

MEASURING WHAT MATTERS

A Critical Framework for Somalia's UHC Service Coverage Index

From a statistical reporting requirement to a national reform instrument for Universal Health Coverage — ten critical questions, a measurement toolkit, a seven-step roadmap, and a domain-level indicator framework for Somalia.

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Executive Summary

Somalia's Universal Health Coverage (UHC) Service Coverage Index (SCI) experienced a notable increase from 22 to 27 between 2019 and 2024, representing a measurable improvement. However, this progress still positions the country among the lowest-performing health systems globally.

The potential risk lies not in the absence of progress, but in the inclination to interpret a rising national average as evidence of enhanced equity, financial protection, or responsiveness to Somalia's specific disease burden.

This brief argues that the UHC index should not be treated as a one-off statistic produced for global reporting. It should instead be reconstructed as a national reform instrument—a tool that systematically interrogates who is served, who is excluded, who pays out of pocket, and which federal member states are advancing or falling behind.

The sections that follow set out: ten critical questions Somalia must confront before reporting or acting on the index; the measurement tools required to answer them; a seven-step roadmap toward a nationally owned UHC measurement system; a three-level reporting architecture; a domain-level indicator framework suited to Somalia's epidemiological and institutional context; and a concluding strategic framework for converting the index from a number into an instrument of accountability.

CONCEPTUAL CLARIFICATION

1. What the Index Measures and What It Does Not

The UHC Service Coverage Index is widely—and often carelessly—equated with “the percentage of people covered by health insurance” or “the percentage of the population receiving care.” Both readings are incorrect, and both carry policy risk. The SCI is a 0–100 composite index built from tracer indicators of essential health service coverage. It is a proxy for whether priority services reach the population—not a census of insurance enrolment, and not a guarantee of quality, timeliness, or affordability.

The World Health Organization frames Universal Health Coverage around two distinct but inseparable measurement streams: SDG indicator 3.8.1, which tracks service coverage, and SDG indicator 3.8.2, which tracks the financial hardship caused by out-of-pocket health spending. A country can improve on one while regressing on the other. Reporting the Service Coverage Index in isolation—without its financial-protection counterpart—produces an incomplete, and potentially misleading, picture of UHC progress.

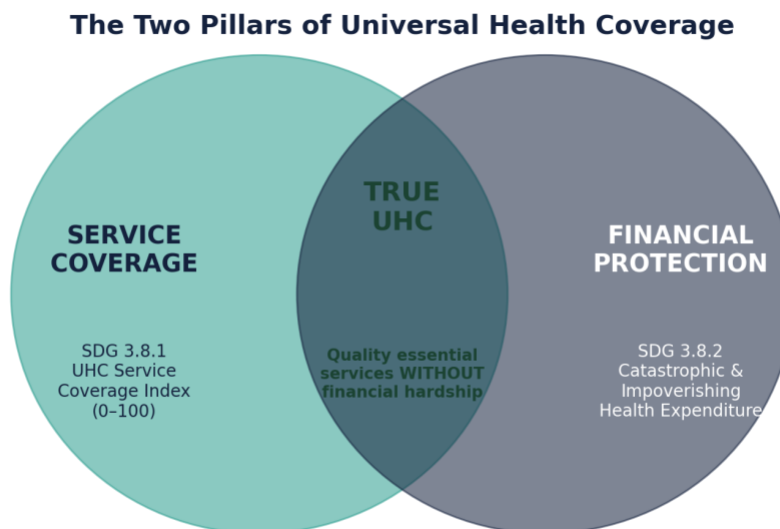


Figure 1. Universal Health Coverage rests on two inseparable pillars: service coverage (SDG 3.8.1) and financial protection (SDG 3.8.2).

Critical Distinction

An individual entering a healthcare facility without a companion does not automatically qualify for Universal Health Coverage.

The essential considerations are whether the provided service was appropriate, timely, of acceptable quality, and did not impose undue financial burden on the household.

It is crucial to distinguish between “service contact” and “UHC” as these terms are not synonymous. Consequently, Somalia’s measurement system must be meticulously designed to differentiate between them.

