

FEDERAL REPUBLIC OF SOMALIA

JAMHUURIYADDA FEDERAALKA SOOMAALIYA

SOCIAL HEALTH INSURANCE AUTHORITY

HAY'ADDA CAYMISKA CAAFIMAADKA BULSHADA

COMMUNITY CONSULTATION REPORT

Identifying Equitable Enrolment and Guaranteed Access within Somalia's Social Health Insurance Scheme

Listening to economically disadvantaged, displaced and marginalised communities in order to translate coverage into usable care



AUGUST 2026
MOGADISHU, SOMALIA

EQUITY • FINANCIAL PROTECTION • TRUST •
ACCOUNTABILITY

About this report

This report consolidates the August 2026 community consultation record prepared for the Social Health Insurance Authority (SHIA), together with the SHIA-ARKAAN strategic dialogue concept materials and the supporting consultation presentation. It is written as an implementation report. Its purpose is to show how community experience should shape enrolment, benefit access, financial protection, provider behaviour, grievance redress and public accountability.

CENTRAL PROPOSITION

Social health insurance succeeds only when a registered member can understand the entitlement, reach an appropriate provider, obtain covered care and medicines, avoid unaffordable costs, and secure a fair remedy when the system fails.

Document control

Title	Community Consultation Report: Identifying Equitable Enrolment and Guaranteed Access within Somalia's Social Health Insurance Scheme
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Evidence discipline

This report does not infer participant counts, consultation coverage, contribution rates, subsidy thresholds or fiscal envelopes that the source record does not document. Descriptive numerical details — such as the approximately three-kilometre facility distance reported in one example from an IDP setting — are treated as consultation evidence. They are not presented as nationally representative estimates. Annex A sets out the evidence limitations in full.

Note on exhibits

Visual material is numbered in three independent sequences. **Figures** are analytical graphics derived from the text of this report. **Tables** present structured findings, requirements and recommendations. **Plates** are photographs from the consultation record. No figure in this report contains empirical measurements; all figures are analytical schematics. Where a figure shows a reporting format rather than a finding, it is labelled as a template and carries no data.

Defined terms and abbreviations

The following short forms are used throughout. Institutional instruments proposed in this report — the **Vulnerable Population Subsidy Window**, the **No Surprise Health Cost Policy**, the **Nine Institutional Commitments** and the **Social Health Insurance Inclusion Compact** — are capitalised at every occurrence.

EPHS	Essential Package of Health Services	IDP	Internally displaced person
M&E	Monitoring and evaluation	OOP	Out-of-pocket (expenditure)
PHC	Primary health care	SHI	Social health insurance
SHIA	Social Health Insurance Authority	UHC	Universal Health Coverage

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Somali section titles are provided for community communication and should be verified by SHIA's communications function before public release.

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01

SECTION 01

Executive Summary*Soo-koobid Fulineed*

From nominal coverage to practical financial protection

Somalia's social health insurance (SHI) reform will be judged not by the number of names entered into a registry, but by whether households can use their entitlements at the moment of illness. The August 2026 community consultation therefore addressed a practical question. How can the Social Health Insurance Authority (SHIA) achieve broad, fair and trusted enrolment while guaranteeing meaningful access to covered health services? The question applies with particular force to people who are poorest, displaced, mobile, living with disability, working informally or otherwise at risk of exclusion.

Participants consistently distinguished formal membership from real protection. A member may be registered and still remain effectively uninsured. Documentation may be rejected. A facility may be too difficult to reach. Referral transport may be unaffordable. Essential medicines may be unavailable. An informal charge may be demanded. A complaint may be impossible to make safely. The consultation therefore treated the insurance journey as a connected access chain rather than as a single enrolment transaction.

10

STAGES IN THE
ACCESS CHAIN

8

CROSS-CUTTING
FINDINGS

9

PROPOSED INSTITUTIONAL
COMMITMENTS

THE DEFINING FINDING

Coverage that exists on paper is not enough. SHIA must finance, contract, monitor and protect the full pathway from enrolment to treatment and remedy.

1.1 What the consultation identified

Seven conclusions carry directly into implementation.

- Members need plain, repeated and accessible explanations of what membership covers, where care may be sought, and what to do when care is denied.
- Documentation, travel cost, distance, disability, mobility and safety constraints can make registration itself an exclusion mechanism.
- Hidden and informal costs — transport, unavailable medicines, diagnostics, unofficial charges and repeated referral journeys — can defeat the promise of financial protection.
- Poor households and vulnerable populations require a transparent, government-funded subsidy pathway linked to the Essential Package of Health Services (EPHS).
- Contracted providers must apply a common non-discrimination standard, so that subsidised members receive the same dignity and quality of care as other members.
- Grievance and appeal mechanisms must be understandable, accessible, confidential where necessary, traceable and protected from retaliation.
- Public trust must be treated as a measurable implementation outcome, supported by transparent reporting on contributions, subsidies, provider payments, claims and administrative expenditure.

1.2 What the report proposes

These findings generate three connected instruments. The ten-stage access chain set out in Section 5 provides the diagnostic frame. The Nine Institutional Commitments in Section 12 convert the diagnosis into accountable obligations. The Social Health Insurance Inclusion Compact proposed in Section 14 gives those obligations public expression. Section 13 sequences all three into a hundred-day implementation pathway.

FIGURE 1

From nominal coverage to effective protection

Six conditions must hold before a registered member is genuinely protected. A failure at any one of them converts the entitlement into a paper right.

01	REGISTERED The household is entered in the scheme and its eligibility and subsidy status is decided.	RISK IF UNMET <i>Documentation, distance, cost or safety turn registration itself into an exclusion mechanism.</i>
02	INFORMED The member can explain what is covered, where care may be sought, and what to do if it is refused.	RISK IF UNMET <i>The entitlement exists on the register but is never claimed at the point of illness.</i>
03	ABLE TO REACH CARE An accredited provider is identifiable, reachable and able to receive the member, including on referral.	RISK IF UNMET <i>Distance, congestion and referral transport cost defeat the benefit before treatment begins.</i>
04	TREATED Care is timely, clinically appropriate, respectful and free of discrimination.	RISK IF UNMET <i>Subsidised members receive a lesser standard of service than contributing members.</i>
05	SUPPLIED AND PROTECTED FROM COST Covered medicines and diagnostics are actually available, and no unauthorised or catastrophic charge arises.	RISK IF UNMET <i>Nominal coverage converts into out-of-pocket expenditure at the counter.</i>
06	ABLE TO OBTAIN REMEDY A complaint or appeal can be made safely and receives a traceable response.	RISK IF UNMET <i>Failure anywhere in the chain is neither detected nor corrected.</i>
Coverage is effective only where all six conditions hold simultaneously. SECTION 1 • SECTION 5		

Note. Derived from the central proposition of the consultation record. The conditions correspond to the ten-stage access chain set out in Section 5 and Table 3.



PLATE 2 Community and civil-society representatives take part in the SHIA-ARKAAN consultation dialogue, Mogadishu, August 2026.

