



SOMALI RED CRESCENT SOCIETY

Health Strategy (2019-2023)



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Executive Summary

This is the third health strategy developed by the Somali Red Crescent Society (SRCS) since its inception in 1993. The first Health strategy, 2004-2009, was extended to 2012. The second 2013-2017, lapsed in 2017. The current health strategy, 2019-2023, is built on strengths and lessons learned under the implementation of the previous strategy, outcomes from a review of the SRCS health programme conducted in 2017, as well the Somali health sector strategic priorities and global health trends. The country context and health system remains fragile and fragmented as a result of almost 30 years of civil wars, conflicts and natural disasters lead to complete breakdown of the health system. However, commendable progress has been achieved in terms institutional building and health system's strengthening in the last few years as a result of peace dividends in parts of the country and investments made by international partners.

The health strategy provides vision and direction, sets strategic priorities and broad strategic interventions for the SRCS health programme. The details of interventions and activities, along with their implementation mechanisms, will be further described in the Program Implementation Plan (PIP) and incorporated into the respective context specific Action Plans (APs) to be developed subsequently, along with an elaborate national Monitoring and Evaluation plan (M&E).

The Health Strategy (2019-2023)

The Vision, Mission and Strategic Goal for the health strategy is derived from SRCS Strategic Plan¹.

Vision; *“Strong communities enabled to deal with the causes of suffering and respond to the needs of vulnerable people.”*

Mission; *“to prevent and alleviate suffering by working with communities, local authorities and other partners to provide basic and quality services to vulnerable people in accordance with the Fundamental Principles of the Red Cross and Red Crescent Movement.”*

Strategic goal for health (SG1) is to *“Develop, promote and strengthen community based health care programmes, focusing on preventive, promotive, curative and rehabilitative health services”.*

The SG1, differs slightly from the current SG in the SRCS Strategic Plan (2015-19), which indicates that SRCS offers “basic” health care, whereas in reality the programme has since expanded to include primary, secondary and tertiary care. SG1, consists of six strategic objectives (SO). SO 1-3, addresses specific health care services i.e. SO1- PHC, SO2- Secondary and SO3- Rehabilitative health care services. The other three strategic objectives are cross-cutting issues. SO4, SO5 and SO6, reflect on SRCS’ strategic directions of integrative approach to service provision and the creation of supportive environment for strengthening community-based health care services.

The health strategy also aims to better position SRCS as a key humanitarian actor and a strategic partner in the health sector within the country context. The Health Strategy (2019-2023) will focus more on; community based surveillance, health promotion and disease prevention, improved access to Universal Health Care (UHC), and building community’s capacity for health emergency preparedness and response. The assumption is that this shift of focus, will contribute towards a health programme that is more responsive to the health needs of the communities, while at the same time is more efficient, cost effective and sustainable. Even more important, the shift of focus towards communitybased health better aligns the health strategy with the SRCS Strategic Plan (2015-2019) and its health goal to **“Develop, promote and strengthen community-based health care programmes focusing on preventive, promotive and curative health services”.**

The Health Strategy was developed through a participatory process reflective of SRCS operational and collaborative structures. A steering committee led by the SRCS and consisting of representatives from the SRCS, International Federation of Red Cross and Red Crescent Societies, International Committee of the Red Cross, Norwegian Red Cross and Finnish Red Cross and was formed to lead the process of developing the new Health Strategy. The process involved a review of the SRCS health programme for the period of 2000-2016; Technical Working Group’s consolidation of bottom-up inputs and drafting of the Health Strategy; and its subsequent finalisation and launching.

A detailed results framework with SMART indicators and targets has been developed for each area of intervention, to facilitate monitoring and evaluation of progress (Annex 1 &2).

¹ SRCS Strategic plan 2015-2019.

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Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal Care
AMISOM:	African Union Mission in Somalia
AWD:	Acute Watery Diarrhoea
BEmONC:	Basic Emergency Obstetric and New born Care
CBHFA:	Community-based Health and First AID
CBS:	Community Based Surveillance
CEmONC:	Comprehensive Emergency Obstetric and Newborn Care services
CHC:	Community Health Committee
EPHS:	Essential Package of Health Services
EPI:	Expanded Programme of Immunisation
FA:	First Aid
GBV:	Gender Based Violence
GRC:	German Red Cross
HC:	Health Centre
IDP:	Internal Displaced Persons
IHCP	Integrated Health Care Program
IMCI:	Integrated Management of Childhood Illnesses
IYCF:	Infant and Young Child Feeding
IFRC:	International Federation of Red Cross
RC/RC:	Red Cross and Crescent movement partners
MCH:	Maternal and Child Health
MOH:	Ministry of Health
NCD:	Non-Communicable Diseases
NorCross:	Norwegian Red Cross
OPD:	Outpatient Department
OTP:	Outpatient Therapeutic Programme
ORS:	Oral Rehydration Solution
PLW:	Pregnant and Lactating Women
PNC:	Post Natal Care
PNS:	Partner National Society
RC/RC:	Red Cross and Red Crescent movement
SRCS:	Somali Red Crescent Society
SCZ:	South Central Zone
TBA:	Traditional Birth Attendant
STI:	Sexually Transmitted Infection
TFG:	Transitional Federal Government
UNICEF:	United Nations Children's Fund
UTI:	Urinary Tract Infection
WASH:	Water, Sanitation and Hygiene

