

Outcome Framework and Institutional Guidelines from the 7th Intergovernmental Conference on Somalia's National Social Health Insurance Act (NSHIA)

Advancing health financing, strengthening primary care resilience, and achieving universal health coverage



Executive Framing Statement

The National Social Health Insurance Authority (NSHIA) serves as a comprehensive federal collaboration platform committed to advancing financial protection, fortifying the resilience of Primary Health Care (PHC), enhancing emergency preparedness, and advancing progress toward Universal Health Coverage (UHC). This platform facilitates coordination and shared responsibility, establishing itself as a central mechanism for health financing reform in Somalia.

7th Intergovernmental Conference Jowhar Framework for Establishing Somalia's NSHIA:
Health Financing PHC Resilience UHC



NSHIA's distinctive role and scope ensure it is not a standalone office, an independent parallel health system, or a commercial insurance entity. Its primary objective is to restructure the health financing architecture through integrated governance, mutual accountability, and active engagement among all levels of government, implementing partners, and stakeholders.

This strategic positioning underscores the significance of interconnected and collaborative initiatives across institutions. It guarantees that health financing protection and the pursuit of UHC are managed collectively through coordinated strategies and joint commitments.

1. Conceptual Overview and Foundational Rationale

1.1 Purpose and Scope

The establishment of the National Social Health Insurance Act (NSHIA) represents a significant advancement in the realm of health financing and protection reform within Somalia. This initiative aligns closely with the overarching objectives of achieving Universal Health Coverage and fortifying the primary health care systems.

The comprehensive framework seeks to foster a unified understanding and commitment among the Federal Government, Federal Member States (FMS), the Banadir Regional Administration (BRA), development partners, health service providers, professional bodies, and communities.

The primary objectives of this initiative are as follows:

1. Clearly define NSHIA as an institutional mechanism.
2. Compellingly articulate the necessity and relevance of this reform within Somalia's current health financing landscape.
3. Outline a phased, pragmatic, and context-sensitive implementation strategy.
4. Establish operational protocols and mechanisms for ongoing intergovernmental cooperation.

1.2 Foundational Principle: Collaboration as an Institutional Prerequisite

A fundamental principle is established from the outset: the success of NSHIA hinges on institutionalized collaboration, not isolated efforts or actions within a single ministry. Effective functioning necessitates:

1. Identification and appointment of delegates from within each stakeholder institution.
2. Explicit definition of roles, responsibilities, and decision-making authorities.
3. Commitment to specific, time-bound deliverables supported by measurable indicators.
4. Implementation of shared accountability frameworks binding all parties involved.

The establishment of robust follow-up mechanisms, including regular review cycles following the Jowhar meeting, is crucial for the success of health financing reform in federal contexts. This



organizational structure recognizes the need for both horizontal coordination and vertical integration to ensure sustained commitment across multiple jurisdictions.

2. Problem Articulation: Health Financing Challenges and Reform Imperatives

2.1 Current Health Financing Reality and Avoidable Hardship

The Outcome Framework, Stated, commences with a comprehensive and evidence-based assessment of Somalia's current health financing conditions and their associated consequences. Somalia's health system is characterized by fragmentation and chronic underfunding, resulting in substantial and preventable hardships for vulnerable populations. Urgent reforms are imperative to address these critical challenges.

1. **Excessive Out-of-Pocket Expenditure:** Individuals and families bear an disproportionate share of health-related costs, with out-of-pocket payments constituting a significant portion of total health expenditure. This impact is particularly regressive, exacerbating poverty among the most disadvantaged households.
2. **Disjointed Financing Architecture:** The absence of a cohesive health financing framework has led to fragmented and uncoordinated funding streams, causing inefficiency, reduced predictability, and compromised priority-setting.
3. **Insufficient Protection Mechanisms:** Current arrangements provide minimal safeguards against catastrophic health expenses. Vulnerable populations lack mechanisms for financial risk management during health shocks, resulting in delayed care, disease progression, and adverse health outcomes.
4. **Vulnerability to Recurrent Shocks:** The health system's limited resilience to repeated epidemiological, climatic, or economic shocks perpetuates vulnerability and diminishes public confidence in reliable services.
5. **Diminished System Trust:** These issues collectively undermine trust in the health system's capacity to deliver reliable, equitable, and protective services.



