Puntland
State of Somalia

Health Sector Strategic Plan
Phase II 2017-2021

October 2017

Contents

Acronyms and Abbreviations

AHSPR	Annual Health Sector Performance Report
ANC	Antenatal clinic
ARI	Acute respiratory infections
ART	Antiretroviral therapy
AWD	Acute, watery diarrhoea
BCC	Behaviour change communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CARMMA	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CBFHW	Community Based Female Health Workers
CBHW	Community Based Health Workers
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CERF	Central Emergency Response Fund
CHW	Community Health Workers
CPR	Contraceptive prevalence rate
CRVS	Civil Registration and Vital Statistics
CSR	Corporate social responsibility
DHIS 2	District Health Information System open source software
DHS	Demographic Health Survey
DMO	District medical officer
DQA	Data quality assessment
DQSA	Drug Quality and Security Act
DSS	Demographic surveillance sites
DTP3	Diphtheria-tetanus-pertussis
EML	Essential Medicines List
EMRO	Regional Office for the Eastern Mediterranean
EPHS	Essential Package of Health Services
EPI	Expanded Programme on Immunization
EPRP	Emergency Preparedness and Response Plan
FCHW	Female Community Health Worker
FGM/C	Female genital mutilation /cutting
FGS	Federal Government of Somalia
FHW	Female Health Worker
FMS	Financial management system
Gavi	Global Alliance for Vaccines and Immunization
GESI	Gender equity and social inclusion
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHE	Government Health Expenditure
HAB	Health Advisory Board
HADMA	Humanitarian Affairs and Disaster Management Agency
HC	Health centre
HF	Health facility
HIS	Health information system
HIV/AIDS	Human immunodeficiency virus / acquired immune deficiency syndrome
HMIS	Health management information system
HP	Health Promoters
HRH	Human resources for health
HSAT	Health Systems Analysis Team
HSC	Health Sector Coordination Committee
HSS	Health system strengthening
HSSP II	Health Sector Strategic Plan II

ICCM	Integrated community case management
ICCM	Integrated Community Case Management
IDP	Internally displaced people/persons
IMAM	Integrated Management of Acute Malnutrition
INGO	International nongovernmental organisation
IPRSP	Interim Poverty Reduction Strategy Paper
IPV	Inactivated polio vaccine
IT	Information technology
JANS	Joint Assessment of National Health Strategies
JHNP	Joint Health and Nutrition Programme
JPLG	Joint Programme on Local Governance
LMIC	Lower and middle income countries
LMIS	Logistics management information system
M&E	Monitoring and evaluation
M/F	Male/female
MCH	Maternal and child health
MDR	Multi-drug resistant
MICS	Multiple Indicator Cluster Survey
MMN	Multi-micronutrients
MOH	Ministry of Health
MOU	Memorandum of understanding
NCD	Non-communicable disease
NDP	National Development Plan
NGO	Non-governmental organisation
NHA	National Health Account
NID	National Immunization Day
NQCL	National Quality Control Laboratory
OOP	Out of pocket
ORS	Oral rehydration salts
OTP	Outpatient treatment programme
PESS	Population Estimation Survey
PFM	Public financial management
PH	Public health
PHC	Primary health care
PHER	Public health expenditure review
PHU	Primary health unit
PNC	Prenatal care
PPP	Public private partnership
QA	Quality assurance
QC	Quality control
RH	Reproductive health
RHC	Referral health centre
RHO	Regional Health Officer
RRT	Rapid Response Team
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SDH	Social determinants of health
SHF	Somalia Humanitarian Fund
SO	Strategic objective
SOP	Standard operating procedure
STD	Sexually transmitted disease

STI	Sexually transmitted infection
SUN	Scaling Up Nutrition
TA	Technical assistance
TB	Tuberculosis
TBMU	Tuberculosis management unit
TOR	Terms of reference
UHC	Universal health coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
WASH	Water, sanitation and hygiene
WHO	World Health Organisation

Foreword

The development of the Puntland Health Sector Strategic II (2017-2021) is informed by Somali National Health Policy and related policy frames of references including the Somali National Development Plan (2017-2019) and Puntland Second Five-Year Development Plan (20154-208). The strategic plan also gives due consideration to Puntland Constitution and related health sector regulations including Law Number 6. The plan is conceived in the recognition that improved health care is imperative in achieving sustainable socio-economic development as accentuated in United Nations 2030 Agenda for Sustainable Development and captured in various National Somali Policies and Plans. With these frames of references, Puntland health sector led by the Ministry of Health and in collaboration with health sector stakeholders elaborated the National Health Policy to define medium term health agenda and ascertain realization of aspirations of Puntland people as outlined in the Puntland Second Five-Year National Development Plan.

The Puntland Health Strategic Plan has been developed using a consultative approach involving all the key stakeholders in the health sector. The development of HSSP 11 has been informed by experience and lessons learnt from implementation of HSSP 1 including lessons drawn from health sector assessment reports such as Joint Health and Nutrition Program (Progress Report 2015). The plan also takes into account key recommendations of health sector the Mid-term Review (2015), evidence from emerging health trends and global priorities. These recommendations have guided prioritization of interventions for implementation during this strategic plan (2017-2021).

The plan implementation will also be closely monitored through the health sector monitoring and implementation framework. The plan recognizes the strengths, challenges and the formidable socio-economic context - that is country showing first signs of recovery from scars of protracted civil war - under which this plan will be implemented.

The Puntland Health Sector Strategic Plan (HSSPII) provides the Health Sector Medium Term focus; objectives and priorities to enable it attain national, state and international health development goals mentioned above. The plan employs the six health system building blocks recommended by WHO and supplement it with additional three critical building blocks for strengthening Puntland health sector over the next five years. This strategic plan conveys the Health Sector Vision, Mission, goal and the core functions; policy priorities, strategic objectives, implementation framework and the resource requirements during plan period. It provides a detailed description of health outcomes to be sought, health investments necessary to achieve the outcomes, and the organizational frameworks required to implement the plan. In doing so, the plan is intended to provide clear health sector strategic priority directions to guide national and international investment in building health sector that improves the health and wellbeing of all people of Puntland.

The Ministry is committed to the full realization of this plan. Effective implementation of the Puntland HSSP II will requires the concerted efforts of health sector and active participation of all stakeholders. I am confident that this plan will inform the process of joint annual planning, sector coordination, partnerships and monitoring. Finally, I would like to urge all members of the sector to ascertain full implementation of this plan in order to realize health development goals.

Dr. Abdinasir Osman Isse
Minister of Health, Puntland State of Somalia

AKCNOWLEDGEMENT

The Health Sector Strategic Plan II (2017-2021) is the end product of a long and complex process of intensive consultations, data & information gathering across the health sector and teamwork tasks as well as detailed examination of state of health sector and review of progress over the past four years. Many people have therefore contributed to formulating this plan which has taken considerable resources and energy transforming long processes into the presently useful form of the plan ready for implementation.

Special thanks go to the Director of Planning and Policy Development, **Abdirizak Hassan Isse**, who provided leadership to the HSSP II Task Force responsible for the facilitation of the development plan processes. I commend the Task Force for the professional manner in which they guided the process and the facilitation of the various working groups and different consultation processes held across the country. The Task Force was assisted by Consultants from **IRIS Consulting Firm lead by Gordon Mortimore**. I would also like to thank **Abdi Musse Kamil, a MIDA–FINNSOM** consultant who provided technical advice throughout the HSSP II development processes, analysing data and information, reviewing and drafting the plan working with stakeholders. I would like to appreciate the tireless efforts of **Idris Abdilahi Mohamed, MoH Reproductive Health Managers**, in coordinating the stakeholder's consultation processes and assembly of datasets and information from different sources. I would finally like to acknowledge the support of WHO for funding this development of the Health Sector Development Plan (2017-2021).

I would like to express my profound grateful to all stakeholders and institutions who contributed to the development of this strategic plan. I would like to acknowledge the coordinated efforts of all MoH departments, regional and district health, international and national NGOs, United Nations Agencies and other stakeholders.

The Health Sector Strategic Plan (2013-2016) showed a significant improvement in relation to access and availability of health services across Puntland regions. There has been substantial fall in mortality of children in health facilities and considerable improvement of maternity health. The availability of medicine and prevention and treatment services of such diseases as TV, Malaria and HIV/AIDS has become more widely available. Puntland has become the first Somali territory to outlaw FGM putting necessary regulatory framework in place to enable public and civil societies institutions devise feasible community based development interventions. Similarly, gender issues have been mainstreamed across MoH policy and plans with significant progress in advancing gender issues in recruitment and implementation of health programs.

HSSP 11 therefore is intended to build on the progress made over the past four years and ascertain realization of health sector gaols, objectivesand priority directions through mobilization of local resources and international assistance to better the general health conditions of people of Puntland.

I commend this plan and do hope that, at its conclusion in 2021, the health sector in Puntland will be capable of providing essential health services at all levels of service delivery in all regions of Puntland for the betterment of quality of life of all communities.

Dr. Abdirizak Hersi Hassan.
Director General
Ministry of Health, Puntland State of Somalia

Executive Summary

Due to decades of civil war, many health indicators are very poor in Somalia. In 2015, maternal mortality ratio was estimated at 732 per 100,000 live births[1]– an improvement since 1990, when the figure was 1210 per 100,000 live births[2], but still poor compared to Kenya (510) or Ethiopia (353) in 2015.Under-5-mortality rate was 137 per 1000 live birth[3] in 2015, compared to Kenya (49) and Ethiopia (59). At 42%, Somalia has one of the lowest Diphtheria-tetanus-pertusis (DTP3) coverage rates in the world (Gavi 2016). In terms of Joint Reporting Form (JRF) data, Penta I coverage was estimated at 50%, Penta III at 46 % and Measles at 43% (Gavi 2016).
The Puntland Government of Somalia developed and revised a three year Puntland Five Year Development Plan (2017-2019) that will be a continuation of Puntland Five Year Development Plan (PFYDP) 2014 – 2018. The NDP reflects priorities of the health sector and include key objectives defined in Somalia's National Health Policy 2014.
The first post-civil war countrywide health sector policy was developed in 2014. The Somali Health Policy provides a national frame of references, outlining health sector priorities. Some sub-sector policies have also been developed.

The vision for the health sector is "all people in Somalia enjoy the highest possible health status, which is an essential requirement for a healthy and productive nation".

In order to work towards the realization of the of the vision, the plan set the following mission statement: "Ensure the provision of quality essential health and nutrition services for all people in Somalia, with a focus on women, children, and other vulnerable groups and strengthen the national and local capacity to deliver evidence-based and cost-effective services based on the EPHS and Primary Health Care Approach".

HSSP II sets the following targets

1. By 2021, reduce maternal mortality ratio from 732/100,000 in 2015 to less than 400/100,000
2. By 2021, reduce <5 mortality rate from 137/000 in 2015 to less than 100/1000 live births
3. By 2021, reduce Infant mortality from 85/000 in 2015 to less than 70 per 1000 live births
4. By 2021, reduce neonatal mortality from 40/000 in 2015 to less than 35 per 1000 live births
5. By 2021, reduce the number of children who are stunted by 15% from 12%
6. By 2021, reduce incidence of TB from 285/100,000 per year to less than 250/100,000
7. By 2021, increase the coverage of Pent 3 from 43% to 80%
8. By 2021, increase skilled birth deliveries from 33% to 55%
9. By 2021, reduce child wasting from 14% to less than 10%
10. By 2021, increase contraceptive prevalence rate (CPR) to >15%
11. By 2021, increase TB case detection rate from 42% to >70%
12. By 2021, increase in per capita expenditure on health from ~$12 per person per year in 2015 to $23 per person per year; with share of Government Health Expenditure (GHE) increased to 12% of the total expenditure on health through public sector.