02

SECTION 02

Strategic Context and Rationale*Xaaladda Istaraatiijiyadeed iyo Sababta Loo Baahan Yahay*

Why community-defined access must sit at the centre of implementation

The consultation materials characterise Somalia's health financing environment in four terms: fragmentation, high household exposure to direct payment, uneven geographic access and heavy dependence on external financing. Within that environment, SHIA is framed as a public pooled-financing and strategic-purchasing platform. It is intended to protect households from catastrophic and impoverishing expenditure, to strengthen primary health care (PHC), to extend coverage progressively to vulnerable and informal-sector populations, and to mobilise domestic resources within a coherent Universal Health Coverage (UHC) architecture.

The consultation also situates SHI within a longer Somali legal and institutional history. Supporting legal review materials document pre-1991 social insurance arrangements, including contributory mechanisms and health-related benefits. The contemporary reform is therefore presented not as a commercial insurance product but as a public solidarity mechanism. As such, it requires legal clarity, sustainable financing, transparent governance and public legitimacy.

STRATEGIC IMPLICATION

The architecture of SHI should be designed around the conditions in which people actually live: displacement, irregular income, mobility, limited documentation, disability, low literacy and distance from services. It should not be designed around an idealised administrative user.

2.1 Five policy pillars carried into the consultation

TABLE 1

Five policy pillars carried into the consultation

Pillar	Implementation meaning
Reform architecture and governance	Institutional clarity, accountability, transparency, stewardship and coordination.
Financing, pooling and strategic purchasing	Sustainable financing, equitable contributions, targeted subsidies, risk pooling and provider-payment rules.
Benefits and primary health care	Explicit entitlements, quality-assured essential services, clear referral pathways and people-centred PHC.
Equity and inclusion	Protection against exclusion associated with poverty, displacement, disability, gender, mobility or geography.
Scholarship, legislation and public trust	Evidence-informed policy, regulatory alignment, transparent communication, grievance redress and sustained partnership.

These pillars establish what the consultation set out to test. Section 3 describes how it was tested.



PLATE 3 Opening policy framing during the strategic dialogue on equitable health coverage and social health insurance implementation.

03

SECTION 03

Purpose and Consultation Design*Ujeeddada iyo Qaab-dhismeedka La-tashiga*

Structured listening, problem-solving and community validation

The consultation was designed to convert community experience into operational choices for SHIA. Its objective was not to establish whether people supported social health insurance. It was to identify where exclusion could occur across the entire member journey, and which concrete design responses would prevent it.

3.1 Objectives

- Identify the financial, administrative, social, geographic and institutional barriers to equitable enrolment and access.
- Examine practical mechanisms — including subsidies, exemptions, risk pooling and strategic purchasing — for people unable to meet contribution requirements.
- Generate actionable recommendations for enrolment, benefit design, primary-care orientation and service delivery.
- Define mechanisms for community engagement, public oversight, grievance resolution and transparent communication.
- Build a collaborative implementation pathway involving government, communities, civil society, academia, providers and technical partners.

3.2 Methodological approach

The source record describes a structured listening and problem-solving process conducted in Somali and supported by community and civil-society actors. Discussions followed the full insurance access pathway, from awareness through enrolment, eligibility and subsidy, membership confirmation, facility access, referral, treatment, medicines and diagnostics, and claims, to complaints, appeals and monitoring. Oral responses were used where literacy was limited. Findings were organised thematically around the barriers participants reported and the solutions they proposed.

INTERPRETATION RULE

A breakdown at any point in the member journey converts an insurance entitlement into a paper right. Equity must therefore be assessed at every stage, not only at registration.

The design deliberately privileged the groups least likely to complete that journey unaided. Section 4 identifies them.

04

SECTION 04

Who the Consultation Sought to Hear*Cidda La-tashigu Doonayay in Codkooda la Maqlo*

Nine priority groups and the reasons the standard pathway may fail them

The consultation prioritised populations for whom a standard administrative pathway is least likely to work. Table 2 sets out each group and the structural reason its members may not complete the access chain without deliberate adaptation. The groups are not mutually exclusive. A displaced older woman living with a chronic condition experiences several of these constraints simultaneously, and accumulated disadvantage is the most common form of exclusion.

TABLE 2

Priority population groups and the reason the pathway may fail without adaptation

Population group	Why the pathway may fail without adaptation
Internally displaced persons (IDPs)	Weak documentation, livelihood insecurity, mobility and constrained facility access.
Extremely poor households	Limited ability to contribute, and high vulnerability to indirect and hidden care costs.
Persons with disabilities	Physical, communication and mobility barriers in both enrolment and service access.
Older people	Difficulty travelling to fixed registration points and health facilities.
Women and women-headed households	Safety and gender-related barriers to information, travel and service navigation.
Children	Dependence on household enrolment and on caregiver navigation of the system.
Pastoralists and mobile populations	Distance from fixed enrolment infrastructure, and continuity-of-coverage challenges.
Informal-sector workers	Irregular income, and inability to contribute at salaried-worker levels.
Chronically ill persons	Need for continuous, affordable medicines, diagnostics and follow-up care.

FIGURE 2

Where the consultation locates the risk of exclusion

Each of the nine priority groups is mapped to the access-chain phase in which the consultation record places its principal constraint.



Note. Derived from the constraints stated in Table 2. Markers classify reported constraints; they are not a quantitative risk assessment. Eight of the nine groups have their principal constraint in Phase I or Phase II, which is why Sections 7 and 8 carry the greatest operational weight.

These groups define the equity test that the remainder of the report applies. Section 5 sets out the framework against which that test is made.

05

SECTION 05

The Access Chain: From Registration to Remedy*Silsiladda Helitaanka: Diiwaangelinta ilaa Xal-u-helidda*

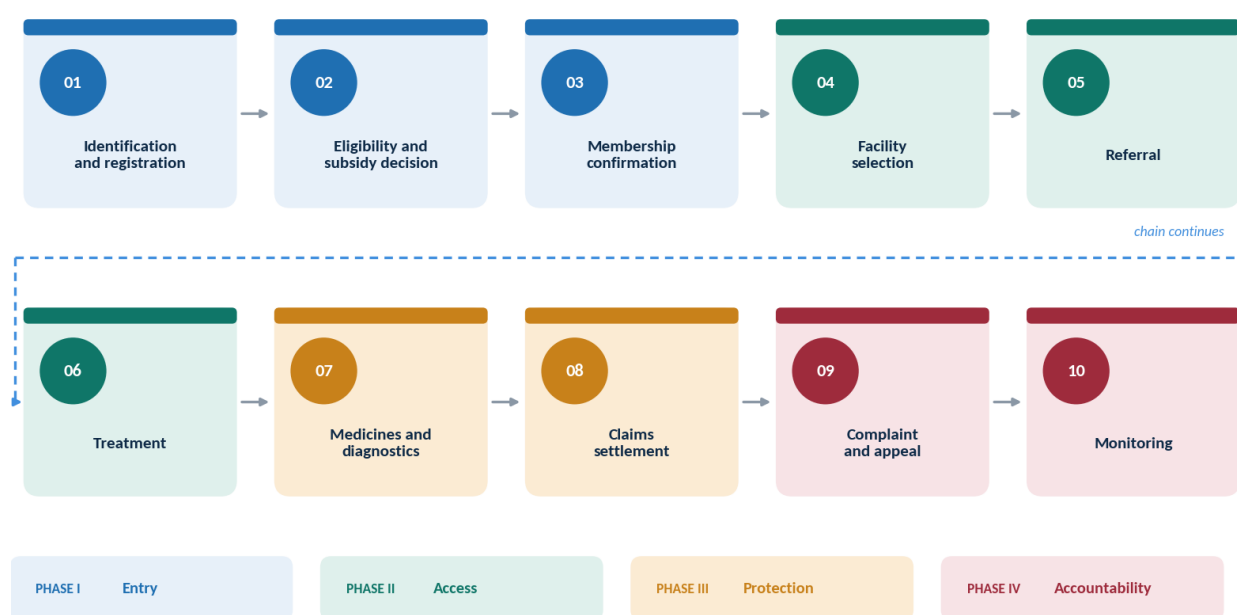
A member-centred framework from identification to monitoring

