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Executive Summary

Universal Health Coverage (UHC) in Somalia is regarded as both a technical measurement initiative and an essential element of comprehensive state building

efforts. Its primary goal is to provide all individuals with access to vital promotive, preventive, curative, rehabilitative, and palliative services without incurring financial hardship. Progress in Somalia is assessed through two interrelated dimensions: service coverage, as reflected in SDG 3.8.1, and financial protection, corresponding to SDG 3.8.2. The executive summary and annex materials emphasize the establishment of a credible policy framework for UHC, although implementation remains constrained by limited service readiness, acute workforce shortages, fragmented data systems, and insufficient domestic health financing.

Analysis reveals measurable progress, albeit with lingering challenges. Somalia's national UHC Service Coverage Index began at a baseline of 22 and has increased to 27 in official reports, aiming to reach 40 by 2029. While this trajectory indicates improvement, persistent structural issues continue to impede effective coverage. Community oriented services such as family planning, basic immunization, and interventions targeting infectious diseases demonstrate stronger performance compared to referral system dependent services, which require specialized personnel, facility preparedness, emergency obstetric care, diagnostics, and continuous medication supply.

Financial protection represents the most vulnerable component within Somalia's UHC agenda. Documentation indicates that out of pocket expenses constitute a significant proportion of health expenditures, with donor funding supporting much of the organized service delivery. This financing model entails dual risks: households may delay or forego necessary care due to prohibitive costs, and the health sector remains exposed to fluctuations in external support. Therefore, sustained improvements in service coverage are contingent upon the gradual implementation of pooled financing, increased public investment, and systematic purchasing mechanisms.

The indicator matrix functions not only as a repository of metrics but also as a management tool, linking policy commitments to specific numerators, denominators, data systems, institutional stakeholders, and review intervals. When effectively employed, it enables ministries, federal member states, programs, and partners to transition from broad statements to rigorous measurement approaches. It further identifies gaps in routine reporting, particularly concerning non communicable diseases, catastrophic expenditure monitoring, private sector data integration, and sub

national disaggregation by geography, socioeconomic status, gender, and displacement.

Strategically, the immediate priority should be on aligning the matrix with practical reform mechanisms rather than expanding monitoring frameworks detached from operational realities. Key areas include strengthening primary health care, deploying female and community-based health workers, improving maternal and newborn service readiness, ensuring consistent medicine and supply availability, maintaining regular National Health Accounts, and enhancing private provider inclusion in reporting and quality assurance. Bolstering these foundational elements will transform the UHC matrix from a descriptive scorecard into an effective instrument for systemic transformation.

Figure 1. Official and Policy Linked UHC Service Coverage Trajectory for Somalia.

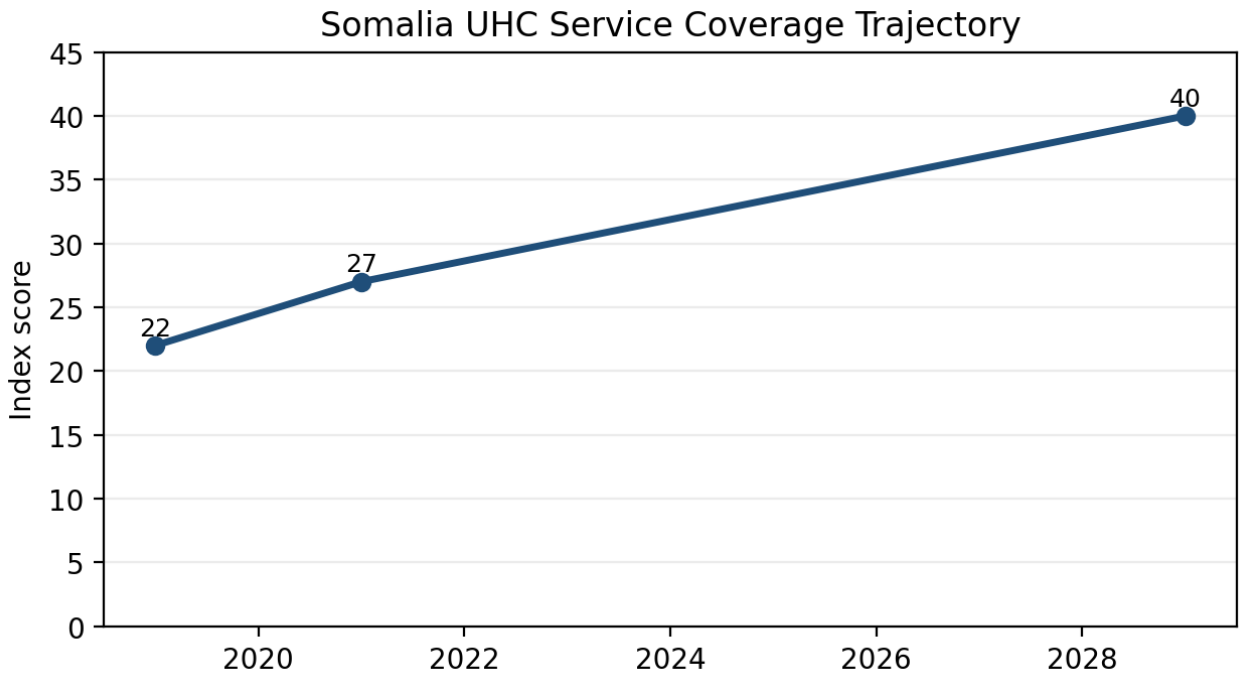


Figure 2. Harmonized Presentation of the UHC Service Coverage Trajectory Used in the Master Document.

1. Why the UHC Indicator Matrix Matters

Universal Health Coverage (UHC) in Somalia should not be regarded as a singular programme or a donor driven workstream; rather, it represents an overarching system objective. Achieving this objective depends on the country's ability to transform fragmented service delivery into an integrated, monitored, financed, and governable framework of essential healthcare services. The UHC indicator matrix is crucial because it translates this framework into measurable components: service coverage, facility readiness, workforce capacity, medicine availability, epidemic preparedness, and financial protection. In the absence of a functional matrix, UHC remains merely aspirational. With a robust matrix, however, it serves as a tool for accountability.

The enhanced matrix presented herein has been developed to fulfil three core functions. Firstly, it enables strategic monitoring of SDG 3.8.1 and SDG 3.8.2. Secondly, it converts policy commitments into operational formulas that can be consistently calculated by ministries, programmes, and partners. Thirdly, it identifies areas where national reporting systems require further strengthening, particularly regarding non communicable diseases, private sector utilisation, and household financial protection.

Table 1. Policy Architecture and Source Alignment.

Framework	Role in UHC reform	Time horizon	Primary operational implication
Somalia UHC Roadmap	Established baseline tracer architecture and initial targets for service coverage and financial protection.	2019 2023	Defines the core indicator logic and baseline values used in the annex registry.
EPHS 2020 and EPHS Implementation Strategy	Specifies the package of services to be delivered at community, PHU, health centre, and hospital levels.	2020 onward	Links tracer performance to actual service entitlements and phased implementation.
Health Sector Strategic Plan III	Provides the medium term sector strategy for resilience, integrated delivery, and governance.	2022 2026	Frames service delivery, workforce, stewardship, information systems, and financing reforms.
National Transformation Plan	Elevates health into a broader state building and human capital agenda.	2025 2029	Pushes PHC expansion, digital accountability, regulation, and public private engagement.