HSSP 11 adapts 9 strategic directions in line with recommendation of Somali National Health Policy. These strategic directions are as follows:

[1]Gavi (2016) Joint Appraisal Report – Somalia 2016file:///C:/Users/user/Downloads/Somalia%20Joint%20Appraisal%202016%20(1).pdf
[2]http://data.worldbank.org/indicator/SH.STA.MMRT
[3]Inter agency estimates http://www.childmortality.org/index.php?r=site/graph#ID=SOM_Somalia

- Scaling up of essential and basic health and nutrition services (EPHS)
- Overcoming the crisis of human resources for health
- Improving governance and leadership of the health system
- Enhancing the access to essential medicines and technologies
- Functioning health information system
- Health financing for progress towards Universal Health Coverage
- Improving health sector physical infrastructure
- Enhancing health emergency preparedness and response
- Promoting action on social determinants of health and health in all policies.

Section 1: Background

1.1 Process for the Development of HSSP II

In October 2016, the MoH constituted a Task Force to oversee the development of the HSSP II. The membership of this TF was drawn from the different departments of the MoH, Development Partners, Civil Society and Private Sector. The involvement of the different stakeholders was important in order to ensure ownership of the plan. The TF was chaired by the Director of Planning and Policy of the Puntland MOH "Mr. Abdirizak Hassan Isse". In order to facilitate the drafting of the HSSP II, nine thematic groups were created namely Health Service Delivery, Human Resource for Health, Leadership and Governance, Essential Medicine and Supplies, Health Information, Health Financing and Budgeting, Health Infrastructure, Emergency Preparedness and Response and Social Determinants of Health. With the support of Consultants from IRIS "Gordon Mortimore" and Abdi Kamil a FINNSOM consultant attached to MoH, the thematic groups reviewed the situation analysis using SWOT tools as well as formulated SMART objectives and strategies for all areas as contained in this HSSP II.

There were also consultations with a wide range of health experts in order to get their inputs into specific issues related to the development of the HSSP II. A review of a wide range of health sector documents was done to provide an in-depth analysis and understanding of the sector such as the HSSP I and its expert review and annual review reports. Consultation meetings were convened in all states. Development Partners, Civil Society and other Ministries were consulted and contributed to the process of developing HSSP II.

The HSSP II consists of 8 sections. Section 1 provides a brief overview of the background and methodology. Section II provides situation analysis of the health sector especially looking at the organisation of the sector and the delivery of health services in Somalia including review of the progress against HSSP I. Section III sets the strategic direction including the overall vision, targets, principles and values. Section IV set out the health policy priorities and is divided into nine chapters (health service delivery, human resource for health, leadership and governance, essential medicine and supplies, health information, health financing, health infrastructure, emergency preparedness and response and social determinants of health). Section V provides an overview of the financing requirements for the health sector. Section VI covers the performance framework as well as monitoring and evaluation arrangements. Section VII covers the plan management, coordination and implementation; whereas, section VIII provides an overview of the risks and assumptions for the plan.

1.2 Purpose and use of the Plan

The opportunity for the Puntland-Somalia Ministry of Health to develop a Health Sector Strategic Plan (HSSP) is an important step in building the government's capacity to improve access to much needed health services for the people of Puntland. The plan aims to improve the allocation and effectiveness of external support for the sector. The HSSP sets realistic, measurable and understandable priorities appropriate to Puntland, rather than setting unreachable global targets. A monitoring system is included to measure progress in implementing the HSSP and revising it based on good evidence of what works and what does not. It recognises the role of the commercial sector and the preference for the private purchase of health services in Puntland. The plan provides a guide for external investments in the health sector by traditional and non-traditional donors, the Somali diaspora, charities and NGOs.

The HSSP provides a starting point for the government to develop annual work plans and budgets that will detail the specific activities and funds that are needed to accomplish the strategies and objectives of the plan. The Plan provides a statement to funding and implementation partners of government priorities for investment so that their support can be harmonised, effective and efficient. Clearer donor-government responsibilities for implementation, management and reporting will lower the transaction costs associated with international development cooperation.

Development Partners and the UN have supported the delivery of many disease-specific vertical programmes. Each of these programmes (HIV/AIDS, TB, Polio, MCH, Reproductive Health etc.) along with other health related interventions such as nutrition and humanitarian responses all have detailed strategies, plans and interventions. In each of these separate programmes there are components of the six building blocks of Health System Strengthening that are outlined in this document. The HSSP is intended to harmonise and align each of these vertical programmes within the overall framework of the HSSP to ensure that national priorities are also reflected within each of the separate vertical programmes.

1. The Plan has three main purposes:

a) It provides a strategic framework to guide the development of annual work plans and budgets that will detail the specific activities and funds that are needed to build a modern health sector and achieve the mission of the Ministry of Health. Annual work-plans and budgets will result in more focussed efforts by all partners and more progress in the meeting the health needs of the people.

b) It provides a clear statement to funding and implementation partners of the strategy and priorities for investment in the health sector so that the human and financial resources needed to implement the Plan can be harmonised and external support made more effective and efficient. The Plan also includes the design of clearer and more efficient donor-government responsibilities for implementation, management and reporting so that coordination can improve and transaction costs associated with development cooperation can be reduced.

c) The Health Sector Strategic Plan also provides a clear statement of accountability for its success with proper divisions of responsibility for implementation, management and reporting of the investment

1.3 Core Values and Principles

The following values and principles provide the basis for the second Health Sector Strategic Plan (HSSP II):

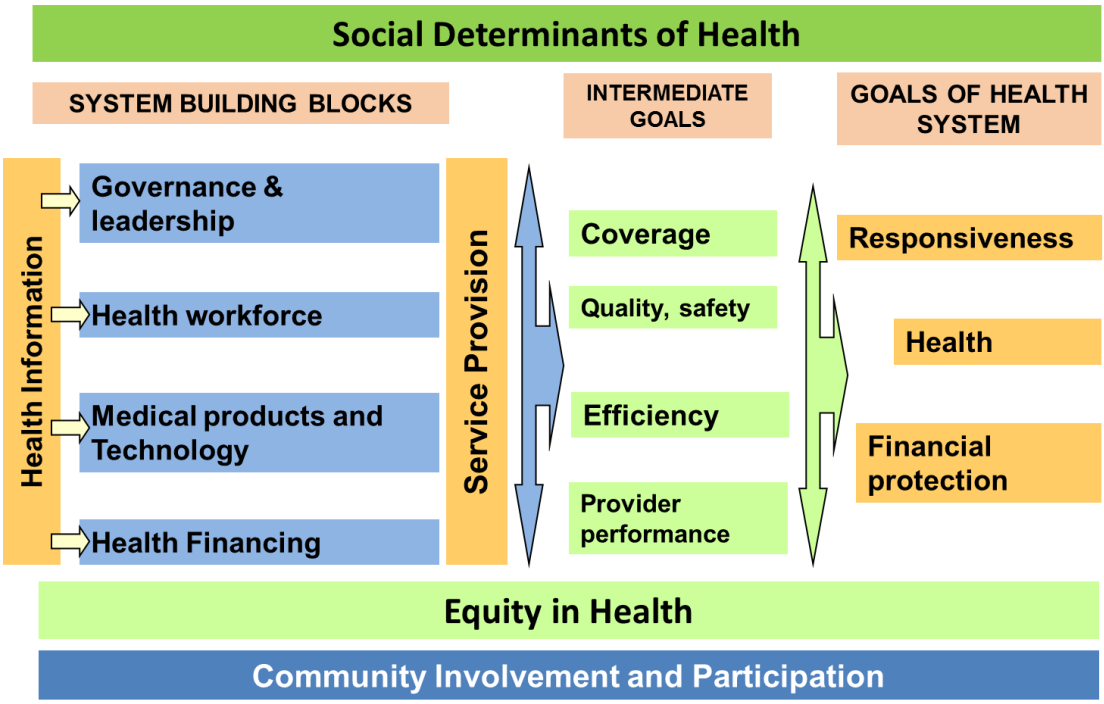
1. Universal and equitable access to acceptable, affordable, cost-effective, and quality health services with maximum impact on Somali populations' health to ensure the realization of the right to health
2. Effective, transparent and accountable governance and leadership in managing the different components of the health system with decentralized management of health care service delivery
3. Building effective collaborative partnerships and coordination mechanisms engaging local community, national and international stakeholders and pursuing the aid effectiveness approaches
4. Good quality services - well managed, sensibly integrated, available, accessible, accountable, affordable and sustainable (with a corresponding reduction in vertically-driven, standalone programmes and projects)
5. Priority emphasis on reproductive, maternal, neonatal, child and adolescent health
6. Promotion of healthy lifestyles and health-seeking behaviour among the population
7. Emphasis on prevention and control of priority communicable and non-communicable diseases, as well as on trauma and related injury
8. Addressing the special needs of vulnerable groups, rural and pastoral communities
9. Evidence-based interventions based on considered use of reliable health information
10. Meaningful engagement and participation of citizens in the review, management and financing of health services
11. Increased and more diverse public-private partnerships
12. Implementation of health financing systems that promote equitable access to priority health services.

1.4 Theory of Change Model

For the development of HSSP I (2013-16), MoH adapted the WHO's Health Systems Framework consisting of six Building Blocks. However, to further strengthen and contextualise the approach, the framework was revised to include equity, community involvement and participation, and social determinants of health.

The revised Health System framework was used for the development of the Somali Health Policy 2014 and the same has been used as a Theory of Change for the development and implementation of HSSP phase II (2017-21).

Diagram 1.0: Theory of change model



It is important that the HSSP is aligned to the health-related Sustainable Development Goals (SDGs). Evidence shows that about 50% of the reduction in child mortality in Lower and middle income countries (LMIC) between 1990 and 2010 was due to interventions beyond the health sector. The following picture highlights the importance of multi-sectoral approach and consideration of all health related SDGs. This approach is utilised in the development of HSSP 11 and key national policies and plans given due regard.

Diagram 1.1: Factors influencing the reduction in child mortality in LMIC between 1990 and 2010

SECTION 2: SITUATION ANALAYSIS

2.1 Overview

The peace dividend, along with investment by Puntland government and international donors, is bringing about a new environment for the Somali health sector with potential for health improvement. Over the years, Somalia has been administratively divided into three zonal operations: Somaliland (North-West Zone), Puntland (North-East Zone) and South-Central Zone. Puntland has its own Constitution, President, Parliament and Executive and functioning central and local levels of government (WHO 2015).

Somalia's population is rapidly increasing. In 2014 it was estimated to be 12.3 million[4] (49.3% male and 50.7% female). The population of Puntland is estimated at 2.4 million[5]. Puntland's population growth rate is very high due to the influx of people from war-torn southern Somalia and neighbouring countries.

Urban settlements are growing at an unprecedented rate with rural-urban migration concentrating the population in and around urban centres. Currently, 30% of Puntlanders live in the fast-growing towns of Bosasso, Gardo, Las-Anod, Garowe, and Galkacyo (Gov. of Puntland). The population in Somalia is also very young, with 45.6% under the age of 15, and 75% under the age of 30. In Puntland, about 70% of the population are under 30 (Gov. of Puntland). Key high-risk groups in Somalia include 2.4 million children under the age of five and more than 3 million women of childbearing age.