The strongest analytical contribution of the consultation is the access-chain perspective. It recognises that social health insurance is not a single transaction but a sequence of linked transactions and service encounters. Each stage requires explicit rules, operational capacity and accountability, and a failure at any stage nullifies the stages that preceded it.

FIGURE 3

The ten-stage access chain, from registration to remedy

The chain is grouped into four phases — entry, access, protection and accountability — which structure the analysis in Sections 7 to 11.



Note. Stage definitions, access tests and operational questions are set out in Table 3.

TABLE 3

The ten-stage access chain: stages, access tests and operational questions

Stage	Access test	Operational question
01	Identification and registration	Can the person enter the system without exclusionary paperwork, travel or digital requirements?
02	Eligibility and subsidy decision	Is vulnerability assessed fairly, transparently and with a right of appeal?
03	Membership confirmation	Does the member receive immediate proof of cover that works offline?
04	Facility selection	Can the member identify an accredited provider and the services it covers?
05	Referral	Can the member move between levels of care without repeated documentation or unaffordable transport?
06	Treatment	Is care timely, respectful, non-discriminatory and clinically appropriate?

Stage	Access test	Operational question
07	Medicines and diagnostics	Are covered medicines and tests actually available, without surprise charges?
08	Claims settlement	Do payment arrangements sustain provider participation and continuity of care?
09	Complaint and appeal	Can a member report denial, cost or discrimination safely and receive a traceable response?
10	Monitoring	Can SHIA detect unequal enrolment, utilisation, denial, waiting time or informal cost across groups?

DESIGN STANDARD

SHIA should measure successful coverage as completion of the access chain, not as possession of a membership number.

The chain also supplies the structure of what follows. Section 6 reports what communities said about it, and Sections 7 to 11 examine the four phases in turn.

06

SECTION 06

What Communities Said*Waxa Bulshadu Sheegtay*

Eight cross-cutting findings with direct implementation consequences

Eight findings recurred throughout the consultation. Each is stated here with the implementation response it requires and the section in which that response is developed.

TABLE 4

The eight cross-cutting findings and their required implementation responses

#	Finding	What participants described	Required implementation response
1	The awareness gap	Even where people knew that a scheme was being developed, many could not explain the benefits, the eligible facilities, medicine coverage or point-of-care requirements.	Issue a plain Somali-language member-entitlement tool at enrolment and explain it face to face, with audio and pictorial options.
2	Registration can exclude	Missing identity documents, travel costs, disability, age and safety concerns make conventional office-based registration inaccessible.	Use mobile enrolment, assisted registration, community attestation and offline membership confirmation.
3	Nominal coverage is not protection	Participants described paying for checks and medicines when facility stocks were unavailable, alongside congestion and long waiting.	Contract for availability, monitor stock-outs and adopt a No Surprise Health Cost Policy.
4	Referral creates acute exposure	Transport to another district or city can exceed a poor household's monthly resources.	Standardise referral, publish receiving facilities and design protection against referral-related financial risk.
5	Hidden costs erode trust	Transport, unavailable medicines, unofficial charges and repeated visits undermine confidence in the benefit promise.	Publish covered services and tariffs, prohibit unauthorised charges and create rapid complaint channels.
6	Ability to pay is unequal	Poor IDP households and informal workers cannot contribute at the level of salaried workers.	Apply progressive contributions and establish a government-funded Vulnerable Population Subsidy Window.
7	Grievance systems must be credible	A mechanism may exist and still be unusable if it requires literacy, exposes the complainant or lacks independence.	Provide oral and assisted channels, confidentiality, tracking numbers, response standards and formal appeal.
8	Trust is operational	Communities reasonably question where funds go and whether promises will be honoured.	Publish financing and performance information, and keep beneficiaries involved in oversight.

FIGURE 4

Where each finding bites: the eight findings mapped to the access chain

Read across each row to see which stages of the chain a finding disturbs, and down each column to see the findings a given stage must withstand.



Note. Derived from the finding statements in Table 4. Every one of the ten stages carries at least one reported constraint, which is the evidential basis for treating inclusion as a whole-chain obligation rather than an enrolment campaign.

The findings divide cleanly among the sections that follow. Findings 1 and 2 concern entry to the scheme and are addressed in Section 7. Findings 3 to 5 concern whether the benefit is usable once entry is secured, and are addressed in Section 8. Finding 6 concerns affordability and is addressed in Section 9. The equity dimension that cuts across all eight is examined in Section 10, and Findings 7 and 8, which concern remedy and trust, are addressed in Section 11.

07

SECTION 07

Equitable Enrolment*Diiwaangelin Caddaalad ku Dhisan*

Designing the front door so that vulnerable people can actually enter

The consultation treats registration as a substantive equity intervention rather than an administrative formality. For households without identity documents or fixed addresses, for persons with disabilities and older people, for women for whom travel may be unsafe, and for pastoralists and people living in displacement, a fixed office with a document-heavy workflow is not neutral. It systematically favours populations that already hold greater administrative and financial capacity.

The implication is consequential. If the entry point is not redesigned, the scheme will reproduce existing inequality at the moment of registration, and will do so invisibly, because those who are excluded never appear in the membership data at all.

7.1 Recommended enrolment architecture

- Mobile enrolment teams visiting IDP settlements, markets, mosques, health facilities and other trusted community locations on published schedules.
- Legally recognised community attestation as a temporary identification pathway where formal documentation is incomplete.
- Immediate and verifiable membership confirmation that remains usable without a smartphone or an internet connection.
- Assisted-enrolment desks at public and contracted health facilities.
- Periodic mobile registration along pastoralist routes and in remote communities.
- Community agents trained to support registration under strict data-protection and accountability rules.
- Integration with government identification and social-protection processes where legally and technically appropriate.
- Somali-language audio, visual and pictorial communication for people with limited literacy.

POLICY PRINCIPLE

The objective is universal accessibility, not biometric perfection. Identity controls are necessary, but the absence of a document must not become a permanent exclusion mechanism.

