

MATERNAL AND NEWBORN HEALTH POLICY PRIORITIZATION IN DEMOCRATIC SOMALIA: ANALYSIS OF KEY STAKEHOLDER PERSPECTIVES AT FEDERAL LEVEL

POLICY BRIEF

BACKGROUND

Somalia has among the world's highest rates of maternal and neonatal mortality with the latest UN reports estimating 621 maternal deaths per 100,000 live births (2020)¹ and 35 newborn deaths per 1,000 live births (2022)². Complications during pregnancy and childbirth remain a leading cause of death and despite efforts to increase access to care, the Somali Health and Demographic Survey 2020 found only 32% of deliveries happen with a skilled birth attendant.³

After decades of conflict and instability, addressing the high burden of maternal and newborn mortality requires a greater understanding of the political and economic factors that influence maternal and newborn health (MNH) policies and financing. This brief outlines a recent political economy analysis (PEA) led by the Somali Research and Development Institute (SORDI) and the International Rescue Committee (IRC) – partners in the EQUAL research consortium – to examine MNH policy prioritization in democratic Somalia.

SUMMARY

- EQUAL conducted a political economy analysis guided by the Health Policy Triangle framework to understand how factors related to policy context, content, processes, and actors influence the prioritization of MNH in Somalia since the new constitution.
- MNH competes for limited political attention and resources. The emphasis on insurgency and complex emergencies has shifted health service delivery to humanitarian and development sectors. Political transitions disrupt project continuity, with MNH often overlooked in political discourse.
- The implementation of Somalia's robust MNH policy frameworks is impeded by resource shortages, infrastructure deficiencies, security concerns, limited political commitment, and insufficient governance structures. This has led to a reliance on international partners to fund and deliver MNH services.
- Somalia has a myriad of MNH actors including the public and private sectors, civil society, multilateral organizations, and Somali diaspora. Inadequate regulation and coordination impact implementation, equity, and quality of care.
- Gender dynamics impact women's participation in decision-making, hindering advocacy for under-addressed MNH issues. Religious and clan leaders yield societal influence over MNH service utilization and the prioritization of women's health issues at state and local levels.

STUDY OVERVIEW

This study examines the prioritization of MNH at Somalia's federal level since 2010, focusing on political, economic, and other factors that impact MNH programs, policies, and financing. In this research, MNH prioritization pertains to the attention paid and resources allocated to reduce preventable mortality and morbidity. It encompasses the issue framing, financing, evidence use, and considerations for equity and political interests.

Study Setting

The study specifically examined the prioritization of MNH in Somalia at the federal level based on where decisions are made and policies formulated.

Study Design

This was a descriptive case study⁴ conducted between July 2022 – February 2023. The Health Policy Triangle framework⁵ was applied to explore how factors related to actors, content, context, and processes influence MNH investment and program implementation. The study relied on evidence from a desk review looking at health policies and strategic plans, national development plan, grey literature, and available health related articles as well as UN reports. 20 key informant interviews were conducted with civil society, donors, UN agencies, private health sector representatives, and government officials. Data were analyzed using inductive approaches and arranged using the thematic categories of the Health Policy Triangle framework.