Nomads constitute a quarter of the total Somali population; in Puntland the figure is 65% (Gov. of Puntland). There are an estimated 1.1 million (8.6% of total population) internally displaced people (IDP) in Somalia, living mainly in the outskirts of urban towns (PESS 2014). This population profile has considerable implications where public sector capacities to deliver health and related services are limited, development and humanitarian assistance are declining, and there are persistent areas of conflict, natural disasters and health emergencies such as drought and epidemics (WHO 2015).

The Federal Government of Somalia (FGS) developed a three year National Development Plan (NDP) (2017-2019) to replace Somalia's New Deal Compact (2014-2016). The NDP reflects priorities of the health sector and include key objectives defined in Somalia's National Health Policy (2014), the country's first post-war countrywide health policy.

In Puntland, several important policies, plans and related documents have been developed. Examples include among others the Puntland HSSP I (2013-2016), the Puntland MoH Health Financing Policy (2016), the Puntland MoH Functional Analysis (2016), MoH Training Needs Assessment (2016), and Health Sector Research Agenda (2015). At the same time, there has been significant progress in programmatic response, with enhanced leadership of government health authorities and a transition from humanitarian to development responses. New developments, such as HSSP II, will need to align with the National Development/

[4]Federal Republic of Somalia, Data for a Better Tomorrow PESS 2014, UNFPA (2014) Population Estimation Survey 2014 for the 18 Pre-War Regions of Somalia October 2014 http://somalia.unfpa.org/sites/arabstates/files/pub-pdf/Population-Estimation-Survey-of-Somalia-PESS-2013-2014.pdf

[5] Government of Somalia http://www.puntland.somaligov.net/about.html

Economic Recovery Plans and the Interim Poverty Reduction Strategy Paper (IPRSP) to ensure the health sector benefits from cross sectoral reforms.

Health outcomes in Puntland, as in wider Somalia, are poor despite improvements in past three years . Capacities of public institutions have improved, but prevailing health system weaknesses pose major challenges for ensuring equitable access to quality, safe and affordable healthcare services (see Health Service Delivery, below). The current mechanisms for health sector coordination[6] need to be considered in light of these new situations, ensuring that sector coordination is implemented in a decentralized way and reflects community needs.

Funding of the Somali health sector beyond 2016 is uncertain. A drop in overall funding is anticipated, due the end of the largest health sector development programme, the Joint Health and Nutrition Programme, in December 2016. However funding for the implementation of the Essential Package of Health Services (EPHS) will continue under different implementation arrangements. The UK Department for International Development (DFID), through the Somali Health and Nutrition Programme, SHINE, will contribute a total of GB£92 million for 5 years up to 2021. The Global Fund to fight AIDS, TB and Malaria (GFATM) and the GAVI Alliance have both renewed their commitment to support the Somali health sector through grants for EPHS and other health system strengthening activities and will be finalising plans and budgets during 2017. Other development partners will also finalising their commitments to the HSSP II during 2017.

2.2 History, legal standing and policy context

The **Puntland Ministry of Health (MoH)** was re-established in 1998 following formation of the autonomous Puntland State of Somalia. Health was one of the key priorities that the embryonic government has to address to bring about positive change in a society marred in devastating impact of protracted civil war and scars of social strife of anarchy. A critical step forward was then development of necessary legislative framework and governance structure to aid socio-economic development. With the development of Puntland constitution, Article 21 Health, stipulating role of the government in promoting health and enshrining in it the following declaration:

- Puntland State shall promote the public health care of the mother and child, prevention of the contagious diseases and encourage public health sanitations.
- The State shall protect the health and promote the health institutions.
- The State shall promote and encourage private institutions for health as regulated by the law.

The constitution thus provides fundamental legal basis on which Puntland health interventions are conceived including the issue of Human Right to Health, protected under Article 25 of the Universal Declaration of Human Rights[7]. In addition to the constitution, a number of Somali government system policies, legislation and strategies provide frames of references to the development of Puntland Health Sector Strategic Plan. These include among others the Puntland Development Plan, Somali National Health Policy (2014-2016), the National Human

[6]The Health Sector Coordination Committee (HSC) assembles constituencies from the donor community, UN agencies and NGOs; it is chaired by the three zonal health authorities and meets on quarterly basis in Nairobi. Similar structures are established at zonal level, feeding back to the HSC. The HSC spells out recommendations to the Health Advisory Board (HAB). Led by the three health Ministers.

[7]The Office of the High Commissioner for Human Rights, November 1948

Resource Development (2013-2017). Despite generation of policy documents at different tiers of governance, consistency between general and sectoral policies has improved. The pace of policy implementation has been varied in application/ enforcement and MoH Puntland has consistently demonstrated commitment to fully operationalise policy frameworks despite fundamental lack of funding.

The most influential international commitment providing direction to the development of Puntland HSSP II is the United Nations 2030 Agenda for Sustainable Development. The agenda outlines 17 Sustainable Development Goals (SDGs) to end poverty, promote well-being, and protect the planet, including SDG 3 which focuses on health: "Ensure healthy lives and promote well-being for all at all ages." SDG 3 calls for dramatic and inspiring achievements, including ending the epidemics of AIDS, tuberculosis, and malaria and achieving universal health coverage. The development of Puntland HSSP II has paid a due regard to these critical issues.

A key legal document for HSSP II, the Puntland Health Act (law # 6), has gone through a long process of development including subsequent revision in 2011 and final approval by the Puntland Parliament in 2012. Law # 6 was thus not fully materialised until 2013: the very year that also marks the development of the first post-civil war health sector strategic plan in the Somali Peninsula, the Puntland Health Sector Strategic Plan 1 (2013-2016).

Furthermore, with the full participation of Puntland State, a common Somali Health policy prioritizing health policy direction was adopted in 2014. The Somali policy focus on country's health system needs through the adoption of WHO approach of Health System Building Blocks. The key health priorities of Somali National Health Policy are:

i. To improve access to Essential health services of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.
ii. To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services.
iii. To build institutional capacity of health authorities at both central and regional levels to provide strong leadership and effective governance, provide core functions of health sector and engage with private sector.
iv. To ensure the availability of essential medicines, vaccines and commodities that satisfy the priority health care needs of the population, in adequate amounts and of assured quality and at a price that the community and the health system can afford.
v. To establish an effective health information system that provide accurate and timely health data for evidence based planning and implementation, supported by effective monitoring and evaluation (M&E) and by targeted research as a problem-solving tool.
vi. To raise adequate funds for health, protecting the poor and under-privileged from catastrophic health expenditure ensuring that people can access affordable service, therefore moving towards universal health coverage.
vii. To bridge the gap in the enormous health infrastructure paucity and create the minimum health infrastructure assets, providing the necessary operational environment for effective service delivery.

viii. To strengthen the health system and surge its capacity to promote public health and prevent, investigate, mitigate, manage, monitor, evaluate and control public health threats and reach out to affected communities with integrated effective assistance targeting their specific public health emergencies.

ix. Improve the health of the population and reduce health disparities by addressing the social determinants of health, integrating health perspectives into the broader development framework and emphasizing on inter-sectoral collaboration across all government and other stakeholder partners and building the capacities necessary for its implementation.

The Puntland HSSP 11 translates macro-level policies, national & relevant international directions, into key health priorities and actions at a smaller scale in a manner that is consistent with the core mandate of Puntland MoH as stipulated in Puntland Constitution and related legislative frameworks.

2.3 Health System Strengthening Building Blocks

The following situation analysis is based on experience and lessons drawn from planning and implementation of the HSSP 1 (2013-2016) building blocks (services, medicines, human resources, finance, management information systems and governance & leadership) with additional analysis for humanitarian response/emergency preparedness, and inequalities. The analysis is informed by information gained through stakeholders consultation workshops in various regions in Puntland (e.g. SWOT), the WHO 2015 Strategic Review of Somali Health Sector: Challenges and Prioritized Actions (WHO 2015), MOH analysis of performance indicators for HSSP I (MOH analysis 2016) based primarily on MOH HMIS and other demographic and epidemiological data and information identified in the text.

2.3.1 HEALTH SECTOR SERVICES – CURRENT STATUS

As in other parts of Somalia, the Puntland health situation is one of the worst in the world; without concerted and coordinated efforts to revitalize the health system, the country will be unable to achieve its SDGs related to health and nutrition. The burden of disease is heavily dominated by communicable disease, reproductive health and under-nutrition issues, although non-communicable diseases and mental illness are also on the rise (WHO 2015).

Polio transmission has been interrupted but routine immunization coverage remains very low and only 42% of children received the Pentavalent III vaccination in 2014. There were than 610,000 malaria cases in 2014 (WHO 2015). Tuberculosis is highly prevalent with 30,000[8] new cases every year, of which fewer than half are detected. Malaria is endemic in some parts and HIV epidemic growing, with a prevalence rate of about 1% with higher prevalence among the high risk groups[9].

Life expectancy in Puntland is estimated to be 53 and 56 years respectively for males and females. One in 7 children dies before their fifth birthday. Infant mortality in Puntland was 85 per I,000 live births[10].

Every two hours a woman dies during pregnancy/childbirth. One out of 18 women has a lifetime risk of death during pregnancy. The country has one of the highest total fertility rates

[8]http://www.emro.who.int/som/programmes/tb.html
[9]http://www.unaids.org/sites/default/files/country/documents//SOM_narrative_report_2014.pdf
[10]Puntland HSSP I performance framework analysis [note: other figures fit with Somalia-wide figures]

(6.7) in the world with unmet need for birth spacing at 26%. In 2015, the maternal mortality ratio was estimated at 732 per 100,000 live births[11] – an improvement since 1990, when the figure was 1210 per 100,000 live births[12], but still poor compared to Kenya (510) or Ethiopia (353) in 2015. Under-5-mortality rate was 137 per 1000 live births[13] in 2015, compared to Kenya (49) and Ethiopia (59).

Underlying causes of health are of critical importance. In terms of inequalities, factors such as poverty, rural isolation, gender, age, lack of access to water and sanitation, HIV status, drug use all have an impact on health outcomes Seventy per cent of Somalis do not have access to safe water supply or sanitation. Half the population practices open defecation; in rural areas this is as high as 83%. As a result, diarrheal diseases accounts for the majority of deaths among children along with respiratory infections (WHO 2015). Ninety-eight per cent of women experience female genital mutilation/cutting (FGM/C[14]), leading to serious obstetrical and gynaecological complications. There are 202,600 acutely malnourished children in the country and 60% of children under-5 and 50% of women suffer from anaemia (WHO 2015). However, much more reliable data and information are needed to be able to point accurately at locations and groups with the worst health outcomes to enable effectively targeted responses.

Due to a two-long decade civil war, many health indicators are very poor. The Burden of Disease (BOD) in both Puntland and wider Somalia is dominated by communicable diseases, reproductive health and under-nutrition. Non-communicable diseases and mental illnesses are also on the rise. A stepwise survey planned to be conducted in 2018 will shed a light on the status of non-communicable disease in Puntland. However, given the current situation, Puntland will be unable to achieve its SDGs related to health and nutrition if concerted, coordinated and consolidated efforts are not made to revitalize the health system.
A summary of health and nutrition-related MDG indicators for Somalia and its comparison with the average of Sub-Saharan Africa are presented in table 2.0.