2.2 The Reform Imperative: Conceptual Reframing

It is essential to emphasize that this reform extends beyond simply creating an insurance designation or adding administrative procedures. The approach focuses on establishing a credible protection framework with three primary objectives:

- 1-Reducing the financial burden on households seeking healthcare
- 2- Strengthening Primary Health Care as the foundation of the health system
- 3- Enhancing national preparedness for epidemiological and other health emergencies

Core Message: “This reform is not about establishing an insurance label; it is about constructing a trusted protection platform that alleviates financial hardship, supports Primary Health Care, strengthens national preparedness, and fulfills the foundational commitment to Universal Health Coverage.”

3. INSTITUTIONAL CLARIFICATION: DEFINING NSHIA

3.1 What NSHIA Is

The National Social Health Insurance Agency (NSHIA) is a government-led pooled financing mechanism grounded in the principles of solidarity, equity, and social health protection—not profit. NSHIA consolidates resources from multiple sources and manages funds transparently to finance essential health services and shield households from catastrophic health expenditures. It operates under the governance of the Ministry of Health and Human Services (MoHHS), in coordination with fiscal authorities and Federal Member States (FMS), maintaining robust public oversight and accountability.

3.2 What NSHIA Is Not

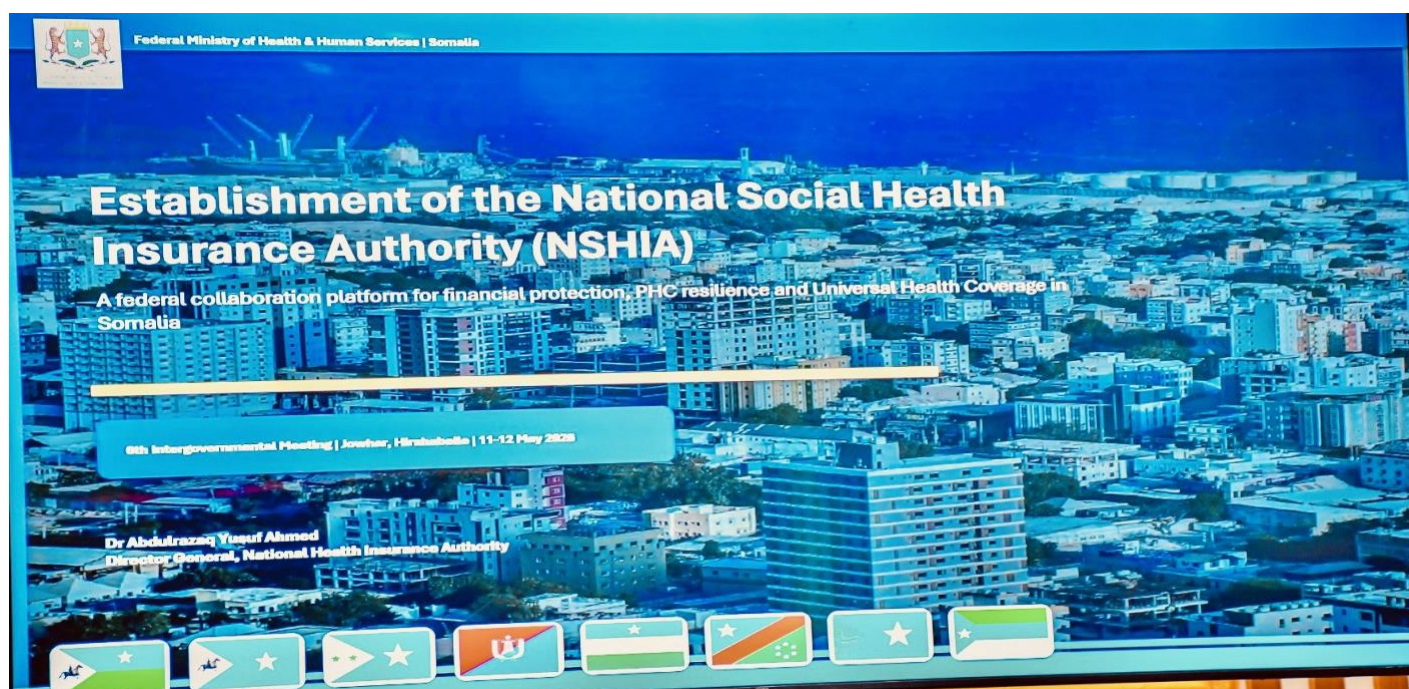
NSHIA does not:

