service providers for the rural and nomadic population, all play a part. Poor quality of services, inappropriate and unpredictable opening hours, high numbers of unskilled staff, incoherent running of services and breaks in supplies, all undermine trust and use of the public sector and further aggravate the situation.

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<sup>15</sup> Often characterized as the three delays: (1) Delay in deciding to seek care; (2) Delay in reaching treatment facility; (3) Delay in receiving adequate treatment at the facility (Thaddeus S & Maine D. (1991). Too far to walk: maternal mortality in context. *News1 Womens Glob Netw Reprod Rights* 36: 22-24.

Table 1.2 Reproductive Health indicators for Somalia

Indicator	Somaliland	Puntland	Central South Zone	All Zones	Source
<b>Total fertility rate (TFR)</b>	5.9	6.2	7.1	6.7 /6.2	MICS 2006/ WHO Statistical Information System (WHOSIS) 2008
<b>Modern Contraceptive Prevalence Rate (CPR):</b> modern methods women 15-49 yr	4.6%	0.1%	0.3%	1%	MICS 2006
<b>Unmet need birth spacing/child limiting</b>	29%	19%	26%	26%	MICS 2006
<b>Maternal Mortality Ratio (MMR):</b> annual number of maternal deaths per 100,000 live births	No zonal estimate	No zonal estimate	No zonal estimate	1044 -1400	MICS 2006/ WHO, UNICEF, UNFPA, World Bank, 2007
<b>Antenatal Care Coverage :</b> % women attended at least once during pregnancy (% with at least 4 visits)	32% (10.3%)	26% (5.8%)	24% (5.2%)	26 % (7.1%)	MICS 2006
<b>Coverage of tetanus vaccination (TT 2+)</b>	17%	21%	30%	26%	MICS 2006
<b>Proportion of births in a health facility</b>	21%	8%	6%	9%	MICS 2006
<b>Percent of births attended by skilled health personnel</b> (according to WHO def.).	21%	7%	6%	9%	Derived estimate/MICS 2006
<b>Availability of BEmOC:</b> No. facilities per 500,000 population	1.1	0.5	1.3	0.8	UNICEF/UNFPA 2006 (NWZ/NEZ)
<b>Availability of CEmOC:</b> No. facilities per 500,000 population	1.7	2.2	1.7	1.9	UNICEF/UNFPA 2006 (NWZ/NEZ)
<b>Caesarean section as proportion of all live births</b>	0.4%	0.6%	No zonal estimate	0.5%	UNICEF/UNFPA 2006 (NWZ/NEZ)
<b>Case Fatality Rate</b> (direct obstetric morbidity in EmOC-facility)	21%	33%	No zonal estimate	20-33%	UNICEF/UNFPA 2006 (NWZ/NEZ)
<b>Perinatal Mortality Rate</b>	No zonal estimate	No zonal estimate	No zonal estimate	81	Neonatal and Perinatal Mortality. Geneva, MPS/ HQ, 2007
<b>Low Birth Weight prevalence*</b>	6%	11%	21%	17%	MICS 2006
<b>Reported prevalence of women with FGM</b>	94%	98%	99%	98%	MICS 2006
<b>HIV prevalence among pregnant women</b>	1.4%	1.0%	0.6%	0.9%	WHO 2004

# 2

## GOALS AND OBJECTIVES DRIVING FORMULATION OF THE NATIONAL REPRODUCTIVE HEALTH STRATEGY

### 2.1 International norms and standards

Each year some eight million of the estimated 210 million women who become pregnant, suffer life-threatening complications related to pregnancy. In 2000, an estimated 529,000 women died during pregnancy and childbirth from largely preventable causes; 2.7 million infants are stillborn every year and three million infants die within the first seven days of life. Globally, the maternal mortality ratio has not changed over the past decade. Ninety-nine percent of all maternal deaths occur in developing countries<sup>16</sup>. ***Somalia has one of the highest maternal mortality ratios in the world.***

The International Conference on Population and Development (ICPD) held in Cairo in 1994 declared that "Reproductive Health (RH) is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes". The definition captures the essential characteristics that make reproductive and sexual health unique compared to other fields of health. ***Sexual and reproductive health is closely associated with socio-cultural factors, gender roles and the respect and protection of human rights.***

All international norms and standards need to be carefully interpreted and adapted in their implementation to the specific cultural and social contexts of Somalia. They do constitute important principles of practice and shared international commitments to progress, that are crucial to explicitly recognise and use in the formulation of new national policy and practice.

#### 2.1.1 Millennium Development Goals

The Millennium Development Goals (MDGs) commit international and domestic stakeholders to work together to ensure progress around a core set of minimum goals. While some progress has been made towards achieving some MDGs in the challenging context of Somalia, little progress has been made in those explicitly related to maternal and reproductive health and therefore development of this strategy has been mindful of the shared responsibility to ensure progress in the MDGs and - most specifically - in MDG5

<sup>16</sup> Reproductive health strategy: WHO, Geneva, 2004 *ibid*

**Box 1.1 Millennium Development Goals for Reproductive Health<sup>17</sup>**

MDGs directly related to reproductive and sexual health	MDGs with close relationship with health, including reproductive health
<p><i>MDG 4: Reduce Child Mortality</i></p> <ul style="list-style-type: none"> <li>Target: reduce by two thirds, between 1990 and 2015, the under-5 mortality rate.</li> </ul> <p><i>MDG 5: Improve Maternal Health</i></p> <ul style="list-style-type: none"> <li>Target: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio</li> <li>Target: Achieve by 2015, universal access to reproductive health</li> </ul> <p><i>MDG 6: Combat HIV-AIDS, malaria &amp; other diseases</i></p> <ul style="list-style-type: none"> <li>Target: Have halted by 2015 and begun to reverse the spread of HIV/AIDS</li> </ul>	<p><i>MDG 1:</i> Eradicate extreme poverty and hunger  <i>MDG 2:</i> Achieve universal primary education  <i>MDG 3:</i> Promote gender equality and empower women  <i>MDG 7:</i> Ensure environmental sustainability</p>

Somalia has demonstrated commitment to the achievement of these goals and has already produced a first report on the status of achievement of all MDGs.

To achieve these goals requires government commitment to strengthen the health system and put in place policies to guide partners and stakeholders in their collective approach to the provision of relevant services.

**2.1.2 International Human Rights instruments**

The definition of reproductive health adopted at the ICPD in 1994 draws heavily on certain human rights adopted in international human rights instruments. Recognizing the imperative to respect and interpret all actions for women and men in light of Somali culture and norms of practice, it remains crucial to interpret the application of specific international human rights instruments in this particular context.

Human rights issues pertaining to sexual and reproductive health that have been considered as fundamental in drafting this document include:

- the right of all persons to the highest attainable standards of health;
- the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so;
- the right of women to have control over and decide freely and responsibly on matters related to their sexuality;
- the right of men and women to choose a spouse and to enter into marriage only with their free and full consent;
- the right of access to relevant health information; and
- the right of everyone to enjoy the benefits of scientific progress and its applications.

<sup>17</sup> Reproductive health strategy WHO Geneva 2004, *ibid.*

In order to ensure that these rights are respected, policies, programmes and interventions must promote gender equality and give priority to the poor and under-served populations and population groups.

## 2.2 Strategy direction

### 2.2.1 Vision

The vision of this National Reproductive Health Strategy is to achieve the highest possible status of reproductive health for Somali citizens and to reduce the numbers of women and newborns that die from a preventable cause or due to lack of access to quality essential reproductive health care and services.

### 2.2.2 Goal 2010-2015

To reduce maternal, neonatal and under-five mortality rates by providing comprehensive quality reproductive and child health services and strengthening the health system.

### 2.2.3 Overall mission and objective

To create an enabling environment for the provision of affordable and equitable access to quality essential reproductive health care and services for the population.

# 3

## ***A NATIONAL REPRODUCTIVE HEALTH STRATEGY***

This reproductive health strategy builds on and explores key aspects of The Essential Package of Health Services (UNICEF 2008). This framework is built around maternal and child services and focuses on improving quality of selected services. A phased approach is recommended. In a second phase, scaling up to achieve geographical coverage is the goal.

### **3.1 Justification and rationale**

When needs are high and ubiquitous, and resources and access to the population limited, a decisive and focussed strategy to address maternal and neonatal survival becomes crucial.

Somali mothers and newborns suffer from high levels of death and disease. This strategy aims to focus attention on:

- the prevailing precarious reproductive health situation with very poor indicators, mass suffering and death;
- lack of a framework for coordinated and coherent action to redress those needs;
- lack of action and appreciable progress made to date; and
- the lack of dedicated funding for maternal and reproductive health programming.

The strategy seeks to establish a coherent, agreed-upon framework to guide and prioritize the phased actions

and responses of the reproductive health sector and as an integrated package, to build synergies between the different components of reproductive health.

#### **A national RH strategy is envisaged to:**

- provide directions to translate the commitments of the MOHL into specific strategic axes/plans in order to meet the critical reproductive health-related needs of the Somali people;
- identify human and financial resources for the development and management plan to establish these RH axes;
- provide guidance for quality assurance;
- provide directions for community mobilization; and
- provide direction in information, advocacy and governance.

### **3.2 Core elements of sexual and reproductive health**

Recognising the specificity and cultural sensitivity of many of the issues that fall under sexual and reproductive health, the complex topic of sexual and reproductive health involves a wide array of possible activities covering a wide array of different sectors, technical capacities and communities of actors. This specific strategy refers primarily to priorities and plans for the organisation of enhanced action by partners involved in the health sector.

Reproductive health services cover a wide range of programme areas. The ICPD decided on a set of core services to constitute Reproductive Health and gave options to countries to adapt the components to their specific needs. Within the WHO EMRO region, the reproductive health agenda includes:

- improving antenatal, delivery, postpartum, newborn care, including post-abortion services;
- providing quality services for family planning/birth-spacing and infertility care;
- elimination of harmful traditional practices;
- protection and promotion of adolescent reproductive health;
- prevention, early detection and management of sexually transmitted infections (STIs) including HIV/AIDS and reproductive tract infections; and
- early detection and management of reproductive system cancer.