2. Conceptual Architecture of the UHC Service Coverage Index

The UHC Service Coverage Index is calculated as the geometric mean of tracer indicators spanning four domains: reproductive, maternal, newborn and child health; communicable diseases; non communicable diseases; and service capacity and access. The application of the geometric mean ensures that imbalances are appropriately addressed, preventing improvements in one domain from offsetting deficiencies in another. This approach underscores the integrity inherent in statistical analysis.

In Somalia, accurate measurement is challenged by three structural factors. Firstly, household survey data are collected periodically rather than continuously. Secondly, although routine programme data are improving, integration across various vertical programmes and private providers remains incomplete. Thirdly, populations most at risk of under coverage including nomadic communities, displaced individuals, and conflict affected settlements are particularly difficult to measure with reliability. Consequently, the indicator matrix should be regarded as a dynamic tool that will advance as the information system becomes more robust.

Table 2. Core Nationally Monitored Tracer Domains.

Domain	Illustrative tracers used in Somalia	Primary data sources	Main stewardship entity
RMNCH	Family planning demand satisfied; ANC4+; child immunization; care seeking for childhood pneumonia	SHDS/MICS/DHS type surveys; HMIS; EPI reports	FMoH RMNCH programmes and National Bureau of Statistics
Communicable diseases	TB effective treatment; HIV treatment coverage; ITN use; HepB prevalence in under fives	Programme databases; WHO/UNAIDS; malaria surveys	TB, HIV/AIDS, EPI, malaria, and surveillance programmes
NCDs	Non raised blood pressure; normal blood glucose; cervical cancer screening	STEPS or NCD surveys; facility data where reliable	NCD unit with laboratories, RH programme, and NBS
Service capacity and access	Hospital beds; core health worker density; essential medicines; IHR core capacity	SARA/HHFA; HRH registry; LMIS; SPAR/JEE	Planning, HRH, essential medicines, and health security directorates

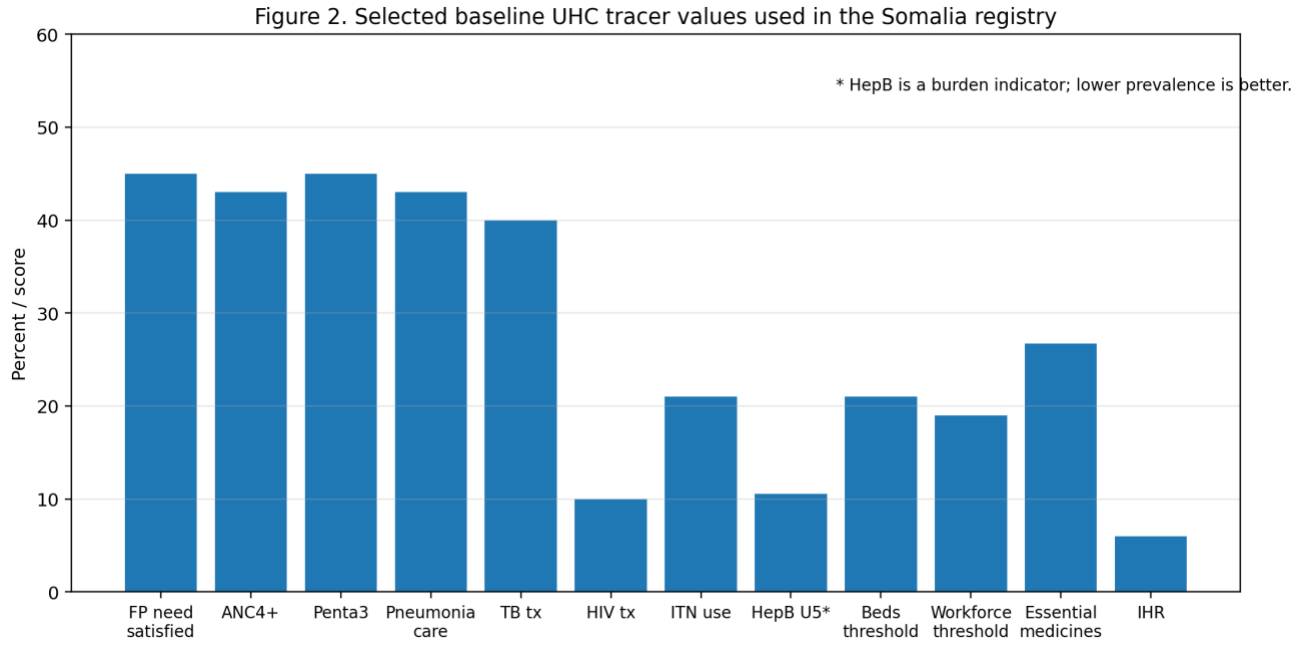


Figure 3. Selected Baseline Tracer Values from the Refined Somalia Registry.

3. Formal Definition and Reporting Logic

For the purposes of this master document, Universal Health Coverage (UHC) is defined as the state in which all individuals are able to access promotive, preventive, curative, rehabilitative, and palliative services of sufficient quality to be effective, without incurring financial hardship. This definition serves as the primary working framework due to its alignment with the terminology prevalent throughout the executive summaries, analytical briefs, and annex materials provided.

The final report delineates three distinct yet interconnected layers of measurement. First, it designates the internationally comparable UHC Service Coverage Index as the principal metric for SDG 3.8.1. Second, it acknowledges that some referenced documents employ broader composite or policy linked summaries, which, while beneficial for planning purposes, may not always align directly with the WHO reported SCI. Third, it maintains the inclusion of contextual indicators such as sanitation, food insecurity, IPC readiness, and private sector reporting gaps as important determinants influencing UHC performance, even when these are not incorporated in the core set of tracer indicators.

This methodology enables the document to preserve substantive content from the source

materials by addressing inconsistencies through classification rather than omission. Official tracer indicators are clearly presented as such, whereas contextual determinants, planning benchmarks, and legacy draft values are incorporated within reconciliation notes and interpretive sections.

4. Policy Architecture and Source Alignment

Table 3. Policy Architecture and Source Alignment in the Master Document.

Framework	Core role in reform	Time horizon	Master document use
Somalia UHC Roadmap	Established the baseline tracer architecture and initial UHC coverage logic.	2019 2023	Used as the primary source for baseline tracer values in the annex registry.
EPHS 2020 and implementation strategy	Defined priority services across community, PHU, health centre, and hospital levels.	2020 onward	Used to align the indicator matrix with actual service entitlements and phased implementation.
HSSP III	Provided the medium term sector strategy for resilience, governance, service delivery, workforce, information systems, and financing.	2022 2026	Used as the principal strategic frame for systems bottlenecks and sector reform.
National Transformation Plan	Positioned health within wider social and human capital transformation.	2025 2029	Used to interpret UHC as a state building and accountability agenda.

5. Conceptual Architecture of the UHC Service Coverage Index

The Universal Health Coverage (UHC) Service Coverage Index is typically calculated as the geometric mean of tracer indicators across four domains: reproductive, maternal, newborn, and child health; communicable diseases; non communicable diseases; and service capacity and access. This analytic approach is significant because the geometric mean penalizes imbalance, ensuring that poor performance in any domain substantially lowers the overall index and cannot be compensated by moderate progress elsewhere.