Function as a hospital or direct service provider; instead, it engages existing providers through contracts.

Operate as a commercial insurer or profit-oriented entity; rather, it allocates revenue to improve access and quality in health services.

Serve as a parallel institution or independent body; it is integrated within governmental structures and remains accountable to them.

Core Message: "NSHIA is a unified, public protection platform managed under



government stewardship, designed to reduce financial barriers and strengthen the national health system. It is not a hospital, insurer, or institution operating outside established government frameworks."

4. FEDERAL OWNERSHIP AND INCLUSIVE DESIGN

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4.1 The Importance of Federal Member State Engagement

To ensure legitimacy, portability, equity, and public trust, active participation from all Federal Member States (FMS) is required from the outset. An inclusive design approach aligns state interests, accommodates internal mobility, and addresses diverse regional needs.

Achieving genuine federal ownership necessitates continuous engagement with FMS throughout both planning and implementation phases. By ensuring every state contributes to decision-making, NSHIA promotes transparency, mutual trust, and shared governance. This collaborative framework upholds the principles of equity and inclusivity, establishing the foundation for a resilient and adaptive health financing system capable of meeting Somalia's evolving population needs.

Core Message: “No state will endorse a system in whose development it has not participated. All FMS must be actively involved in the design phase.”

4.2 Realizing Federal Ownership::

The National Social Health Insurance Authority (NSHIA) is established as a federal platform dedicated to advancing financial protection, strengthening primary health care, improving emergency preparedness, and promoting progress toward Universal Health Coverage in Somalia.

NSHIA operates through coordinated governance and shared accountability among all levels of government, implementing partners, and stakeholders. It is not a standalone office, an independent health system, or a commercial insurance entity. Instead, NSHIA's primary purpose is to reform health financing by fostering integrated collaboration and mutual responsibility.

The initiative addresses key challenges in Somalia's health financing landscape, including excessive out-of-pocket expenditures, fragmented funding streams,



insufficient protection mechanisms, vulnerability to recurrent shocks, and diminished trust in the health system.

NSHIA aims to alleviate financial burdens for households, reinforce primary health care, and enhance national preparedness for health emergencies.

NSHIA is a government-led, pooled financing platform founded on principles of solidarity, equity, and social health protection.

It consolidates funds from various sources and manages them transparently to support essential health services and protect households from catastrophic health expenses.

The platform is governed by the Ministry of Health and Human Services in collaboration with fiscal authorities and Federal Member States, ensuring public oversight and accountability.

Federal Member States are actively engaged throughout the planning and implementation stages to ensure legitimacy, portability

5. The Somalia-Fit Implementation Model

5.1 Phased Approach:

NSHIA will adopt a phased, evidence-based implementation strategy rather than a rapid, nationwide rollout. The process will begin with incremental expansion through carefully selected pilot sites. These pilots will provide valuable lessons and data, which will be used to adapt and refine the model as it expands across Somalia.