In an environment such as Somalia with high levels of unmet need, low levels of resources (human and financial), low levels of health system access, utilisation and performance and significant social and cultural sensitivities and attitudes regarding sexual and reproductive health issues, all the above areas require urgent development. However, there are some topics that cannot progress under the current conditions and some others of more or less priority.

Progress in any area will depend upon a focussed, determined and long-term effort. The main focus of this strategy is to lay emphasis on those components of Reproductive Health that directly contribute to reductions in maternal and neonatal mortality and thus promote survival.

The range of activities and coverage of services can be gradually enlarged as capacities, resources, opportunities and demand develop, but a sequenced and committed long-term effort is required by all

stakeholders. This strategic framework covers a first period 2010 – 2015.

## 3.3 Prioritized strategic axes

### 3.3.1 Main findings implying a need for priority actions

The situation analysis has provided a comprehensive and disturbing picture of the status of maternal and reproductive health services in the three zones of Somalia and the resultant humiliation, suffering and death faced by women on a daily basis. The short summary provided in Chapter 1 indicates that the main needs established in the situation analysis are:

- High maternal mortality ratios and the fact that most maternal deaths arise from complications during childbirth (haemorrhage, prolonged and obstructed labour, eclampsia and infection), implying a strong ethical and practical imperative for assuring the survival of the mother and her newborn.
- Very high fertility and considerable unmet needs for birth spacing imply a pragmatic requirement to focus on expanding access to affordable, safe and effective modern means to empower men and women to take control over major decisions affecting the health and well-being of their families, specifically birth spacing.
- The high prevalence of traditional practices and the medical evidence that some of these practices seriously endanger reproductive health imply the need for increased awareness about the negative health and social consequences of some of the practices employed today in Somalia.

These findings drive the choice of the three main strategic axes for action within which core areas of reproductive health will be specifically addressed.

Due to close links between the different aspects of reproductive health, interventions in one area are likely to have a positive impact on others (for example the main entry point for developing promotion of healthy families and birth spacing is through maternal

and neonatal health services). The strengthening of existing services can be used as entry points for new interventions, looking for maximum synergy.

### 3.3.2 Three strategic axes for action

*The three strategic priorities for action, as derived above, include:*

National targets for actions are included in Annex IV.

#### **Strategic Axis 1: Making pregnancy and childbirth safer**

##### **Overall objective:**

*Accelerate the reduction of maternal and neonatal mortality towards the achievement of MDGs 4 and 5.*

#### **Strategic Axis II: Promoting healthy families**

##### **Overall objective:**

*Empower men and women to take informed actions for optimum spacing of births to help reduce risks to the lives of women and children and improve the health and welfare of families, communities and the nation.*

#### **Strategic Axis III: Promoting beneficial and addressing harmful practices**

##### **Overall objective:**

*Improve the lifetime health of women and children by raising awareness of the beneficial and harmful effects of certain practices connected to reproduction, working towards their reduction and eventual elimination of practices that endanger health.*

## 3.4 Cross-cutting issues

As mentioned, sexual and reproductive health is a unique sub-sector due to its close association with important, sensitive socio-cultural factors and gender roles which define and prescribe appropriate opportunities and avenues of action. The field is sensitive and therefore must involve explicit exploration across all areas of activity of some critical cross-cutting issues.

### 3.4.1 Gender

Gender inequities represent a barrier to progress generally and nowhere more specifically than in the field of reproductive and sexual health. Somalia remains a highly gendered society, despite major shifts in the role of women during the past 20 years with women

taking a much more active role in economic life and serving as the main breadwinners of a significant proportion of Somali families. Investment in girls' education, health and nutrition as well as affirmation of a woman's right to choose and take control over her own life is essential to making real progress in reducing the burden of maternal and infant mortality. Gender analysis and programming must be a critical lens through which all sexual and reproductive health programming is planned, analysed and evaluated. Gender sensitivity and action should be a component of all actions across all three strategic axes.

### 3.4.2 STIs, HIV and AIDS

STIs and HIV-AIDS is another health issue of enormous socio-cultural and economic significance. While the STI and HIV-AIDS prevalence estimates are not particularly high for Somalia, there are particular high risk groups

in specific locations and prevalence in neighbouring countries in the region is very high. While there is strong financial support for HIV and AIDS programming (through the Global Fund for HIV/AIDS TB and Malaria), this does not mean that HIV and AIDS actions can be ignored in the context of this strategic framework. HIV and AIDS programming has tended to be highly vertical; integrating testing, counselling and care for people living with HIV in normal health services would benefit both HIV and AIDS programmes as well as broader health efforts and moves towards improving reproductive health. At the very minimum, precautions must be taken to ensure that safe blood transfusion services are guaranteed in all facilities offering EmOC; all medical staff at all levels must be made aware of and protected against transmission of HIV; awareness of the modes of transmission of HIV must also be raised systematically.

### 3.4.3 Adolescent reproductive health

Fifty-seven percent of the Somali population is estimated to be under the age of 20. As in all countries, taboos and norms around sexuality (including practices such as early marriage and FGM) pose strong barriers to providing information, reproductive health services and other forms of education and support that young people need to exercise their rights and ensure their reproductive health.

Efforts need to be taken in all three strategic action areas to ensure that the specific needs of adolescents and their access to essential services are catered for and ensured.

## 3.5 Health system development

Availability, accessibility and quality of health services are critical to progress in reproductive health. In the Somali environment, where the health system is fragmented and performing poorly, these critical services are hardly available to the majority of the population. They are to all intents and purposes unassisted or subsisting in a “natural state”, unaffected by advances in modern medicine. The strategic action plan recognises specific areas of system improvement that are essential to providing opportunities for improving maternal, reproductive and sexual health.

They are:

- Human Resources development
- financing Health Services
- Health Service Delivery (availability, accessibility, quality, utilisation and equity)
- Health Information System
- mobilizing political will for action
- good governance and accountability
- monitoring and evaluation

and will be dealt with in detail in Chapter 7.

# 4

## STRATEGIC AXIS 1: MAKING PREGNANCY AND CHILDBIRTH SAFER

### 4.1 Health systems development approach

Universal access to comprehensive health services concerning pregnancy, birth and the postpartum/ neonatal period are necessary to ensure the survival of the mother and the neonate. Due to the current low level of health service performance and constraints to rapid improvement (restrictions in access, logistic, human and financial resources), a phased approach is recommended.

The initial thrust of Axis 1 is to **improve the quality of Maternal and Neonatal Health (MNH) service provision and not, in the first phase, the quantity of health** facilities offering services. The short-term aim cannot be to meet targets defined by availability of services per population, as resources do not exist and there are too many other constraints. The focus will have to be on concentrating available resources to ensure minimum production/availability of quality services per geographic region. Existing facilities (health centres or hospitals) will be transformed into functional interlinked EmOC centres in places where resources (HR, supporting NGO, donor support) and beneficiaries (reasonable population density) can be found.

A **regional unit** will consist of three to five existing facilities, upgraded to provide the complete range of MNH and Basic Emergency Obstetric Care (BEmOC)

services linked by referral to one centre able to provide Comprehensive Emergency Obstetric Care (CEmOC).

The selection of regional units will need to be based on specific criteria (availability of staff, population density and feasibility of referral) and will in part be opportunistic. However, each major population concentration should be served. Selected existing BEmOC service providers (health centres or district hospitals) must be interlinked to CEmOC centres with a maximum distance (transport availability) for effective and timely referral.

The BEmOC centres will be able to offer MNH services such as focused antenatal and postnatal care, treatment of miscarriage, normal deliveries and BEmOC including neonatal care as well as timely referral to CEmOC. Comprehensive birth spacing counselling and services will be an integrated part of the service package (Axis II). Such upgraded facilities will also have the capacity and competence to deal with other areas of reproductive health which are not core to this strategy, namely management of STIs for non-pregnant women, medical treatment for victims of sexual and gender-based violence and treatment of obstetric or traumatic fistula.

Phase II of the strategy will be to expand the number of functional service-providing networks and hence geographic coverage, offering timely access to quality MNH services (BEmOC and CEmOC). New regional

networks or units should be established to prioritize underserved areas (IDPs, nomads) where necessary supportive requirements can be found or realistically established (human resources, NGOs, population density).

The strategy will require extensive investments in human resources to dramatically increase the numbers of:

- qualified midwives and community midwives;
- professionals able to perform obstetric surgery, including Caesarean section; and
- properly trained and supervised community health workers.

## 4.2 Specific objectives to achieve Axis I

Overall objective: Accelerate the reduction of maternal and neonatal mortality towards the achievement of MDGs 4 and 5.

Under the Overall Objective for Strategic Axis I, three specific objectives with the following strategic directions have been identified:

**Specific objective 1:** *Improve access, availability and quality of Maternal and Neonatal Health (MNH) services*

### Strategic directions:

**SD1:** Ensure provision of Essential MNH services<sup>18</sup> at HC and hospital level by targeting a limited number of existing providers according to agreed criteria<sup>19</sup>.

<sup>18</sup> See Annex: Essential Maternal and Neonatal Health Services as defined in the revised version of the Essential Package of Health Services (UNICEF 2009).

<sup>19</sup> To be discussed

**SD2:** Optimize and standardize management of MNH, including focused antenatal<sup>20</sup> and perinatal<sup>21</sup> care.

**SD3:** Ensure full supervision and management of MNH services.

**SD4:** Increase community awareness and demand for MNH:

- The Community Health Worker (CHW) will be instrumental in promoting health services at HC level by home-visits and individual counselling.