In Somalia, careful methodological consideration is necessary when interpreting this index. The provided files consistently indicate that household survey data are periodic rather than continuous, routine program data are advancing but not fully integrated, and populations most vulnerable to under coverage such as nomadic communities, displaced persons, and settlements affected by insecurity remain challenging to measure reliably. Therefore, the

matrix should be viewed as a dynamic tool whose precision will increase as the information ecosystem evolves.

The finalized harmonized presentation distinguishes official core tracers from broader contextual indicators. For instance, factors such as sanitation, nutritional stress, and exposure to outbreaks remain crucial for interpretation and planning, yet may be addressed differently across various drafts. Instead of omitting these elements, this document retains them and situates them within the comprehensive explanatory framework of UHC performance.

Table 4. Harmonized Tracer Domains, Primary Data Sources, and Stewardship Entities.

Domain	Illustrative tracers in master document	Primary data sources	Stewardship entity
RMNCH	Family planning demand satisfied; ANC4+; child immunization; childhood pneumonia care seeking	SHDS/MICS/DHS type surveys; HMIS; EPI reports	FMoH RMNCH programmes and National Bureau of Statistics
Communicable diseases	TB effective treatment; HIV treatment coverage; ITN use; HepB under five prevalence (registry tracer); sanitation retained as contextual determinant	Programme databases; WHO/UNAIDS; malaria surveys; population surveys	TB, HIV/AIDS, malaria, EPI, surveillance, and health information programmes
NCDs	Blood pressure control; blood glucose control; cervical cancer screening; tobacco non use	STEPS or NCD surveys; outpatient and laboratory data where sufficiently reliable	NCD unit, RH programme, laboratories, and NBS
Capacity & access	Hospital beds; workforce density; essential medicines; IHR core capacity	SARA/HHFA; HRH registry; LMIS; SPAR/JEE	Planning, HRH, essential medicines, and health security directorates

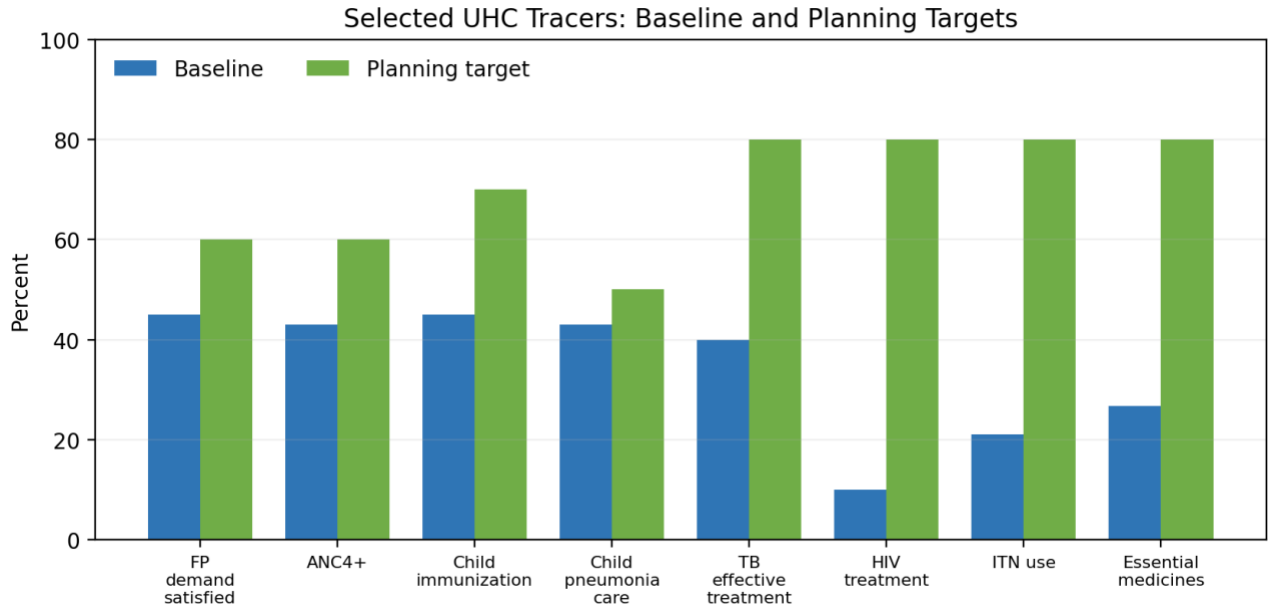


Figure 4. Selected Baseline Tracers and Indicative Planning Targets Used in the Harmonized Brief.

6. Domain Analysis

6.1 RMNCH Remains the Decisive Frontier

In Somalia, RMNCH remains the most consequential domain for mortality reduction, household welfare, and long term human capital formation. The uploaded materials consistently emphasize that high fertility, a youthful age structure, recurrent food insecurity, and weak referral systems combine to make RMNCH performance a decisive test of whether the system is reaching households with effective and timely care.

The harmonized registry retains roadmap linked baseline values of 45 percent for family planning demand satisfied, 43 percent for ANC4+, 45 percent for the child immunization tracer, and 43 percent for childhood pneumonia care seeking. Earlier working files also cited alternative survey linked values for some items. Rather than suppress those differences, the master document treats the roadmap figure as the baseline used for the policy registry and preserves the alternative figures in the reconciliation appendix.

Maternal mortality remains a powerful system proxy because preventing maternal deaths requires the entire continuum of care to function: community awareness, antenatal screening, nutrition support, referral preparedness, skilled delivery, emergency obstetric capacity, and postnatal continuity. The drafts consistently describe the decline from

approximately 1,040 1,044 maternal deaths per 100,000 live births in 2006 to around 692 in the 2015 2019 period, while retaining a national ambition of approximately 332 by 2030.

Facility readiness evidence shows why contact coverage alone is insufficient. The uploaded analyses repeatedly cite that only 45 percent of assessed facilities offered basic delivery services, 57 percent reported postnatal care, and 13 percent had the full set of BEmONC signal functions. A woman may therefore reach a facility without reaching effective care.