[11]Gavi (2016) Joint Appraisal Report – Somalia 2016
file:///C:/Users/user/Downloads/Somalia%20Joint%20Appraisal%202016%20(1).pdf
[12]http://data.worldbank.org/indicator/SH.STA.MMRT
[13]Inter agency estimates http://www.childmortality.org/index.php?r=site/graph#ID=SOM_Somalia
Puntland Wasaarada Caafimaadka Ministry of Health Health Sector Strategic Plan. January 2013 – December 2016

Table 2.0 Health and nutrition-related MDG indicators, 2009 – 2010[15] and 2013-14[16]

Health and Nutrition-Related MDG Indicators	Somalia		Sub-Saharan Africa	
	2009-10	2013-14	2009-10	2013-14
MDG 1: Poverty and Hunger				
% under-5 children malnourished (underweight)**[17]	32	32	30	21
% under-5 children chronically malnourished (stunting)**	42	42	41	38
% under-5 children acutely malnourished (wasting)**	13	13	10	9
MDG 4: Child Mortality				
under-5 mortality rate (per 1,000 live births)	200	146	144	98
infant mortality rate (per 1,000 live births)	119	91	86	64
measles immunization (% children 12-23 months)	24	46	72	72
MDG 5: Maternal Mortality				
maternal mortality ratio (per 100,000 live births)	1400	850	900	500
% births attended by skilled health staff	33	33	39	50
MDG 6: HIV/AIDS, Malaria, and Other Diseases				
prevalence of HIV (% adults aged 15-24)	0.5	0.2	5	1.9
contraceptive prevalence rate (% of women ages 15-49)	15	15	23	24
number of children orphaned by HIV/AIDS	9,000	110	10,200	15,100
% under-5 children sleeping under insecticide-treated bednets	11	11	..	36
% under-5 children with fever treated with anti-malarials	8	8	42	37
incidence of tuberculosis (per 100,000 per year)		285	343	290
tuberculosis cases detection rate (all new cases) (%)	73	43	46	51
MDG 7: Environment				
access to an improved water source (% of population)	35	30	58	63
access to improved sanitation (% of population)	50	24	54	30
General Indicators				
Population – million	9	12.7	772	914
total fertility rate (births per woman ages 15-49)	6.4	6.7	5.2	5.2
life expectancy at birth (years)	50	55	49.6	56

However, a new environment is emerging. Maternal mortality ratio and under five mortality rates, which remained unchanged at a very high level for about two decades are showing slow but persistent declining trends (WHO 2015.

2.3.2 Organization of Health Service Delivery

Health service provision in Somalia is structured on a four tier system involving referral hospitals, regional hospitals, health centres (HCs) and primary health units (PHU) It is divided into 10 programmes18of which six are provided at all levels and four additional programmes are provided only at the referral levels[19]. All levels should provide some elements of the EPHS,

[15]Sources for 2009-2010: UNICEF Somalia Statistics (2010); World Bank Millennium Development Goals Global Data Monitoring (2010)

[16]Sources for 2013-2014: UNICEF The State of World Children 2014; UN Interagency estimates for child and maternal mortality, 2013; Population Estimation Study, Somalia 2014; World Bank Data Monitoring (2013)

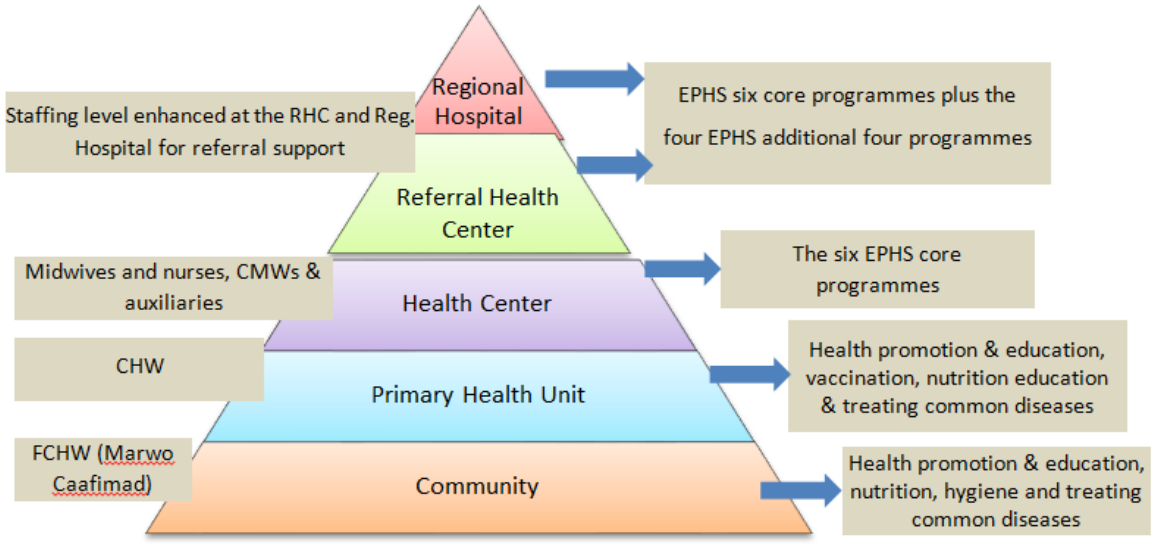
[17]** Indicators for undernutrition are cumulative for moderate and severe malnutrition. The latest Somalia FSANU data for 2015 for Severe under-nutrition indicate underweight: 13.4%; stunting 12% and wasting: 13.6%

[18] Maternal, reproductive health and neonatal health; child health; CDC & surveillance WATSAN; first aid and care of critically ill and injured; treatment of common illnesses; HIV, STI &TB; management of chronic disease and other diseases, care of the elderly and palliative care; mental health and mental disability; dental health; eye health (WHO 2015)

[19]Essential Package of Health Services, 2012. UNICEF. Nigel Pearson and Jeff Muschell

although this is not followed in practice. Figure 2.0 presents the regional health system organization, staffing and performance functions (WHO 2015).

Figure 2.0: The Regional Health System Organization, Staffing and Performance functions



Source: Somali Health Policy, 2014

During HSSP 1, full implementation of EPHS has not been successful due to severe shortages of trained staff, scarcity of medical supplies and lack of quality care. Nevertheless, in a relatively short period, MoH managed to turn around deteriorated facilities and improve standards of staff performance, implement essential drug list and ensure good treatment. Consultation and vaccination rates have increased and there has been a rapid rise in in-facility deliveries with skilled attendants, which has had a positive effect on maternal, neonatal and young child survival. Recent patient satisfaction assessment shows that overall 92% clients expressed receiving good (24%) and excellent (68%) health services[20]. Such assessments are also a reflection of people's low level of expectations (WHO 2015).

2.3.3 Health Service Performance Review

Health service delivery is structured around the EPHS framework and is the corner stone on which the extant health service delivery in Puntland stands on. EPHS was first introduced in 2013 as the primary vehicle of implementing the Puntland Health Sector Strategic Plan 1 (HSSP 1): the first post-civil war strategic plan in Somalia. With support from DFID, EPHS was initially piloted in Karkaar region in 2013 and subsequently rolled out in Nugal, Bari and Mudug regions.

Key health service delivery strategic objective of Puntland HSSPI (2013-2016) was "equitable access to the 6 core interventions of the EPHS in all public health facilities in all regions by December 2016". Prior to HSSP 1 conception, the scope of health service delivery in the Puntland was confined to main urban centres and provided very limited services. In 2013 number of health facilities were 162 (40% barely functional) in contrast to 284 fully functional health facilities as of December 2016, operationalised through EPHS and other assistance. The number of hospitals at regional and district levels remain the same but service provision has considerably improved. Three hospitals now provide 24/7 CEmONC services though this still falls short of international standards (1 hospital /500,000 people), progress is substantial

[20]Review of the implementation of the essential package of health services. Nigel Pearson & Saba Khan. 2013

given the fact that none existed in 2013. Non-the-less state of secondary health in Puntland is in need of immediate attention as focus of HSSP1 and related health development support essentially revolved around primary health care.

Health facilities density is 1.1 and average hospital bed density is also 1.1 per 10,000 populations. The density of primary health unit (health posts) per 10,000 populations stands at 2 in Puntland. The average level of 0.2 out of patient visits annually per capita (HMIS, 2014)[21] signifies serious underutilization of these facilities.

Table 2.1: Distribution of the health facilities

	Puntland	
	Number	per 10,000
Health post	193	1
MCH	105	2
Hospitals	12	0.05
Total	310	1

Source: MOH 2016. Based on calculations from different sources

The percentage of health facilities implementing the six core EPHS stands at 72.3%. Due to resources constraints, full implementation of EPHS has not been feasible in all regions of Puntland. Consequently Sool & Sanaag regions currently remain non-EPHS with no or very little basic elements of health services. During HSSP I implementation, efforts of improving access in these two regions focused on outreach program in key health concerns. Although overall access to health services greatly improved through introduction of the 6 core interventions of EPHS regions, equitable access to these services did not fully materialized.

Significant progress is made in improving service provided by NGOs, CBOs and the private sector through partnership working. For example, less than 40% of EPHS implementing partners had MOU in 2013. With MoH's revision and standardization of MOU, all partners have now a signed agreement with six monthly reporting undertaken on adherence to MOU terms and conditions. Furthermore, efforts on private sector engagement during HSSP 1 implementation led to collaborative initiatives on training and accreditation of health educational institutions degree/diploma programs such as nursing and midwifery.

There are about 17 different community health cadres (e.g. female health workers [FHWs], CHWs, Trained TBA, Hygiene Promoters, Community Development Mobilizers, Community Educators, Mother-to-Mother Support Groups, and Female Health Promoters)[22], each with different training and scope of work. Three – CHWs, FHWs and the integrated Community Case Management (iCCM) – have more advanced systems, job descriptions, training curricula and administrative systems and therefore have the highest potential to grow and provide forth coming community health services.
The female community health worker (FCHW) (*Marwao Caafimaad*) concept was established to extend a range of promotive and preventive health services to communities: they have helped improve access to remote populations, reducing the rural-urban discrepancies, and improving maternal, reproductive, new-born and child health care outcomes.

[21]Only data from MCHs and hospitals. Some hospitals and new MCHs are not included in Puntland. SC data is only till April 2015. This needs validation with HMIS
[22]Somali Community Health Strategy. WHO Ref Number 2014/413682-0. 2014

Similarly, basic health services in rural areas were instigated through deployment of community health workers. Consequently 120 Village Health Workers and 160 Female Health Workers employed. Furthermore, 150 midwives and additional 60 post-basic midwives currently work in various rural localities throughout Puntland giving preferential treatment in areas of least access to health services. Further 20 clinical officers, 10 doctors and 100 female workers are currently under training

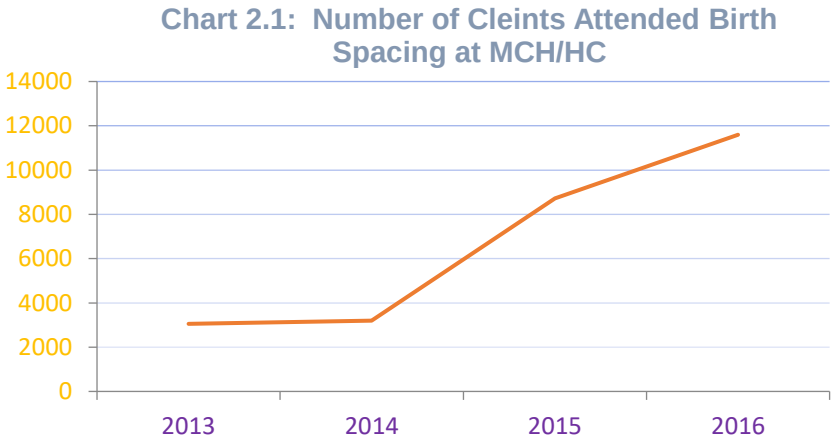
Integration of HIV/AIDS into EPHS facilities marks significant progress given that only three standalone VCTs with limited capacity provided these services in 2014 and before. All EPHS facilities (76) now provide integrated HIV services. Total number of clients tested for HIV/AIDS in 2014 stood at 3244 compared to 4204 in 2016 with percentage positive cases increasing from 2.5% to 3.1% respectively. The change in total number tested (willing to take test) have increased as result of persistent awareness campaigns and increased availability of counselling services and testing tools.