**SD5:** Bridge the health professional gap where no skilled care is available:

- Urban/rural differential approach to TBAs. A differentiated approach is taken to non-professional staff (TBAs). In areas with easy access to skilled birth attendants there is no role or support foreseen for TBAs. In rural and underserved areas TBAs will be relied upon, but their role should be transformed to one of promotion of MNH services at community level and early referral to skilled care during childbirth. A long-term strategy will be to replace all non-professional health workers with professionals (community midwives will gradually be able to replace TBAs in delivery care). Eligible TBAs should be accorded opportunities to retrain and upgrade as other professional cadres (including community midwives and CHW).
- Other differential interventions: The focus on expanding access to quality care in specific highly populated areas where resources exist, necessarily means rural and under-populated

<sup>20</sup> Focused ANC: four visits w/ identification of pre-existing health conditions, early detection of complications arising during pregnancy, health promotion and disease prevention, birth preparedness and complication readiness planning (WHO 200x).

<sup>21</sup> Essential Newborn Care (WHO 1996)

areas will be neglected in the immediate future. There is therefore a requirement to develop other actions that might serve to reduce morbidity and mortality even in areas where skilled birth attendance and EmOC are unavailable:

- community-based initiatives (breastfeeding, thermoregulation of neonates, complementary feeding, early warning signs for referral);
- promotion of ANC and PHC service attendance (TT+, multi-vitamins, etc.) must be expanded and improved;
- primary prevention of PPH by distribution of misoprostol to pregnant women/ women in labour by non-skilled personnel such as CHWs and TBAs is one potential intervention for areas where presently there is no access to skilled attendance. However, this needs piloting in the Somali context as well as careful management and control, and should be part of the operational research agenda.

**Specific objective 2:** *Improve access, availability and quality of Emergency Obstetric Care (EmOC)*

**Strategic directions:**

**SD1:** Increase community awareness and demand for EmOC.

**SD2:** Increase quality and accessibility (geographic and financial) of CEmOC through optimizing and standardizing case management.

**SD3:** Increase availability and accessibility of BEmOC.

**SD4:** Strengthen localised systems of referral:

establish formal referral forms, indications and agreements between facilities (private or public)

nominal referral vouchers for free emergency obstetric care for referrals from BEmOC centre to CEmOC centre (prepaid by NGO or other donor)

**Specific objective 3:** *Improve coverage of skilled attendance at birth*

**Strategic directions:**

**SD1:** Increase births in a health facility attended by skilled personnel.

**SD2:** Increase pool of skilled attendants in the public sector (and rational deployment).

**SD3:** Lower barriers (cultural and financial) and increase awareness and demand for skilled attendance:

- promotion by CHW
- vouchers or reduced fees

**SD4:** Increase provision of community-based MNH and PHC attendance.

### 4.3 Axis I: National indicators and targets 2010–15

1. To reduce MMR from 1,400/100,000 live births to 900/100,000.
2. To reduce peri-natal mortality rate from 81/1,000 to less than 66/1,000.
3. Increase BEmOC facilities per 500,000 population from 0.8 to 2.4.
4. To increase deliveries in a health facility from 9% to 18%.
5. To increase delivery by skilled attendants from 10% to 25%.
6. To increase percentage Caesarean section of all deliveries from 0.5% to 5%.
7. To increase one ANC visit - coverage from 26% to 35%.
8. To increase four ANC - coverage from 6% to 12%..
9. To increase postnatal care from 8% to 16%.
10. Number of EmOC facilities performing neonatal resuscitation (no baseline).
11. Percentage pregnant women tested for anaemia (no baseline).
12. Percentage pregnant women tested for HIV (Phase II).

The prioritized activities and actions to follow in the short- (Phase I: 2010 – end 2012) and medium-term (Phase II: 2013 - 2015) are outlined in the action plan below.

#### 4.4 ACTION PLAN: AXIS I: Making pregnancy and childbirth safer

#### Overall Objective: Accelerate reduction of maternal and neonatal mortality towards the achievement of MDGs 4 and 5

Specific objectives (SO)	Strategic directions (SD)	Primary actions and activities		Expected output	Indicators	Agency	Budget
		PHASE I	PHASE II				
SO 1: Improve access, availability and quality of MNH services.	SD1: Ensure provision of Essential MNH services at health centre and hospital level by targeting a limited number of existing providers according to criteria*  Essential MNH	<p>PHASE I</p> <ul style="list-style-type: none"> <li>- Facility renovation (watsan, electricity, capacity and space for deliveries).</li> <li>- Increasing opening hours at health centres, with an on-call system for emergencies at evening and night.</li> <li>- Provide affordable or free services by promoting adoption of facility by NGO.</li> <li>- Supplies and equipment</li> <li>- Review staff structure at facility, job standards, job descriptions, working hours, on-call roster, standardized incentive structure.</li> </ul> <p>Focused ANC, neonatal and postnatal care, STI syndromic management in pregnancy, anaemia prevention and control, nutrition screening pregnant and lactating (MUAC), skilled attendance at birth.</p>	<p>PHASE II</p> <p>Continue expansion by the same means beyond existing centres, especially focusing on IDPs and the nomadic population, aiming at geographical coverage of Minimum Package of MNH. Free Minimum MNH Package Review staff structure according to utilization of services + Screening all pregnant women HIV, Hep B, syphilis, Hb</p>	Increased coverage of focused ANC and PNC  Increased utilization Continuous supply of RH commodities	Percentage pregnant women receiving at least 1 ANC/at least 3 ANC  Percentage TT2+ coverage pregnant women	NGOs  NGOs  UNFPA UNICEF MOHL  UNFPA UNICEF	GAVI/HSS  NGOs    GAVI/HSS
	SD2: Optimize and standardize management of MNH, including focused antenatal and postnatal care  SD3: Increase the supervision and management of MNH services	<p>In-service refresher training of qualified RH staff Revise and adapt international standards and protocols</p> <p>-Engagement of Community Health Committee - Regular supervision by MOHL/NGOs - Explore performance-based incentives</p>	<p>Continue in-service refresher training of qualified RH staff</p> <p>- Explore performance-based financing</p>	Updated knowledge of qualified RH staff All staff using protocols  Increased performance	Percentage staff updated per topic Percentage facilities using protocols  Percentage supervisors using monthly supervision tools/ score cards	WHO UNFPA UNICEF NGOs  MOHL	WHO/ UNFPA/JUN pooled funds  MOHL NGOs
	SD4: Increase community awareness and demand for MNH  SD5: Bridge the health professional gap where no skilled care available	<p>- Community Health Workers conducting home visits for health promotion and disease prevention and refer to MNH services at health centre level</p> <p>- For rural and underserved population - Prevention activities by TBA (misoprostol)</p>	<p>- Once services are running a broad-based BCC and IEC campaign in media, using community leaders, artists</p> <p>- To be replaced with facility-based births as soon as possible</p>	Increased utilization of MNH services	Percentage coverage home visit of pregnant women		GAVI-HSS

SO 2: Improve access, availability and quality of EmOC.	SD1: Increase community awareness and demand for EmOC SD2: Increase quality and accessibility (geographic and financial) of CEEmOC through optimizing and standardizing case management. SD3: Increase availability and accessibility of BEEmOC. SD4: Strengthen localised systems of referral	- Community Health Workers conducting home visits for health promotion and disease prevention and promotion of use of in-facility delivery - Training of trainers in EmOC In-service refresher training of qualified RH staff Revise and adapt international standards and protocols - Upgrade existing facilities to create islands of 1 CEEmOC + 4 BEEmOC centres in each population centre. - Communication (mobile phone) and transport networks(private/NGO) for emergency referral from BEEmOC to CEEmOC - Referral vouchers from BEEmOC to CEEmOC - Pilot maternity waiting shelters	- Scale up BCC and IEC to beneficiaries, also in rural areas Continued in-service refresher training - Continue expansion beyond existing centres, in order to meet the min. standards of availability of BEEmOC - Scale up maternity waiting shelters (if feasible pilot) - Pilot voucher schemes and output/performance reimbursement schemes.	Updated knowledge of staff All staff using standard protocols Increased no. facilities offering BEEmOC	Percentage RH qualified staff updated per topic Percentage health facilities using protocols No. BEEmOC centres per 500 000 pop.	THET LATH WHO UNFPA UNFPA UNICEF	NGOs UNICEF NGOs EC? Local business
SO3: Improve coverage of skilled attendance at birth.	SD1: Increase births in a health facility attended by skilled personnel SD2: Increase pool of skilled attendants in the public sector SD3: Lower barriers and increase awareness and demand for skilled attendance SD4: Increase provision of community-based neonatal care	- Community Health Workers conducting home visits for health promotion and disease prevention, referring deliveries to BEEmOC for skilled attendance - Pre-service training of post-basic and community midwifery in all zones - Rural recruitment to stipends for training linked to two years commitment to deployment in public sector - Affordable or free facility delivery (vouchers) - Community Health Workers motivating for delivery with skilled attendant by home visits - Community Health Workers conducting home visits for health promotion, disease prevention, providing essential newborn care and promotion of care-seeking behaviour			Percentage women who deliver in a health facility Percentage coverage home visit of pregnant women % skilled attendants Percentage coverage Essential Newborn Care by CHW		

# 5

## STRATEGIC AXIS II: PROMOTING HEALTHY FAMILIES

### 5.1 Attaining healthy families

A happy and healthy family is not only based on the numbers of children that are born to that family, but on how many survive and how healthy the surviving children are. Best evidence indicates that maternal and child health and survival are compromised if births occur less than 24 months apart. In addition, maternal and child survival and health are compromised if mothers give birth while too young. Families need to ensure resources are available to maximise the growth and development of each child; too many children can drain resources and result in them having their health and development compromised.

#### Benefits for women:

Birth spacing methods help women protect themselves from too close pregnancies that can endanger their health. They can also help very young women wait with the first pregnancy until it is safe. If all women could avoid high-risk pregnancies, the number of maternal deaths would fall by one-quarter. Some birth spacing methods have other health benefits; for example some hormonal methods help prevent anaemia and certain cancers, whilst condoms can help prevent sexually transmitted diseases, including HIV/AIDS.