Introduction

The Somali Red Crescent Society (SRCS) has been providing humanitarian services to the Somali people since its inception in 1963, expanding its mandate to include basic health care services through the Integrated Health Care Program (IHCP) in 1993. SRCS development of the health programme was a response to the void left by the aftermath of the civil war and consequent disintegration of the health system. This is the third health strategy developed by the SRCS. The first Health strategy 2004-2009, was extended to 2012. The Second 2013-2017, lapsed in 2017. The current health strategy 2019-2023, builds on strengths and lessons learned under the implementation of the previous strategy, a review of the health programme conducted in 2017 (Jama Mahmud, 2018), as well the global health trends such as Universal Health Care and the changing socio-political- and health sector contexts. The sociopolitical changes include availability of sector coordination mechanism, health clusters as well as development of steering documents at national levels, for example; National Health Policy, Health Sector Strategic Plans (HSSPI-II) and the nation-wide Health Management Information System (HMIS). However, Somali health sector is still fragile after almost three decades of civil war, and frequent natural disasters. However, commendable progress in the development of the health sector, especially in the development of infrastructure and institutional capacity of health authorities as a result of peace dividends in larger parts of the country, and investments made by international partners.

This strategy will guide decisions related to the allocation of resources, prioritization of activities and management arrangements, among other key priorities. It will also serve as a yardstick for measuring performance and holding the SRCS accountable. The health strategy will be supplemented by annual Plans of Action (PoA) and detailed activity budgets for different regions. This will allow for programmatic tailoring under the strategy, in recognition of the unique challenges, as well as opportunities, found in the different contexts/regions.

The health strategy addresses strategic goal number one of the SRCS Strategic Plan 2015-2019. It is also aligned with the Somali Health Policy (2014) and Health Sector Strategic Plan (HSSPII), 2017 - 2021

The SRCS Health Programme

The SRCS Health Programme consists of the following components,

- **PHC:** Integrated health care programme (IHCP) and community-based health promotion activities widespread throughout the regions
- **First aid program and pre-hospital care:** FA training to communities, health workers throughout the country, FA actions teams ready to respond to emergencies in Mogadishu, Galkayo and Lascaanod, and internal capacity FA training in all SRCS 19 branches
- **Secondary Health Care:** Keysaney Hospital in Mogadishu.
- **Tertiary Health Care:** Orthopaedic rehabilitation services for the physically disabled/challenged persons in Hargeisa, Galkayo and Mogadishu

IHCP has been the flagship of the SRCS since 1993, comprises of a network of maternal and child health (MCH) and out-patient department (OPD) clinics. In February 2018, the SRCS ran a total of 129 clinics (75 stationary and 52 mobile) with approximately 454 staff, serving a target a population of approximately 1,799, 554 in the country. The SRCS network of MCH/OPD health facilities offer, among others, expanded programme of immunization (EPI), therapeutic and preventive nutrition (OTP) services, case management of childhood and common ailments (IMCI), safe motherhood and the referral of complicated cases to regional hospitals. In addition, SRCS also supports community-based activities through trained volunteers to work with a range of preventive and promotive activities as well as awareness creation on HIV/AIDS and other stigmatised and harmful traditional practices such as female genital mutilation and cutting (FGM/C).

The secondary health care services at Keysaney Hospital in Mogadishu, previously provided services for weapon-wounded and medical emergencies, however, a fistula program was added in 2017 and plans are underway to provide hospital and Comprehensive Emergency Obstetric and Newborn Care (CEmONC)².

² Under ICRC support since 1991 and currently in joint support ICRC and Norway Red Cross

The tertiary health care/ orthopaedic rehabilitation centres in Galkayo, Hargeisa and Mogadishu, provide services for war related injuries and for physically disabled/challenged persons. The services include prosthetic, orthotic appliances and physiotherapy.

The SRCS is the only national organisation that offers health care services that consists of Primary Health Care, Secondary and Tertiary care in the region. As such, the SRCS offer a continuum of care that is unique and which is complemented with mobile clinics and community based health services.