DIAGNOSTIC FRAMEWORK

2. Ten Crucial Questions Somalia Must Address

Before Somalia adopts, reports, or takes action based on a UHC Service Coverage Index figure, ten questions grouped across three domains should be answered as a matter of institutional discipline. Each question directly impacts how the index should be interpreted, reported, and utilized in policymaking

2.1 Definition and Interpretation

Critical Question	Why It Matters for Somalia
1. Are we measuring real UHC, or only service contact?	A facility visit is not sufficient evidence of UHC. The index must be interrogated for whether the right service was delivered at the right time, with acceptable quality, and without financial hardship to the household.
2. Is the index being reported correctly?	The SCI should be reported as an index score out of 100 — not as a percentage of the population whose health needs have been met. The World Bank explicitly cautions against this misinterpretation, and Somalia's official communications should avoid it.
3. Does the index reflect Somalia's real burden of disease?	A credible UHC measurement system must capture maternal and newborn mortality, child health and malnutrition, TB and vaccine-preventable diseases, the rising burden of NCDs, trauma and emergencies, mental health, and access gaps among displaced and pastoralist populations.
4. Does the national figure conceal federal member state inequalities?	A national score can rise while Galmudug, Hirshabelle, Jubaland, South West, Puntland, Somaliland, Banadir, rural districts, IDP settlements, and conflict-affected areas remain underserved. Aggregation without disaggregation is a governance blind spot.

2.2 Data Quality

Critical Question	Why It Matters for Somalia
5. Are private-sector, NGO, and donor-funded services captured?	A substantial share of care in Somalia is delivered outside the public sector. Excluding private, faith-based, and humanitarian providers from the data will understate — or distort — the real picture of service coverage.
6. Is HMIS/DHIS2 data complete, timely, and validated?	Facility-reported data alone is insufficient. It must be triangulated against household surveys, facility assessments, medicine-availability data, staffing records, and health-expenditure data before it is used to calculate or report the index.
7. Are nomadic, rural, IDP, and marginalized populations visible in the denominator?	A UHC index is only as credible as the population denominator behind it. If mobile and displaced populations are undercounted, the index will systematically overstate coverage for the country as a whole.

2.3 Equity and Financial Protection

Critical Question	Why It Matters for Somalia
8. Who is being left behind?	Somalia must be able to disaggregate results by federal member state, district, rural/urban location, sex, age, income or wealth quintile, disability status, IDP status, and distance from the nearest facility.
9. Are households protected from catastrophic health spending?	An improving service-coverage score is not, by itself, a policy success if households continue to sell assets, borrow money, delay care, or fall into poverty because of health payments. Financial-protection data must accompany every coverage statistic.
10. Does social health insurance improve both coverage and financial protection?	The National Social Health Insurance pathway should be assessed against a dual test: does it expand access to essential services for vulnerable groups, strengthen primary health care, and — at the same time — reduce the burden of out-of-pocket payments?

MEASUREMENT ARCHITECTURE

3. Selecting the most suitable measurement instruments for each domain.

No single survey or information system can provide a comprehensive answer to the ten questions posed. Somalia's official Universal Health Coverage (UHC) measurement framework should integrate complementary tools, each tailored to the specific domain it best addresses.

Measurement Area	Recommended Tool	Purpose
Service coverage	WHO UHC Service Coverage Index / SDG 3.8.1	National and international comparability
Financial protection	SDG 3.8.2: catastrophic & impoverishing health expenditure	Measures whether people suffer financial hardship
Facility readiness	SARA / Harmonized Health Facility Assessment	Measures infrastructure, staffing, equipment, medicines, and diagnostics
Routine services	DHIS2 / HMIS	Tracks service delivery, utilization, and reporting completeness
Population coverage	DHS, MICS, household expenditure surveys, LQAS	Captures services missed by facility-based data
Health financing	National Health Accounts / SHA 2011	Tracks government, donor, private, and out-of-pocket spending
Equity monitoring	Subnational UHC dashboard / equity scorecard	Shows who benefits and who is excluded
Benefits package monitoring	EPHS and insurance benefit package indicators	Links UHC measurement to Somalia's essential services

WHO Somalia's Standing Priorities

Somalia has identified a consistent set of foundational priorities for Universal Health Coverage (UHC) measurement: the implementation of the Essential Package of Health Services, the establishment of National Health Accounts, the conduct of the Service Availability and Readiness Assessment (SARA), the strengthening of the Health Management Information System (HMIS), and the monitoring of UHC progress through an explicit equity and financial-risk-protection lens. These priorities should serve as the guiding principles for Somalia's measurement taskforce from its inception.