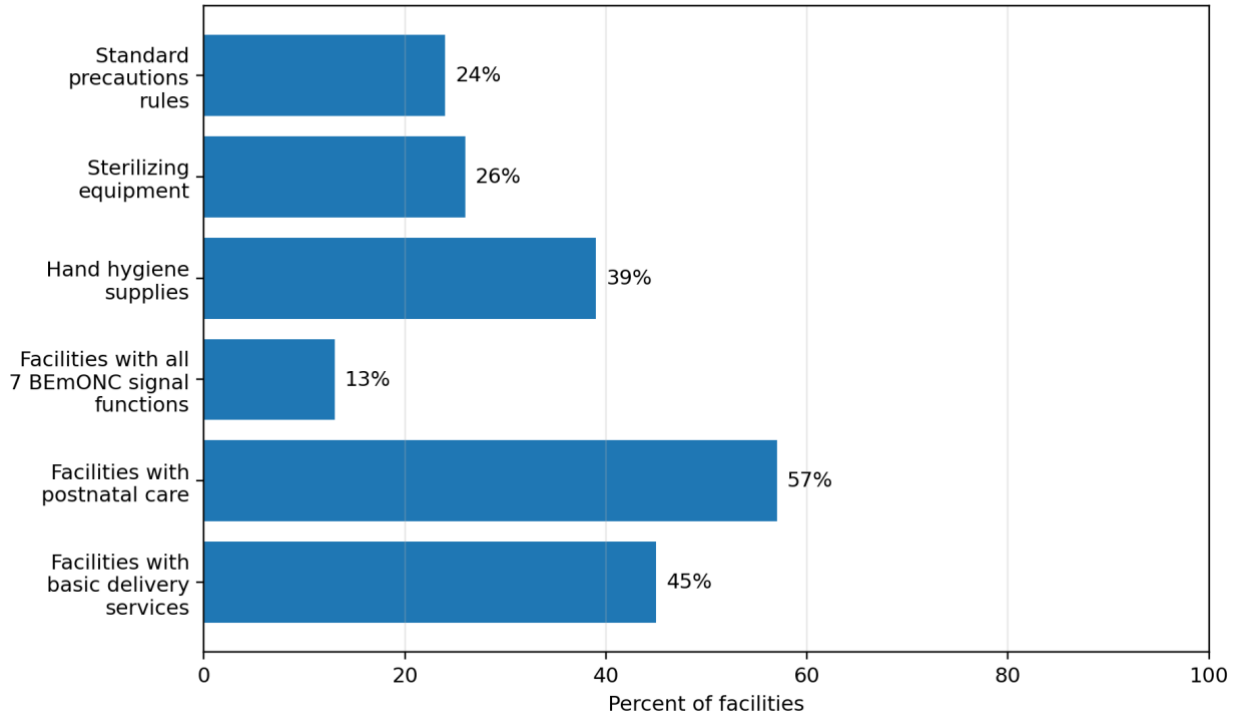
6.2 Nutrition and Child Survival Within the UHC Frame

The final document preserves the strong nutrition narrative across the source files and integrates it more explicitly into UHC interpretation. The uploaded materials note that by early 2026, about 6.5 million people were projected to face IPC Phase 3 or higher food insecurity, more than 2 million were in Emergency conditions, and roughly 1.84 to 1.85 million children aged 6 59 months were projected to be acutely malnourished, including more than 483,000 with severe acute malnutrition.

The 2026 MIYCAN package is therefore presented not as a stand alone nutrition policy, but as a strategic extension of life course UHC delivery. The master report retains the baseline behavioural indicators cited in the drafts exclusive breastfeeding approximately 34 percent, early initiation of breastfeeding about 60 percent, two dose vitamin A coverage 14 percent, and adequately iodized salt use about 7 percent of households while linking them to community counselling, household resilience, and climate sensitive service delivery.

To preserve content without redundancy, the repeated discussions of drought, unsafe water, and post discharge vulnerability have been merged into a single systems argument: clinical nutrition gains are fragile when water insecurity, transport cost, and household poverty undermine continuity of recovery.

Figure 3. Facility readiness and IPC constraints from nationwide assessment



6.3 Infectious Diseases, Immunization, and Epidemic Preparedness

Communicable disease control remains central to Somali UHC because outbreaks repeatedly divert scarce operational capacity away from routine service continuity. Across the uploaded materials, the recurring signals are measles, AWD/cholera, malaria, dengue, respiratory infections, and ongoing public health security stress.

The master narrative preserves the measles outbreak reference used in the source files: 1,665 suspected measles cases in the first four weeks of 2026, with 72 percent among children under five. It also retains the baseline communicable disease tracer values in the registry TB effective treatment 40 percent, HIV treatment coverage 10 percent, ITN use 21 percent, and HepB under five prevalence 10.54 percent while clarifying that HepB prevalence is an inverse tracer requiring transformation before inclusion in the SCI.

A major inconsistency across the source package concerned whether sanitation should appear as a core communicable disease tracer or as a broader environmental determinant. The final document resolves this by keeping sanitation as an essential contextual determinant of infectious disease performance, while using the registry based HepB under five prevalence as the formal fourth communicable disease tracer in the annex table. In this way, no substantive content is removed; the content is simply classified more precisely.

Similarly, the apparent contradiction between an IHR baseline of 6 and a later IHR score of 31 out of 100 is resolved chronologically. The value of 6 is retained as the historical roadmap era baseline, while 31 out of 100 is presented as a later reported performance level used in strategic narrative and dashboard interpretation.

6.4 NCDs, Mental Health, and Injury Burden

The uploaded files are consistent in one important respect: NCDs and mental health are no longer peripheral to Somali UHC. EPHS 2020 explicitly expands the service architecture to include hypertension, diabetes, chronic respiratory disease, cancers, mental health, and substance use care across primary and referral pathways.

The greatest methodological weakness in this domain is not lack of relevance but lack of high confidence national measurement. Several source files correctly flagged NCD baselines as to be confirmed or not fully legible from the original roadmap figure. The final document retains those placeholders rather than inventing precision. This is a deliberate scientific choice: unresolved denominators are identified as evidence gaps, not converted into false certainty.

To preserve all substantive content, the master text also retains the task shifting logic described in the drafts. Community and PHC based screening, periodic STEPS type surveys, outpatient reporting, and better laboratory capture are presented as the minimum conditions required for scientifically credible monitoring of NCD and mental health components within SDG 3.8.1.

6.5 Capacity, Access, and Workforce

Across the uploaded materials, capacity and access emerge as the most persistent structural bottlenecks. Workforce density, facility readiness, essential medicines, IPC functionality, and emergency preparedness repeatedly appear as the limiting conditions that prevent policy commitments from translating into effective service coverage.

The files consistently describe a critically low clinician density of roughly 0.11 per 1,000 population, or about 4.3 core health workers per 10,000 population, far below functional thresholds for essential service delivery. The narrative also emphasizes geographic maldistribution, public sector attrition, and the strategic importance of community based female health workers as a pragmatic mechanism for extending reach while larger workforce reforms are built.

A second inconsistency concerned hospital bed metrics. Some drafts preserved a raw figure equivalent to 4.28 beds per 10,000, while others referenced 5.34 beds per 10,000, yet both were interpreted as roughly 21 percent of the threshold used for standardized capacity scoring.

The master document resolves this by reporting the standardized baseline as 21 percent of the target threshold in the core registry, while preserving both raw legacy figures in the reconciliation appendix pending final source verification.