EVIDENCE

Registration procedures designed around documents, offices and travel exclude precisely the groups the scheme is intended to protect.

IMPLICATION

Inequity introduced at entry is invisible in administrative data, because those excluded are never counted as members.

REQUIRED ACTION

Adopt assisted, mobile and attestation-based enrolment, and report enrolment by vulnerability group from the first quarter of operation.



PLATE 4 A participant contributes during the consultation. The report treats lived experience as a direct input into enrolment and eligibility design.

Entry, however, only opens the chain. Section 8 examines whether the entitlement holds once the member seeks care.

08

SECTION 08

Meaningful Access to Covered Care*Helitaan Macno Leh oo Daryeelka la Caymiyay*

From membership confirmation to treatment, medicines and referral

8.1 Facility access and congestion

The consultation records an example from an IDP setting in which the nearest facility was approximately three kilometres away, yet residents still faced congestion and long waiting times. The example matters because it demonstrates that distance alone is an insufficient access indicator. Availability, capacity, waiting time and continuity of covered services must be monitored alongside it.

8.2 Medicines and diagnostics

Participants reported out-of-pocket (OOP) payment when medicines or tests were unavailable within nominally free service arrangements. For SHIA this is a purchasing and contracting issue rather than a communications one. A covered benefit is not financially protective if the member must buy the medicine or the diagnostic externally because the contracted provider cannot supply it.

8.3 Referral as a financial-risk event

Referral to secondary and tertiary care was identified as one of the largest points of household exposure. Transport to a receiving facility in another district or city can exceed the resources available to a poor household. Referral protection must therefore be financed as part of the benefit pathway. It cannot be left as an unfunded administrative instruction.

8.4 Operational safeguards

TABLE 5

Risks to meaningful access and the safeguards required to contain them

Risk	Required safeguard
Unclear provider network	Publish and regularly update a directory of accredited providers and covered services, accessible by SMS and through community notice points.
Repeated documentation at referral	Use a standardised portable referral record that carries verified coverage status.
Medicine and diagnostic stock-outs	Contract for essential availability, monitor stock-outs and define escalation rules.
Unauthorised charges	Publish covered services and tariffs, and create an immediate complaint pathway.
Unequal treatment	Include non-discrimination, dignity and waiting-time requirements in provider contracts, and audit them.
Referral transport burden	Develop a targeted approach to referral-related financial protection for vulnerable members.

EVIDENCE

Distance, congestion, stock-outs and referral transport were each reported as points at which covered care ceased to be obtainable.

IMPLICATION

Access failures are purchasing failures. They are corrected through contracts and tariffs, not through communication campaigns.

REQUIRED ACTION

Write availability, non-discrimination and waiting-time obligations into provider contracts, and audit them as core performance.

Each safeguard above assumes that the member has been able to afford entry to the pool in the first place. Section 9 addresses that condition.

09

SECTION 09

Affordability, Subsidies and Financial Protection*Awoodda Bixinta, Kaalmooyinka iyo Ilaalinta Maaliyadeed*

Solidarity without fragmentation

The consultation supports a progressive, solidarity-based and Sharia-compliant financing approach. It rejects any model in which households are excluded simply because they cannot contribute at the level of salaried workers. Financing design must therefore separate entitlement from financing route. Different sources may finance the national pool, but the member should experience one entitlement and one quality standard.

PROPOSED FINANCING INSTRUMENT

Establish a government-funded Vulnerable Population Subsidy Window within the national pool, anchored in the costing and progressive operationalisation of the Essential Package of Health Services (EPHS).

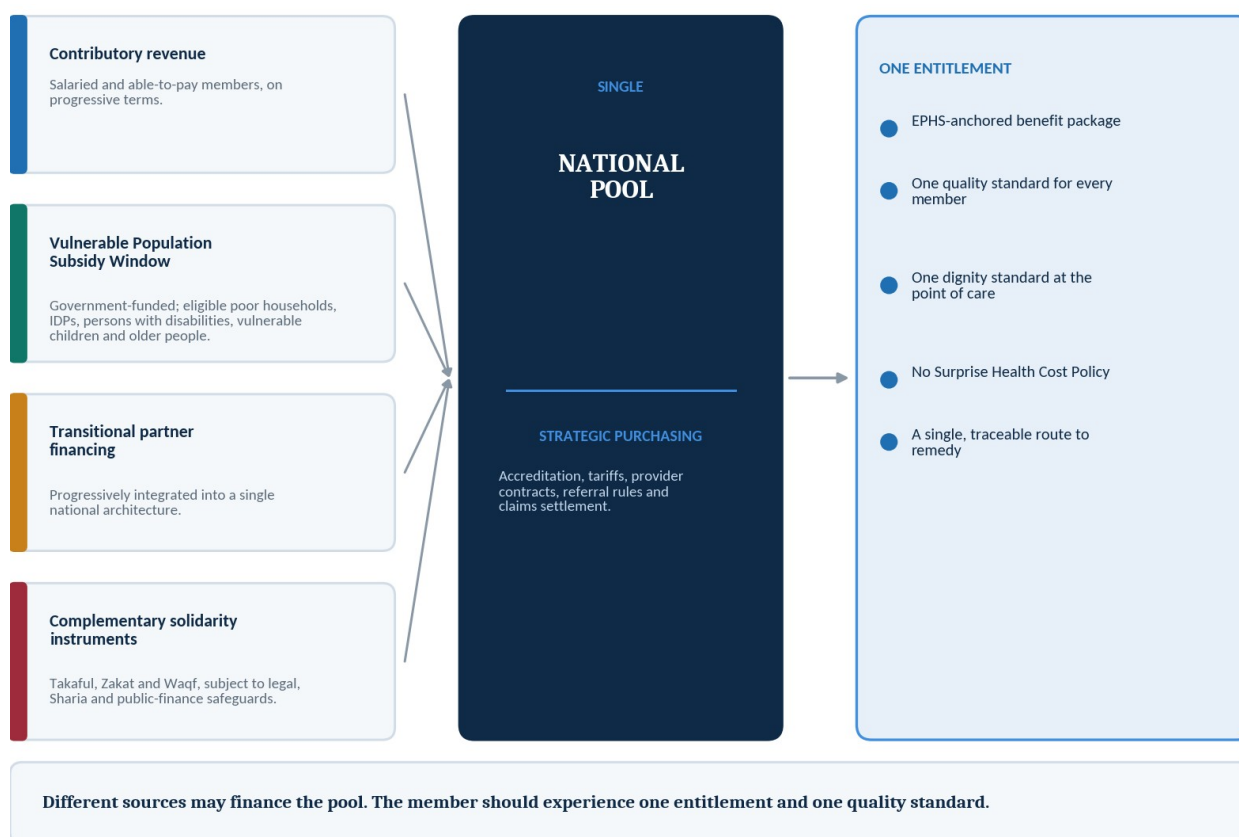
9.1 Priority design features

- Prioritise eligible extremely poor households, IDPs, persons with disabilities, vulnerable children, older people and other legally recognised groups.
- Apply transparent subsidy-eligibility rules, with defined registration, review and appeal pathways.
- Use EPHS costing to inform benefit scope, financing requirements, subsidy needs, contribution levels and provider-payment arrangements.
- Combine government financing, pooled contributions and the planned transition of partner support progressively within a single architecture.
- Explore complementary Takaful, Zakat, Waqf and community solidarity mechanisms only with appropriate legal, Sharia and public-finance safeguards.
- Protect members against hidden costs through a No Surprise Health Cost Policy, with monitoring of unauthorised charges and essential stock-outs.