5.2 Components of the Model:

- Development of a federal compact that clearly outlines roles and accountability structures for all actors involved.
- Initial focus on delivering primary health care benefits to maximize impact and feasibility.
- Financing mechanisms will adhere to mutual aid principles, drawing on the concept of Takaful to promote collective responsibility.
- Systems will be designed to function effectively in environments with both low and growing digital capacity, ensuring accessibility and adaptability.

- Establishment of emergency-ready pooling mechanisms to rapidly mobilize resources in crisis situations.
- Scale-up of the model will be guided by operational success and sustainability, expanding only as each phase proves effective.

5.3 Implementation Phases

- Phase 0: Legal and institutional setup, including readiness assessments to ensure foundational capacity.
- Phase 1: Launch of pilot sites in FMS that are ready, with the goal of demonstrating feasibility within two to three years.
- Phase 2: Expansion of the platform based on the outcomes and lessons learned from the pilot phase.
- Phase 3: Sustained growth with the objective of achieving universal coverage over time.

Establish a comprehensive national framework, and expand its reach through the deployment of FMS-certified pilots and iterative learning processes





6. Stakeholder Responsibilities and Accountabilities

6.1 Responsibility Framework

Clearly defined roles for all actors are essential to prevent duplication of effort and to promote effective coordination throughout the NSHIA implementation process.

6.2 Federal Ministry of Health and Human Services

The Ministry of Health and Human Services (MoHHS) leads NSHIA, ensuring alignment with national health policy. MoHHS is responsible for developing benefit packages, setting standards, coordinating with partners, and providing technical support to all stakeholders.

6.3 Ministry of Finance

The Ministry of Finance is tasked with ensuring protected fund flows, providing predictable budgets, upholding audit discipline, and securing the long-term financial sustainability of the platform.

6.4 Federal Member States and BRA

Federal Member States and the Banadir Regional Administration (BRA) share responsibility for owning and implementing NSHIA. This includes conducting readiness assessments, maintaining facility inventories, engaging with communities, establishing data and reporting systems, operating grievance mechanisms, participating in joint monitoring, and supporting the portability of services.

6.5 Health Service Providers

Health service providers must meet defined minimum standards, report transparently, adhere to referral protocols, participate in quality improvement activities, provide feedback on payment arrangements, and uphold professional standards at all times.

6.6 Development Partners, Private Sector, Civil Society

Development partners, the private sector, and civil society provide crucial support by offering technical assistance, coordinating funding, advocating for public awareness, fostering trust, and promoting accountability and ongoing learning.

6. Critical Commitments from the conference

7.1 The specific commitments outlined during the meeting.

1. Recognition of NSHIA as National Reform Initiative: Formal recognition and endorsement of NSHIA as a central health financing and protection reform linked to national commitments such as Universal Health Coverage, Primary Health Care strengthening, and health system resilience. This acknowledgment elevates NSHIA from a technical project to a political priority



2. Nomination of Federal Member State and BRA Technical Delegates from: Each FMS and BRA Stated designate technical delegates from to participate in all technical discussions, communicate decisions to their respective jurisdictions, and ensure accountability.
3. Validation of Inclusive Design Approach: Formal validation that all FMS will be involved in the design process from the outset, with recognition that while implementation may be phased, inclusive participation in design is non-negotiable.
4. Support for Legal Finalization and Mandate Clarity: Endorsement of legal finalization for NSHIA, support for presenting enabling legislation or directives to the cabinet, and clarification that NSHIA operates under MoHHS stewardship with cross-government coordination requirements.
5. Agreement on Federal Compact Process: Agreement to establish a federal compact process to negotiate and operationalize fund flow mechanisms, data sharing protocols, provider readiness requirements, portability arrangements, and dispute resolution processes, along with a specified timeline (typically 6-12 months) for completion.
6. Partner Alignment Behind One Roadmap: Commitment from development partners to align their technical and financial support behind the joint national NSHIA roadmap, avoiding support for parallel or competing initiatives.