#### Benefits for children:

Birth spacing saves the lives of children by decreasing the proportion of underweight babies, and also overall under-five malnutrition. If all children are born at least

two years apart, many child deaths can be avoided as closely-spaced children are at a higher risk of disease.

#### Benefits for men:

Family planning helps men and women care for their families. Men around the world say that planning their families helps to provide a better life for them.

#### Benefits for families:

Family planning improves family well-being by ensuring reduced maternal and child deaths and allowing families to postpone childbearing until they have necessary resources to be able to care for all their children (food, clothing, housing, medical services and schooling).

### 5.2 Specific objectives to achieve Axis II

**Overall objective:** Improve women's and infant health and reduce risk of death or disability through ensuring adequate birth spacing.

Two specific objectives with the following directions have been identified:

**Specific objective 1:** *Improve affordable ready access to good quality birth spacing services for men and women, especially focusing on preferred methods.*

Ready access to good quality care is key to the success of birth spacing (BS) and related reproductive health services. With ready access, people can easily obtain safe and effective services that meet their needs, free from unreasonable barriers. *Good quality care* includes courteous, supportive interactions that help clients express their needs and make informed choices and the technical knowledge and skills to provide birth spacing methods and other reproductive health care effectively and safely. Providers who offer ready access to good-quality care can see their success in terms of healthy, satisfied clients with successful spacing of children.

**Strategic directions:**

**SD1:** Improve availability of modern birth spacing methods through integrated birth spacing services at all levels of the health system.

**SD2:** Improve accessibility of birth spacing services through reduction of barriers (cultural and financial).

**SD3:** Improve quality of birth spacing services through optimizing and standardizing client counselling and provision of services.

**SD4:** Increase number of service providers trained in birth spacing.

Birth spacing will be an integrated part of services provided at different health facility levels, and is a part of the EPHS. Services should be available at all times and all health staff, including CHWs, should be trained.

**Table 5.2: Birth spacing services at level of health system**

Service delivery level	HR	Birth spacing package of interventions
Community	Community Health Worker (CHW)	Increasing awareness and demand Referral to health centre level services Household visits and focus groups. Promotion of exclusive breast feeding for 4 to 6 months after birth
Primary Health Unit	CHW	Promotion of exclusive breastfeeding for 4 to 6 months after birth Community based distribution of condoms Re-supply of pills after first consultation visit at MCH level
Health Centre	Nurse/ Midwife	All the above + Service delivery of injectables and IUDs Counselling, management, referral for side effects, change of method where indicated Postpartum and post-abortion contraceptive counselling Supervision and support to community level activities and CHW
Referral Health Centre/Hospital	MD Nurse/Midwife	All activities at HC-level + Permanent contraception (surgical) on the basis of informed consent following a medical indication. Postpartum and post-abortion contraceptive counselling Management of FP/BS complications/side effects

**Specific objective 2:** *Strengthen awareness of health benefits and demand for birth spacing*

**Strategic directions:**

**SD1:** Enlist support among community leaders in politics, religion and health.

**SD2:** Expand demand among the general public:

- Promotion by trained and supervised (female) CHW

### 5.3 Axis II: National indicators and targets 2010–15

1. Increase percentage of eligible couples who access birth spacing services (no baseline).

2. Number of birth spacing service delivery points per 500,000 population (no baseline).

3. Percentage of service delivery points prepared (with stocks and trained providers) to provide at least three methods of birth spacing (no baseline).

4. Increase modern contraceptive prevalence rate from 1% to 5%.

5. Tracking unmet need for birth spacing.

6. Country funding for birth spacing/limiting (administrative records MOHL/NGO) (no baseline).

7. Reduce total fertility rate (TFR) from 6.2/6.7 to 5.5.

*Prioritized activities and actions following in the short- (Phase I) and medium-term (Phase II) are outlined in the action plan below.*

#### 5.4 ACTION PLAN: AXIS II: Promoting healthy families

### Overall Objective: Improve women's and infant's health and reduce risk of death or disability through assuring adequate birth spacing (BS)

Specific objectives	Strategic directions (SD)		Primary actions and activities		Expected output	Indicator	Agency	Budget
	PHASE I	PHASE II						
SO 1: Improve affordable ready access to good-quality birth spacing services for men and women.	SD1: Improve availability of modern birth spacing methods through integrated birth spacing Services at all levels of the health system.	PHASE I - Ensure contraceptive commodity availability by ensuring part of health kits for every level of health facilities. - Synchronize/update kit content and logistics to different levels of health system.	PHASE II - Expand geographically to cover rural and underserved areas.	Quality birth spacing services available and scaled up to cover a majority of health facilities.	TFR CPR(modern) No. birth spacing service delivery points per 500,000 pop	UNFPA UNICEF NGOs	Major donor	
	SD2: Improve accessibility of birth spacing services through reduction of barriers (cultural and financial).	- Affordable services	- Free services	TFR CPR(modern) % eligible couples who access birth spacing services				
	SD3: Improve quality of birth spacing services through optimizing and standardizing client counselling and provision of services.	- Establish National protocols and guidelines for quality family planning/birth spacing service delivery by revising and adapting international standards and protocols (Family Planning: A Global Handbook for Providers -WHO/USAID/J.Hopkins Bloomberg 2007).	- Liaison with key actors in establishing Somali Birth spacing Association. - Revise National Protocols and Guidelines.	CPR (modern)				
	SD 4: Increase number of service providers trained in birth spacing.	- Training of trainers (ToT) - In-service training of different categories of staff in protocols and guidelines Development/ review and adaptation of existing training modules in BS (from NGO/UN-bodies) for different cadres of staff.	- Continue and expand in-service training to include private for-profit providers (pharmacies etc).	TFR CPR				
SO 2: Strengthen awareness of health benefits and demand for birth spacing.	SD1: Enlist support among community leaders in politics, religion, health.	- Involve professional bodies, e.g. nurse, midwives and doctor's associations to enlist their support for birth spacing. - Involve community leaders (political, religious (sheiks), men's, women's and youth networks, NGO's) to enlist and voice their support for birth spacing.	Innovative approaches such as the involvement of well-known cultural personalities for the manufacturing of cultural products such as songs, poems, videos and plays where the positive health benefits of BS is highlighted, to be broadcast and promoted using radio and television and through learning institutions. - Expand geographical coverage of CHW in rural and underserved areas.	TFR CPR	WHO UNFPA UNICEF	GAVI/HSS		
	SD2: Expand demand among the general public.	- Piloted household visits by CHW - Develop BCC and IEC material for different media channels (radio, posters, mosque etc). - Information, education and behaviour change communication (IEC/BCC) addressing the positive health effects of birth spacing and avoiding early teenage pregnancy, communicated to youth, men and women in a socio-culturally acceptable way starting in the urban areas.	Unmet need for birth spacing/ limiting.					

# 6

## **STRATEGIC AXIS III: PROMOTING BENEFICIAL AND ADDRESSING HARMFUL PRACTICES**

### 6.1 Traditional practices

Somali culture has many traditions and traditional practices. While traditional and cultural norms and practices may have important benefits in defining identities and binding societies together, some of them might have consequences for the health and wellbeing of individuals. Somali women have good traditions for prolonged breastfeeding which is of great benefit to child nutrition. The culture also has a strong ethos of marital fidelity which has positive health benefits and protects against sexually transmitted infections.

On the other hand, some traditions can be a health hazard. Female Genital Mutilation or Cutting (FGM/C) has serious negative health consequences for a woman and can be potentially life-threatening. It makes childbearing more dangerous for women and babies are more likely to die or suffer birth injuries. FGM is a violation of the mother's and child's universally accepted human rights and right to health<sup>22</sup>. The practice of FGM can be ended without giving up meaningful aspects of Somali traditional culture. Some regions of the country (Puntland) have already banned the practice.

<sup>22</sup> The African Charter on Human and People's Rights (Art. 16 and 21)

The African Charter on the Rights and Welfare of the Child

The United Nations Convention on the Elimination of All Forms of Discrimination of Women (Art. 12)

Universal Declaration of Human Rights (Art. 25)

Early marriage and pregnancy for adolescent girls before the age of 18 are related to increased health risks. The young adolescent is more prone to complications of pregnancy and childbirth, and her baby has a higher risk of dying than if she delays first childbirth to after she is 18 years old.

In order to avoid resistance from the population, the following general approach will be used:

- Establish dialogue with communities to identify positive and negative cultural practices in order to discuss options for behavioural change.
- Strengthen positive cultural practices that enhance reproductive health<sup>23</sup>.
- Use participatory approaches in providing community health education to stop harmful practices, thereby reducing risk to health.
- Traditional and religious leaders, counsellors and practitioners should be sensitised to the dangers of harmful practices so that they provide necessary leadership and information.
- Promote gender empowerment and enhanced female decision-making regarding improved reproductive health.

<sup>23</sup> Various communities manage collective resources including money. This money is often used as a rapidly available fund for timely referral of women with obstetric complications to hospital.

## 6.2 Specific objectives to achieve Axis III

**Overall objective:** Improve the health of women, adolescents and children by promoting beneficial and reducing harmful practices connected with reproduction.

Three specific objectives with the following directions have been identified:

**Specific objective 1:** *Strengthen awareness among the population of the positive health benefits of certain traditional practices.*

Strategic directions:

**SD1:** Strengthen awareness of beneficial health effects of exclusive and prolonged breastfeeding for mother and child.

**SD2:** Strengthen awareness of beneficial health effects of marital fidelity.

**Specific objective 2:** *Strengthen awareness among population concerning the harmful effects of FGM.*

Strategic directions:

**SD1:** Strengthen awareness of harmful effects of FGM among community and religious leaders.

**SD2:** Strengthen awareness of harmful effects of FGM among women and men at community level.

**Specific objective 3:** *Reduce adolescent pregnancy.*

Strategic directions:

**SD1:** Strengthen awareness of health hazards related to adolescent pregnancy targeting decision makers (men, fathers, mothers).