FIGURE 5

One entitlement, several financing routes

Financing design should separate the route by which money reaches the pool from the entitlement the member experiences at the point of care.



Note. Indicative architecture derived from the consultation record. Contribution rates, subsidy thresholds and the fiscal size of the subsidy window are not established by this consultation; see Annex A.

9.2 The No Surprise Health Cost Policy

A practical financial-protection standard should state, in plain language, which covered services, medicines and diagnostics must not generate additional payment. It should set out how exceptions are handled, where a member may report an unauthorised charge, and how SHIA will monitor facility stock-outs and referral-related costs. Stated in these terms, financial protection ceases to be a policy aspiration and becomes an auditable service promise.

EVIDENCE	IMPLICATION	REQUIRED ACTION
Participants identified inability to contribute, and unpredictable point-of-care costs, as the two decisive affordability barriers.	Subsidy without cost predictability is incomplete protection; a fully subsidised member can still face catastrophic expenditure.	Establish the Vulnerable Population Subsidy Window and the No Surprise Health Cost Policy as a single, jointly monitored package.

Financing determines who can enter the pool. It does not by itself determine who is treated equally within it. Section 10 turns to that question.

10

SECTION 10

Equity, Gender and Social Inclusion*Sinnaanta, Jinsiga iyo Ka-qaybgalka Bulshada*

Equal entitlement may require differentiated support

The consultation draws an important distinction between equality of entitlement and equality of pathway. Every member should receive the same dignity and the same quality standard. People facing greater barriers, however, may require additional support in order to realise that entitlement. Mobile registration for pastoralists, disability-accessible communication, assisted enrolment for older people and community attestation for displaced households are equity measures. They are not preferential treatment.

10.1 Differentiated responses

Table 2 identifies why each group is at risk. Table 6 states what SHIA should do about it.

TABLE 6

Differentiated equity responses by population group

Group	Equity response
Women and women-headed households	Design safe and locally accessible enrolment; work through women's groups and trusted female outreach channels; monitor access and denial by sex.
Persons with disabilities	Provide accessible registration, communication, facilities and referral arrangements; monitor service use and complaint patterns.
Older people	Offer assisted and mobile registration, and simplified member support.
Children	Ensure that household enrolment and subsidy arrangements protect vulnerable children and essential child-health services.
Pastoralists and mobile populations	Use portable membership, mobile registration and continuity rules that do not assume permanent residence.
Internally displaced persons	Recognise documentation constraints, use community attestation, prioritise eligible households for subsidy and bring enrolment to sites.
Chronically ill persons	Avoid treating high-burden chronic, disability-related and mental-health needs as peripheral to financial protection.

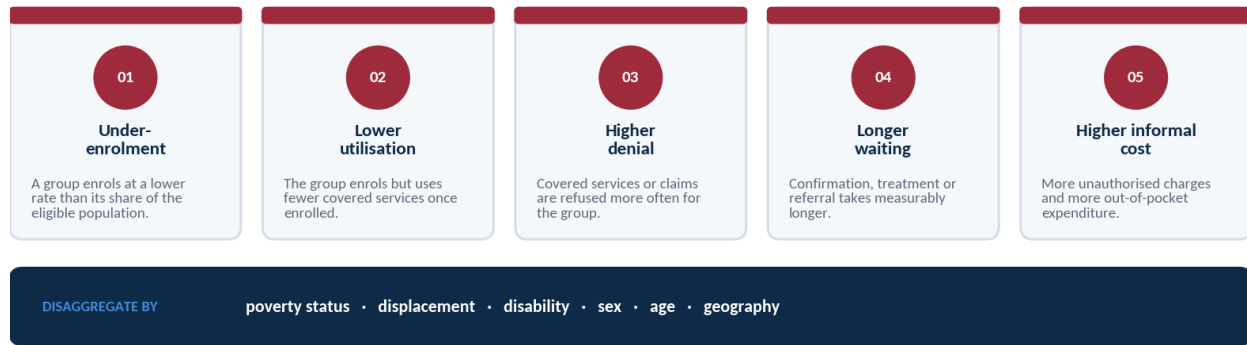
10.2 Equity monitoring

SHIA should disaggregate enrolment, utilisation, denial, complaint, waiting-time and cost data by the relevant dimensions of vulnerability: poverty status, displacement, disability, sex, age and geography. Under-enrolment is not the only equity signal. A group may enrol and still use fewer services, face more denials, wait longer or incur more unauthorised costs.

FIGURE 6

Five equity signals that routine monitoring must be able to detect

Under-enrolment is not the only warning. A group may join the scheme and still be systematically underserved within it.



Note. The people least likely to complain may also be the people most likely to be underserved. Routine reporting should therefore be complemented by community scorecards, beneficiary feedback and independent spot checks.

OPERATIONAL RISK

The people least likely to complain may also be the people most likely to be underserved. Formal reporting should therefore be complemented by community scorecards, beneficiary feedback and independent spot checks.



PLATE 5 A participant addresses the consultation session, Mogadishu, August 2026. Oral contribution was used throughout, so that participation did not depend on literacy.

That observation makes the credibility of the grievance system an equity question rather than an administrative one. Section 11 develops it.

11

SECTION 11

Trust, Grievance Redress and Public Accountability*Kalsoonida, Cabashooyinka iyo Xisaabtanka Dadweynaha*

Trust must be earned, measured and renewed

The consultation cautions that mass enrolment will fail if communities experience SHI as another government charge or as an uncertain promise. Trust should therefore be treated as an implementation outcome. It is produced by visible protection, honest communication, equal treatment, reliable provider performance, accessible remedy and transparent stewardship.

11.1 Minimum member information at enrolment

- What the member is entitled to receive.
- Where covered services can be obtained.
- What the member should do if a covered service is denied, delayed or charged incorrectly.

11.2 Grievance and appeal architecture

TABLE 7

Requirements of a credible grievance and appeal architecture

Requirement	Design implication
Multiple entry points	Toll-free telephone, SMS and messaging channels where feasible, in-person, community-agent and facility-based routes.
Low-literacy accessibility	Permit oral complaints and assisted submission.
Safety	Provide confidential pathways and explicit protection against retaliation.
Traceability	Issue a reference number and an expected response time for every complaint.
Appeal rights	Create a formal route of appeal for benefit, subsidy, provider and claims decisions.
Learning loop	Aggregate grievance data to identify recurrent provider, access and equity failures.

11.3 Transparency commitments

- Quarterly public reporting on contributions received, government subsidies, claims paid and administrative expenditure.
- Publication of provider-payment and accreditation standards.
- Regular internal and independent audit.
- An annual public-facing health financing and financial protection report.
- A beneficiary advisory forum with representation from poor households, IDPs, women, young people and persons with disabilities.
- Simple Somali-language public summaries, and periodic community meetings explaining performance and the use of funds.