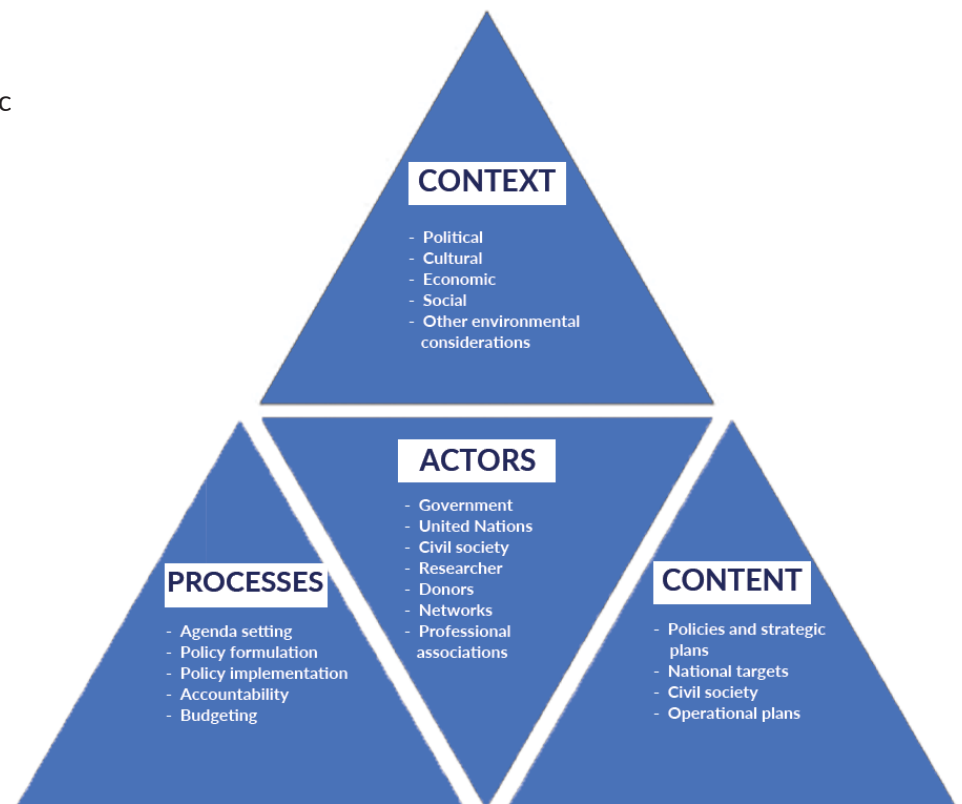
EQUAL CONSORTIUM OVERVIEW

Funder: UK International Development from the UK government

Length: July 2021 – April 2026

Locations: DRC, Nigeria, Somalia, and South Sudan

Partners: Institute of Human Virology Nigeria, International Rescue Committee, Johns Hopkins Center for Humanitarian Health, Somali Research and Development Institute, and Université Catholique de Bukavu.



RESULTS

The following represents the key findings from this study, organized according to the framework.

CONTEXT: Competing priorities detract focus from MNH

- MNH competes for political attention and resources within and outside of the health sector, leading to limited funding and support for MNH services. Resources are often redirected from MNH to respond to other public health emergencies like infectious disease outbreaks.
- Somalia's focus on fighting insurgency and addressing other complex emergencies has shifted health service delivery to humanitarian and development sectors, weakening public administration capacity, contributing to resource disparities, concentrating services in urban areas, and creating sustainability concerns.
- Elections and political transitions interrupt the introduction of new MNH projects and the functioning of current ones. Reproductive health/MNH issues do not feature prominently in the political discourse, which may translate into less resource allocation during budgeting.

CONTENT: MNH policies exist, but implementation remains inadequate

- Somalia has robust MNH policy frameworks and locally adapted guidelines, yet implementation is impeded by resource shortages, inadequate infrastructure, security concerns, and limited political commitment.
- International development and humanitarian actors drive the design and implementation of many MNH policies and strategies.
- There are inadequate policies and guidelines for delivering MNH services to vulnerable groups such as women with disabilities.
- Somalia's overall health budget remains insufficient to meet population needs and it is difficult to determine spending directed specifically to MNH
- Implementation of Somalia's Every Newborn Action Plan (SENAP) reveals bottlenecks in delivering newborn care interventions, including a lack of leadership and governance needed to effectively coordinate actors and implement MNH policies and strategies.