Major achievements, challenges and lessons learned (Health Strategy 2013-17)

SRCS has an excellent reputation as a reliable and trusted partner within the RC/RC movement as well DRAFT as in the communities they operate in. A comprehensive review of the health programme carried out in 2017 (Jama Mahmud, 2018), revealed:

1. Major achievements for SRCS health programme (and its contribution to the health sector)

- A programme that is versatile and adapts to the need of the community it serves. The health programme has evolved from Primary Health Care Unit (PHU) in 1993 to a comprehensive and integrated PHC with MCH and OPD services. SRCS also provides secondary and tertiary health care through the rehabilitation and fistula services.
- The health programme has successively increased its coverage over the years. For example, the IHCP programme provided health care services to an average 914,436 beneficiaries per year, which is 7% of the national population.
- Majority of the Health Centres offer integrated health and nutrition services targeting the most vulnerable in the society, such as young children, pregnant and lactating women.
- Screening and curative services in the OTP continue to improve, the number of cured children in OTP from 83% (2013) to 86.9% (2017).
- The SRCS health programme is dynamic and has adapted to the needs on the ground over time. For example; Keysaney hospital will changed its main programme from a focus on war-wounded surgery to fistula and CEmONC, which are services offered by few actors in the health sector. The Health Review also showed the same trend for the PHC, where the services evolved from Health Posts (HP's) offering basic health care to HC, offering comprehensive and integrated MCH/OPD and nutrition services.
- The SRCS is one of the few health providers whose health personnel attend regular training.
- SRCS has contributed to the innovation of the Somali health sector, for example, SRCS were first to introduce mobile health care services in some regions of the country.
- SRCS Health programme provides services in remote areas where no other actors have access.
- As one of the few surviving national institutions to work throughout the geographical areas of the country, SRCS has a large network of volunteers and has strong support in the communities ensuring SRCS neutrality and impartiality.
- SRCS has been on the forefront of health emergency response through the county.

2. Challenges and lessons learned:

Some of the challenges identified in the health review include:

- Poor staff motivation (mainly due to poor remunerations and other incentives)
- Inadequate staff training and capacity building for non-clinical staff.
- Lack of/poor economic resources leading to short term funding as well as over dependence on external funding.
- Unreliable medical supplies, especially emergency medical and non-medical supplies and poorly maintained infrastructures.
- Existing services are insufficient to cater for new developing health problems such as NCD's.
- Lack of proper Monitoring and Evaluation, and general poor capacity in data management, despite the introduction of Health Management Information System (HMIS).
- Difficulties in estimating target population as there is lack of reliable national population statistics, hence the inconsistencies in basic population figures makes it difficult to calculate the catchment or target population for the HC's and other health services.
- Poor implementation and documentation of community-based health programmes such as Community Based Health and First AID (CBHFA).
- The implementation and evaluation of the previous health strategy was poor, the annual evaluation was ad-hoc

and no mid-term evaluation was conducted. As a result, it is difficult to evaluate the achievements of the previous health strategy.

- Lack of steering documents to be able to implement the health strategy.

As a result of the identified strengths, challenges and lessons learned, and the health sector priorities as well as global trends, the following strategic priority areas were identified as important for the SRCS health strategy (2019-2023):

1. Quality over quantity: Among other things, the need to decide on the relevance of the clinics based on actual and emerging needs.
2. Harmonise the health programme, to enable quality evaluation and quality improvement.
3. Increase resource mobilization to mitigate over dependence on external donors.
4. Improvement of relations with local communities, volunteers and authorities. This will entail the need for better communication strategies.
5. Enhance ownership of the SRCS strategy.
6. Ensure the implementation of continuum of care.

Background and Context

Socio-political context

The Somali Red Crescent Society (SRCS) is a member of the Red Cross and Red Crescent movement (RC/RC). It is an independent, non-political, humanitarian organization that was founded in April 1963 and established through a Presidential Decree No. 187 in 1965. It became a member of the International Federation of the Red Cross and Red Crescent Societies in 1969. The SRCS has been providing humanitarian services to the Somali people since its inception, expanding its mandate to include basic health care services through the Integrated Health Care Program (IHCP) in 1993, in response to the vacuum left by the aftermath of the civil war of 1991, and consequent breakdown of the central government.

As with many humanitarian organisations, SRCS faces challenges due to the geo-political context in the country. This may have profound implications for the SRCS health programme, particularly in aligning the programme with the local health sector structure and mechanisms. It is therefore important that the Health Strategy framework and its parameters are purposely broad and flexible to accommodate change, as well as providing the SRCS the flexibility to respond to continuously changing contexts and needs.

The Humanitarian Context

Somalia has one of the fastest growing population in Africa, with 2.9% annual growth rate, and fertility rate of 6.7%. The current population is estimated at 13 million (2016), with 42.4% living in urban and 22.8% in rural areas³. Nomads make up 25.9% of the total population, whereas 8.6% of the total population are internally displaced people (IDP), living mainly in the outskirts of urban towns. Over 65% of the population is under 30 years and faces high unemployment. In addition, more than half of the population lives in poverty with about 43% living on less than 1 US dollar a day. Hence, large proportion of the population is sensitive to negative shocks.

Somalia is often referred to as complex emergency, where a complex predicament of human activity including civil strife, war, and political repression often co-exists with and exacerbates natural phenomena such as famine. Natural hazards such as drought, flooding and cyclones are recurring in Somalia and because of the high level of vulnerability, natural hazards often turn into humanitarian disasters such as high mortality, population displacement, and the disruption of civil society and its infrastructure (Schull & Shanks, 2001).