IMPLEMENTATION PATHWAY

4. A Seven-Step Roadmap Toward a Nationally Owned Measurement System

Somalia does not require the creation of its own parallel Universal Health Coverage (UHC) index. Instead, it should adopt the official methodology of the World Health Organization (WHO) and the World Bank Sustainable Development Goals (SDGs) and localize it through a Somalia UHC dashboard. This dashboard should be constructed and maintained through a seven-step cycle.

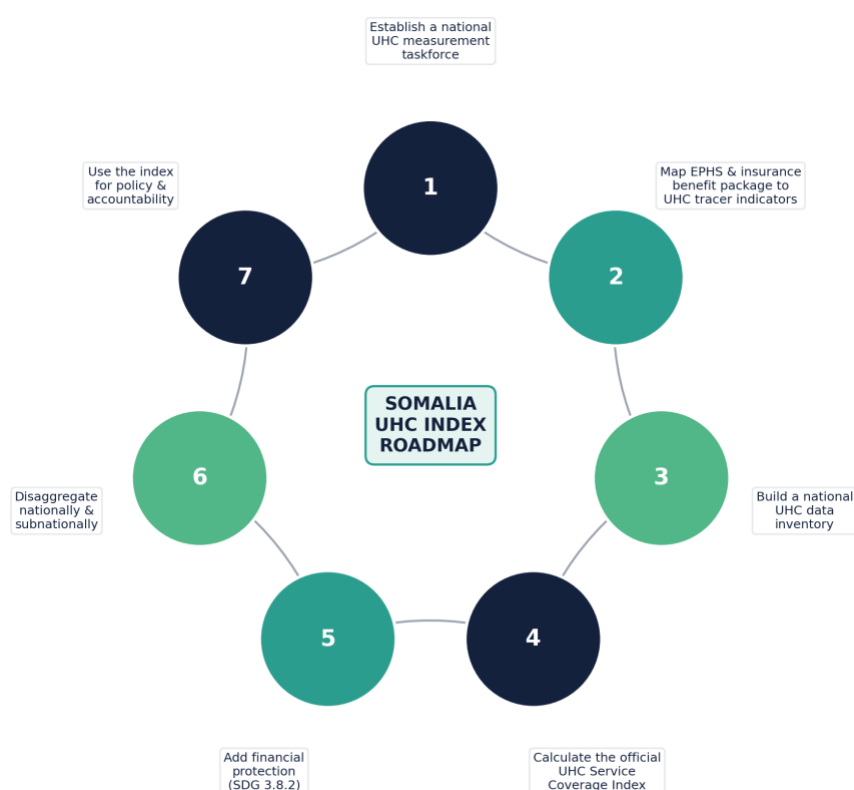


Figure 2. The seven-step UHC measurement roadmap operates as a continuous cycle — each round of disaggregated evidence feeds back into taskforce priorities and benefit-package design.

Step	What It Involves
1. Establish a National UHC Measurement Taskforce	Convened and led by the Ministry of Health and Human Services, NHIA, and the National Bureau of Statistics, with representation from federal member states, WHO, the World Bank, UNICEF, UNFPA, donor partners, academia, and the private sector.