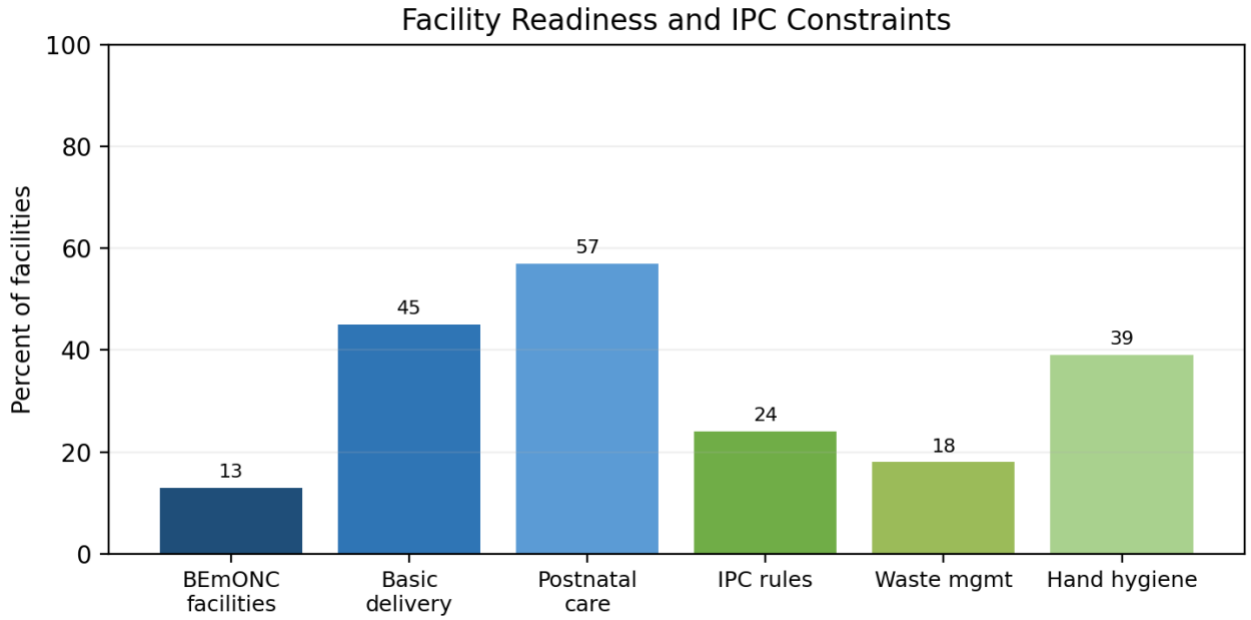


Figure 5. Facility Readiness and Infection Prevention and Control Constraints Repeatedly Cited Across the Source Package.

7. Data Governance, Information Systems, and Financial Protection

The source package repeatedly highlights DHIS2/HMIS, SARA/HHFA, LMIS, iHRIS/HRMIS, National Health Accounts, and programme databases as the central machinery through which UHC becomes measurable. The final report consolidates these repeated discussions into one integrated data governance section to reduce redundancy while preserving the full conceptual content.

Indicator credibility depends on triangulation. Routine HMIS alone is insufficient; survey data, service readiness assessments, logistics systems, workforce registries, expenditure tracking, and private provider reporting must be brought into a common national frame. This is especially important in Somalia, where under reporting from private pharmacies and clinics can distort both epidemiological surveillance and financial burden estimation.

The financial protection discussion required particular reconciliation. Some uploaded materials retained the older roadmap framing of catastrophic expenditure based on the 10 percent threshold of total household consumption or income; others used the revised

global framing based on out of pocket spending above 40 percent of discretionary capacity to pay. The master document preserves both by stating clearly that the roadmap baseline used the earlier framing, while current international reporting increasingly uses the revised capacity to pay approach. This is not treated as contradiction in the final version; it is treated as methodological transition.

8. At a Glance Strategic Dashboard

Table 5. At a Glance Strategic Dashboard.

Domain	Key message	Illustrative signals retained in master brief
RMNCH	Largest opportunity for mortality reduction	MMR around 692; U5MR around 104 106; only 13% of facilities with full BEmONC signal functions
Infectious diseases	Outbreak risk remains structurally high	Measles outbreaks, AWD/cholera persistence, malaria upsurge, IHR later score 31/100
NCDs and mental health	Service architecture is advancing faster than baseline measurement	Screening and treatment coverage remain weak or incompletely measured
Capacity and access	Workforce and readiness remain decisive bottlenecks	HRH density about 4.3 per 10,000; IPC readiness remains low
Financing and data governance	Sustainability depends on domestic stewardship and system integration	OOP burden remains high; donor financing dominant; regular NHA and expenditure measurement remain essential

9. Methodology and Indicator Construction

The methodological foundation of the Somali UHC framework is conceptually clear, though its practical implementation poses notable challenges. Each tracer indicator is calibrated to yield a standardized value ranging from 0 to 100, ensuring higher scores consistently signify enhanced performance. For positive indicators, scores are directly derived from observed coverage rates, while inverse indicators such as certain prevalence measures are adjusted to align directionally with optimal health system outcomes. The service coverage index is calculated as the geometric mean of tracer values across four principal domains: reproductive, maternal, newborn and child health; communicable diseases; non communicable diseases; and service capacity and access.

Utilizing geometric aggregation is essential, as it contrasts with arithmetic averaging by

highlighting shortcomings in any single domain, thereby preventing overall high performance from compensating for deficiencies elsewhere. Consequently, Somalia's low Universal Health Coverage score accurately reflects systemic bottlenecks in critical health areas, such as HIV treatment, emergency obstetric care readiness, and financial protection, each substantially influencing the national index.

Infographic 1. Standardization and Calculation Logic for SDG 3.8.1 and SDG 3.8.2.

10. Policy Architecture and Strategic Alignment

Table 6. Policy Architecture and Strategic Alignment.

The provided materials indicate that Somalia's Universal Health Coverage (UHC) agenda is now incorporated into a more systematic reform framework than in previous post conflict eras. The roadmap, EPHS 2020, EPHS implementation strategy, HSSP III, and the National Transformation Plan each serve distinct operational functions. The accompanying table outlines the interconnections among these frameworks and emphasizes the importance of the indicator matrix in ensuring implementation accountability.

FRAMEWORK	CORE ROLE IN REFORM	OPERATIONAL CONTRIBUTION	TIME HORIZON

SOMALIA UHC ROADMAP	Established the tracer architecture and early baseline values	Defines the basic logic for service coverage and financial protection monitoring	2019 2023
EPHS 2020 AND IMPLEMENTATION STRATEGY	Specifies priority services across community, PHU, health centre, and hospital levels	Translates coverage ambitions into an entitlement and service delivery package	2020 onward
HSSP III	Frames medium term sector strategy and implementation sequencing	Links governance, workforce, service readiness, medicines, and information systems	2022 2026
NATIONAL TRANSFORMATION PLAN	Elevates health within whole of government transformation	Strengthens accountability, digital monitoring, and cross sector reform alignment	2025 2029

11. Selected Tracer Performance and Target Direction

The executive summary registry provides a useful operational snapshot of the baseline distribution of Somalia's UHC tracers. The pattern is uneven but revealing. Family planning demand satisfied, antenatal care continuity, and the child immunization tracer are all low to moderate relative to long term coverage aspirations. Coverage is especially weak for HIV treatment, insecticide treated net use, and basic sanitation, while service capacity indicators remain far below functional thresholds. The chart below compares baseline values carried in the supplied registry against indicative policy targets used for planning discussion.