³ Gavi & WHO, 2016

The Somali Health System

The health system is still recovering from over two decades of war, which has resulted in a variety of relief and vertical programs, run by NGOs and UN agencies. In addition, a large number of private practitioners are operating clinics, hospitals, pharmacies, in an unregulated system. The quality of basic health services is generally poor and accessibility to health care is limited due to high out-of-pocket costs, poor/lack of transportation as well as, insecurity in some parts.

The Somali health authorities adopted the Essential Packages of Health Services (EPHS)^{4,5} as the de facto model for the health sector in 2013. Since then, it has been integrated into the HSSP I (2013-2017) and later in HSSP II (2017-2021). EPHS marked the first government level effort, to harmonise and systematise the health services. The SRCS has adopted the EPHS as the framework for the current Health Strategy (2019-2023).

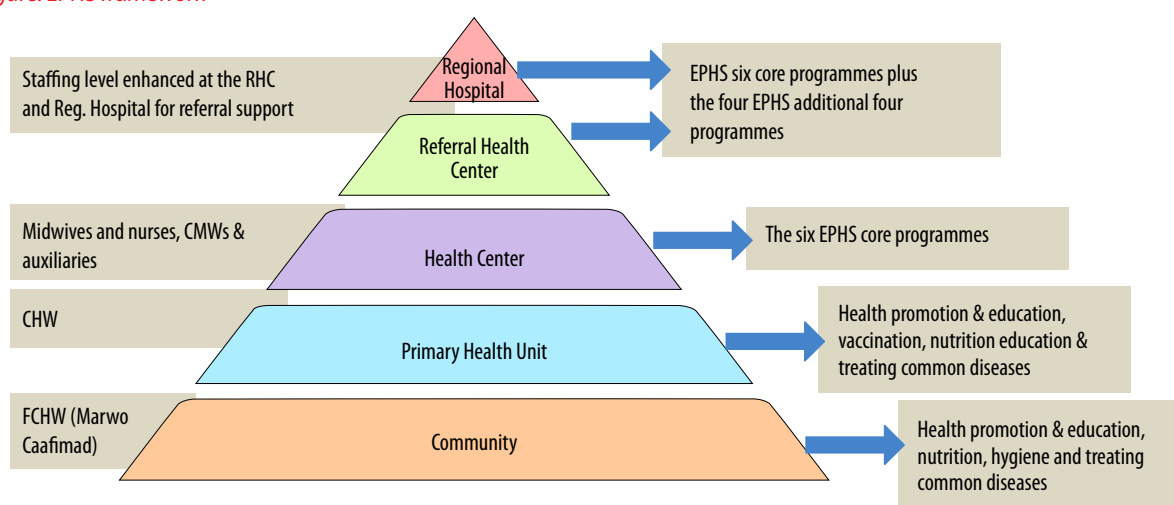
The EPHS stipulates four levels of service provision; Primary Health Care Unit (PHU), Health Centre (HC), Referral Health Centre (RHC) and Hospital (H); divided into 10 programmes; six core and four additional (Figure 1). For each facility level, there are specified minimum requirements for all the health service components and human resources needed. The framework also includes CHC's or elected community representatives in all the four facility levels to help in management of clinics and to raise funds.

1. Maternal, reproductive and neonatal health,
2. Child health,
3. Communicable disease surveillance and control, including Watsan promotion,
4. First aid and referral of critically ill and injured,
5. Treatment of common illness,
6. HIV, STIs and TB

The four additional programmes are;

7. Chronic Disease management
8. Mental health/mental disability
9. Dental health
10. Eye health

Figure: EPHS framework



4 The Somali Health Sector Strategic Plan(s) (HSSPI and II).

5 The EPHS is the prime mechanism for strategic service provision of the public sector health service. It helps to clarify health priorities and directs resource allocation, and defines the health systems standard for the government, UN, NGOs and private providers.



Development of the Health Strategy

The health strategy 2019-2023 was developed in a highly participatory process involving four major steps

1. A health strategy review committee was formed by the SRCS president to lead the development process of the health strategy.
2. A review of the SRCS health programme for the years 2000-2016 was carried out to establish the nature, development, relevance and added value of the programme, as well as the strengths and weaknesses.
3. A series of workshops were then conducted
 - The first workshop with senior representatives from SRCS, IFRC, ICRC, Finnish Red Cross and NorCross was conducted in Nairobi to set the strategic directions and priorities for the next 5 years for the health strategy.
 - 3 bottom-up consultative workshops (2 days in each location) were conducted in Hargeisa, Garowe and Kismayo
 - A 2-day technical workshop was conducted to consolidate the outcome from the workshops - A health technical meeting was called to specify activities and try to cost the health strategy.
4. Finally, the draft was reviewed by the health strategy committee and movement partners. The group provided feedback which was integrated and used to finalise the strategy.

