

RIYAADA THOUGHT LEADERSHIP SERIES

THE DISPARITY AMONG A NUMERAL AND A LIFE

Strategic Leadership in Health Research, Data Integrity, and the Required Evidence Architecture for Somalia

**EVIDENCE SOVEREIGNTY • DATA GOVERNANCE • KNOWLEDGE
TRANSLATION • INSTITUTIONAL LEADERSHIP**

By Dr. Abdulrazaq Yusuf Ahmed

MBCbB · MPH · MSc(HM) · PhD (Health Economics) · PhD (Demography & Social Sciences) · FRSPH · FRSTMH

Director General, Social Health Insurance Authority, Federal Ministry of Health and Human Services, Somalia

Associate Professor of Health Systems Management, Benadir University;

Founder, RIYAADA Institute for Leadership & Governance

Leadership proposition

A figure attains evidentiary status only when a system can articulate its provenance, significance, degree of uncertainty, and the decision it should influence.

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Executive thesis

Somalia's primary challenge is not a deficiency of health data but rather systemic discontinuities across data generation, validation, synthesis, decision making, implementation, and learning. The central leadership responsibility lies not in producing additional statistics but in establishing an institutional framework that ensures reliable evidence is standardized, readily available for decision making, and impactful.

Evaluation of Research Capacity

The primary performance indicator is not publication volume; rather, it is the capacity to identify, validate, interpret, escalate, and transform frontline uncertainties into safer decisions prior to adverse events.

Five Key Arguments: Single Page Summary

1

Research serves as a stewardship function.

A ministry that audits financial resources without assessing the metrics employed for service allocation sustains an incomplete accountability framework.

2

The evidence support function serves as a critical intermediary stage. Although training researchers is vital, the development of rapid synthesis, appraisal, contextualization, and policy support capabilities is essential for effectively bridging research and decision making..

3

Data quality is a managerial imperative rather than a strictly statistical issue. Leadership must ensure data completeness, consistency, denominator governance, verification, feedback mechanisms, and properly

	aligned incentives.
4	Sovereignty includes evidence sovereignty. Continental financial constraints and the Africa Health Security and Sovereignty Agenda necessitate the strategic prioritization of domestic control over data, methodologies, and decision making processes.
5	Prioritize operational instruments over aspirational goals. Somalia requires a streamlined framework of institutional mechanisms defined by clear ownership, established timelines, standardized protocols, and quantifiable outcomes...

Prologue: An Unclaimed Metric

At a regional health office, a district officer reviews a monitor display of facility based deliveries from the preceding quarter and questions its validity. Incomplete reporting from peripheral sites, several weeks of closure at two health centers, and flood related damage to a register suggest the figure may be materially inaccurate.

She confronts three options: transmit the data unchanged, adjust it and risk being held accountable for poor performance, or label it unreliable. However, the reporting platform lacks a field for uncertainty, guidance provides no escalation pathway, and the system offers no protection for individuals who raise concerns.

The figure progresses through successive stages: aggregation into a regional total, inclusion in a national dashboard, incorporation into a review, a strategic plan, and a funding proposal. At the end of this chain, decisions are made regarding midwife deployment, allocation of emergency obstetric supplies, and prioritization of communities.

Between this number and a woman who may experience hemorrhage in a remote village lies a gap not measured in kilometers but in institutional processes: verification protocols, standardized denominators, evidence synthesis, ethics, data stewardship, research commissioning, implementation support, and leadership capable of formulating a researchable question and acting on the findings.

Leadership principle

Bridging institutional gaps is the fundamental objective of health research capacity. While publications, citations, and conference presentations serve as valuable outputs, they are not the primary purpose.

I. Why 2026 is not 2016

For decades, a precarious yet functional arrangement governed health systems in numerous aid dependent environments: external partners provided substantial funding for service delivery and research, while national institutions coordinated implementation and integrated the outcomes. This model never ensured full sovereignty. The fiscal conditions of 2025–2026 have rendered this instability untenable.