EVIDENCE	IMPLICATION	REQUIRED ACTION
Participants questioned both the destination of funds and the usability of remedy, and connected the two directly.	Grievance redress and financial transparency are the same trust instrument observed at different points in the chain.	Publish quarterly financial and performance reporting, and report grievance resolution rates within the same document.

Sections 7 to 11 each conclude in an obligation. Section 12 consolidates those obligations into a single accountable instrument.

12

SECTION 12

The Nine Institutional Commitments*Sagaalka Ballanqaad ee Hay'adeed*

A measurable inclusion agenda for SHIA

TABLE 8

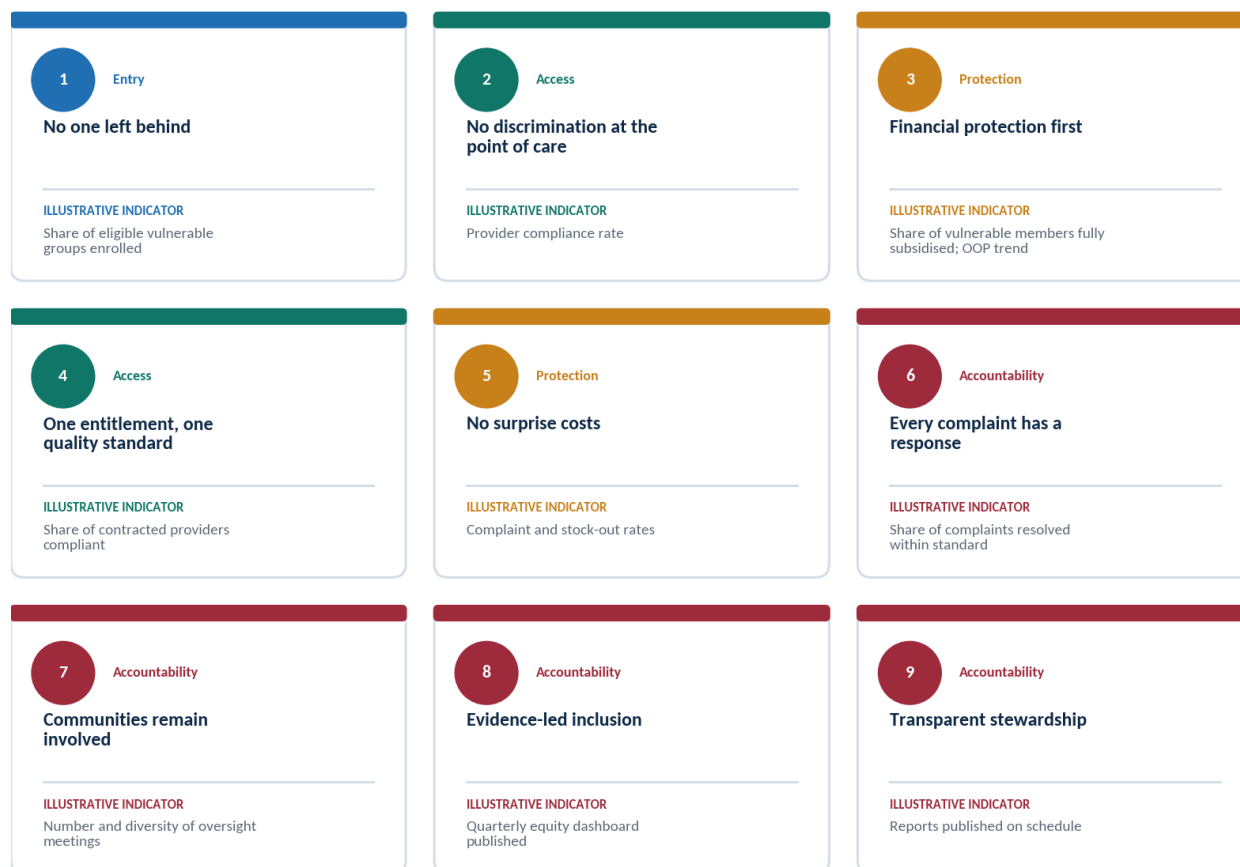
The Nine Institutional Commitments, practical actions and illustrative indicators

#	Commitment	Practical action	Illustrative indicator
1	No one left behind	Assisted and mobile enrolment for poor households, IDPs, pastoralists, persons with disabilities and informal workers.	Share of eligible vulnerable groups enrolled
2	No discrimination at the point of care	Equal-treatment clauses, provider audits and a patient rights and service charter.	Provider compliance rate
3	Financial protection first	Government subsidy window and a progressive contribution model.	Share of vulnerable members fully subsidised; OOP trend
4	One entitlement, one quality standard	Unified benefits, tariffs, accreditation and referral rules.	Share of contracted providers compliant
5	No surprise costs	Monitoring of unauthorised charges, medicine stock-outs and referral-related costs.	Complaint and stock-out rates
6	Every complaint has a response	Accessible grievance and appeal mechanism with end-to-end tracking.	Share of complaints resolved within standard
7	Communities remain involved	Permanent beneficiary advisory and community-feedback mechanisms.	Number and diversity of oversight meetings
8	Evidence-led inclusion	Disaggregated data by income, disability, displacement, sex, age and geography.	Quarterly equity dashboard published
9	Transparent stewardship	Quarterly public reporting and independent audit.	Reports published on schedule

FIGURE 7

The Nine Institutional Commitments and their illustrative indicators

Each commitment converts a consultation finding into an observable obligation with an owner, a deadline and a published measure.



Note. Colour indicates the access-chain phase in which each commitment principally operates. Indicators are illustrative; definitions and baselines are for SHIA to set.

These commitments should be assigned formally to responsible SHIA functions, incorporated into provider contracting and operational plans, and tracked through a small number of public indicators. Their value lies in converting principle into observable behaviour. A commitment without an owner, a deadline and an indicator remains a statement of intent.

13

SECTION 13

Implementation Framework and Priority Actions*Qaab-dhismeedka Fulinta iyo Tallaabooyinka Mudnaanta Leh*

Sequencing inclusion into SHIA operationalisation

The findings can be embedded in SHIA's existing operational roadmap without creating a parallel programme. The priority is to build inclusion requirements into the core functions: enrolment, eligibility, benefit design, strategic purchasing, provider contracting, digital systems, grievance redress, monitoring and public reporting.

13.1 Priority implementation sequence

TABLE 9

Priority action packages by time horizon

Time horizon	Priority action package
Days 0–30	Adopt the Nine Institutional Commitments; assign inclusion focal responsibility; approve the minimum member-information standard; draft non-discrimination clauses; define grievance channels; begin design of the subsidy window.
Days 31–60	Prototype mobile and assisted enrolment; develop the community-attestation procedure; design the entitlement card and audio content; publish the draft provider and referral directory; define No Surprise Health Cost rules.
Days 61–100	Pilot enrolment in selected vulnerable communities; activate complaint tracking; test provider equal-treatment and stock-out monitoring; publish the first inclusion dashboard; convene the beneficiary advisory forum.
Beyond 100 days	Scale on the basis of evaluation; refine subsidy eligibility and financing; institutionalise quarterly transparency reporting; integrate equity metrics into strategic purchasing and provider performance management.