Guiding Principles

The 2019-2023 Health Strategy has a number of guiding principles of the RC/RC movement. These are outlined below:

Principles and Code of Conduct of the RC/RC Movement:

The Health Strategy is guided by the fundamental principles of the Red Cross and Red Crescent Movement. These are humanity, impartiality, neutrality, independence, volunteerism, unity and universality. The Health Strategy is further guided by the ethical standards for humanitarian intervention set out in the Red Cross and Red Crescent Movement Code of Conduct:

- The humanitarian imperative comes first;
- Aid is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone;
- Aid will not be used to further a particular political or religious standpoint;
- We shall endeavour not to be used as an instrument of government foreign policy;
- We shall respect culture and custom;
- We shall attempt to build disaster response on local capacities;
- Ways shall be found to involve program beneficiaries in the management of relief aid;
- Relief aid must strive to reduce vulnerabilities to future disaster as well as meeting basic needs;

- We hold ourselves accountable to both those we seek to assist and those from whom we accept resources;
- In our information, publicity and advertising activities, we shall recognize disaster victims as dignified human beings, not hopeless objects.

Sphere standards

The Health Strategy is aligned to the Humanitarian Charter and Minimum Standards in quality and accountability to Humanitarian Response (Project, 2011), as defined under the Sphere project. These standards aim to improve the quality of humanitarian assistance and the accountability of humanitarian actors to their constituents, donors and affected populations, a guiding principle in the DRAFT development of the SRCS Health Strategy.

Community participation and ownership: The Health Strategy places Somali people at its centre and is guided by the principle of community participation. Under the Health Strategy, communities have and will continue to be engaged in the process of identifying health priorities and in realising their right to health. This will be facilitated through community committees, SRCS volunteers and health personnel. Through a process of engagement and participation, community members will become more aware of their right to health and their responsibility in contributing to this. The SRCS firmly believes that effective community participation in planning, designing, delivery and monitoring of its health services is a prerequisite for community ownership. All its health services will be designed in such a way as to engage the community in which it is working, and thereby instil community ownership.

Rights and equity based approach: The Health Strategy employ a rights based approach. These encompass human rights, child rights, age and disability as well as gender equality. A rights based approach will inform all aspects of the strategy as well as plans of action developed to suit the different contexts within which SRCS operates. Plans will balance principles of equity, in order to reach IDP, disabled, nomadic and other vulnerable groups in remote areas.

Partnership: Partnership is integral to the Health Strategy – with communities, with local authorities as well as local and international non-government partners. ‘Partnership’ can be understood as an ongoing working relationship where risks and benefits are shared. In practical terms this means each partner is involved in co-creating projects, committing tangible resources and ensuring mutual accountability. This principle will guide the SRCS in its approach to partnership under the Health Strategy.

Asset rather than deficit approach: The Health Strategy is intended to build on the assets found within Somali communities. An asset model accentuates positive ability and capacity to identify problems and activate solutions. This is in contrast to deficit models which tend to define communities (and institutions) in negative terms based on their deficiencies and needs. An asset based approach is particularly important given the evolving context in the country and a situation of limited external resources. The SRCS has had some notable success with this approach in the past having successfully piloted community contributions (financial and in-kind) to the operation of its IHCP.

Quality over quantity: The Health Strategy looks to consolidate advances made in scaling up SRCS health infrastructure and interventions with equal attention to quality. This is in line with the EPHS which sets out to improve the quality of service provision and not, in the first phase, the quantity of health facilities created. Transition from conflict to recovery should allow the SRCS greater access to its facilities and enable more effective support and supervision. This will allow the organisation to address both the productivity as well as quality of services provided.

Sustainability: In the design and delivery of health services, SRCS shall focus on health programmes that result in sustainable health services. Sustainable health services are those which are technically appropriate, cost effective, and owned by the community.

Auxiliary to Public Authorities: The SRCS believes that providing health services is the primary DRAFT responsibility of the government. As an auxiliary to government, all health services offered by the SRCS will be supplementary and complementary to health authorities, and will be designed to meet the gaps in the health services in the country or strengthen already existing services, if need be.

Rationale for the Health Strategy

The SRCS health programme, like majority of other programmes in the Somali health sector, has been focusing mainly on emergency and curative health care services for over two decades. MoH's have endorsed the EPHS and PHC approach as the framework for the health sector.

SRCS sees an opportunity to understand the relevance of its core health programs and the quality of services provided through the network of health activities. Hence this framework provides guidance for the health services, health infrastructures, medicine and service delivery, as well as staff cadres and number.

In addition, donor fatigue and changing donor priorities towards development oriented and cost-effective programmes are also factors taken into consideration. These changes call for innovative approaches to health programming, an approach that is more flexible, and can combine both humanitarian and development oriented components.