The financing rupture

According to the Africa CDC (2026), development assistance for health in Africa declined from approximately US\$25.8 billion in 2021 to roughly US\$13 billion in 2025 a reduction of about 50%. At the broader development finance level, preliminary OECD data (2026) indicate that official development assistance from DAC members and associates decreased by 23.1% in real terms in 2025 relative to 2024, representing the largest annual contraction on record. U.S. official development assistance fell by 56.9% during the same period.

The health consequences extend beyond immediate service disruptions. A 2026 modeling study of 93 low and middle income countries projected that sustained moderate funding reductions could be associated with 9.4 million additional deaths by 2030, whereas severe reductions could result in 22.6 million deaths, including 5.4 million children under age five. Although these figures represent scenarios rather than certainties, they underscore a critical risk: financing shocks may reverse health gains more rapidly than institutions can restore them (Rasella et al., 2026).

Research, surveillance, and data quality are especially vulnerable because their absence may not produce immediate visible consequences. Their loss manifests later through undetected outbreaks, suboptimal benefit design, misallocated human resources, unmeasured inequities, or policies based on flawed assumptions. Consequently, safeguarding evidence based functions is a leadership imperative rather than a budgetary adjustment.

The sovereignty rupture

In February 2026, African Heads of State and Government endorsed the transition from the New Public Health Order to the Africa Health Security and Sovereignty (AHSS) Agenda. This initiative is organized around five strategic pillars: predictable domestic and innovative financing, institutionalized preparedness, digital transformation, and local manufacturing.

The Africa CDC defines the digital pillar as a continent-wide Digital Intelligence Ecosystem designed to transmit data from local communities to national and continental decision-making platforms. The overarching objective is clear: health sovereignty requires the capacity to finance, produce, and govern the information that informs policy decisions (Africa CDC, 2026).

The national policy window

Somalia is managing this continental shift during a rare convergence of domestic reforms. The National Transformation Plan 2025–2029 began on March 17, 2025, followed by the Somalia Community Health Strategy 2025–2029 on April 6, 2026, which sets a government led structure for community health delivery. At the same time, the Health Sector Strategic Plan III ends its 2022–2026 cycle. The National Institute of Health (NIH) is expanding duties in research, surveillance, laboratory systems, emergency readiness and response, the Public Health Emergency Operations Centre, the Field Epidemiology Training Programme, and evidence-based policy support (Federal Government of Somalia, 2025; UNICEF, 2026; FMoH, 2021; NIH Somalia, 2026).

This creates a vital policy window. The main question is whether these reforms will merge through a national evidence architecture or stay as strong institutions limited by weak links.

A baseline that demands precision

Somalia's current indicators underscore the necessity of robust evidence governance. According to the World Health Organization (WHO) country portals, the universal health coverage service index stands at 25. In 2022, WHO reported 0.48 physicians and 2.61 nursing and midwifery personnel per 10,000 population. Maternal mortality data further illustrate methodological discrepancies: the Somali Health and Demographic Survey documented 692 maternal deaths per 100,000 live births during its study period, whereas WHO's 2023 modeled estimate is 562.6 per 100,000 with a wide uncertainty interval. These figures are not interchangeable due to differences in methodology, temporal scope, and uncertainty modeling (WHO, 2026; Somali National Bureau of Statistics, 2020).

Institutional rule

When two credible sources present conflicting data, leadership should not select the more convenient figure. Instead, they must maintain consistency in the year, definition, methodology, and associated uncertainty and then determine which estimate is appropriate for the specific decision.

II. The leadership deficit nobody names

The conventional diagnosis of weak research capacity is a list of missing inputs: funding, laboratories, trained investigators, journals, ethics committees and datasets. The list is correct but incomplete. Inputs have entered fragile systems before and dissipated. The binding constraint is often the leadership behaviour that turns those inputs into repeatable institutional practice.