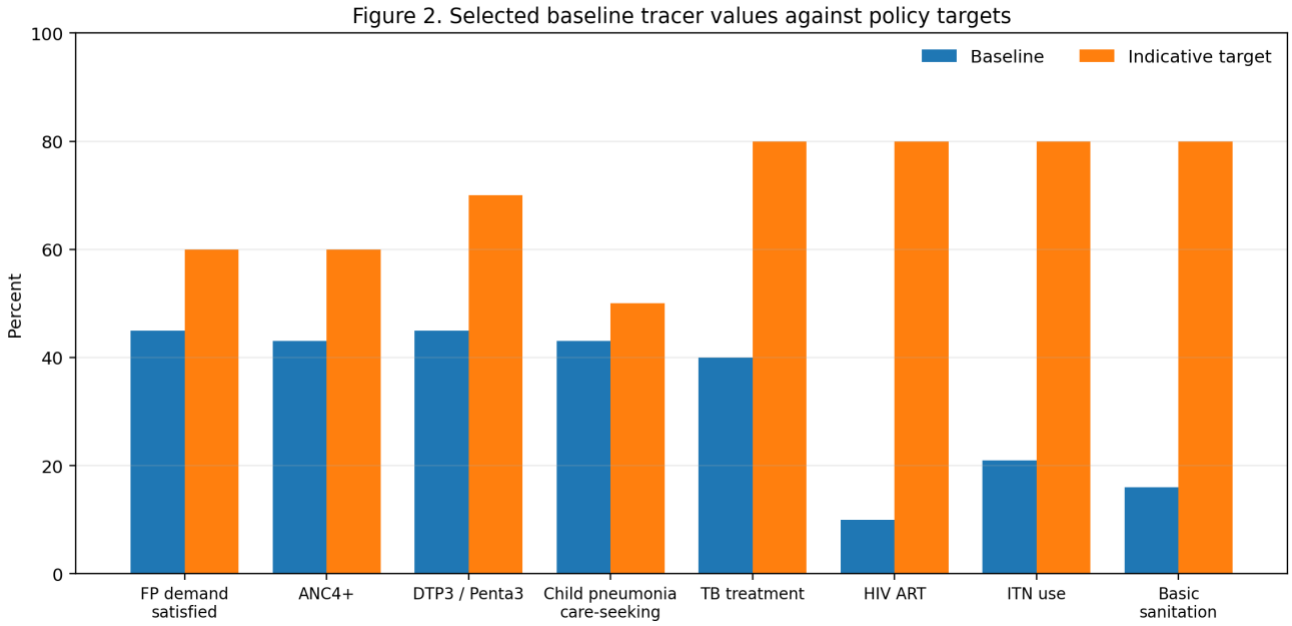


Figure 6. Baseline Tracer Values from the Supplied Registry Against Indicative Policy Targets.

Two analytic conclusions emerge from this pattern. First, community delivered or prevention oriented interventions tend to perform better than referral intensive and system dependent services. Second, the distance between baseline and target is not merely a matter of financing volume; it also reflects the implementation complexity of the tracer itself. Antenatal contact can be expanded through outreach and primary level strengthening, whereas TB effective treatment, HIV ART coverage, or sustained cervical screening require diagnostics, logistics, supervision, referral continuity, and long term patient follow up.

12. Health Financing and Structural Bottlenecks

The financing profile described in the attached content underscores why financial protection remains fragile. Out of pocket spending remains high, donor financing continues to sustain a large share of organized provision, and public expenditure on health remains comparatively modest. This combination distorts both access and accountability. Households face direct payment barriers, while the state's capacity to steer sector priorities is weakened when major financing flows remain outside unified national purchasing arrangements.

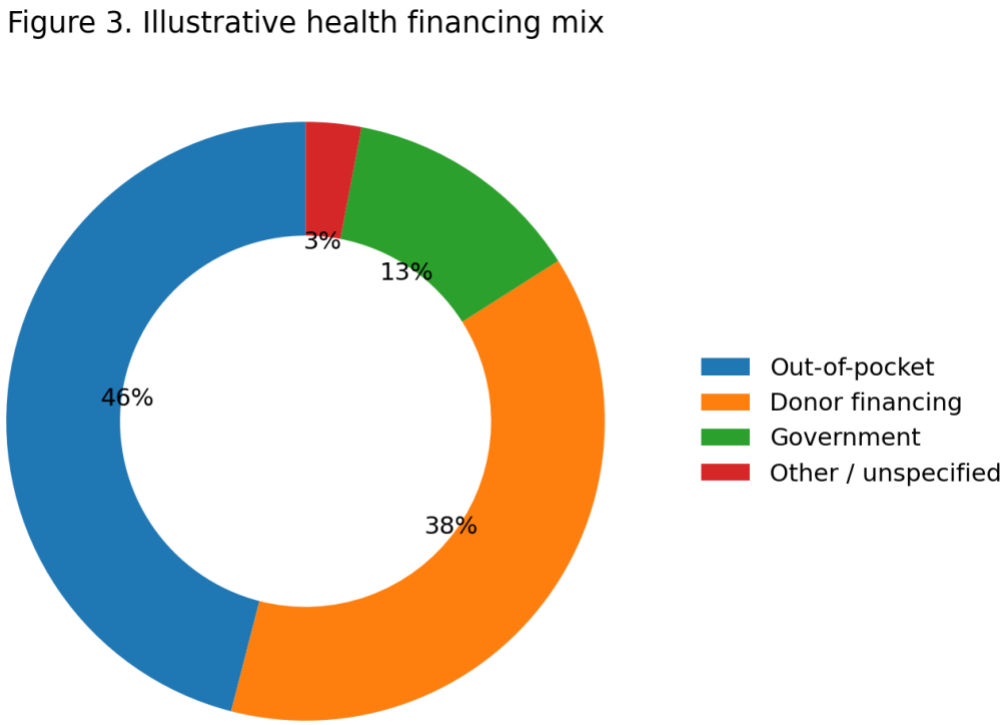


Figure 7. Illustrative Financing Mix Derived from the Supplied Strategic Materials.

At the same time, low service coverage cannot be explained by financing alone. Physical and human capacity constraints remain severe. Hospital bed density, core workforce density, essential medicine availability, and IHR core capacity all remain well below robust system thresholds. These deficits affect both routine coverage and shock responsiveness. They also help explain why progress in service coverage is incremental even when policy frameworks are comparatively well articulated.