7.2- Formal resolution reached during the Conference.

"Endorse a joint NSHIA establishment pathway and authorize convening a technical follow-up process within 30-90 days of the Jowhar meeting."

This decision formalizes our commitment and establishes a formal mechanism for its implementation.

8. RISK ACKNOWLEDGMENT AND MITIGATION STRATEGY

8.1 Honest Assessment of Implementation Risks

The Jowhar conference underscored that sustainable reform depends on the proactive identification and mitigation of critical risks during implementation. Failure to address these challenges effectively may compromise credibility and substantially heighten the risk of unsuccessful outcomes.

8.2 Specific Risks Requiring Early Attention



Legal and Cabinet Endorsement Risk: The establishment of NSHIA requires legal finalization and explicit cabinet endorsement. Absence of clear legal authority and political commitment creates uncertainty about the reform's durability and invites institutional resistance. Mitigation requires completion of legal drafting, parliamentary or cabinet approval, and public commitment from political leadership.

Budget and Operational Resource Risk: Sustainable operation of NSHIA requires dedicated budgetary allocations and operational resources (staffing, systems, monitoring, evaluation). Inadequate resourcing results in non-functional systems and loss of credibility. Mitigation requires realistic resource projections, explicit budget allocations, and alternative funding mechanisms (development partner support) if government capacity is limited.

Fragmented Partner Financing Risk: When development partners support parallel initiatives rather than aligning behind one roadmap, resources are wasted, implementation becomes confusing, and competing structures undermine the central reform. Mitigation requires early, intensive partner alignment processes and explicit agreements to direct support toward the joint roadmap.

Federal Member State Coordination Risk: Without genuine FMS engagement, buy-in, and coordination, the reform may be perceived as federal imposition rather than collaborative undertaking. Portability and population movement require standardized systems across states. Mitigation requires inclusive design, genuine responsiveness to FMS concerns, and mechanisms for ongoing coordination.

Provider Readiness and Data Quality Risk: Service delivery facilities may lack readiness (equipment, supplies, trained staff, data systems) to support NSHIA. Poor data quality undermines management and accountability. Mitigation requires realistic readiness assessments, targeted capacity building, and investment in data systems before expecting full implementation.

Public Trust and Social Legitimacy Risk: Public skepticism about government institutions, experience with failed reform initiatives, and suspicion about insurance schemes generally may undermine willingness to contribute or utilize NSHIA. Trust is built through demonstrated integrity, transparency, grievance responsiveness, and visible benefits. Mitigation requires robust community engagement, transparent financial management, and visible service improvements.

8.3 Risk Management Philosophy

CORE MESSAGE TO EMPHASIZE: "Start small, prove integrity through careful implementation and transparent management, learn fast from pilot experience, and expand only when readiness is real and evidence supports scaling."

This approach opposes the pursuit of swift and extensive growth, favouring instead a measured and evidence-driven implementation strategy.



9. Guidelines for post-conference communication and operations:

VISION FOR COLLABORATION AND ESTABLISHMENT

9.1 Confident Yet Realistic Conclusion

The conference, along with its central message, reflected both confidence in the importance of the reform and a practical awareness of the prerequisites for effective partnership:

Collaboration serves as the foundation of our strategy. Our objective is to develop a unified national NSHIA framework, guided by common standards and shared principles. Federal Member States will be actively involved from the initial design phase. We are committed to prioritising Primary Health Care in benefit design and ensuring the continuity of essential services during emergencies. Sustainable financing mechanisms will be mobilised to support ongoing protection and enhance resilience. Transparency, accountability, effective grievance response, and measurable improvements in access and protection will be central to building trust. The initiative will commence with carefully selected pilot programmes, incorporate rigorous learning from practical experience, and scale up based on demonstrated readiness and robust evidence.