**SD2:** Strengthen awareness of health hazards related to adolescent pregnancy targeting young people.

**SD3:** Increase adolescents' access to contraception.

**SD4:** RH education in schools and learning institutions.

## 6.3 Axis III: National indicators and targets 2010–25

1. Exclusive breastfeeding rate (0- 5 months) increased from 9% (baseline) to 18%.
2. Promote reform of Somali law to prohibit all forms of FGM (policy review).
3. Promote reform of Somali law to prohibit marriage for both men and women prior to age 18 (policy review).
4. Reduce adolescent fertility rate (women 15-19 years) from 123/1,000 to 100/1,000.
5. RH education in learning institutions (policy review).

Prioritized activities and actions following in the short- (Phase I) and medium-term (Phase II) are outlined in the action plan below.

### 6.4 ACTION PLAN AXIS III: Promoting beneficial and addressing harmful traditional practices

Overall Objective: Improve health of women, adolescents and children by promoting beneficial and reducing harmful practices in connection with reproduction

Specific objectives	Strategic directions (SD)	Primary actions and activities		Expected output	Indicator	Agency	Budget
		PHASE I	PHASE II				
SO1: Strengthen awareness among the population of the positive health benefits of certain traditional practices.	SD1: Strengthen awareness of beneficial health effects of exclusive and prolonged breastfeeding for mother and child.	- CHW to promote early exclusive breast feeding at community-level - Professional health staff at all levels to promote early exclusive breastfeeding at all contacts at ANC, birth and PNC	- National breast feeding campaign	- Improved child nutrition - Increased use of lactation amenorrhea to space births	Percentage exclusive breastfeeding Average length of breastfeeding period	UNICEF	
	SD2: Strengthen awareness of beneficial health effects of marital fidelity.	- Develop advocacy material and key BCC messages in liaison with other efforts to reduce the spread of STIs and HIV and AIDS			Prevalence STIs and HIV and AIDS	NGOs USAID	
SO 2: Strengthen awareness among the population concerning the harmful effects of FGM.	SD1: Strengthen awareness of harmful effects of FGM among community and religious leaders.	- Liaison with local political leaders, religious leaders (sheiks), men's, women's and youth networks to voice their support for the elimination of FGM - Liaison with professional bodies, e.g. nurse, midwives and doctor's associations to enlist their support for the elimination of FGM - Develop BCC and IEC material addressing different community groups for different media channels (radio, posters, mosque etc)	- Expand activities geographically	Increased community support for the elimination of FGM	Policy review and legislation regarding FGM	UNFPA MOHL	Core funds
	SD2: Strengthen awareness of harmful effects of FGM among women and men at community level.	- Conduct context-appropriate media campaigns to raise public debate and awareness of FGM - Develop BCC and IEC material addressing different community groups through different media channels (radio, posters, mosque etc).	- Innovative approaches such as the involvement of well-known cultural personalities for the manufacturing of cultural products such as songs, poems, videos and plays where the health effects of FGM is highlighted, to be broadcasted and promoted using radio and television and through learning institutions				UNFPA

SO 3: Reduce early teenage marriage and pregnancies.	SD1: Strengthen awareness of health benefits/hazards related to adolescent marriage/pregnancy targeting decision makers (men, fathers, women).	<ul style="list-style-type: none"> <li>- Conduct context-appropriate media campaigns to raise public debate and awareness of beneficial effects of delaying first childbirth</li> <li>- Develop BCC and IEC material addressing different community groups through different media channels (radio, posters, mosque etc).</li> <li>- Liaison with youth networks and groups to raise awareness of health benefits/hazards related to adolescent pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>- Innovative approaches such as the involvement of well-known cultural personalities for the manufacturing of cultural products such as songs, poems, videos and plays where the health hazards of teenage pregnancy is highlighted, to be broadcasted and promoted using radio, television, learning institutions.</li> </ul>	Improved adolescent RH Reduced unsafe abortion among adolescents	Adolescent fertility rate (women 15-19 years) Policy review regarding law prohibiting marriage before the age of 18	UNFPA MOHL	Core funds
	SD2: Strengthen awareness of health benefits/hazards related to adolescent marriage/pregnancy targeting adolescents.	<ul style="list-style-type: none"> <li>- Liaison with youth networks and groups to raise awareness of health benefits/hazards related to adolescent pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>- Develop concept and action plan</li> </ul>	Improved adolescent RH Reduced unsafe abortion among adolescents	Adolescent fertility rate (women 15-19 years) Policy review education	UNFPA PSI	Core funds
	SD3: Increase adolescents' access to contraception.	<ul style="list-style-type: none"> <li>- Explore cultural acceptability</li> <li>- Pilot options (social marketing through pharmacies/youth RH clinics/ health centres)</li> <li>- Explore cultural acceptability</li> <li>- Pilot options</li> </ul>	<ul style="list-style-type: none"> <li>- Develop culturally sensitive teaching material</li> <li>- Liaison with Ministry of Education and MOHL</li> </ul>				
	SD4: RH education in schools and learning institutions.						UNFPA UNICEF MOHL

# 7

# IMPLEMENTATION STRATEGIES AND MECHANISMS: STRENGTHENING HEALTH SYSTEMS TO HELP WOMEN AND CHILDREN

Basic health service capacity will have to be substantially strengthened to enable provision of a comprehensive range of RH services. The Essential Package of Health Services (UNICEF 2008) defines the reproductive health services that should be available at each level of care and the staff and competencies required to provide these services. These include the strengthening of crucial human, financial, logistic and governance resources.

## 7.1 Human resource development for RH

Education of professionals in reproductive health has been virtually non-existent for many years, due to conflict and disintegration of public services. Most training that has occurred has only been focused either on the production of nurses and/or medical doctors and the majority have not entered the public sphere. There has also been some ad hoc on-the-job training by service providers to enhance programme performance at the local level.

Present staffing patterns reveal too few professionals at each level, an aging cohort of professional staff and too few cadres of staff and with little or no systematic update of skills. The present market forces that govern education of health staff will not produce adequate human resources required to fill the reproductive health gaps. Both pre-service and in-service training are

necessary, but more effort is also required to ensure deployment and retention of skilled staff in the right place in the public system.

A core strategy will be dramatic up-scaling of midwifery training in all three zones, both for post-basic midwifery to produce qualified midwives (QMW) and for lower-level training to produce community midwives (CMW). Plans for deployment to rural and underserved areas linked to two-year fixed postings and salary, as well as career ladders and future opportunities in the public system, will be established. New doctors and clinical officers must be recruited and equipped with skills to provide EmOC. The development of the role of community health workers (CHW) is essential for community mobilization, support and promotion of reproductive health services.

### Urban/rural approach

A differentiated approach is taken with non-professional staff (TBAs). In areas with easy access to skilled birth attendants, there is no role or support foreseen for TBAs. In rural and underserved areas TBAs will continue to be relied upon, but their role should be transformed to one of promotion of MNH services at community level and prompt referral to skilled care during childbirth. A long-term strategy will be to replace all non-professional health workers with professionals (community midwives will gradually be able to replace TBAs in delivery care). Eligible TBAs should be

accorded opportunities to retrain and upgrade as other professional cadres (including community midwives) to attain other means of livelihood.

### 7.1.1 Specific objectives for HR for RH

Overall objective: Assuring adequate numbers and quality of human resources for RH.

Six specific objectives with relevant strategic directions have been identified:

**Specific objective 1:** *Increase numbers of qualified midwives (QMW) available for public sector in all three zones.*

Strategic directions:

**SD1:** Establish continuous post-basic midwifery courses in all three zones.

**SD2:** Retain midwives in the public system.

**Specific objective 2:** *Increase number of community midwives (CMW) available for rural and underserved areas in all three zones.*

Strategic directions:

**SD1:** Establish continuous community midwifery training courses in all three zones.

**SD2:** Deploy and retain CMWs in rural and underserved areas.

**Specific objective 3:** *Increase number of professionals able to provide comprehensive obstetric surgery, including CS.*

Strategic directions:

**SD1:** Recruit new MDs for in-service EmOC training in referral hospitals.

**SD2:** Senior staff available as ToT in EmOC.

**SD3:** Introduce short diploma courses for qualified staff in EmOC/CS.

**Specific objective 4:** *Deploy skilled and competent cadres of staff in EmOC teams to produce real RH outcomes with respect to BEmOC and CEmOC in prioritised facilities according to specific criteria.*

Strategic directions:

**SD1:** Identify and select BEmOC/CEmOC sites according to agreed criteria.

**SD2:** Determine composition of the EmOC team and assign roles and responsibilities to each team member with respect to BEmOC/CEmOC.