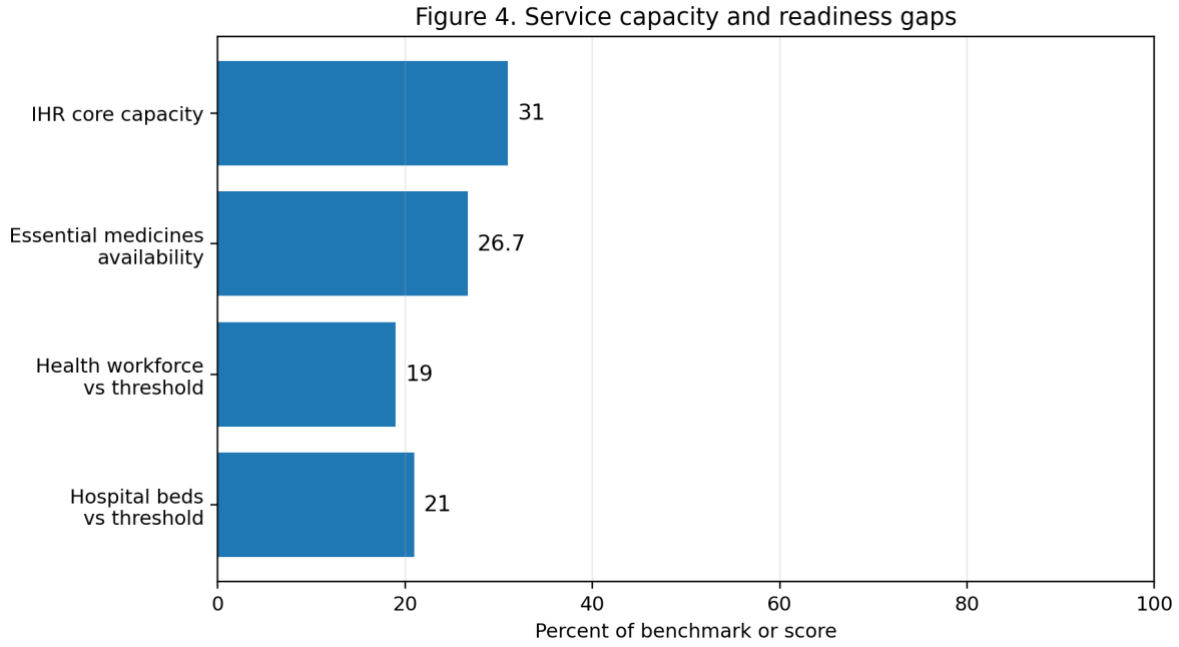


Figure 8. Illustrative Service Capacity and Readiness Gaps Carried in the Registry and Summary Materials.

13. Data Governance, Institutional Ownership, and Implementation Priorities

The attached executive summary is especially valuable in clarifying institutional roles. The Federal Ministry of Health acts as technical steward, while routine information flows through DHIS2/HMIS, programme databases, household surveys, service readiness assessments, logistics systems, and the health workforce registry. That architecture should be treated as an ecosystem rather than a set of isolated tools. Indicator credibility depends on triangulation across surveys, administrative data, and facility assessments; it also depends on bringing private sector reporting and partner managed data into a common national frame.

Several practical priorities follow from this assessment. Somalia should institutionalize a regular household expenditure survey or equivalent instrument capable of generating credible SDG 3.8.2 estimates. Routine disaggregation by federal member state, urban rural residence, sex, wealth, and displacement status should become standard for high value tracers.

Non communicable disease indicators require more systematic survey and clinical capture. Finally, the indicator registry should be used as a live management tool for annual review rather than as a static annex produced for policy documents and then abandoned until the next planning cycle.

Table 7. Priority Reform Areas, Rationale, and Near Term Operational Implications.

Priority reform area	Why it matters	Near term operational implication
Primary health care expansion	Improves equitable reach and early service contact	Invest in community health workers, outreach, and rural service points
Maternal and newborn readiness	Drives mortality reduction and RMNCH gains	Upgrade BEmONC/CEmONC readiness, referral systems, and postnatal continuity
Health financing reform	Improves affordability and sustainability	Expand pooled financing logic, routine NHA, and strategic purchasing design
Medicine and supply systems	Prevents stock outs from undermining effective coverage	Strengthen LMIS integration, procurement discipline, and tracer medicine availability
Integrated data governance	Turns policy commitments into measurable performance	Use the registry for annual review, triangulation, and sub national accountability

15. Comprehensive Annex Registry for Policy Implementation

The annex below integrates the registry logic from the indicator matrix annex and the executive summary registry files. It retains the operational formula, preferred data source, review frequency, stewardship, and baseline logic, and highlights where values are provisional or require methodological adjustment. This section is intended to provide a unified reference for monitoring policy implementation, ensuring that measurable performance is tracked consistently across all domains.

Table 9 presents the Consolidated Policy Ready Annex Registry. The table includes the following columns: ID, Domain, Indicator, Baseline, Operational Formula/Note, Preferred Data Source, Frequency, and Responsible Institution. Each entry consolidates the relevant information to facilitate annual review, triangulation, and sub national accountability.

Table 9. Consolidated Policy Ready Annex Registry.

ID	Domain	Indicator	Baseline	Operational formula / note	Preferred data source	Frequency	Responsible institution
UHC 00	Overall UHC	SDG 3.8.1 UHC SCI	22	Geometric mean of standardized national tracer indicators in the Somalia UHC set. Later official reporting of 27 is discussed in text.	National synthesis dataset combining surveys, HMIS, programme databases, SARA, HRH, emergency capacity data	Annual or biennial	FMoH Policy/Planning & Health Information Directorate with FMS MoHs and WHO support
UHC 01	Financial protection	SDG 3.8.2 catastrophic health expenditure	TBD	Historical roadmap frame cites 10% of total consumption/income; current international	Household budget or expenditure survey; NHA for triangulat	Every 3 5 years	Health Financing Unit / future NHIA functions / NBS

				reporting often uses OOP >40% of capacity to pay.	ion		
RMNCH 01	RMNCH	Family planning demand satisfied with modern methods	45	Women whose need for family planning is satisfied with modern methods divided by women in need of family planning ×100.	DHS/MICS/SHDS type survey; programme reports	Every 3 5 years	FMoH RMNCH / Reproductive Health Programme; NBS
RMNCH 02	RMNCH	Antenatal care 4+ visits	43	Women with recent live birth receiving at least four ANC visits divided by women with recent live birth ×100. Legacy draft value 42 preserved in reconciliation table.	SHDS/MICS/DHS; HMIS maternity registers	Survey cycle with annual review	FMoH RMNCH / Maternal Health Unit; FMS MoHs
RM	RMNCH	Child	45	Children aged	EPI	Annua	National

NCH 03		immunization tracer (Pentavalent 3 or equivalent)		12 23 months receiving tracer vaccine dose divided by children aged 12 23 months ×100.	administrative data and coverage surveys	l with survey validation	EPI Programme; FMS EPI units
RM NCH 04	RMNCH	Care seeking for childhood pneumonia	43	Children under five with suspected pneumonia taken to appropriate provider divided by children under five with suspected pneumonia ×100. Legacy draft figure 13 preserved separately.	SHDS/MICS/DHS; child health programme data	Survey cycle with annual review	Child Health / IMCI Unit; FMS MoHs
CD 01	Communicable diseases	Tuberculosis effective treatment	40	New and relapse TB cases successfully treated divided by total new	National TB programme database; WHO TB	Annual	National TB Programme, FMoH

				and relapse TB cases registered ×100.	reporting		
CD 02	Communicable diseases	HIV treatment coverage	10	People living with HIV currently on ART divided by estimated PLHIV or nationally approved denominator ×100.	National HIV programme database; UNAIDS estimates	Annual	National HIV/AIDS Programme, FMoH
CD 03	Communicable diseases	Insecticide treated net use in malaria risk areas	21	Population sleeping under ITN previous night in malaria risk areas divided by population in malaria risk areas ×100.	Malaria surveys; programme LLIN distribution data	Annual review; survey every 2 3 years	National Malaria Control Programme; FMS malaria units
CD 04	Communicable diseases	HepB surface antigen prevalence among children	10.54	Children under 5 testing positive for HBsAg divided by children under 5 tested in a	Serosurveys, immunization studies, modeled estimates	Periodic survey or modeling updat	EPI + surveillance / public health institute function