FIGURE 8

Sequencing inclusion: the first hundred days and beyond

Inclusion requirements are embedded in existing SHIA functions rather than delivered through a parallel programme.



Note. Full action packages are set out in Table 9 and allocated to accountable functions in Table 10. Bar widths indicate sequence, not effort or resource share.

13.2 Implementation ownership matrix

TABLE 10

Implementation ownership and community accountability interface

Workstream	Primary SHIA responsibility	Community and accountability interface
Enrolment and eligibility	Membership and registration; scheme administration	Community agents, IDP representatives, disability and women's networks
Subsidy and financing	Finance, actuarial and policy functions	Published eligibility rules and an appeal mechanism
Benefits and strategic purchasing	Provider contracting and purchasing	Patient rights charter, provider directory and referral information
Claims and provider payment	Claims and finance functions	Monitoring of denied and queried claims and their effect on continuity of care
Quality and equity monitoring	M&E, quality assurance and data	Equity dashboard, community scorecards and spot checks
Grievance and appeals	Member services, legal and complaints	Toll-free, assisted, confidential and community-based channels
Transparency	Director General and Board oversight; finance and audit	Quarterly public reporting and beneficiary advisory forum

IMPLEMENTATION DISCIPLINE

Every commitment should have an accountable owner, a deadline, a measurable indicator and a public reporting pathway. Inclusion should be managed as core insurance performance, not as a communications activity.

14

SECTION 14

The Social Health Insurance Inclusion Compact*Heshiiska Ka-mid-noqoshada Caymiska Caafimaadka Bulshada*

A public agreement that defines what coverage must mean

The consultation culminates in a proposal for a Social Health Insurance Inclusion Compact: a concise public agreement among SHIA, government, providers, communities, civil society, academia and development partners. The Compact would not replace legislation or detailed scheme rules. Its purpose would be to state the minimum public promise that implementation must progressively honour.

FIGURE 9

The Social Health Insurance Inclusion Compact

Nine public promises that define the minimum meaning of coverage, and the seven parties who would be accountable for honouring them.



Note. Full wording of each promise is set out in Table 11.

TABLE 11

Proposed Compact principles and the corresponding public commitments

Compact principle	Public commitment
Accessible entry	No person should be permanently excluded because they lack a smartphone, an internet connection, a fixed address or a conventional document pathway.
Solidarity and subsidy	Ability to pay should influence financing responsibility, not the dignity or the quality of the benefit entitlement.
Usable benefits	Coverage must include a realistic pathway to accredited care, essential medicines, diagnostics and referral.
No discrimination	Subsidised, displaced, poor and otherwise vulnerable members, and members with disabilities, must receive equal respect and quality at the point of service.

Compact principle	Public commitment
No surprise costs	Members should know what is covered, and should have rapid redress for unauthorised charges.
Right to remedy	Every member must be able to complain, to appeal and to receive a traceable response, without retaliation.
Transparent stewardship	The public should be able to see how contributions, subsidies and pooled resources are used.
Continuous community voice	Vulnerable communities should remain part of governance, monitoring and reform after enrolment campaigns end.
Evidence-led correction	Disaggregated data should trigger corrective action whenever any group is systematically underserved.

Adopting the Compact would give the Nine Institutional Commitments a public counterpart. The commitments state what SHIA will do; the Compact states what the public is entitled to expect.

15

SECTION 15

Conclusion*Gunaanad*

The measure of success is whether the entitlement works when illness occurs

The consultation provides a clear implementation test for Somalia's social health insurance reform. Success is not primarily a membership-card target. It is whether a poor household can enter the scheme and understand its rights. It is whether that household can reach an accredited provider and receive the same standard of care as any other member. It is whether covered medicines and diagnostics are actually obtained, whether catastrophic or hidden expenditure is avoided, and whether a fair remedy follows when something goes wrong.

Meeting that test requires SHIA to act simultaneously as a financing institution, a strategic purchaser, a member-protection mechanism and a steward of public trust. Enrolment, subsidy design, provider contracting, referral, medicines, grievance redress and transparency are therefore not separate workstreams. Together they determine whether coverage is real.

The practical next step is to adopt the Nine Institutional Commitments formally, to assign them to accountable functions, to resource their implementation and to track them through a concise equity and financial-protection dashboard. The Inclusion Compact can then give public expression to the reform's central promise: progressive coverage that is equitable, financially protective and genuinely usable by people who have historically struggled to reach formal systems.

“

People should not have to choose between food and medicine, between treatment and shelter, or between membership and dignity. Social health insurance should make solidarity visible at the point where people need care.

A

ANNEX A

Evidence Limitations

What the consultation record does, and does not, establish

This report does not infer participant counts, consultation coverage, contribution rates, subsidy thresholds or fiscal envelopes that the source record does not document. The following data categories were not available in the core consultation record and are therefore not presented as established facts.

- The total number of consultation sessions, and a complete named list of locations.
- The total participant count, and a disaggregated participant profile by sex, age, disability, displacement status or occupation.
- Verbatim, individually attributed participant quotations from a transcript.
- Specific contribution or premium rates, subsidy income thresholds, or the fiscal size of the proposed Vulnerable Population Subsidy Window.
- A complete named list of consultation partner organisations beyond the generic references in the source materials.

Where a numerical or descriptive detail is included — for example, the approximately three-kilometre distance to a facility in the IDP example reported in Section 8 — it is reported as consultation evidence. It should not be generalised to all IDP settlements or to all areas of Somalia.

NOTE ON THE ACCESS-CHAIN REFERENCE

The ten-stage access-chain reference that appeared as a separate annex in the working draft has been consolidated into Table 3 in Section 5, so that stage definitions are held in one authoritative place.

B**ANNEX B****Source Materials Reviewed**

The documentary basis of this report

1. SHIA Community Consultation Report: Identifying Equitable Enrollment and Guaranteed Access within Somalia's Social Health Insurance Schemes (August 2026). [Original title reproduced as published.]
2. Community Consultation for Finding Equitable Enrolment and Ensured Access to Somalia's Social Health Insurance Schemes (August 2026).
3. SHIA-ARKAAN Strategic Dialogue Concept Note: Advancing Equitable Health Coverage — A Strategic Dialogue on Social Health Insurance Implementation (August 2026).
4. SHIA-ARKAAN consultation presentation: Dood-wadaag iyo Falanqayn — Yoolka Caafimaadka Loo Dhan Yahay iyo Tubta Horumarineed ee Lagu Xaqiijinayo Helitaanka Daryeel Caafimaad oo Loo Siman Yahay.
5. Supporting Somali legal background review on social and health insurance history, 1950–1991.
6. Photographic documentation supplied with the consultation record.