1. Research is treated as ornament, not stewardship

Research is often located near planning and reporting and understood as a document producing activity. Yet evidence generation and use are core stewardship functions. Leaders who would never accept an unaudited financial ledger can be remarkably tolerant of an unverified service indicator. That asymmetry should be reversed: a material health indicator deserves a provenance trail, validation routine and accountable custodian.

2. The commissioning deficit

Health systems obtain research that aligns with clearly articulated requirements. A decision grade question is well defined and answerable, linked to a designated decision owner, synchronized with the policy window, and precise regarding evidence needs. Somalia has completed a national research prioritization exercise in which 231 questions were ranked across access, evidence utilization, antimicrobial resistance, noncommunicable diseases, mental health, and maternal care. The subsequent objective is to institutionalize priority setting and commissioning as a recurring annual governance cycle rather than a one time event (Ssendagire et al., 2023).

3. Extraction by agreement

Authorship inequity persists as a structural issue in global health. Mbaye and colleagues reported that 6.8% of infectious disease studies in Africa lacked any author from an African institution, and a later review of sub Saharan research showed roughly 15% without local co authors. During COVID 19, one in five Africa focused articles in a sample of leading medical journals had no African author (Mbaye et al., 2019; Rees et al., 2021; Naidoo et al., 2021). The remedy is not ceremonial credit but scientific authority: co design, budget control, data access, analytic leadership, and contribution based authorship agreed before data collection..

4. Report rich, evidence poor

Somalia possesses numerous assessments, mappings, evaluations, surveys, and situational analyses. The challenge lies not in the volume of data but in its retrieval, appraisal, and synthesis at the point of decision making. A report that cannot be located, compared, contextualized, and translated within a ministerial timeframe function as information storage rather than evidence based support.

5. The incentive inversion

Universities reward journal outputs more consistently than policy impact. Ministries reward operational delivery more consistently than analytical challenge. Researchers therefore optimise for publication and managers optimise for implementation while the interface between them remains nobody's primary job. Promotion and performance systems should recognise policy briefs, guideline contributions, reproducible datasets, implementation evaluations and documented policy influence as serious scholarly and public service outputs.

6. The political economy of inconvenient findings

Empirical evidence supports rapid program implementation. Conversely, data challenging a flagship initiative may be suppressed due to financial stakes, reputational risks, and partner dynamics. Consequently, the ultimate challenge for research leadership is institutional: whether an organization can safeguard valid findings that may discomfort its leadership. If the messenger is vulnerable, data will inevitably skew toward favorable outcomes.

7. Analytic capacity is not absorptive capacity

Even with highly skilled analysts, a system may fail to integrate evidence effectively. Absorptive capacity refers to the ability of a directorate, regional office, or facility to receive findings, evaluate their quality, interpret their implications, implement operational changes, allocate funding, and monitor outcomes. Training analysts without enhancing decision making processes may yield technically proficient reports while leaving operational practices unchanged.

III. Three systems not one

A systems based framework distinguishes three components frequently conflated under “research capacity”: the research system, the evidence support system, and the evidence implementation system. The Global Evidence Commission has repeatedly emphasized the necessity of formalizing domestic evidence support systems, as this intermediate function providing timely, accessible evidence to decision makers is often the least developed (Global Evidence Commission, 2022; 2025).

SYSTEM	PRIMARY FUNCTION	CORE ACTORS	TYPICAL FAILURE MODE
Research system	Produces new knowledge	Universities, NIH, research institutes, journals	Under funded; externally driven; weak alignment with decision priorities
Evidence support system	Finds, appraises, synthesises and contextualises evidence for a specific decision	Evidence units, knowledge translation platform, HTA/guideline functions, rapid response service	Often fragmented or absent; evidence arrives too late or in the wrong form
Evidence implementation system	Turns decisions into changed practice and measures results	Directorates, FMS and district teams, facilities, professional bodies, QI collaboratives	Weak implementation support; supervision and feedback loops are inconsistent

Somalia requires comprehensive investment across all three systems; however, the strategic priority is their integration. Alternative research teams may increase publication output. A functional evidence support mechanism could influence the timing and quality of national decision making. This distinction is operational rather than theoretical.