		under 5		representative survey ×100; inverse transformation required before composite aggregation.		e	s
NCD 01	NCDs	Non raised blood pressure among adults	To be confirmed	Adults with BP below threshold divided by adults assessed ×100; retained as unresolved baseline pending source verification.	STEPS or national NCD survey	Every 3 5 years	FMoH NCD Unit; NBS
NCD 02	NCDs	Controlled blood glucose / diabetes control	To be confirmed	Adults with controlled blood glucose under national definition divided by adults assessed ×100; retained as unresolved baseline	STEPS / NCD survey; laboratory surveillance	Every 3 5 years	FMoH NCD Unit; reference laboratories

				pending source verification.			
NCD 03	NCDs	Cervical cancer screening	To be confirmed	Women in target age group screened according to national protocol divided by eligible women ×100.	RH programme records; facility registers; surveys where available	Annual programme review	FMoH Reproductive Health / FMS MoHs
NCD 04	NCDs	Tobacco non use	To be confirmed	Adults not using smoked or smokeless tobacco divided by all adults assessed ×100.	WHO STEPS; demographic surveys	Every 3 5 years	FMoH NCD/Tobacco Control Unit
SCA 01	Capacity & access	Hospital bed capacity (standardized)	21% of threshold	Standardized score used in master registry; raw legacy values of 4.28 and 5.34 beds per 10,000 are preserved in reconciliation notes.	Facility census, SARA, national infrastructure registry	Every 2 3 years	FMoH Planning / Health Systems

SCA 02	Capacity & access	Core health worker density (standardized)	19% of threshold	Doctors+nurses+midwives per 10,000 converted to standardized capacity score. Narrative retains approximately 4.3 per 10,000 as interpretive signal.	HRH registry; payroll; professional councils	Annual	FMoH HRH Directorate
SCA 03	Capacity & access	Essential medicines availability at PHC	26.7	PHC facilities with tracer medicines in stock on assessment day divided by PHC facilities assessed ×100.	SARA/service readiness assessment; LMIS	Quarterly LMIS and periodic assessment	FMoH Logistics / CMS
SCA 04	Capacity & access	IHR core capacity index	6 historical baseline; 31 later reported score	Historical roadmap baseline preserved as 6; later strategic reporting preserved as 31/100.	WHO SPAR/JEE reports	Annual SPAR; periodic JEE	FMoH Emergencies / IHR Focal Point

16. Concluding Synthesis

The harmonized interpretation is that Somalia's UHC indicator matrix serves both as a measurement instrument and a reform management dashboard. The advancement from the roadmap baseline of 22 to official reporting at approximately 27, with a strategic target of 40 by 2029, demonstrates quantifiable progress, although complete transformation has not yet been achieved.

A comprehensive review of the uploaded documents yields optimal effectiveness: executive summaries establish a logical framework for reform, analytical briefs deliver in depth systems analysis, and the annex outlines operational procedures for calculation and accountability. This master version consolidates all three components within an integrated structure.

The resulting document is a professional, policy focused Word file designed for executive communication, technical deliberation, monitoring frameworks, and continuous improvement.

Reference List

1. Global Financing Facility. (2022). *Investment case for the Somali health sector 2022 2027*. https://www.globalfinancingfacility.org/sites/default/files/Somalia_GFF_Investment Case.pdf.
2. United Nations Development Programme. (2025). *Somalia country programme document 2026 2030 (CPD) Executive Board submission*. https://www.undp.org/sites/g/files/zskgke326/files/2025_12/somalia_cpd_2026 2030_5_december_clean_1.pdf.
3. World Bank Blogs. (n.d.). *Tracking universal health coverage with updated indicators in the World Development Indicators*. https://blogs.worldbank.org/en/opendata/tracking_universal health_coverage_with_updated_indicators_in_th0.
4. WHO EMRO. (n.d.). *Improving essential health services in Somalia using a secondary hospital based care approach* (brochure). https://www.emro.who.int/images/stories/somalia/documents/Improving_ essential_health_services_in_Somalia_brochure.pdf.
5.
6. World Bank. (n.d.). *Universal health coverage (UHC) World Bank Open Data (UHC dataset)*. https://data360.worldbank.org/en/dataset/WB_UHC.
7. World Health Organization. (2024). *UHC service coverage index (SDG 3.8.1) WHO Global Health Observatory*. https://data.who.int/indicators/i/3805B1E/9A706FD.
8. Federal Ministry of Health, Federal Republic of Somalia. (2024). *Essential Package of Health Services implementation strategic plan (EPHS ISP)*. https://moh.gov.so/so/wp content/uploads/2024/08/EPHS_Implementation_stratigy.pdf.

9. Somalia National Bureau of Statistics. (2020). *The Somali health and demographic survey 2020*. https://nbs.gov.so/wp content/uploads/2023/07/Somali Health Demographic Survey 2020.pdf.
10. World Health Organization Regional Office for the Eastern Mediterranean. (n.d.). *Communicable diseases Somalia: tracking and disease control measures*. https://www.emro.who.int/ar/somalia/priority areas/tracking of diseases and implementation of disease control measures.html.
11. United Nations Development Programme. (n.d.). *Supporting efforts to combat HIV/AIDS, tuberculosis, and malaria while strengthening health systems* (project page). https://www.undp.org/afghanistan/projects/supporting efforts combat hiv/aids tuberculosis and malaria while strengthening health systems.
12. The Global Fund. (n.d.). *Somalia Data Explorer*. https://data.theglobalfund.org/location/SOM/results.
13. UNICEF Somalia. (2025). *UNICEF Somalia 2024 annual report*. https://www.unicef.org/somalia/media/5681/file/unicef%20annual%20report%202024%20FINAL.pdf.pdf.
14. Federal Ministry of Health, Federal Republic of Somalia. (2018). *Somali roadmap towards universal health coverage (2019 2023)*. https://extranet.who.int/countryplanningcycles/sites/default/files/country_docs/Somalia/final_draft_somali_roadmap_towards_uhc_2019 23 2.pdf.
15. Federal Ministry of Health and Human Services, Federal Government of Somalia. (2021). *Somalia health sector strategic plan 2022 2026 (HSSP III)*. https://moh.gov.so/so/wp content/uploads/2022/11/Health Sector Strategy Plan III.pdf.
16. 1*UHC service coverage index | Data*. https://data.worldbank.org/indicator/SH_UHC_SCI
17. 2*Transforming health in post conflict Somalia: a multi stakeholder roun* .... https://www.dovepress.com/transforming health in post conflict somalia priorities from a multi s peer reviewed fulltext article JHL
18. 3*Essential Package of Health Services Implementation Strategic Plan* .... https://moh.gov.so/so/wp content/uploads/2024/08/EPHS Implementation stratigy.pdf
19. 4*SOMALIA HEALTH SECTOR STRATEGIC PLAN 2022 2026 (HSSP III)*. https://moh.gov.so/so/wp content/uploads/2022/11/Health Sector Strategy Plan III.pdf
20. 5*THE FEDERAL REPUBLIC OF SOMALIA The Somali Health and Demographic Sre 20*. https://nbs.gov.so/wp content/uploads/2023/07/Somali Health Demographic Survey 2020.pdf