TB and Malaria also made strides of progress in relation to service availability and access. Number of malaria cases diagnosed at ODP almost doubled from 35666 in 2014 to 68803 in 2016. Malaria outbreak in 2015 resulted in extraordinarily higher positivity rate of 12% in 2015 relative to 6% in 2013. Correspondingly, malaria positivity rate has slightly gone up from 12% in 2015 to 13% in 2016. Anti- malarial interventions including utilization of long-lasting insecticide-treated mosquito nets is encouraged and supplies provided in Bari region where malaria is epidemic. Consequently, percentage of U5 with uncomplicated malaria managed at health facilities increased by 30%. Similarly, 100% of households in malaria areas with at least one LLIN have been achieved during the HSSP1 implementation.

TB services remain vertically managed and plans for integration have not materialized over plan period. However scope of the services expanded with number of TB centres from 7 to 15 dedicated services.

MoH scaled up of community abandonment of FGM/C intervention focusing on demand creation, training of community health workers, inter-sectoral collaboration and adoption and implementation of regulatory framework. During HSSP I Puntland has became the first Somali territory to outlaw FGM. Combined effects of these interventions have led to number of communities declaring total abandonment of FGM/C. An opportunity now exists to further consolidate this gain during HSSP 11 implementation.

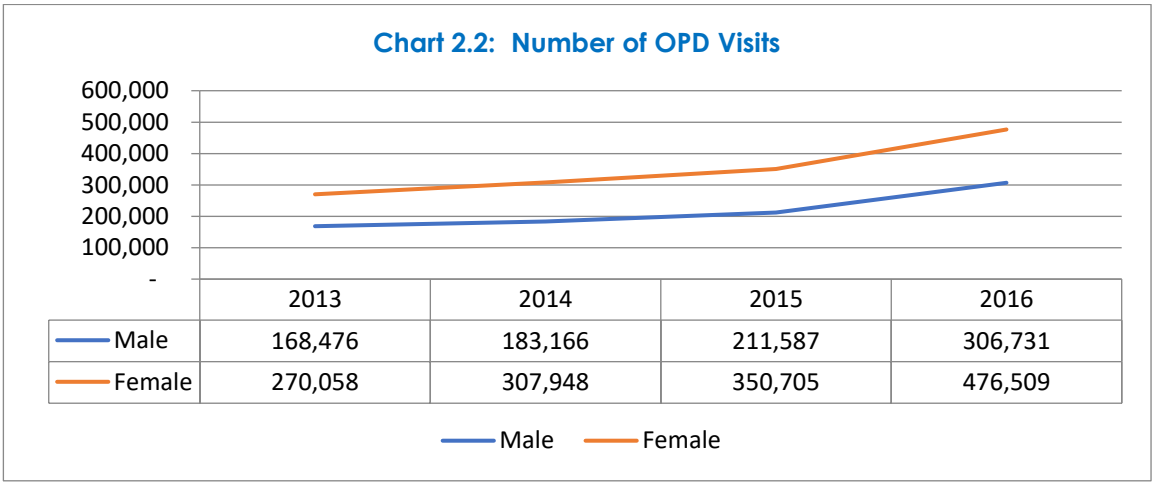
Reproductive health services have seen continual improvement since deployment of HSSP in 2013 with key priority targets achieved. Total number of BEmOC facilities is currently 62 with basic packages of medical interventions to treat life threatening complications during pregnancy and child birth. Reproductive Health interventions implemented during HSSP I include among others initiation of community based family planning services at MCH/HC with clients counseled on modern methods of family planning quadrupling in 2016 from baseline figure of 3053 in 2013. In addition to counselling services, family planning contraceptive supplies is also made available at EPHS facilities.



Number of deliveries in MCH/HC has gone up from 18280 in 2014 to 28597 in 2016[23]. Correspondingly, deliveries at hospitals have increased from 4473 deliveries in 2013 to 5201 in 2016. While home deliveries are still significantly higher, skilled birth attendance has increased from 33% in 2014 to 38% in 2016. Similarly, number of Antenatal Care visits at MCH/HC has considerably improved from 121511visits in 2013 to 189448 visits in 2016. Continual increase use of the service is attributable to improved access through deployment of EPHS resulting in employment of 150 newly graduated midwives and 60 post basic nurse-midwives as well as intensive awareness raising campaigns at grassroots level.

OPD utilization

In 2013, there were approximately 167476 MCH/HC male visits and 270058 female visits relative to 306731 male visits and 476509 female visits reported in 2016. The female visits have constantly been higher than male overall: almost an annual average of 35% higher. Data on reasons for the visits are captured at health facilities level but not compiled as part of HMIS datasets at Headquarters.



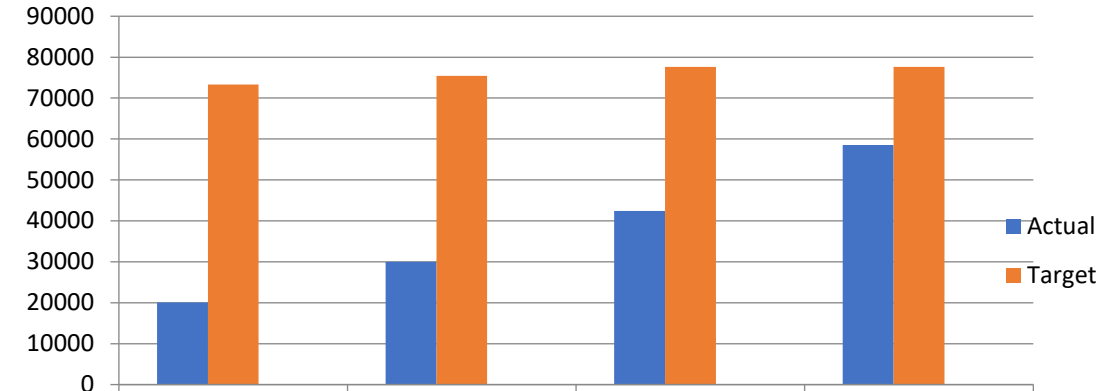
Immunization

During 2013, total number of children immunized for DPT3 in Puntland was 2008 against annual target of 73319 achieving only 23% of target. In subsequent years, however, as the number of health facilities increased, progress has significantly improved although annual targets have

[23] HMIS 2013 data available only in karkaar (EPHS pilot region)

not been achieved. Consequently, coverage gradually increased from 40% in 2014 to 55% in 2015 with current HMIS data for 2016 indicating 75% coverage.

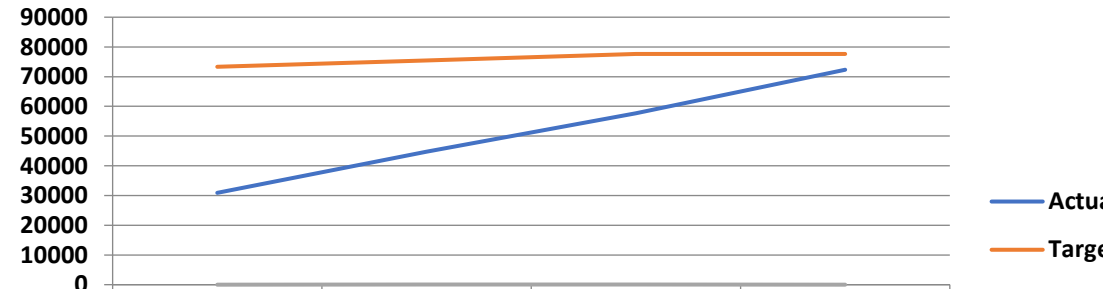
Chart 2.3: Number of Children Immunized for DPT3



	2013	2014	2015	2016
Actual	20088	30001	42440	58520
Target	73319	75445	77633	77633
Coverage	27%	40%	55%	75%

Similarly, HMIS measles data has shown considerable improvement of number of children immunized. 2013 coverage was 42% and has gradually gone up on annual basis with 2016 figures getting much closer to the target numbers.

Chart 2.4: Number of Children Immunised Against Measles



	2013	2014	2015	2016
Actual	**30903**	**44741**	**57706**	**72321**
Target	**73319**	**75445**	**77633**	**77633**
Coverage	**42%**	**59%**	**74%**	**93%**

Interruption of polio transmission is great achievement. With multiple rounds of national polio days held since 2013, last reported case was in August 2014. Similarly, three-round of child health days were also organized with community leaders playing key role leading to increased community awareness.

The private sector is a key player in the Somali health sector, having grown significantly over the past two decades at all levels. Donors channel their contributions to the health sector through a chosen implementing partner, and this is primarily with NGOs in Puntland although a very

limited public and private partnership currently exist: an opportunity that need to be further explored.

The fact that the majority of patients seek help from the private sector for health care is an indicator of the poor quality in public health facilities, or that public health services are simply unreachable to most people. The main goal will be to contract the private sector to provide public health services at affordable prices (WHO 2015).

CHALLANGES: Despite significant progress over the past four years, challenges are currently being faced in relation to service availability and access. Due to resources constraints, full implementation of EPHS has not been feasible in all regions of Puntland across the health sector. Two key areas of concern exist in relation to availability and access of service. First, Sanaag and Sool regions, with significant population, remain non-EPHS with very little health service available to the public. Approximately 52% of populations have no access to EPHS services in these regions. Second, as EPHS essentially focuses on primary health, the state of secondary health remains in dismal disarray with only minimum investment made over the past few years. Throughout the country, hospitals are underfunded with inadequate capacity in terms of supply, infrastructure and human resources. Thus secondary health care in Puntland need immediate attention should a looming catastrophic public health disaster of unprecedented scale be averted. Similarly, due to lack of resources, health facilities don't offer all six core EPHS components and main service now focus on maternal and child health. Other challenges include the fact that rural areas health services is essentially non-existent with only ad-hoc outreach services infrequently conducted. The following challenges are also identified in the WHO report include:

- Despite the EPHS strategy's focus on quality, there are no quality assurance standards/programme, an absence of patient safety and infection control norms, outdated infrastructure and insufficient maintenance
- Weak regional and district leadership skills and managerial capacities for supervision, monitoring and evaluation of EPHS implementation
- TB/HIV have not been fully integrated in primary health care services
- Patchy and uncoordinated MoH community level services resulting in either overlapping or gaping services
- Current broad-scope community health cadres are not sustainable. It is importantto apply the standardized approach which will provide cost effective services for women and children particularly in underserved districts.
- Ongoing training is needed for CHWs and TBAs to work effectively.
- There is no accurate information on private sector, with no system to collect data on the size, utilization and quality of care provided. Regulation and enforcement of standards in the private sector are among the greatest challenges facing MOHs in all three zones.