The changing environment presents an opportunity for SRCS to capitalise on its strengths presence in almost all regions, - large volunteer network, local and well-trained health staff, social capital and neutrality. In addition, focus is on provision of the health services to the most vulnerable populations in hard to reach areas or areas where there are no other providers, as stipulated in the SRCS overall Strategic Plan (2015-2019). This health strategy differs from the previous one in five major aspects:

- i) It has a nuanced community-based orientation, with community engagement, community preparedness and response to health emergencies, as cross-cutting issues and priority areas.
- ii) New components have been added to respond to the emerging health and other needs;
 - Management and treatment of NCD's specifically Asthma, Diabetes, Epilepsy and Hypertension will be introduced into the PHC services, to cater for the rising prevalence of NCD cases among Somalis.
- iii) First Aid and pre-hospital care is integrated into the SRCS health programme, which serves to further strengthen community-based health components.
- iv) It adopts the EPHS framework as the de-facto model for its facility-based health care services, enabling SRCS to have one "national health programme" and services that are easily definable. This process will also facilitate harmonisation of the SRCS health programme.
- v) It contains a results framework with SMART targets and indicators that will facilitate Monitoring and Evaluation (M&E) of achievements, thereby increasing transparency and accountability. One of the major challenges is the lack of baseline data.

Strategic Goal and Objectives

Strategic Goal 1

Develop, promote and strengthen community based health care programmes, focusing on preventive, promotive, curative and rehabilitative health services.

Strategic Objective 1: Primary Health Care

Provide quality, preventive and curative services through SRCS facility and Mobile Health Facilities network

To better integrate with the health sector, a strategic decision was taken to use the EPHS framework, hence the previous MCH/OPD clinics will be referred to as Health Centres (HC), providing the services as defined in the EPHS. In addition, community participation and referral system will be strengthened to ensure better continuum of care.

Priority interventions

- 1.1. Continue the provision of high-quality preventive and curative services through HC, integrated mobile clinics and outreach services
- 1.2. Provide comprehensive and integrated reproductive, maternal and child health services with referral for continuum of care
- 1.3. Enhance preventive and promotive health services that address the underlying causes of childhood diseases
- 1.4. Provide therapeutic and preventive nutritional services in targeted communities (OTP, TSFP, DRAFT defaulter tracing, IYCF promotion)
- 1.5. Strengthen physical infrastructure and human capacity to delivered high quality PHC services





Strategic Objective 2: Secondary Health Care

Secondary Health Care: Provide quality and effective surgical, obstetric and neonatal health care through the SRCS Keysaney hospital

Due to the decreasing number of weapon wounded patients during the last 4 years, the services will be transformed and gradually include Fistula clinic (currently running) and complicated emergency maternity and neonatal health care (in the near future). Keysaney hospital is located in a former detention centre that will require a rehabilitation of the infrastructure. There are few hospitals/clinics that provide fistula repairing services in Somalia, hence Keysaney provides access to a much needed and highly specialised medical service for reproductive health.

Priority interventions

- 2.1. Provide surgical services to the war wounded and other surgical emergencies.
- 2.2. Develop capacity for the provision of emergency obstetric neonatal care as well as fistula repairs
- 2.3. Strengthen the referral system with communities and allied peripheral health facilities
- 2.4. Strengthen the infrastructure, clinical and management capacity of the referral hospital aligning with the health authorities' health system



Strategic Objective 3: Rehabilitation of physical disabled persons

Enable the rehabilitation of people with physical disability and their effective support and integration into society.

For the next five years, priorities will be given to establishment of community-based rehabilitation (CBR) services in all branches, as a way to expand the services nearer the people but also to ensure continuum of care and greater support of those living with disability as well as their families in dealing with daily challenges and stigma. Strong focus will be given to strengthening and systematisation of referral system as a strategy to attain continuum of care.



Priority interventions

- 3.1. Provide equitable, accessible and acceptable quality based physical and rehabilitation and physiotherapy services
- 3.2. Provide CBR near the people including, extended supportive physiotherapy and psychosocial services
- 3.3. Strengthen a 3-way referral system between communities, SRCS branches and physical rehabilitation centre.
- 3.4. Enhance and increase capacity of the professionals and physical infrastructures' ability to deliver high quality rehabilitation health care services and human capacity to delivery high quality rehabilitative health care

Strategic Objective 4: First Aid

Enable SRCS and communities to provide pre-hospital/first aid assistance to wounded and acutely sick persons in SRCS areas of operations in a timely, effective and safe manner⁶

SRCS vision in First Aid is "Wounded and sick people receive a First Aid assistance where and when they need it". The SRCS will collaborate with partners and other stakeholders in the expansion of the program. SRCS is committed to improve the quality of first aid programme by strengthening the skills of the first aid trainers and provision of equipment and materials.



⁶ This SO is guiding objective for the revision of SRCS First Aid Strategy in 2020

Priority Interventions

- 4.1. Ensure that all SRCS staff and volunteers are trained on first aid
- 4.2. Build the capacity of communities, public and private institutions in first aid
- 4.3. Provide first aid services to the people affected by accidents and emergencies in an effective, timely and safely manner

Strategic Objective 5: Community Based Health

Build community capacities for identifying and addressing priority health concerns and health determinants in order to prevent and mitigate risks and other underlying causes of poor health through community engagement.