C

ANNEX C

Suggested Dashboard Indicators

A concise equity and financial-protection reporting set

TABLE 12

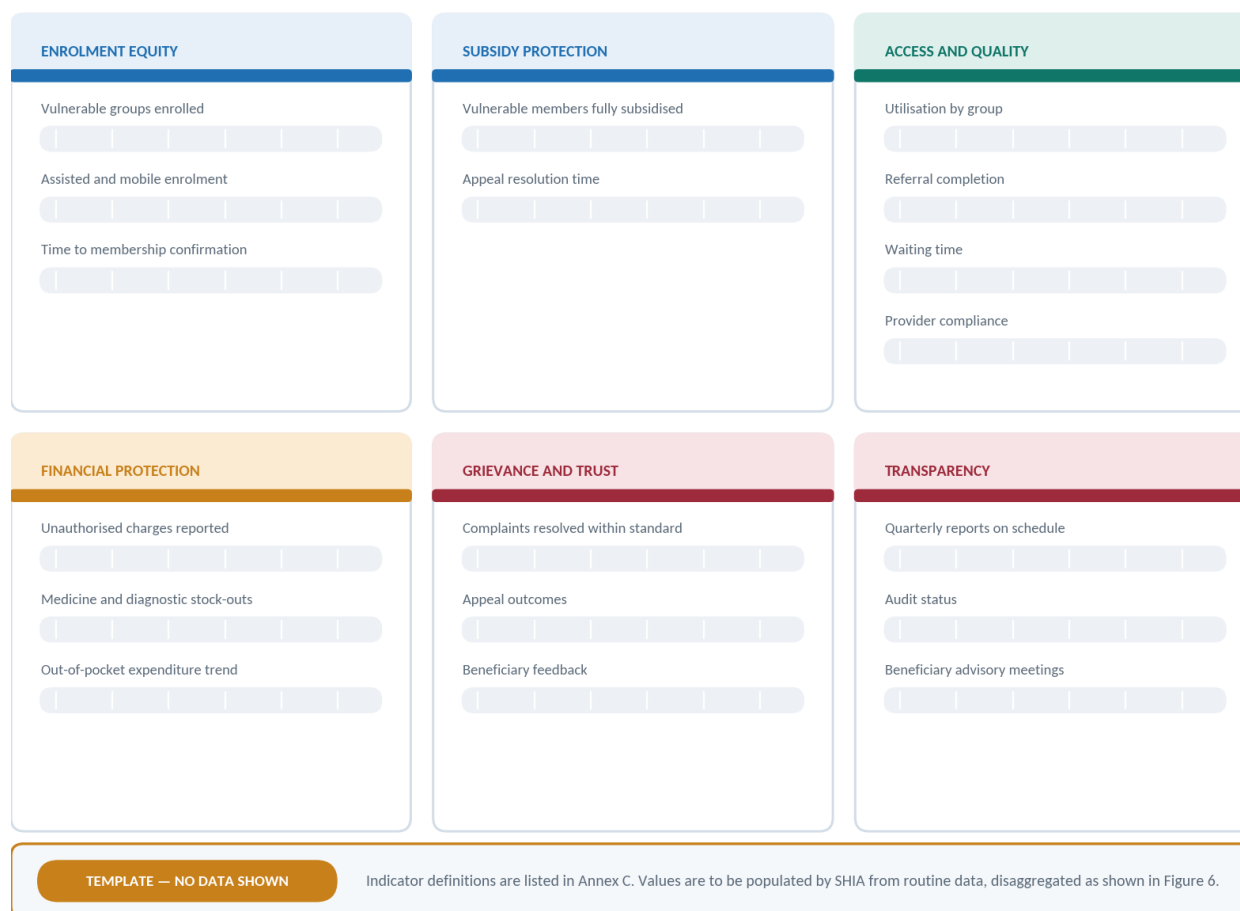
Suggested dashboard domains and indicator examples

Domain	Indicator examples
Enrolment equity	Vulnerable groups enrolled; assisted and mobile enrolment; time to membership confirmation.
Subsidy protection	Eligible vulnerable members fully subsidised; appeal resolution time.
Access and quality	Utilisation, referral completion, waiting time and provider compliance, by group.
Financial protection	Unauthorised charges; medicine and diagnostic stock-outs; out-of-pocket expenditure trend.
Grievance and trust	Complaints resolved within standard; appeal outcomes; beneficiary feedback.
Transparency	Quarterly reports published on schedule; audit status; beneficiary advisory meetings held.

FIGURE 10

Equity and financial-protection dashboard: reporting template

The reporting structure SHIA should publish quarterly. This is a layout template only; it contains no measurements and implies no baseline.



Note. Values are to be populated by SHIA from routine data, disaggregated along the dimensions shown in Figure 6.

D

ANNEX D

Soo-koobid Fulineed

Somali-language summary for community communication

EDITORIAL NOTE

This Somali summary is provided to support community communication, consistent with the report's own recommendation that member information be issued in plain Somali. It should be verified by SHIA's communications function before public release.

La-tashiga bulshada ee Agoosto 2026 wuxuu ku saleysnaa hal su'aal oo muhiim ah: sidee Hay'adda Caymiska Caafimaadka Bulshada (SHIA) u gaari kartaa diiwaangelin ballaaran, caddaalad ah oo la aaminsan yahay, iyadoo isla markaana la dammaanad qaadayo in xubnuhu dhab ahaan heli karaan adeegyada caafimaad ee la caymiyay?

Ka-qaybgalayaashu waxay si joogto ah u kala saareen xubinnimada rasmiga ah iyo ilaalinta dhabta ah. Qof diiwaangashan ayaa weli noqon kara mid aan caymis lahayn haddii dukumiintigiisa la diido, xarunta caafimaadku ay fog tahay, kharashka gaadiidka gudbinta uu awoodi waayo, dawooyinka lagama maarmaanka ah ay maqan yihiin, lacag aan rasmi ahayn laga dalbado, ama uu si ammaan ah cabasho u gudbin waayo.

Warbixintu waxay silsiladda helitaanka u qaybisaa toban tallaabo, laga bilaabo aqoonsiga iyo diiwaangelinta ilaa la-socodka iyo xal-u-helidda. Waxay soo bandhigaysaa siddeed natiijo oo guud, sagaal ballanqaad oo hay'adeed oo la cabbiri karo, iyo Heshiis Ka-mid-noqosho oo dadweyne ah oo qeexaya waxa ugu yaraan ee caymisku macnihiisu yahay.

Fariinta ugu muhiimsan waa tan: caymiska warqadda ku qoran kuma filna. SHIA waa inay maalgeliso, heshiisyo la gasho, la socoto oo ilaaliso wadada oo dhan — laga bilaabo diiwaangelinta ilaa daaweynta, dawooyinka iyo xal-u-helidda. Dadku waa inaysan doorasho ku samayn cuntada iyo dawada, daaweynta iyo hoyga, ama xubinnimada iyo sharafta.

SOCIAL HEALTH INSURANCE AUTHORITY

HAY'ADDA CAYMISKA CAAFIMAADKA BULSHADA

Equitable enrolment. Guaranteed access. Financial protection.

Mogadishu, Somalia | August 2026