Guidelines for successful institution development

Competence is not determined by the knowledge of a single person; instead, it is the continual performance of a task irrespective of the expert's involvement.

IV. Data quality is a leadership discipline

Data quality is frequently assigned to statisticians and monitoring teams, which constitutes a category error. Although technical assessments are essential, the root causes of poor data are typically organizational: ambiguous definitions, inadequate oversight, redundant reporting, unstable denominators, punitive performance cultures, lack of feedback, and unowned remediation processes.

The World Health Organization's Data Quality Assurance framework evaluates routine health information across dimensions such as completeness, timeliness, internal and external consistency, and the accuracy of population estimates and denominators. It integrates desk reviews with site level verification including reconciliation of source registers with reported figures and evaluates the systems generating the data (WHO, 2023).

Why timing matters

A mistake in the data corrected within this month is considered an administrative error. Nevertheless, if this same data remains uncorrected for three years, it evolves into a fundamental assumption for planning, a key element in budgeting, and eventually becomes an established historical fact.

A Somali Data Quality Compact six commitments

- 1. One governed indicator architecture. Every national routine indicator has one definition, one source of truth pathway, one accountable custodian and version controlled metadata. Partner tools may extend the system, but should not create competing national truths.
- 2. Verification is scheduled, not exceptional. Publish an annual national data quality review and conduct quarterly facility level verification on a rotating, risk based sample. Findings must return to the facility and district that generated the data.
- 3. Denominators are governed. Catchment and target population estimates should be produced through a defined national process, dated, versioned and accompanied by the assumptions used. Silent denominator changes should be treated as a governance failure.
- 4. Uncertainty is reportable, not punishable. Facilities and districts need a formal mechanism to flag suspect data, document reasons, and request verification without being automatically labelled as underperforming. A system that punishes doubt teaches staff to conceal it.

- 5. Metadata travels with the number. No material figure should enter a national strategy, policy brief or performance review without source, reference period, definition, method and known limitations. Where estimates are modelled, the uncertainty range should be visible.
- 6. Data sovereignty is contractual and ethical. Every externally supported study should deposit a governed data package nationally: metadata, protocol, codebook, analytic code, and a de-identified dataset where consent, ethics, law and security allow. Access rules should protect participants while ensuring Somalia retains durable scientific value from research conducted on its population.

V. The Evidence to Impact Cascade

Health programmes have recognized the cascade's value because it reveals leakage across stages: diagnosed, linked, treated, suppressed. Evidence should follow a similar approach. Each phase raises a distinct performance question with an accountable owner.

STAGE	THE PERFORMANCE QUESTION	COMMON LEAK
1. Generated	Was the data captured at all?	Non-reporting facilities; displaced, nomadic and remote populations remain invisible.
2. Trusted	Is it verified, plausible and sufficiently complete?	No verification routine; unstable denominators; unexplained outliers.
3. Synthesised	Has it been combined with the wider evidence and critically appraised?	Single study decision making; reports remain isolated.
4. Contextualised	What does the evidence mean for this budget, workforce, geography and population?	Global guidance imported without local costing, feasibility or equity analysis.
5. Considered	Did the evidence reach the decision maker before the decision?	Wrong format, excessive length, unclear options, late delivery.
6. Decided	Did the evidence materially change the choice?	Sunk commitments, political incentives, financing conditions, weak deliberation.
7. Delivered	Did policy change frontline practice and outcomes?	No implementation support, supervision, measurement or feedback loop.