**SD3:** Deploy, equip, and manage EmOC teams (supervise, monitor and evaluate by region).

**Specific objective 5:** *Increase and improve in-service continuing education and updates on RH topics.*

Strategic directions:

**SD1:** In-service training in prioritized list of topics for all EmOC centres based on identified gaps.

**Specific objective 6:** *Increase HR (CHW/TBA) for community mobilization and promotion of RH services.*

Strategic directions:

**SD1:** Scale up training of CHW.

**SD2:** Transform/review the role of TBA.

**Specific objective 7:** *Create regulatory frameworks for certification of staff.*

Strategic directions:

**SD1:** Certifying legal body for HR established in all three zones.

*Prioritized activities and actions following in the short- (Phase I) and medium-term (Phase II) are outlined in the action plan below.*



SO 4: Deploy skilled and competent cadres of staff in EmOC teams to produce real RH outcomes with respect to BEmOC and CEEmOC in prioritised facilities according to specific criteria.	SD1: Identify and select BEmOC/CEEmOC sites according to agreed criteria.  SD2: Determine composition of the EmOC team and assign roles and responsibilities to each team member with respect to BEmOC/CEEmOC.	<ul style="list-style-type: none"> <li>- With relevant stakeholders, and according to population density, distances and availability of staff, choose sites ( 1 CEEmOC + 4-5 attached BEmOC within referral distance) per urban area ( 2-3 units/zone = 12 – 18 facilities)</li> <li>- According to EPHS organograms, compose standardized teams for CEEmOC and BEmOC centres including managerial and supervisory functions with the appropriate skill mix and support functions</li> <li>- Roles and responsibilities established</li> <li>- Job descriptions established</li> </ul>	Scale up 4-5 regional units/zone	Sites selected	UN-indicator 1: Coverage BEmOC min. 2/ 500 000	MOHL/ UNFPA UNICEF WHO	
	SD3: Deploy, equip, and manage EmOC teams ( supervise, monitor and evaluate) by region	<ul style="list-style-type: none"> <li>- Deployment mechanisms</li> <li>- Salary and performance-based incentive structure established</li> <li>- Supervisory mechanisms and tool kits in place</li> <li>- Management structure and tool kits established for performance based evaluation</li> <li>- Output targets defined</li> </ul>	Scale up to 4-5 regional units/zone Evaluate performance-based incentives and revise	Organograms filled	10% yearly increase in emergency CS (CEEmOC) 15% yearly increase in facility-based deliveries (BEmOC)		
SO 5: Improve in-service continuing education and updates in RH topics.	SD1: In-service training in prioritized list of topics for all EmOC centres based on gaps	<ul style="list-style-type: none"> <li>- Training of Trainers ( 2-4 per zone)</li> <li>- Assess knowledge gaps for different cadres of professional staff for RH (RN/MW, MD, auxiliary MW) making prioritized list of important topics</li> <li>- Yearly regional plan of topics, ensuring no duplication and coverage of all facilities</li> </ul>	- Expand geographical coverage of facilities - Revise yearly plans	> 50% of		NGOs	

SO 5: Improve HR(CHW/TBA) for community mobilization around RH services.	SD1: Scale up training of CHW  SD2: Transform/ review the role of TBA.	<ul style="list-style-type: none"> <li>- Recruit trainers</li> <li>- Establish curriculum and responsibilities</li> <li>- Establish operational research conditions to evaluate effect in intervention areas</li> <li>- Areas with easy access to skilled care: No support for role in delivery care</li> <li>- Areas without easy access to skilled care: maintain contact with nearest facility (HC) for a role in providing incentives for prompt referral for delivery and community based promotion of MNH services</li> <li>- Formal training of TBAs phased out</li> <li>- Recruit eligible young literate TBAs into CHW/CMW training programme</li> </ul>	<ul style="list-style-type: none"> <li>- Expand geographical coverage</li> <li>- Eligible TBAs recruited into cadre of community midwives or CHW with emphasis on community-based promotion of MNH services</li> </ul>		WHO UNICEF NGOs	GAVI/HSS
SO 6: Create regulatory frameworks for certification of staff.	SD1: Certifying legal body for HR established in all three zones.	<ul style="list-style-type: none"> <li>- Engage professional associations, leading clinicians and MOHL to form certifying bodies for HR for RH in each zone after the model of Hargeisa</li> <li>- Develop lists of skills/competencies/ limitations for each cadre</li> <li>- ID-cards</li> </ul>	<ul style="list-style-type: none"> <li>- Develop ethical code of conduct for health staff</li> </ul>		MOHL/ WHO	

## 7.2 Financing services

Somalia suffers from low levels of public financing for welfare sectors, as well as an under-regulated but vibrant private sector. Low levels of organisation, public funds and inequity of distribution of private funds mean that options for financing of health services are limited. Sustainability of external contributions is also highly questionable in the Somali context, where future financing will remain heavily dependant on donor funding. In order to ensure availability of funds and avoid duplication of efforts by donors and development partners, external financing should be organised to promote synergies and reduce overlaps in accordance with MOH priorities and funding agency mandates (see Annex IV).

Direct payment of services by users (out-of-pocket/user fees) more or less cushioned by input-based support (incentives, drugs and equipment) from donors, is the existing model in private and public facilities today, as governmental support to health care is limited due to financial constraints. To ensure a common strategic direction the question is how to best protect people from financial risk and disastrous expenditures, as well as to secure performance and optimal spending of scarce resources. So far, attempts such as financial exemption schemes for maternity services have proved costly, inefficient and with low accountability.

In general, options for future financing mechanisms can take advantage of the current underutilization of health staff and health facilities by making ensuring that some support is performance-based. This can take the form of donor purchasing of output services (from private or public facilities), enabling the facility to increase outputs and lower marginal costs and potentially improve quality. A voucher scheme could be a simple option that does not demand high organizational capacity but would need continuous monitoring and evaluation (as in

all performance-based schemes), especially in the initial phase.

Preventive services (MNH services, birth spacing services) must be affordable and preferably free at point of delivery as user fees have been shown to be a major deterrent for use, especially for vulnerable populations. The same goes for facility-based delivery of services and referral for emergency obstetric services, as even the expectation of costs will deter users. Presently the user-fees are too high in many facilities.

### 7.2.1 Specific objectives to finances for RH

Overall objective: To ensure adequate and (to the degree possible) sustainable funds are available and allocated for accessible, affordable, efficient and equitable RH health care provision and consumption.

#### Strategic directions:

**SD1:** Increase donor support for reproductive health:

A strategic framework is expected to increase interest in the field of reproductive health. Donor alignment with the strategy will be expected. Interventions will have to be costed after endorsement, and realistic plans for services developed.

**SD2:** Explore community-based financing mechanisms

**SD3:** Ensure affordable essential services.

**SD4:** Increase performance output and lower marginal costs.

*Prioritized activities and actions following in the short- (Phase I) and medium-term (Phase II) are outlined in the action plan:*

<b>7.2.2 ACTION PLAN: FINANCING RH SERVICES</b>							
<b>Overall Objective: To ensure adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable RH health care provision and consumption</b>							
<b>Specific objective</b>	<b>Strategic directions (SD)</b>	<b>Primary actions and activities</b>		<b>Expected output</b>	<b>Indicator</b>	<b>Agency</b>	<b>Budget</b>
		<b>PHASE I</b>	<b>PHASE II</b>				
SO 1: To ensure adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable RH health care provision and consumption.	SD1: Increase donor support for reproductive health.	- Strategic framework for Reproductive Health and action plan endorsed by governments and stakeholders	- Regular donor meetings	Increased funds available for RH	Dedicated budget allocation for RH	CISS	
		- Annual donor meetings in Nairobi					
	SD2: Explore community-based financing mechanisms.	- Advocate use of humanitarian funds for RH	- Pilot revolving emergency fuel funds for transport to BEmOC facility by private sector	- Increased timely access to EmOC			NGO
		- Collect information on small-scale initiatives that have been effective in the Somali context	- Scale up effective interventions where organizational capacity				
SD3: Ensure affordable essential services.	- Encourage diversification of resource base for health facilities and advocate for more resources from communities, regional/ municipal authorities, MOH and private/diaspora contributions	- All MNH-services free	- Increasing access to services	- Utilization rates of services	MOHL NGO		
	- Free preventive services	- Free delivery in a health facility and free EmOC					
SD4: Increase performance output and lower marginal costs.	- Piloting of simple performance based initiatives, such as vouchers for referral	- Scale up successful interventions	- higher health facility output	- activity indicators	NGO		

## 7.3 Medical equipment and supplies

For logistic and access reasons, the delivery of RH commodities for the stated period will be based on kits.

There is a potential for better alignment between agencies involved in reproductive health who deliver kits to health facilities, both in content and supply and distribution chain to assure continuous and constant availability.

**Overall objective:** Improved alignment of existing logistical systems for sustained provision of essential reproductive health commodities

### Strategic directions:

**SD1:** Collaborative effort between UNFPA, UNICEF, WHO and NGOs to update and improve kits as to content, ordering, distribution and monitoring.

## 7.4 Information and operational research

Improving data collection and analysis are an essential basis for selecting among competing approaches and priorities for action, and to identify interventions appropriate to the limits of available resources. Given the acute constraints in resources and actions in the Somali context there is an even greater need for well-founded decision making. Operational research and appropriate information systems need to be aligned and put in place as an integrated part of all activities.

**Overall objective:** Improving evidence for setting priorities

### Strategic directions:

**SD1:** Strengthen HMIS-system for collecting and analyzing core RH indicators at district, regional and national level.

**SD2:** Ensure operational research agenda.

**SD3:** Ensure indicators for monitoring and evaluation and operational research in place.

**SD4:** Improve use of routine information to inform planning and set priorities.

Suggested operational research agenda:

- Pilot maternity waiting shelters in 50% of upgraded CEmOC centres to determine feasibility, sustainability and effectiveness.
- Pilot communication strategies as well as user incentives for utilization of services (kanga, baby kit).
- Pilot distribution of Misoprostol for primary prevention of PPH for home deliveries by CHW / TBAs in areas where skilled attendance is not available.
- Pilot voucher systems and performance-based financing.

## 7.5 Governance, advocacy and accountability

The people and governments of the three zones of Somalia must develop an agenda for action and begin to drive it forward. It will take time and commitment and therefore can only be achieved on the ground, with clear and long-lasting leadership.