Table 2.2: SWOT analysis for Scaling up of essential and basic health and nutrition services

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Well established network of health facilities at all 4 service delivery levels covering 60% of the State with EPHS services being delivered at 70% of all facilities	✓ Service Level 4: Hospitals are in acute situation due to inadequate capacity, infrastructure and supplies to meet	✓ Commitment from donors, governments and all stakeholders towards various programs and initiatives ✓ Potential community & diaspora contribution in to the Health Sector	✓ Recurrence of emergencies (droughts and Security crisis) ✓ Continued donor dependency

✓ EPHS components 1, 2 and 6 fully delivered at all 4 service delivery levels ✓ EPHS coordination and management aligned with decentralization processes in 3 districts ✓ Improved and increased capacity of MOH at central level to manage service delivery during HSSP I ✓ Increased accuracy and efficiency of HMIS to assure validity of data under HSSP I	increasing demand for services at this level ✓ Low investment on community health education ✓ Unable to currently offer Universal Access to all EPHS components due to lack of resources	✓ Strong institutions and good coordination systems exist within the sector ✓ Ability to predict institutions and good coordination systems exist within the sector ✓ Newly graduated professionals entering the job market ✓ Increased community awareness and ownership of health issues as a community priority	✓ Gaps in service provision by implementers ✓ Continued environmental crisis ✓ Unpredictable and non-aligned funding ✓

2.3.2 MEDICINES AND SUPPLIES

The essential medicines programme in the Puntland is in its infancy and requires a great level of support to establish its key components. Following the fall of the central Government in Somalia in 1991 and the collapse of the public medicines supply systems, UN agencies and international NGOs (INGOs) began to engage in provisioning medical supplies to public health facilities as part of their humanitarian and emergency interventions (WHO 2015).

Under current arrangements, donors, agencies and NGOs operate their own parallel supply chain systems, largely as a pre-packed kit system with little coordination and integration. UNICEF provides medicines and supplies to MCHs facilities and Health Posts using a kit system while medicines for malaria, HIV, Expanded Programme on Immunization (EPI) and nutrition are supplied based on request.

Over the HSSP 1 period, MoH Medicine and Consumables strategic priories were aimed at addressing safety and quality of imported medicine as well as improving MoH capacity to effectively manage and distribute supplies. Specific HSSP 1 objectives of this critical component of health sector block priorities were first to Improve quality and safety of medicine and consumables. Second, it also aimed to develop minimum standards to improve the safety and practices of medicines of wholesalers and retailer and also that MoH has the capacity to manage all supplies in the public sector.

The progress made included improving quality and safety of medicine and consumables, MoH undertook number of tests to ascertain that imported medicine and consumables are fit for public consumption and not of a sub-standard. Towards this end, for example TB and HIV drugs tests were undertaken in 2013 and 2014 and results all turned out negative. No counterfeit medicines were found in 2013/14 sample tests. However, due to resource constraints, sample tests were not conducted in 2015/16.

Puntland has an established and functioning warehouse at central level, and significant investments have resulted in improved effectiveness and efficiency. There is a supply chain master plan coordinated through a supply chain working group. LMIS tools and forms have been developed. MOH manages a cold-chain and the Essential Drug List has been

updated. A significant investment made in logistical infrastructure and management resulted in overall improved effectiveness and efficiency. Substantial progress has been achieved in developing MoH logistical management capacity. Key achievements include establishing a well-functioning warehouse and cold chain at central level with capacity to distribute medicine and supplies to districts. A logistical management information system was also developed and staff trained in use of the software. Staffs training aimed at improving capacity of supply chain management in order to have effective storage practice and better reporting stock situation for better planning and forecasting. As this training took place in 2016 and immediate effects is already evident in reporting, most of the benefits associated with it is likely to occur over the next year or so for more effective management and smooth running of the services. Similarly, supply chain master plan and standard treatment guidelines and protocols were also put in place. Furthermore, essential drugs list was also revised and modern shelving system in the central warehouse implemented.

Key challenges in Medicine and Consumables management include Inadequate infrastructure at regional, district and service delivery levels, namely, lack of storage facilities for medicines/supplies, Inadequate essential supplies particularly at non-EPHS facilities and hospitals, Weak quality control systems and weak forecasting systems at all levels of service delivery and Inadequate transportation system capable of providing regular coverage of all facilities in supply chain. There is insufficient funding for transportation and warehouse administrative activities. LMIS is not integrated with HMIS and issues of data quality remain though the new systems recently developed are likely to overcome this in the short term.

However, there is no regulatory system for the pharmaceutical sector in Puntland. It is estimated that the private sector provides around 80% of the country's medicines through importation and distribution through private retail outlets and pharmacies. This includes information technologies and equipment apart from those provided through projects and partners' support.

Access to quality medicines is limited. Implementation of the supply chain management master needs substantial additional funding. The existing kit based push system often results in stock-outs and at the same time oversupply with medicines and equipment that are not appropriate or in use. Insecurity in many geographical areas poses an additional challenge to the transportation of supplies and trigger increased costs. The distribution system is often inefficient due to lengthy funding and procurement procedures, resulting in short shelf life by the time medical products reach to the facility.

Medicines are generally poorly managed and stored at facility and central warehouse level without a proper inventory system but SOPs for warehouse management and storage practices have been introduced.

There is no regulatory authority to ensure the safety, quality and efficacy of medical products, proper drug importation and utilization, especially of private importers. Reports of counterfeit and low-quality drugs appear in the mass media. Six mini-labs have been established throughout the country for basic quality testing of ARVs, anti-TB, antimalarial, antibacterial and some analgesic medicines. Additional quality testing is being performed in Kenya's National Quality Control Laboratory (NQCL). A system for sending Alert Warnings on Withdrawn Medicines is also in place.

Medicines therapeutic committees have been established at zonal level to ensure oversight by health authorities of essential medicines related activities; a medicines policy has been developed and endorsed. However, a pharmaceutical unit at the level of health authorities is not in place and not included in respective organizational structures of the central health administration. Accredited training curricula for pharmacists are not developed and

structured pharmacy training is not included in pre- or in-service training of health professionals.

So far, the rational use of drugs has not been introduced and over-prescription is widespread. The availability of paediatric formula is limited. Treatment protocols though for the implementation of the EPHS including hospitals have been developed that should standardize the utilization of medical products, based on lists for essential drugs for each level.

Table 2.3: SWOT analysis for enhancing the access to essential medicines and technologies

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Well established and functioning warehouse at central level.Significant investments made resulting in improved effectiveness and efficiency ✓ Existing supply chain master plan coordinated through a supply chain working group ✓ LMIS tools and forms all developed ✓ Implementation a priority ✓ Cold-chain managed by MOH ✓ Recently updated Essential Drug List	✓ MoH unable to procure medicines and equipment ✓ Weak forecasting systems at all levels of service delivery ✓ Inadequate infrastructure storage of medicines and drugs at district and regional level ✓ Regular stock-outs or over-stocks reported for all medicines and supplies ✓ Supply chain based on kit-based PUSH not demand	✓ Strong private pharmaceutical companies ✓ Planned expansion of regional warehouses	✓ High prevalence of counterfeit medicines ✓ Un-regulated private sector ✓ No drug regulatory or QA system in place ✓ Regular stock-outs or overstocks reported for all medicines and supplies

2.3.3 HUMAN RESOURCES FOR HEALTH

A skilled workforce is central to effective healthcare. Despite formidable challenges in human resources for health, Puntland has made progress in a number of areas. Key achievements include establishing and operationalizing its Human Resource Department in 2014[24]. The HR Department undertook a functional review and developed an HR policy and master plan, along with an In-service Training Strategic Action Plan.

Over 72 per cent of health facilities meet EHPS staffing norms, with 76 out of 105 facilities adopting standardized staff allowance and incentives. Harmonised incentives are supported by JHNP, Gavi, GFATM, HCM and other humanitarian projects. Health educational institutions increased from two in 2013 to seven training providers in 2016. MoH also intervened to improve access to qualified health providers in rural areas, through employing 150 community midwives in rural areas with least access to health services and 60 post-basic completed-training. A further 60 community midwives are undergoing similar training and will be deployed in rural areas. An internship programme for 30 medical students has commenced in July 2017. Table 2.4 provides data disaggregated by gender on public sector staff by professional categories.

[24]MOH analysis 2016

Table 2.4: The Puntland public sector employed health professional categories with number serving(MOH analysis 2016)

Professional Categories	Female	Male	Total	%
Physician	20	39	59	3.0
Pharmacist	0	2	2	0.1
Registered Nurse	258	177	435	22.2
Registered Midwife	138	5	143	7.3
Auxiliary Midwife	14	13	27	1.4
Auxiliary Nurse	223	85	308	15.7
Aesthetic Assistant/Tech	8	8	16	0.8
Laboratory Technician	9	26	35	1.8
Laboratory Technician Assistant	4	7	11	0.6
X-ray Technician	3	5	8	0.4
Pharmacist Technician	3	4	7	0.4
Dental Technician	0	1	1	0.05
CBFHWs*, CHWs**, &HPs***[25]	207	103	310	15.8
Administration/Management Staff	63	189	252	12.8
Support Staff	162	184	346	17.65
Total	1,112	848	1,960	100.0

Despite these achievements, challenges remain. In Puntland[26], as in Somalia, the health workforce is characterised by serious shortages for all cadres, including specialist physicians. MOH estimates (2014) suggested Puntland had 1962 public, 830 private for a total of 2792 health workers (WHO 2015). There were both low density and numbers of doctors, nurses and midwives, with the overall density remaining below 4 per 10,000 population, much below the threshold level of 23 doctors, nurses and midwives per 10,000 population, defined as critical shortage.

Graduate and post-graduate intake has substantially increased across the board. Compared to 2013 figures, significantly higher numbers of employees serve in a range of health professional categories. Female public health workers outnumber their male counterparts, an achievement which resulted from specific gender mainstreaming activities such as ensuring adequate numbers of female in training and employment.
Health professional education capacity is gradually improving and new programmes are being introduced. However, a lack of ongoing professional development for the health workforce, with poor infrastructure and limited faculty capacity, contributes to poor quality services. At the same time, private education institutions are increasing, although the lack of regulation of these has raised quality concerns.

There're currently more than 12 health educational institutions providing medical education, nursing, midwifery, public health and related health professional trainings. Increasingly health education is provided by the private sector. However, regulation or accreditation to ensure quality training does not exist and government has recently embarked on plans to develop accreditation system. The current lack of regulated system has led to proliferation of educational institutions with inadequate capacity to train health professionals. MoH is currently working with Ministry of education to address these issues. Such Inter-sectoral collaboration

[25]*Community Based Female Health Workers, **Community Health Workers, ***Health Promoters
[26] WHO (2015) Strategic Review of Somali Health Sector: Challenges and Prioritized Actions. Report of the WHO Mission to Somalia 11-17 September 2015

led to development of curricula for midwifery and nursing qualifications now recognized by International Federation of Midwifery.

The overwhelming majority of facility-based health personnel are concentrated around urban centres rather than rural and hard-to-reach communities.

Health expenditure is low and mainly allocated to salaries, but these are still not sufficient. The WHO review (2015) noted the need to increase health budgets and fiscal space for salaries of health workers through both national and external resources. The review also found that salaries are often released after long delays. Staff retention is problematic due to lower incentives compared to the private sector. Despite a common agreement to standardize incentives among development partners, there are still discrepancies among health personnel, even within the same facility. Similar funding arrangements across the zones for expatriate physicians risk a dependency on external resources, reducing the involvement of MoHs in decision-making, and sustainability concerns.