The arithmetic is deliberately sobering. If a system performs at 70% at each of seven stages, only 0.70^7 about 8.2% of the original evidence pathway survives intact to the frontline. Small improvements across every stage therefore compound. A spectacular improvement in one stage cannot compensate for systematic leakage in the others.

Management insight

Assess the cascade. When leakage is identified with a stage, a metric, and an owner, "evidence use" transitions from a goal to a fundamental operational framework.

VI. What to build instruments, not intentions

The next stage should avoid needless institutional growth. Somalia already has national bodies with relevant roles. The main aim is to define duties clearly, build lasting links, and embed practices grounded in evidence. The tools below are deliberately practical..

A An NIH led National Health Research & Evidence Council

A formal mechanism led by the National Institute of Health and linked to the Federal Ministry, Federal Member States, universities, professional bodies, the health insurance authority, and civil society should anchor the national research agenda, evidence standards, ethical coherence, and external research partnership rules.

Its annual output should include a refreshed national research agenda, an evidence system performance report, priority commissioning questions, and a public account of major evidence gaps.

B A national Knowledge Translation Platform with a rapid evidence service

Create a standing, ministry facing function that can frame policy questions, retrieve and appraise research, combine global and Somali evidence, and translate it into decision ready products. WHO EVIPNet provides a mature model for this form of evidence informed decision support.

Two products should define the service: concise evidence briefs that present policy options with benefits, harms, costs, equity and implementation considerations; and rapid evidence responses delivered against pre agreed timelines such as 3, 10 or 30 days. WHO published standard operating procedures for rapid evidence products in 2025, and the Global Research Agenda on Knowledge Translation was formally published in 2026 after its May 2025 launch.

C A stage gate for high impact policy decisions

For policies exceeding established financial, service coverage, or population thresholds, approval should require four sequential criteria:

Evidence: What is known, and with what degree of certainty?

Equity: Who benefits, who is excluded, and what is the impact on financial protection?

Feasibility: What are the implications for workforce capacity, supply chain, financing, and absorptive capacity?

Learning: What metrics will be monitored, when will the policy be reviewed, and what outcomes will trigger adaptation or discontinuation?

The fourth criterion distinguishes a policy that merely launches from one capable of continuous improvement.

D An Equitable Research Partnership Charter

External research collaborations must ensure substantive Somali scientific leadership through co design, shared decision making authority, equitable data access, transparent budgetary arrangements, fair institutional cost recovery, and pre established publication protocols. Authorship should adhere to recognized contribution standards; the objective is to eliminate structural exclusion rather than confer honorary status.

Partnership agreements should specify capacity transfer as a deliverable, incorporate national data stewardship requirements, establish dispute resolution mechanisms, and promote reflexivity regarding power dynamics, credit allocation, and benefit distribution.

E Training pipelines that end in institutional roles

Investment in doctoral programs and fellowships should, where practicable, be aligned with a receiving mechanism such as a university appointment, National Institutes of Health program, ministerial evidence unit, insurance authority, laboratory, surveillance initiative, or research center accompanied by protected time to apply acquired expertise.

Diaspora expertise should be institutionalized through joint appointments, co supervision, visiting faculty arrangements, and shared research infrastructure, rather than relying on intermittent goodwill.

F A domestic health research fund

Even a modest ring fenced national research fund alters institutional leverage. It enables Somalia to commission inquiries that external donors may overlook, establishes a transparent framework for competitive local research, and signals joint investment rather than dependency.

Funding criteria should prioritize policy relevance, methodological rigor, equity, data stewardship, reproducibility, and implementation potential.

VII. What success actually looks like

Research capacity is often judged by what is simplest to count. A robust national evidence strategy should instead track whether the evidence pathway grows faster, more reliable, more fair, and more influential.