Community engagement has been envisaged to be inclusive as possible, ensuring the participation of both men and women - as volunteers, community leaders and household members. Creating greater community awareness of underlying determinants of ill health and formulating solutions to these will be sought and supported under this strategic objective

Priority interventions

- 5.1. Improve community engagement and coordination to improve coverage, acceptance and implementation of SRCS health services, including Water and Sanitation
- 5.2. Enhance CBHFA interventions to improve health promotion and disease prevention
- 5.3. Strengthen referral systems with communities and allied peripheral facilities
- 5.4. Strengthen communities' capacity to understand the case definitions of selected common illnesses and take appropriate and approved steps
- 5.5. Improve community's knowledge, attitudes, beliefs, skills and practices related to harmful traditional practices, HIV and other stigmatized conditions such as traditions and taboos on maternal and infant health and nutrition
- 5.6. Establish efficient community based surveillance systems for early detection of outbreaks and nutrition crisis



Strategic Objective 6: SRCS and Community preparedness and response to health emergencies

Build/strengthen SRCS and community's capacity to manage the risks of epidemics, and to mitigate health effects of emergencies and disasters.

Priority interventions

- 6.1. Implement alongside MoH and WHO EWARN system to improve response to epidemic emergencies
- 6.2. Provide effective and integrated disease early case detection and surveillance for active health warning systems

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Annexes

ANNEX 1: RESULTS FRAMEWORK						
Outcomes/Indicators		Targets				
Baseline		2019	2020	2021	2022	2023
SO 1: Provide quality, preventive and curative services through SRCS facility and Mobile Health Facilities network						
1.1. Continue the provision of high quality preventive and curative services through HC, integrated mobile clinics and outreach services.						
1.1.1	Improved access to healthcare services	N/A	Assessment of the relevance of the existing and upcoming SRCS clinics	Assessment of the relevance of the existing and upcoming SRCS clinics	Assessment of the relevance of the existing and upcoming SRCS clinics	Assessment of the relevance of the existing and upcoming SRCS clinics
1.1.2	Established and integrated basic treatment for NCD's: Asthma, diabetes, epilepsy and hypertension into PHC service	N/A	SOP and programme proposal for NCD developed	Ensure training for SRCS staff on NCD	NCD component fully incorporated into SRCS PHC programme	
1.1.3	Developed structures, systems and capacity to pilot community based mental health	N/A		SOP and programme proposal for community based mental health care services developed	Volunteers and staff trained in detection and counselling	System, structure and capacity in place to start community-based mental health services
1.1.4	% of sick children treated according to IMCI protocol	30%	55%	65%	70%	80% of children under 5 are treated following IMCI protocols
1.1.5	Gender based violence integrated in PHC services	5%	15%	20%	25%	25% of rape survivors treated 100% of treated consenting victims referred to relevant facilities for appropriate actions Ensure all SRCS clinics provide post rape kits

1.2. Provide comprehensive and integrated reproductive, maternal and child health services with referral for continuum of care									
1.2.1	Improved ANC services following the national guidelines (# ANC 1, ANC 4 and drop rate)	33% of delivering mother received ANC services	14%	14%	14%			14%	75% of pregnant women in target population receive ANC
1.2.2	Increased PNC services following the national guidelines (#PNC 2)	Outreach mobile MCH services 0 rounds per month 32358 (32%) delivered mothers received PNC services	35%	38%	42%			47%	Increase outreach for MCHs' services to 2 rounds per year 50% of women delivered at Health Clinic receive PNC
1.2.3	Number of women who delivered in the facility by the midwives	35%	40%	45%	50%			60%	70%
1.2.4	Increased number of Health facilities providing BeMONC services	N/A	2%	5%	9%			15%	18% of health SRCS health facilities have BeMONC services
1.3. Enhance preventive and promotive health services that address the underlying causes of childhood diseases									
1.3.1	Improved availability and coverage of routine EPI	N/A	20%	30%	40%			65%	80% of <1 year from the catchment area population are fully cover vaccinated
1.4. Provide therapeutic and preventive nutritional services in targeted communities (OTP, TSFP, defaulter tracing, IYCF promotion)									
1.4.1	% of children that are screened for SAM and MAM in all SRCS clinics	N/A	30%	40%	50%			60%	80%
1.4.2	% caregiver that are provided IYCF sessions	N/A	20%	50%	60%			70%	80%
1.4.2	% Defaulter rate in nutritional program	8%	7%	6%	5%			4%	2%