Step	What It Involves
2. Map the EPHS and Insurance Benefit Package to UHC Tracer Indicators	This step links the global index to Somalia's real policy instruments primary health care, the Essential Package of Health Services, social health insurance, vulnerable-group coverage, and strategic purchasing arrangements.
3. Build a National UHC Data Inventory	Catalogue available data sources for each tracer indicator across DHIS2, the EPI, TB, HIV, and malaria programmes, reproductive health, NCDs, the workforce registry, medicine availability, SARA, household surveys, and health-expenditure data.
4. Calculate the Official UHC Service Coverage Index	Apply the WHO methodology — a geometric mean of tracer indicators across four domains: reproductive, maternal, newborn and child health (RMNCH); infectious diseases; non-communicable diseases; and service capacity and access — reported on a 0–100 scale.
5. Add Financial Protection (SDG 3.8.2)	Present the service-coverage index alongside catastrophic and impoverishing out-of-pocket spending data. A country can improve service coverage while still failing UHC if households are pushed into poverty by user fees, medicines, diagnostics, transport, or informal payments.
6. Disaggregate Nationally and Subnationally	Produce a national UHC score alongside scores for each federal member state, district, and priority vulnerable population, so that both progress and stagnation can be identified and acted upon.
7. Use the Index for Policy, Not Only Reporting	Embed the index in budgeting decisions, primary health care investment, insurance benefit-package design, provider payment mechanisms, strategic purchasing, medicine regulation, workforce deployment, and federal member state accountability frameworks.

REPORTING MODEL

5. The Recommended Reporting Architecture: A Three Level Model

The most defensible measurement model for Somalia is a hybrid approach that combines the official global index with a Somalia-specific contextual dashboard, financial protection data, and equity analysis. In practice, this entails reporting at three distinct, complementary levels.

Level	Focus	Primary Purpose
Global Reporting Level	SDG 3.8.1 (service coverage) and SDG 3.8.2 (financial protection), calculated using the WHO/World Bank methodology.	International comparability and global accountability reporting.
National Policy Level	EPHS coverage, primary health care readiness, social health insurance enrolment, benefit-package utilization, service quality, and financial protection.	Guides domestic policy design, budgeting, and benefit-package reform.
Equity Level	Federal member state, district, rural/urban, IDP, nomadic, poor-household, women, children, elderly, and disability disaggregation.	Ensures accountability for leaving no one behind.

Recommended Official Reporting Statement

Somalia's Universal Health Coverage (UHC) Service Coverage Index should be reported as an index score out of 100, calculated using the World Health Organization (WHO) and the World Bank's Sustainable Development Goal (SDG) 3.8.1 methodology. This index should be interpreted in conjunction with SDG 3.8.2 financial-protection indicators. The national score should be disaggregated by federal member state, district, population vulnerability, and service domain. This disaggregated data should be utilized to guide primary health care investment, the implementation of social health insurance, the design of benefit packages, and the accountability of leaving no one behind.

TECHNICAL REFERENCE

6. A Domain-Level Indicator Framework for Somalia

Translating the four global Service Coverage Index domains into Somalia-specific priority indicators ensures the index remains analytically rigorous while speaking directly to the country's epidemiological profile and institutional priorities.

Domain	Somalia Priority Indicators
Reproductive, Maternal, Newborn & Child Health (RMNCH)	Antenatal care, skilled birth attendance, facility-based delivery, immunization coverage, management of childhood pneumonia and diarrhoea, and nutrition services.
Infectious Diseases	TB treatment success rate, malaria prevention and treatment, HIV treatment coverage, outbreak preparedness, and water, sanitation and hygiene (WASH) services.
Non-Communicable Diseases (NCDs)	Hypertension screening and treatment, diabetes care, cancer screening, and integration of mental health services into primary care.
Service Capacity	Primary health care facility readiness, health workforce density, essential medicines availability, diagnostic capacity, referral systems, and emergency care.
Financial Protection	Out-of-pocket health spending, catastrophic and impoverishing expenditure, social health insurance coverage, and subsidies for vulnerable groups.
Equity	Federal member state and district coverage, IDP populations, rural/urban gaps, gender, poverty, disability, and nomadic populations.
Quality	Clinical care standards, patient safety, referral completion rates, medicine quality assurance, and provider regulation.

EVIDENCE IN CONTEXT

7. Somalia's Trajectory in Context: Progress Without Complacency

Somalia's UHC Roadmap recorded a Service Coverage Index of 22 among the lowest scores recorded anywhere in the world at the time — and called for government-led monitoring of UHC progress. A more recent review found the index had risen to 27 by 2024, an improvement of five points over five years, while Somalia remained among the lowest-scoring countries globally.