Actors: MNH actors are diverse and interdependent, yet hindered by poor coordination

- The private sector plays a crucial role delivering MNH services, yet there remains inadequate regulation and inclusion in decision-making processes.
- While gender mainstreaming has improved with more women in decision-making positions, societal gender dynamics still prevent women's voices from being heard at decision-making tables, potentially affecting advocacy for MNH issues, including those currently under-addressed.
- The Somali diaspora actively engages in various aspects of Somalia's healthcare sector, contributing through investments and expertise, yet despite their leadership positions in both public and private sectors, they are not adequately engaged and coordinated to help achieve health system goals.
- Religious and clan leaders wield significant societal and political influence in the uptake of MNH services and in the prioritization of women's health issues at the state and local levels.
- Somalia's MNH sector relies heavily on donor support for funding and non-state actors including international NGOs and the private sector for the delivery of essential MNH services.

PROCESS: A fragmented policy and funding community results in multi-faceted governance gaps

- Without the resources to fund MNH, the Somali federal government primarily oversees efforts through reporting systems to monitor spending, implementation, and health outcomes/needs.
- Parallel data and health information systems exist for donor-funded organizations and the private sector, leading to a fragmented approach in reporting, accountability, and coordination processes.
- Current MNH budgeting processes tend to be vertical, with partners mobilizing much of the RMNCH budget and the government approving its allocation.
- The heavy reliance on donors for health and MNH programs affects their sustainability. While Somalia joined the Global Financing Facility (GFF), there are challenges in identifying available resources to transform health financing, improving public sector capacity, reducing fragmentation, increasing funding, and enhancing accountability, with alignment to the Essential Package of Health Services (EHPS) implementation.

CONCLUSIONS AND RECOMMENDATIONS

This study focused on the perspectives of stakeholders in decision-making and implementation about factors involved in the prioritization of MNH. The study found that despite the existence of many MNH policies and strategies, implementation is hindered by numerous factors including inadequate political support, weak stakeholder coordination, inequitable resource distribution, and a lack of regulation for engaging the private sector and diaspora actors. Based on these findings, the following recommendations may be considered.

FOR POLICYMAKERS:

- 1 Enhance civil society and women's involvement and influence in high-level MNH decision-making processes by increasing representation and strengthening leadership capacities.
- 2 Develop specific guidance and health worker trainings to improve access to and quality of MNH care for women with disabilities.
- 3 Establish a clear accountability mechanism for setting and monitoring MNH targets, coordinating partners, and reducing parallel systems,.
- 4 Ensure diverse MNH actors, including the private sector, are actively engaged in ongoing policy dialogues and strategy development.

FOR DONORS:

- 1 Invest in strengthening government systems and capacities to manage MNH funds, programs, and accountability efforts in line with localization efforts.
- 2 Fund activities related to gender mainstreaming across government departments to increase engagement of women in decision-making across sectors including MNH.
- 3 Support the government's existing Public Private dialogue unit to advance understanding and collaboration between the public and private health sector actors. This includes strengthening coordination through regulations, consultation in policy making processes, health service planning, delivery, and reporting.

FOR CIVIL SOCIETY & RESEARCHERS

- 1 Conduct a gender analysis of the sector and the potential impact for MNH decision making.
- 2 Proactively engage religious and clan leaders in the design and implementation of MNH interventions and in the prioritization of women's issues at the state and local levels.

FOR RESEARCHERS:

- 1 Intensify efforts to use evidence to inform policy and practice. This requires intentional efforts among researchers and INGOs to consult diverse actors in designing and implementing studies that meet local needs/demands.
- 2 Leverage the Somali Medical Association's research working group to plan and execute health literacy workshops for government and other influential MNH actors to build the capacity to understand and use the evidence for action.

FOR ALL ACTORS:

- 1 Strengthen participation in the Reproductive Health Technical Working Group (TWG) as a platform for agenda setting, coordination, and accountability. This includes ensuring a consistent frequency of meetings and follow up on key actions.
- 2 Engage Ministry of Health TWGs to establish and pursue research agendas relevant to policy needs, ensuring validation of findings and the dissemination of actionable recommendations.

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- ⁵ Walt, Gill, and Lucy Gilson. "Reforming the health sector in developing countries: the central role of policy analysis." Health Policy and Planning 9.4 (1994): 353-370.

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