Policy direction and leadership of coordination frameworks in reproductive health are the ultimate responsibility of the political leadership of the country. A Reproductive Health Unit can be localized in the organograms of the governments of Somalia and Somaliland. In this connection the Ministry of Health should establish a clear national programme for reproductive health and promote the creation and functioning of the following structures:

1. A Directorate for Reproductive Health – With a full time director based in the MoH.
2. Inter-ministerial collaboration - It is universally recognised that full attainment of the goals of reducing maternal and neonatal deaths can only be achieved through a collaborative effort between the MoH and other stakeholders, particularly other line ministries. It is in line with this thinking that it is necessary to establish an Inter-ministerial Committee on the implementation of the MRNH Strategy for Somalia, to provide strategic guidance to ensure efficient and effective implementation of the MRNH Strategy by all appropriate Ministries. The specific Terms of Reference for this committee will be elaborated and should include defining the roles and responsibilities for each of the participating ministries.
3. Advocating with key cultural and religious institutions - A major factor in the success of any reproductive health strategy is co-operation between government programme implementers and the community, especially the religious leaders. Religious leaders should be engaged in wider discussions and decision-making processes relating to implementation of the MRNH Strategy from the onset, which will ensure their input and support. They should be educated on the components of RH and involved in BCC/IEC activities especially as they relate to birth spacing, and maternal and neonatal mortality reduction in their community. They should be encouraged to include MRNH messages and information during their prayer meetings and will be encouraged to form an action group, namely the Islamic Action Group (ISLAG) to coordinate their activities in support of MRNH.
4. International technical coordination - In the absence of a central government in Somalia, the international donor community (including stakeholders in the health sector in Somalia) developed a mechanism to guide and coordinate external assistance to the country. This interim arrangement, known as the Coordination of International Support for Somalia (CISS), set up five sectoral coordination platforms (one of which is for health) with a series of working groups under each platform. The Health Sector Committee was established to develop a joint common vision and provide guidelines to increase efficiency and effectiveness of investments in the health sector in Somalia. As part of this technical coordination, specific attention should be paid to RH. Terms of reference for a RH working Group have been defined, but the WG is yet to become fully operational. The WG needs to become operational under strong leadership from UNFPA and with strong coordination and information exchange with local working groups in the zones of Somalia.
5. Advocating with the international community for attention to RH - A very big challenge is to achieve the priority status that RH deserves. At the moment, maternal health is an ignored area in Somalia despite the alarming situation as evidenced by the poor statistics, making Somalia one of the countries with the highest maternal mortality ratios in the world. The government should identify important allies such as DFID, SIDA, UNAIDS, UNICEF, UNFPA and WHO, to lobby within the international donor community to accept that maternal mortality is a national crisis in Somalia and to declare maternal mortality reduction as a top priority to be included within any humanitarian assistance programme for Somalia. The Ministry of Health should develop advocacy materials and use these to lobby for high national priority to be accorded to reduction of maternal mortality in Somalia. This should include a high profile launching of the “Campaign to reduce maternal mortality”

and subsequent implementation of the campaign throughout the country.

**Overall objective:** Ensure the RH agenda is well understood and supported among key platforms (political, religious, economic) and is well represented in national planning and strategy development processes.

#### **Strategic Directions:**

**SD1:** RH officers at central and regional MoHs (with technical support from partners) to establish and lead a reproductive health programme and task force or working group that brings along all implementing partners, professionals, donors and other stakeholders at different levels.

**SD2:** Inter-ministerial collaboration with regular contact between relevant ministries such as Ministries of Health, Finance, Planning, Education and Law.

**SD3:** CISS at Nairobi level to accommodate and energize a Reproductive Health working group.

## 7.6 Monitoring and evaluation

The national HMIS system should be the backbone for monitoring performance in the area of reproductive health. HMIS tools will include necessary indicators to provide appropriate information to plan, monitor, supervise and review national RH components. Selecting standardized core RH indicators that withstand operationalization in a Somali context must be a priority. To establish and operationalize M&E for RH, the final indicators must be harmonized within M&E

national indicators (see suggested indicators under each axis as well as overall indicators and targets for the five-year period).

Health workers must be trained in M&E for RH; this can be aligned with general training for national health indicators.

Monitoring of maternal/neonatal/perinatal mortality and fertility can only happen by regular MICS or DHS and must be aligned with the chosen core RH-indicators.

Overall objective: Ensure monitoring and evaluation of competing strategies to be able to evaluate differential impact of operations.

#### **Strategic directions:**

**SD1:** Establish and operationalize monitoring and evaluation for RH.

#### **Midterm review**

Because circumstances regarding access and security can and do change substantially in Somalia, there will be a need to revise and update strategy targets by midterm (end of 2012), possibly with an external consultant and a consultative workshop.

#### **End term evaluation**

By the end of the period, in 2015, a full evaluation is due and will coincide with the final year of the Millennium Development Goals.

*Prioritized activities and actions following in the short- (Phase I) and the medium-term (Phase II) are outlined in the action plan below.*

**7.3-7.6 ACTION PLAN: Medical equipment & supplies/Information & operations research/Governance, advocacy & accountability/M&E**

Overall objective	Strategic directions (SD)	Primary actions and activities		Expected output	Indicator	Agency	Budget	
		PHASE I	PHASE II					
<b>MEDICAL SUPPLIES</b>								
SO1: Improved alignment of existing systems for sustained provision of essential RH commodities.	SD1: Standardize kit contents	- Revise kit content at hospital, MCH and HP –level (UNICEF/UNFPA-kits)	- Evaluation	- Un-interrupted supply of essential drugs and equipment	Frequency of stock-outs	UNICEF UNFPA WHO		
	SD2: Synchronize logistics	- One logistic chain for storing, distribution and transport of RH commodities for all UN-agencies	- Evaluation					
	SD3: Train staff in safety and storage of RH commodities	- Total of 1-2 logistic managers from each agency (courses arranged by UNFPA) - Coordinated interagency training course for all relevant staff	- Evaluation	- Quality management of supplies	- Frequency of expiring drugs/equipment			
<b>INFORMATION AND OPERATIONAL RESEARCH</b>								
SO1: Improve evidence for setting priorities.	SD1: Strengthen HMIS-system for collecting and analyzing core RH indicators at district, regional and national level	- Interagency standardization of HMIS-tools	- Initiate data collection from private health facilities			MOH UNICEF UNFPA WHO NGOs		
		- Training of all facility staff in HMIS						
	SD2: Ensuring operational research agenda	- Pilot maternity waiting shelters in 50% of upgraded CEmOC centres	- Pilot communication strategies	- Evaluate sustainability and cost-effectiveness	- Defined quantitative and qualitative RH indicators			
		- Pilot community-based initiatives (distribution of misoprostol)	- Pilot user-incentives, performance-based financing and vouchers					
SD3: Ensure indicators for M&E and operational research in place	- Align and harmonize RH indicators in HMIS and strategy	- Effective M&E						
SD4: Improve use of routine information for informing planning and setting priorities	- Ensure user-friendly timely provision of data to decision-makers							

### 7.3-7. 6 ACTION PLAN cont:

Overall objective	Strategic directions (SD)	Primary actions and activities		Expected output	Indicator	Agency	Budget
		PHASE I	PHASE II				
<b>GOVERNANCE, ADVOCACY AND ACCOUNTABILITY</b>							
SO1: Ensure RH agenda well understood and supported among key platforms and well represented in national planning and strategy development processes.	SD1: RH officers at central and regional MoH to establish and lead a RH programme and taskforce/working group.	- Create a directorate for RH with a full-time director based in MOH		- Strategic guidance to ensure effective RH programme implementation	- RH among top priorities in health	MOH UNFPA WHO UNICEF	
	SD2: Establish inter-ministerial collaboration with regular contact between relevant ministries.	- Establish ToR for committee - Central RH officer/Director to establish contact point within relevant Ministries such as Education/ Gender/Family Health/Youth/ Law/Planning/Finance	- Include additional ministries as relevant	- Strategic guidance to ensure effective implementation of strategy	- Quarterly meetings taking place	MOH	
	SD3: CISS to accommodate and energize a RH working group at Nairobi level.	- Establish and chair group - Endorsement of ToR for working group	- Strong coordination and information exchange with local working groups in the zones of Somalia	- Shared RH strategy - Effective fund-mobilization	- Monthly meetings taking place	UNFPA WHO	
	SD4: Advocacy within the national and international community for attention to RH.	- Develop advocacy materials for lobbying for high national priority to RH - Advocacy towards cultural and religious leaders, including education on RH-topics, for the promotion of RH messages in religious and cultural institutions	- High profile national/international campaign to reduce maternal mortality in Somalia to be launched	- RH a top priority in national and international agenda	-Implementation of campaign	MOHL Donor community UN-agencies	
<b>MONITORING AND EVALUATION</b>							
SO1: Establish and operationalize monitoring and evaluation for RH.	SD1: Ensure M&E of competing strategies to be able to evaluate differential impact of operations.	- Interagency standardization of HMIS tools - Estimate catchment population for facilities (figures from polio, HABITAT, UNDP/FSAU, water-registration survey)	Midterm review and end-term evaluation of RH-strategic indicators	Effective M&E for decision-makers	Midterm review + end-term evaluation conducted	MOHL UN-agencies	

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3. Managing Newborn Problems (WHO 2003)
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7. "Southern Sudan Maternal, Neonatal and Reproductive Health Strategy. Action Plan 2008 – 2011 " Government of Southern Sudan Ministry of Health , 2008.
8. "The National Sexual and Reproductive Health Logical Framework, 2001-2006" Ministry of Health and Population, Malawi
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# ESSENTIAL MATERNAL AND NEONATAL HEALTH (MNH) SERVICES

*(based on the Essential Package of Health Services, UNICEF revised version 2009)*

## **Focused Antenatal Care (WHO)**

Four visits with:

- identification of pre-existing health conditions
- early detection of complications arising during pregnancy
- health promotion and disease prevention
- birth preparedness
- complication readiness planning

## **Neonatal and Postnatal Care (WHO Essential Newborn Care 1996)**

Clean delivery and clean cord care

Thermal protection

Initiation of breathing; resuscitation

Early and exclusive breastfeeding

Prevention and management of ophthalmia neonatorum

Immunization - BCG, oral polio, HepB

Management of newborn illness

Care of the preterm and/or low birth weight newborn

## **Postpartum care**

Identification of postpartum disorders

Health promotion and disease prevention

Postpartum contraceptive counselling

## **Skilled birth attendance**

### **Post-abortion care**

Medical treatment of complications of abortion

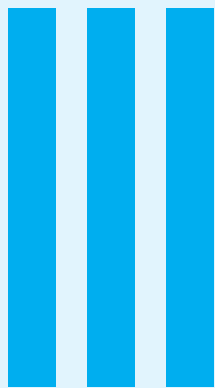
Post-abortion contraceptive counselling

## **Comprehensive birth spacing and limiting services**

## **STI screening and syndromic management**

## **Medical treatment for victims of SBGV**

## **Medical treatment and referral of common gynaecological problems**



## ***ORGANISING DONOR INVESTMENT IN REPRODUCTIVE HEALTH***

<b>RH SERVICE AREA</b>	<b>KEY ACTIVITY</b>	<b>NAME OF DONOR/ AGENCY</b>	<b>COMMENTS</b>
Upgrade health facilities and provide basic equipment, supplies and drugs to be able to provide BEmOC services.	Renovation of RH infrastructure (Maternity units)		
	Provide equipment, supplies and drugs to selected Health Centres for BEmOC services		
Increase utilization and quality of CEmOC services.	Provide equipment, supplies and drugs to RHC and hospitals to ensure provision CEmOC services		
	Provide RHC and hospitals with functional blood transfusion services for maternity cases		
Increase and improve training of Maternal and Neonatal Health staff.	Human resource training		
	Provide institutions with teaching and learning materials to provide competency based training, with priority focus on BEmOC		
Family Planning/Birth spacing.	Ensure availability of contraceptive commodities		

It is possible for several partners to support the same area, as long as all areas are adequately covered.