1.5. Strengthen physical infrastructure and human capacity to deliver high quality PHC services						
1.5.1	Number of days per month with shortage of the essential drugs	N/A	Less than 4 essential drugs	Less than 3 essential drugs	Less than 3 essential drugs	Less than 2 essential drugs
1.5.2	Number of facilities rehabilitated or established	N/A	DRAFT		5	8
1.5.3	% of facilities with access to clean water and sanitation	N/A	100%	100%	100%	All SRCS facilities
S02: Provide quality and effective surgical, obstetric and neonatal health care through the SRCS Keysaney hospital.						
2.1. Provide surgical services to the war wounded and other medical emergencies.						
2.1.1	Number of war wounded cases received and managed by the hospital					
2.1.2.	Hospital mortality rate	N/A	More than 6%	6%	Less 6%	Less than 5%
2.1.3	Hospital bed occupancy rate	N/A	More than 14 days	12 days	10 days	Less than 8 days
2.2. Develop capacity for the provision of emergency obstetric neonatal care as well as fistula repairs						
2.2.1	Number of staff trained for specialized care (neonatal, maternal or fistula care)	N/A	1			
2.3. Strengthen the referral system with communities and allied peripheral health facilities						
2.3.1	Number of patients referred from SRCS structures to the fistula program	N/A	2%	6%	10%	14%
2.3.2	Number of surgical cases referred from primary health care (Access)	N/A	0			
S03: Enable the rehabilitation of people with physical disability and their effective support and integration into society.						
3.1. Provide equitable, accessible and acceptable quality based physical and rehabilitation and physiotherapy services						
3.1.1	Number of cases referred from primary and secondary care to the rehabilitation centres	N/A				
3.1.2	Number of beneficiaries supported with orthosis and prosthesis	1009 & 489 (2018 data)				
3.1.3	Number of beneficiaries supported with Physiotherapy care	5295 (2018 data)	5560	5825	6089	6884

3.2. Provide CBR near the people including, extended supportive physiotherapy and psychosocial services					
3.2.1	Number of branches that provide Community based rehabilitation services	N/A	1		
S04: Strengthen the capacity of SRCS and communities to enable them provide pre-hospital/first aid assistance to wounded and acutely sick persons in SRCS areas of operations in a timely, effective and safe manner					
4.1 Ensure that all SRCS staff and volunteers are trained on first aid					
4.1.1	Number of SRCS staff and volunteers trained on first aid				
4.2 Build the capacity of communities, public and private institutions in first aid					
4.2.1	Number of communities who receive first aid training				
4.2.2	Number of commercial first aid sessions conducted				
4.3 Provide first aid services to the people affected by accidents and emergencies in an effective, timely and safely manner					
4.3.1	Number of first aid action teams established				
4.3.2	Number of ToT sessions conducted for first aid action teams				
S05: Build community capacities for identifying and addressing priority health concerns and health determinants in order to prevent and mitigate risks and other underlying causes of poor health through community engagement.					
5.1 Improve community engagement and coordination to improve coverage, acceptance and implementation of SRCS health services, including Water and Sanitation					
5.1.1	Number of health facilities with functional and trained community health committees				
5.1.2	Number of clinics with established feedback and complaint mechanisms (CEA)				
5.2. Enhance CBHFA interventions to improve health promotion and disease prevention					
5.2.1	Number of staff and volunteers trained on health promotion activities				
5.2.2	Number of staff and volunteers trained on community first aid				

5.3. Strengthen communities' capacity to understand the case definitions of selected common illnesses and take appropriate and approved steps					
Training programmes and plans for volunteers to enable community members to provide treatment and refer life-threatening conditions according to international and national guidelines (ORS, homemade ORS for diarrhoea, Sponging for fever)	25%	Training plans and programmes for community-based health care services developed and implemented	Introduce and implement basic health care and referral of selected lifethreatening conditions to community level		
SO 5: Build community capacities for identifying and addressing priority health concerns and health determinants in order to prevent and mitigate risks and other underlying causes of poor health through community engagement.					
5.1. Implement alongside MoH and WHO EWARN system to improve response to epidemic emergencies					
% of SRCS clinics that are reporting into the EWARN system	weekly surveillance report all HF to MOH/WHO				
Number staff/volunteers trained in epidemic control and response					
% of SRCS clinics reporting into HMIS/DHIS	????????????????				
5.2 Provide effective and integrated disease early case detection and surveillance for active health warning systems					
Number of SRCS branches with community-based surveillance activities	N/A	1			

Comments SO3: 3.1.1 not systematic but the clinic and Hospital they refer to the rehabilitation center We are not seen the staff number or standardized implantation (# of staff, # HF rooms or attached implantation guidelines)

THE FUNDAMENTAL PRINCIPLES OF THE INTERNATIONAL RED CROSS AND RED CRESCENT MOVEMENT

HUMANITY: The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

IMPARTIALITY: It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

NEUTRALITY: In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

INDEPENDENCE: The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

VOLUNTARY SERVICE: It is a voluntary relief movement not prompted in any manner by desire for gain.

UNITY: There can be only one Red Cross or one Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

UNIVERSALITY: The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.





ABOUT SRCS

The Somali Red Crescent Society (SRCS) is an independent, non-political humanitarian organization that was founded in April 1963 and was established with presidential decree No. 187 in 1965.

It was then recognized by the ICRC in 1969 and in the same year became a member of the International Federation of the Red Cross and Red Crescent Societies.

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