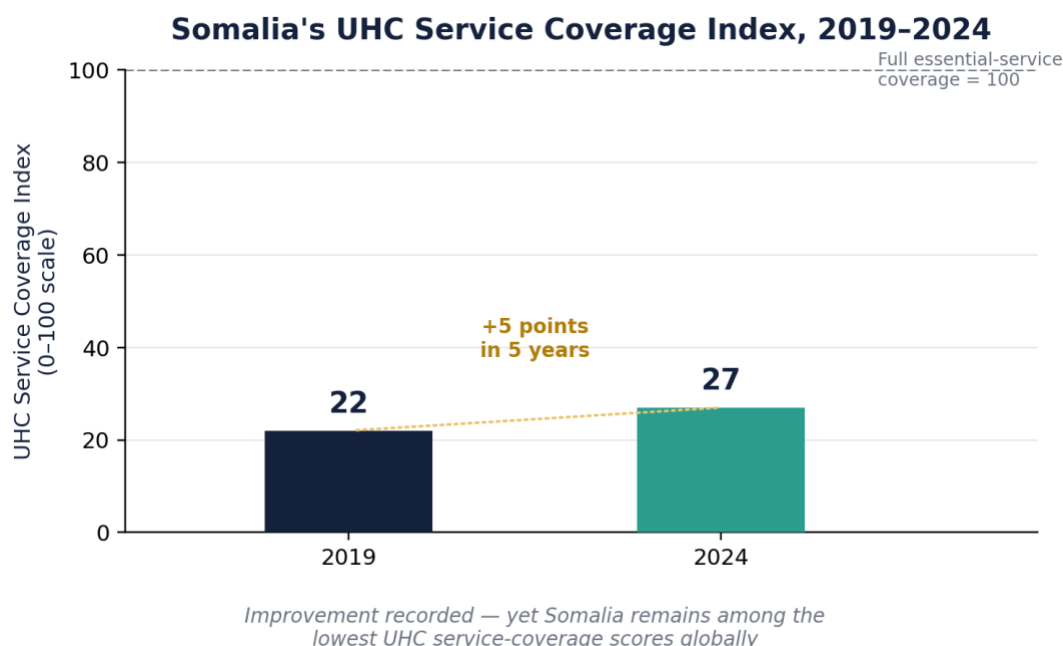


Figure 3. Somalia's UHC Service Coverage Index rose from 22 (2019) to 27 (2024) — a real gain on a scale of 0 to 100, but still far from the threshold of adequate essential-service coverage.

The Perils of Statistical Comfort

A five-point improvement on a 0–100 scale signifies tangible progress, warranting acknowledgment. However, a rising national average can coexist with stagnant or deteriorating conditions within specific federal member states, districts, or population groups, without any improvement or even deterioration in financial protection. Without subnational disaggregation and SDG 3.8.2 data presented alongside it, a national score of 27 fails to provide Somalia's policymakers with the necessary information to ascertain whether the gain represents widespread improvement or concentrated gains in already well-served areas.

CONCLUSION

8. Strategic Bottom Line: From Index to Instrument

For Somalia, the UHC Service Coverage Index should serve as a national reform tool, not just a periodic reporting statistic. When used effectively, it prompts a recurring set of questions that shape the policy agenda:

1. Who receives essential health services, and at what quality level?
2. Are services available, staffed, equipped, and stocked to deliver them?
3. Who is excluded from these services due to factors like geography, displacement status, income, gender, age, or disability?
4. Who pays out of pocket, and how much?
5. Who is pushed into poverty due to health-related expenses?
6. Which federal member states are progressing, and which are lagging behind?
7. How should these findings inform budgeting, benefit package design, and provider payment reform?

Consistently answering these questions and transparently reporting the results is the key to linking the UHC index to Somalia's broader health financing reform agenda, the implementation of National Social Health Insurance, the strengthening of primary health care, and the country's accountability commitments under Universal Health Coverage.e.

Bottom Line

The UHC Service Coverage Index becomes a serious policy tool only when it is reported correctly, paired with financial-protection data, disaggregated to the federal member state and district level, and used to direct not merely describe Somalia's investment in primary health care, social health insurance, and Universal Health Coverage.

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