Human resources for health component of HSSP I commenced at "ground zero" at plan conception. There was no Human Resources Department in 2013. The overall objective of Human Resource for Health under HSSP1 was to "establish a skilled, well managed, motivated and equitably distributed workforce to provide EPHS". HSSP 1 focused on the following key areas:

- Development of human resource policy and development of master plan
- Designing and keeping up-to-date record of all public health workers and their qualifications
- Agreeing standard incentives and allowances package
- Improve access to qualified health providers in rural areas

Significant progress is made and key HR target set for 2016 mainly achieved. Key areas of achievements include formally establishing and operationalizing Human Resource Department in 2014. Immediate tasks the Department undertook include development of MoH wide functional review and of human resource policy and master plan. The Department also made possible the development of MoH In-service Training Strategic Action Plan in 2016. The Human Resource Department developed a database to record all public health workers and their qualifications. Furthermore, an electronic attendance recording system is installed at MoH headquarters providing a reliable data on employees attendance.

Despite significant achievement in overcoming crisis of human resources, certain formidable challenges linger. Key challenges include insufficient numbers of mid-level and technical staff including Pharmacist, Laboratory Assistant Technician and X-ray Technicians standing at percentage total of public health sector work forces of 0.1%, 0. 6% %, 0.4% respectively. Similarly, continuing health professional development plan do exist, however, implementation have been confronted with resource constraints. contributing to poor quality services. Furthermore, overwhelming majority of facility based health personnel concentrate around urban centres to detriment of rural and hard to reach communities. Staff retention has also remained problematic attributable to lower incentives compared to the private sector and absence of career development strategy in public health sector.

Table 2.5: SWOT analysis for overcoming the crisis of human resources for health

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Established HR department at central MoH and regional level ✓ Established HRH policy and standardized curricula for nurses and midwives ✓ Established cadre of Community Health Workers, nurses and midwives covering all regions ✓ Harmonized service pay scales ✓ Increasing numbers of students pursuing health qualifications ✓ Existing HR needs assessment to facilitate planning and allocation of staff	✓ Insufficient mid-level and technicians (pharmacy, lab, x-ray etc) available at all facility levels ✓ There is no Continues professional development (CPD) programme for health staff ✓ Majority of facility-based health personnel concentrated in urban areas ✓ Retention of staff is very low (high turn over ✓ No HRH data base ✓ Limited access to post-graduate/continuing professional development for medical staff	✓ Increasing number of training institutions in the Private Sector ✓ New cadres of health professionals graduating in the next 2-5 years	✓ No private sector regulation or accreditation of health professionals and training institutes in order to assure training quality standards ✓ Staff retention and lack of incentives

2.3.4 HEALTH CARE FINANCING

Health financing in Somalia has been extremely limited as the country's economic performance is poor. Health sector resources are mainly from out-of-pocket (OOP) payments or through donor funding. The Somali diaspora contributes significantly to the health sector, but this contribution is not documented. Per capita public expenditure on health is approximately US$10–12 per year, far below the global standard for health sector investment (WHO 2015). This increases the risk of financial burden, especially on poor people with higher out-of-pocket expenditure.

Strengths of the current health finance systems across Somalia include that access to basic health services (both through development and humanitarian investment) is ensured to half the population. Rationalized humanitarian assistance means more focus on conflict-affected areas and de-funding the stable/ post-conflict areas.

Major challenges across the country include limited institutional capacity to collect and allocate funds to health from indigenous sources; a financing gap to ensure provision of services to the remaining half of the population, along with pre-payment mechanisms to reduce catastrophic/OOP health expenditure; lack of current data on health financing, including OOP expenditure and an absence of a mechanism to update data; an urgent need for public financial management (PFM) reforms in the health sector aligned to cross-sectoral PFM reforms; a need to develop rules and procedures for the purchase of services and goods in the public sector and to ensure strong accountability system in the public sector (WHO 2015).

Current funding approach: The past decade has seen a significant increase in funding for the health sector in Somalia. Financing from conventional donors increased by 180%, from US$53.6 million in 2005, to US$103 million in 2009,[27] and approximately US$150 million in 2014[28]. A trend of increasing development assistance for health has been noted over last few years, whereas there has been an element of donor fatigue in humanitarian funding (other than in 2011 when humanitarian funding increased to US$127 million compared to US$22 million in 2010 for the health sector as a result of drought) despite continued fragility and lack of capacity in the country. Contributions for vertical disease specific programmes, financed largely through polio eradication, GFATM and Gavi, fell from almost 50% to 33% of the total public financing during 2014.

External financing greatly exceeded government contributions to health: altogether governmental funds constitute less than 5% of the allocation through the public health sector (see table 2.6) (WHO 2015).

Table 2.6 :Status of Government health budget and total budget in 2014

Zone	MoH Budget	Total Budget	% share of health
Somaliland	$7.1m	$156m	4.5%
Puntland	$1M	$41m	2.5%
South Central	$0.88m	$216m	0.4%

Many donors, particularly non-traditional donors, channel their contributions to the health sector through a chosen implementing partner, depending on the type of support provided, usually by contracting out private providers to deliver EPHS or basic services.

Puntland achievements: Puntland's HSSP I called on government to "develop health financing system that relies more on national financing and local resources which aligns funding to key health priorities and is based on sound financial management", including increasing the proportion of the national budget spent on health to 6% by the end of the HSSP I.

Despite having meagre national resources, government of Puntland has indicated strong commitment in increasing health sector government financing. However, due to socio-political factors impeding overall economic growth, the health sector strategic objective of increasing proportion of national budget on health to 6% has not been fully achieved. In retrospective, given the magnitude of the country's post-conflict reconstruction challenges, a high bar might have been set to achieve the target of this indicator. The governments' national financing priority number has been safeguarding and improving security gains. Over the four-year HSSP1 period, Puntland average total annual budget have been at around US$ 42million of which 65% is allocated to national security with aim of preserving whatever little peace dividend, political stability and community cohesion. The remainder 14.7 million is rationalized among ever competing national priorities. With 1.2million allocation, health sector receives lion's share of national cake, more than most of other key sectors. Average annual health budget in Puntland stood at US% 0.3million between 2007-2009 and subsequently increased to US $1million in 2014 and US $2.7Million in 2016. However, these only meet partial staff salaries. Thus bulk of health sector finance remains externally funded by donors through key health sector program. More recently, however, the government of Puntland has

[27]World Bank, 2010, A decade of AID to the health sector in Somalia (2000-2009)
[28] Mission estimates

embarked on fiscal measures and monetary policies intended to accelerate economic growth and increase government revenue. Such measures include development of regulatory framework and more effective enforcement tools for collection of taxation and fees. With expected increase in government revenues, health sector allocations is expected to increase at annual increment of 1.5%, aiming at cumulative health sector allocation of 10% of national budget by 2021. This annual increase will still fall far short finance requirements for implementation of health sector strategic directions in HSSP II. Given this state of affair, it's critical that external assistance is sought to secure funding for implementation of HSSP II. To this end, continuation and scaling up core components of EPHS is essential in meeting minimum health needs of Puntland populace.

The government of Puntland has embarked on fiscal measures and monetary policies intended to accelerate economic growth and increase government revenue, including development of a regulatory framework and more effective enforcement tools for collection of taxation and fees. With an expected increase in government revenues, the health sector allocation is expected to increase annually by 1.5%, aiming at 10% of the national budget by 2021. As this will still fall far short of finance requirements for implementation of HSSP II, it is critical that external assistance is sought to secure funding to meet Puntland's minimum health needs.

However, significant progress has been made in health financing including establishing of Health Finance Unit in 2015. The Unit developed MoH first Health Finance Strategic Plan in 2016. The strategy outlined key health financing priority areas underlining the need for capacity building. A training of trainers on national health account tools was conducted in December 2016 and similar training for Regional Officer is planned to be held first quarter of 2017. Following on staff training, national health account tools has been adopted and operationalized at MoH headquarters. Government funded health activities account processing is completed in December 2016 and donor funded activities are currently under process. Health facility cost piloting is completed in November 2016 and Puntland-wide costing assessment is currently underway. Public health expenditure assessment was conducted in 2014. A computer based financial management system was developed during second quarter of 2016 and staff training on system functions was completed.90% of financial manual system has now been computerized and program reports completed on time. Annual auditing of MoH account has been regularly conducted by both Puntland National Audit Office and a similar exercise is conducted by UN through deployment of consultants.

Contextually, magnitude of challenges meant that though progress has been made, milestones` set for finance strategic directions have partially been achieved. The Finance Unit was not established until 2015 which have led to delaying of undertaking key strategic direction activities. Similarly, the Unit is under-resourced and only one Officer has been employed to undertake activities with wide remit: the very reason that health account preparation is delayed. Although public health expenditure review was undertaken in 2014, adequate data were not available to provide any useful health expenditure analysis as the basic infrastructure was poorly developed and finance unit structure not then fully operationized.

An important role for health finance systems is GESI-sensitive budgeting and tracking – linked to relevant indicators – expenditure on equity related issues to determine progress in these areas.

Table 2.7 SWOT analysis for Health financing for progress towards UHC

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Government allocated 2.5% of national income to the health sector ✓ Health financing plan exists ✓ Public financial management system (FMS) from MOF ✓ Basic level of health financing capacity within MOH ✓ Planned rollout of PEACHTREE payment system	✓ Limited progress on implementation of plans ✓ Delays in establishing National Health Accounts ✓ Multiple funding sources and requirements ✓ Continued donor dependency for health system	✓ Demographic Health Survey (DHSs) and Household Expenditure Surveys planned ✓ Funding Mechanisms (World Bank) for institutional capacity building and public FMS ✓ Software now available for establishment of National Health Accounts ✓ World Bank engagement ✓ Planned establishment of fund managers embedded in the MOH for upcoming DFID programme	✓ The 'Competition of Crisis' for resources from external sources (i.e. funding fatigue) ✓ Significant gap between income and demand/need for entire sector

2.3.5 HEALTH MANAGMENT INFORMATION SYSTEM

The health information system [HIS] faces enormous challenges in terms of overall functioning, performance and institutional frameworks, capacity and mechanisms to support information use for decisions. However, some progress has been made under selected components of the HIS (WHO 2015)

Accurate data disaggregated by factors such as sex, age and location, and used in planning, implementing and reviewing health initiatives can be critical to effectively targeting and reducing inequalities based on factors such as rural isolation or gender. Effective use of data can help ensure that overall improvements in health outcomes are not hiding lack of improvements for vulnerable groups.

Achievements include HMIS units established at different levels; a National M&E Framework and costed plans developed, HSAT, M&E, HMIS, research units (Health Information delivery team) in place and conducting regular data analysis and produce quarterly reports. Major challenges include questionable quality of data reported through HMIS; no national household level health survey conducted in last decade; HIS of vertical programmes, surveillance systems not integrated with HMIS; system of CRVS in not in place.

The Puntland HMIS is functional and it is being supported mainly through GFATM, GAVI and JHNP. Functionality of the HMIS varies across Zones in terms of established structures, timeliness

and completeness of reporting at the various levels (facility, regions and central MOH). The current HMIS platform uses an Excel database and generates monthly and quarterly reports. DHIS2 has now become fully operational following training workshop at regional and district levels. This has made a significant improvement in meeting reporting requirement and aiding decision making processes.