- 1. Evidence coverage of major decisions Share of key national health policy or financing choices paired with a recorded evidence brief or appraisal.
- 2. Decision response time Median duration from a clearly stated policy question to delivery of an appraised synthesis or rapid evidence product.
- 3. Somali scientific leadership Share of Somalia based studies showing substantial Somali leadership in protocol, analysis, data governance, and primary outputs, using contribution based authorship.
- 4. Routine data quality Published annual performance across completeness, timeliness, internal consistency, external consistency, and denominator quality, broken down enough to guide action.
- 5. Research asset retention Share of approved studies depositing the required national data package and documentation, within ethics, law, and privacy limits.
- 6. Domestic co investment Domestic budget assigned to health research and evidence support as a portion of public health spending, with trend and execution rate published.
- 7. Policy to practice completion Share of evidence informed decisions that include an implementation plan, supervision mechanism, learning indicators, and documented review point.

The metric that matters most

Avoid inquiring solely about the existence of evidence. Instead, consider if there was a shift in decision making, if the planned actions were carried out, and if the results were evaluated.

Coda reducing the gap.

Revert back to the district official at her workstation..

Within a mature evidence architecture, individual uncertainty is not an isolated concern; it is addressed through a structured environment and a formal verification process. The denominator is governed and versioned, enabling districts to receive feedback rather than directives alone. When discrepancies recur across multiple districts, the pattern is escalated, as it may indicate systemic failure rather than localized underperformance. A rapid evidence function can then address subsequent policy questions. Decision processes can document changes, and implementation teams can verify whether practices have shifted at the facility and community levels.

This framework does not require advanced computing or substantial funding. It depends on standards, routines, authority, ethics, institutional memory, and leadership willing to be guided by evidence that may be unsolicited or unwelcome.

Somalia is establishing major institutions precisely as external financing becomes less predictable and continental policy shifts toward sovereignty. Consequently, the National Transformation Plan, the Community Health Strategy, the National Institute of Health, health financing reform, digital transformation, and the forthcoming health sector strategy should be viewed as a unified institutional endeavor: the capacity to understand the health system with sufficient accuracy, timeliness, and integrity to govern it effectively.

Conclusive leadership proposal

A nation's inability to produce, regulate, and analyze data regarding itself will inevitably result in it being influenced to some extent by an external party's portrayal of its requirements. This concept is known as state capacity.

The contrast between quantitative data and tangible reality reflects the separation between theoretical knowledge and practical application. Somalia has the capacity to close this divide, depending on the establishment of necessary institutional frameworks.

Ten reasonable recommendations for immediate action

1. Formally designate an NIH led national research and evidence governance mechanism with clear decision rights and annual public outputs.
2. Complete a rapid assessment of Somalia's evidence support system and publish the gaps, owners and 12 month corrective plan.
3. Adopt a national Data Quality Compact and integrate it into HMIS/DHIS2 supervision, partner agreements and performance reviews.
4. Launch a small rapid evidence service before building a large centre; prove demand, turnaround time and decision value first.
5. Require metadata and source limitations in all national strategies, dashboards and high level briefing materials.
6. Introduce a stage gate for major benefit package, guideline, workforce, procurement and public health decisions.

7. Adopt an Equitable Research Partnership Charter that protects scientific leadership, fair institutional financing and national data stewardship without encouraging honorary authorship.
8. Create a governed national research repository with privacy preserving access rules and reproducible analytic documentation.
9. Align university promotion and ministry performance systems with policy relevant outputs, implementation research and documented evidence use.
10. Publish one annual “evidence changed this decision” case study to demonstrate that research capacity is producing public value, not only publications.

Selected references and further reading

Evidence note: References highlight primary institutional sources and peer reviewed literature

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About the author

Dr. Abdulrazaq Yusuf Ahmed writes on health financing, health system governance, evidence informed policy, institutional development and public sector reform in fragile and conflict affected settings. His work links clinical service, public health, health economics, leadership and implementation.

Correspondence and commissioned commentary: drjalaaludiin.com