# Annex IV

## SUMMARY OF NATIONAL INDICATORS AND TARGETS 2010-2015

To achieve the objectives defined in the strategy paper, significant investments need to be made in the provision of Maternal and Neonatal Health services. To modify the objectives to the time frame of 2010-2015, the aims are:

	Baseline	Midterm target end 2012	End term target 2015 (MDG)
Maternal mortality ratio (MMR)	1,400/100,000 live births *	1200	900
Perinatal mortality rate (PMR)	81/1,000 live births ***	73/1000	66/1000
Percentage women with skilled attendant at birth <sup>1</sup>	10% *	15%	25%
Percentage women who deliver in a health facility	9.4% *	13%	18%
Percentage women with obstetric complication treated at EmOC facility	15% **	20%	30%
Caesarean sections as proportion of all births	0.5% **	2.0%	5.0%
Case fatality rate (direct obstetr. Compl.)	20-44% **	17%	12%
Percentage pregnant women receiving at least 1 ANC visit	26% *	30%	35%
Percentage pregnant women attending at least 4 ANC visits	6% *	8%	12%
Percentage women receiving TT2+	26% *	30%	35%
Exclusive breastfeeding rate (0-5 months)	9% *	12%	18%
Contraceptive prevalence rate (Modern methods)	1% *	3%	5%
Percentage service delivery points prepared (with stocks and trained providers) to provide at least 3 modern methods of birth spacing	No baseline	Tracking progress	
Adolescent fertility rate (15-19 years)	123/1,000 women	111	100

\* MICS 2006

\*\* EMOC Assessment UNICEF/UNFPA 2006

\*\*\* WHO 2007

## ***PRIORITY AREAS FOR ACTION – CONCLUSIONS FROM CONSULTATIONS***

Three major workshops and a number of individual consultations were held to inform this strategy and the main conclusions and suggestions are summarized below. A number of Somali medical and health staff in public, private and governmental service have contributed to and defined these main areas for action in order to ensure appreciable progress.

### **1. Essential and Emergency Obstetric Care**

- Skilled attendance at birth is the ultimate goal.
- Dramatically increase the number of midwives by scaling up post-basic midwifery and community midwifery pre-service training in all three zones, linked to mechanisms for deployment, motivation and retention.
- Intermediate-term measures to assure skilled attendance at home births by scaling up training of community midwives to take over the role of TBAs.
- Classic TBA training in safe delivery to be phased out. Due to the gap in skilled care at delivery to be expected during the intermediate period, strategies to bridge gaps whilst waiting for output of human resources must remain. In areas where no skilled care is available, the role of TBAs can be transformed to one of antepartum referral to facility-based care, a role in newborn care and possibly a role in piloting of community-based distribution of new RH technologies (such as misoprostol for primary prevention of postpartum haemorrhage).
- Increase number of professionals eligible to perform obstetric surgery by establishing six-month in-service diploma training in Emergency Obstetric Care for newly-graduating doctors and clinical officers.
- Comprehensive refresher EmOC in-service standardized trainings for all doctors and midwives.
- Avoid third delay by ensuring 24/7 crucial staff (OT-nurse, midwife, MD) presence in CEmOC centres as well as appropriate communication tools to warn of incoming patient/s.
- Improve blood safety and timely availability of blood at CEmOC centres.
- Increase access to EmOC by upgrading existing MCHs to health centres that can provide Basic Emergency Obstetric Care 24/7 within referral distance of a facility offering CEmOC services and with appropriate referral mechanisms.
- Initiate Maternity waiting shelters at CEmOC centres to improve access for rural and nomadic population to Emergency Obstetric Care.
- Ensure affordable services by free referral vouchers for major obstetric interventions and facility-based births.

- Explore innovative practices, such as providing incentives for prompt referral and recruitment into other cadres, such as CHW.
- Increase family and community acceptance of Caesarean section and other major obstetric interventions before needs arise by promotion by CHW, use of mass media and regional health boards.
- Promote behaviour change and increase demand for services among the population.

## **2. Antenatal and Neonatal Care**

- Address underutilized health staff for the public sector by paying realistic salaries according to accepted scales, to be able to expand opening hours at health centres and improve performance.
- Explore performance-based financing and incentives.
- Improve uninterrupted supply chain of RH commodities by revised kits and shared logistics between partners (UNFPA/UNICEF).
- Upscale in-service training capacity, with a focus on major gaps.
- Adapted and updated protocols and guidelines in place.
- Improve quality and comprehensiveness of antenatal and neonatal care by addressing missed opportunities.
- Explore innovative practices, such as providing incentives for prompt referral and new roles for unskilled staff, among them TBAs, such as a role in newborn care and recruitment into other cadres such as the CHW.
- Integrate prevention of STI and HIV-AIDS at the health centre level.
- Ensure increased community demand for services by upgrading the role of the community health worker to that of a trained, paid health worker and as an extended arm of the health centre.
- Promote behaviour change and increase demand for services among the population.

## **3. Birth spacing and limiting**

- Universal affordable access to a reasonable choice of contraceptive methods at each level of health facilities.
- Emphasis on preferred and culturally accepted methods.
- High acceptability of lactational amenorrhea as a method for the first 4-6 months after birth.
- Addressing training needs of health staff.
- Introducing national guidelines as well as protocols for facilities.
- Early involvement of men and key community actors, including religious leaders, for programmatic sanction.
- Expanding demand by extensive behaviour change communication through community health workers and health facilities, emphasizing the positive health benefits of birth spacing.

#### **4. Obstetric fistula, post-abortion care, sexual and gender-based violence including FGM**

- Prevention prioritised by increased access to quality Emergency Obstetric Care services.
- Antepartum referral to waiting shelter for primiparas in rural and nomadic areas.
- Adequate family planning program to delay first birth beyond early adolescence.
- Increased access to and quality of health services and commodities, for comprehensive management of post-abortion care, fistula, sexual and gender-based violence including complications of FGM.
- Increase awareness of the harmful effects of FGM among decision-makers in the community.
- Integrate RH lessons in school or education curricula.

#### **5. Human resources, finances and governance**

- Major investment in human resources management crucial to make facilities perform; such as ensuring professional staff, a living wage, job descriptions, enforced management structures and supportive firm supervision.
- Scaling up graduation of quality post-basic midwives and community midwives in all three zones.
- Recruit newly qualified doctors and clinical officers for in-service diploma on emergency obstetric care training of six months.
- Capacity building for training institutes.
- Ensure more equitable coverage of rural and underserved areas, by recruitment from such areas linked to deployment and commitment to placement for a defined time period, with adequate reimbursement and career opportunities.
- Needs identified for post-basic training course for matrons/in-charge maternity to improve management, supervision and quality of facility-based services.
- Promotion of behaviour change for health staff to promote better attitudes towards clients/users.
- Innovative and sustainable financing mechanisms necessary.
- Explore performance-based financing to increase output and efficiency of existing facilities and health staff.
- Establish reproductive health national policies and develop strategies for each zone.
- Establish clear guidelines and protocols adapted to the Somali context.
- Establish governance structures and consortia to ensure national programme ownership.
- Improved interagency collaboration, coordination and convergence of RH services at all levels.







Reproductive health (RH) is fundamental to individuals, families and the social and economic development of communities and nations. Somalia is marked by decades of poverty, under-investment, conflict, insecurity, displacements and natural disasters. Reproductive health suffers considerably in such an environment, as more than in any other field of health, progress depends on a comprehensive functioning health system.

Somalia has one of the highest maternal mortality ratios in the world (1,400/100,000 live births). When needs are high and ubiquitous, and resources and access to the population limited, a decisive and focussed strategy to address maternal and neonatal survival becomes crucial.

In response to requests from Health Authorities in Somalia to assist them with defining a way forward on maternal, reproductive and neonatal health, the UN agencies (UNFPA, WHO and UNICEF), have collaborated to try to: define the current situation; draft suggested policies to guide collective action and finally to develop a strategic plan of action.

Prior to the development of a RH strategy, a situation analysis was undertaken based on a comprehensive review of all published and non-published literature available – and after extensive consultation with international and Somali partners. The analysis provided a comprehensive and disturbing picture of the status of maternal and reproductive health services in Somalia – and the resultant humiliation, suffering and death faced by women on a daily basis.

Chapter 1 provides an overview of the country and the reproductive health situation. The goals and objectives are explained in Chapter 2. The situation analysis led to a process of working with health authorities to formulate an explicit national RH policy and strategy which is set out in Chapter 3 and further detailed in Chapters 4 to 6. The RH strategy has been used to develop an Action Plan for the immediate future (2010 – 2015) and presented in Chapter 7.

The national RH strategy and Action Plan 2010-2015 presented in this document is intended for a broad audience of governmental actors, professional associations, training institutions, non-governmental organizations, donors and other stakeholders within reproductive health.



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