National Surveys and Census

A multiple indicator cluster survey (MICS) covering all regions was in 2006. However, the 2011 MICS covered only Puntland and Somaliland. There are ongoing discussions on conducting regular MICS/DHS and the HSSPs, M&E framework and plans have a list of surveys that are being planned and/or considered. Among planned survey include Malaria Indicators Survey & EPI coverage survey, Stepwise survey and Demographic and Health Survey.

The last census was in 1975. However the government and partners conducted a population estimation survey (PESS) in 2014 to provide population estimates at regional level. The district level and disaggregation of this data need to be analyzed. Yet again, current population projections used for health interventions are based on this estimates.

Independent monitoring and evaluation

MOH, partners and donors have discussed and planned some independent M&E of some health sector components/programmes. Some examples include joint annual review of the HSSP/annual workplan, review of the Gavi programme (currently ongoing), review of the JHNP (ongoing) and the strategic review (conducted in Sept 2015 and covered in this report). To further strengthen the M&E capacity of the MOH and guide programmatic planning, implementation and M&E, the M&E framework and plans were developed in 2013. It The overall nutrition M&E has greatly improved in terms of reporting, nutrition database and dashboard as well as integration into the HMIS at all levels.

Births and deaths registration

The coverage for birth registration among children under 5 years old (MICS 2006) was estimated to be only 3%. The coverage varied across the three zones with Puntland at 3%, Somaliland 7% and South Central 2%. In the HSSPs, a vital registration system of birth and death is now being piloted in Garowe districts and full rollout planned in 2018.

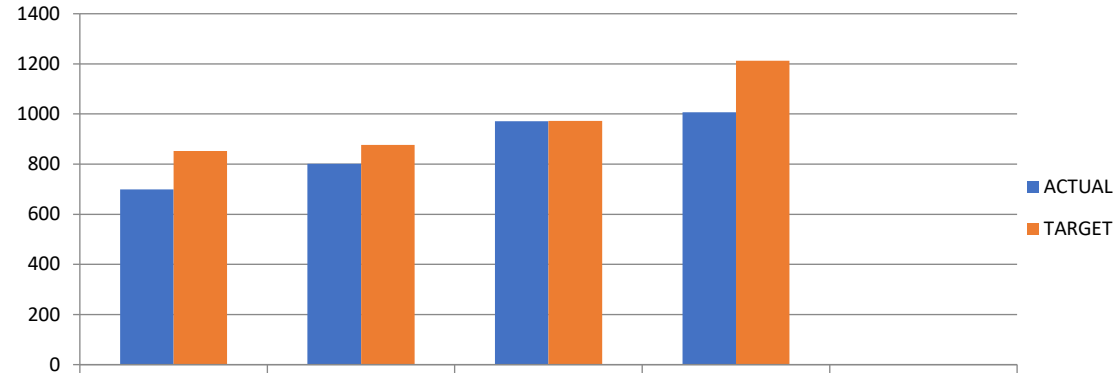
Community input and impact assessment

It is important to ensure meaningful input by communities into collection of information to inform planning and review of services, including representation from women and vulnerable groups, such as nomadic communities. This could include approaches such as participatory needs assessment, social audits and collection of information from complaints procedures. Using approaches such as health impact assessments (HIA) in planning services can help ensure their effectiveness and reduce negative impacts.

HSSP I set broad objectives and progress indicators for HMIS component to achieve. A key objective was to "Improve the scope, quality and utilization of the existing HMIS". MoH made significant achievements in a wide variety of HMIS activities leading to overall improvement in data and information storage, availability, scope and quality to aid decision making processes. Most significant progress relate to establishment of HMIS infrastructural foundation operating in all health facilities and strengthening MoH organizational capacity to collect, collate, analyze and monitor HMIS progress. A regular quarterly data audits and feedback,

continual training on data quality (including on the job training) across the sector resulted in improved data quality and utilization. The combined effect of such operational activities led to increase in timely reporting requirements across health facilities. For example, number of health facilities providing timely and complete HMIS reports significantly increased and stand at 81% as of December 2016 as opposed to 35% in 2013. This has led to similar increase in number of quarterly reports disseminated and shared with parterres and stakeholders (100%).

CHART 2.5: NUMBER OF HEALTH FACILITIES SUBMITTING TIMELY HMIS REPORTS



	2013	2014	2015	2016	
ACTUAL	699	801	971	1007	
TARGET	852	876	972	1212	

Important achievements also include expanding scope of HMIS by integrating standalone databases such as nutrition, malaria and HIV into system. Significant milestones also include development and automation of logistical Management Information System which now operational at all levels of health system.

Operational Research (OR)

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During HSSP I period, MoH Research Unit was established and research capacity significantly improved. Among the first activities the Unit undertook included implementation research trainings, establishing Puntland Health Ethical Committee (PHEC) and development of health research agenda. The PHEC is drawn from health educational institutions, private sector, regional health and hospitals, health association and MoH. PHEC is fully functional and since its establishment assessed more than twenty research protocols for ethical approval. Important achievements of the MoH Research Unit included putting together a research proposal on improvement of child immunization and winning health implementation research grant by the Alliance for Health Policy and Systems Research. This is indicative the fact that MoH has the research capacity to independently undertake implementation research project in-house without external technical assistance.

Challenges: despite increase in data utilization, there is still limited use in available data by decision makers at all levels. Significant numbers of development support use other sources of data and collaborative efforts are required to improve use of HMIS data as the main source of data for health sector in Puntland.

The main challenges also include inadequate funding for implementation research priority areas. The research agenda is not fully promoted across the sector and development partners often have little knowledge about existing MoH operational research agenda. This has resulted in lack of coordination of key research priority areas. Challenges also include that HMIS has

not been designed for financial data and information and there're other programs not integrated in HMIS.

Table 2.8: SWOT analysis for effectively functioning health information systems

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ HMIS Unit in place at central, regional and district and hospital levels ✓ Facility reporting at 80-85% timeliness and 90% completeness ✓ Established data collection and reporting tools ✓ Mapping of all health facilities at all levels ✓ Research unit established ✓ Improved research capacity within MOH ✓ Health research ethics committee established and research agenda set ✓ Functioning data quality system in place ✓ Well established data collection and reporting tools ✓ MOH staff trained in operations research	✓ No systemized use of HMIS and M&E data for decision making ✓ HMIS Unit is under-funded (stocks out of reporting tools, limited supervisions and no DQA and DQSA)	✓ Upcoming DHIS2 ✓ Research opportunities (Alliance health systems and research) ✓ Implementation of the DHIS II system will enable better analysis of data ✓ Health Alliance for Policy and Research grant to enable implementation of priority research identified in the research agenda	✓ Lack of civil registration and Vital Statistics for recording data on mortality

2.3.6 LEADERSHIP AND GOVERNANCE

The WHO review (2015) pointed to leadership strengths across the country, including the Somali Health Policy (2014) and related policies and plans, availability of improved data and intelligence for policy-making in Puntland, and an organisational structure with clear lines of communication and job-descriptions. Major challenges include limited institutional capacity, a weak culture of accountability and transparency, limited capacity for ensuring effective decentralization at central, state, regional levels, and insecurity in many regions.

Puntland reviewed its progress in relation to HSSP I indicators and reported achievement of key leadership and governance milestones in policy and planning, capacity development, health sector coordination, and emergency preparedness and response (MOH analysis 2016).

Policy and planning: As part of the overall reconstruction efforts, the Somali government prioritised social services. This resulted in the health sector's HSSP I (2013-2016), with strategic objectives and high-level indicators for review, with emergency preparedness and response at the centre of Plans. The three zonal HSSPs are functionally linked to the Somali Compact and New Deal, with efforts placed on aid effectiveness. Common challenges facing planning, implementation and monitoring include limited resources, weak regional and district capacities, high turnover of qualified staff and poor coordination among health-supporting

agencies. In Puntland, the HSSP has been endorsed although limited resources have largely hindered the full implementation of the zonal strategy.

Puntland MOH produced 10 Puntland-specific and actively contributed to 15 national policies, plans and procedural guidelines, including the following:

Table 2.9: List of policy documents guiding MOH work

• Health Sector Strategic Plan (HSSP). Ministry Of Health, Garowe Puntland 2013-16	2013-2016
• Programme Guide: Infant and Young Child Feeding Strategy for Puntland 2012-2016 Ministry of Health in collaboration with UNICEF Garowe-Puntland	2012-2016
• Human Resource for Health Strategic Plan for Puntland .2014-2018	2014 -2018
• National Policy on HIV/AIDS and sexually Transmitted Diseases (STD) for Puntland state. Puntland AIDS Commission. November 2009	2014
• MOH Financial Policy and Procedures. MoH, Garowe, Puntland	2013
• Puntland Costed Plan of Action Nutrtion-2013-2016	
• Health System Strengthening Support for Somalia (GAVI) Strategic Plan. WHO & UNICEF Somalia in collaboration with Ministry of Health, Garowe, Puntland	2011-2015
• The Health Policy Frame Work. Report on The Consultation process Coordinated by the Ministry of Health Puntland	2012-2017
• Hygiene and Sanitation Policy. Ministry of Health, Government Puntland, Garowe Puntland	2013

A Puntland governance and leadership management plan was designed and implemented, and a Health Administrative law was being drafted at the time of the MOH review.

Coordination: Well established coordination of the health sector takes place at Nairobi level. Donor and UN agencies and the NGOs consortium coordinate activities through regular forums and share information with field staff. However, overlap of services in some areas and lack of services in others is common due to lack of both effective coordination and Government leadership to coordinate external assistance to health sector. Health sector coordination has been improving in Puntland at central and regional level (WHO 2015).

In Puntland, MoH organized donor pledging meetings and coordinated production of joint annual operational plans with key partners. Programme assistance included JHNP, GAVI, GFATM, HCS and a number of humanitarian projects. MoH is actively working with the Puntland Diaspora Office to develop a strategy for mobilizing diaspora assistance. Similarly, an emergency preparedness and response plan, and a rapid response team have been developed to respond to increasing natural and related emergencies. Emergencies that were responded to include cyclones (2013, 2015), Yemen refugees (2015), droughts (2016), and Mudug region conflict, which resulted in displacement of significant populations of Galkacayo and surrounding settlements (MOH analysis 2016).(See also SO 8, below.)

Inter-ministerial coordination has substantially improved and MoH Coordination Unit regularly participate in monthly meetings. This has resulted in effective collaboration on implementation of FGM strategy, SUN and CARMMA). MoH is actively working with the recently established Puntland Diaspora Office in developing strategy of mobilizing Diaspora assistance

Institutional capacity: Establishing a legal framework for health has been initiated In Somalia, although the process has stagnated due to lack of capacity and resources. Regulations for

health remain a major issue throughout the country. Regulating health professionals and facilities and enforcement of health regulations are almost non-existent although some efforts have been made in Puntland. Public health laws are outdated and have not been reviewed for more than 25 years in all three Zones (WHO 2015).

Forty governance and leadership courses were held in Puntland over the four years of HSSP I, with 242 senior and mid-level managers, drawn from all tiers of health governance, were trained (MOH analysis 2016). The WHO review pointed to achievements at central level, but also to the need for further capacity building at regional and district levels. The Government is committed to the need for effective leadership and governance, without which the health system will continue to be fragmented, inefficient, externally-driven and less than effective (WHO 2015). A priority is the implementation of in-service and on-the-job training programmes to develop necessary skills for enhancing leadership and governance in health.

Structure: The organizational structure of MOH has been reviewed. A structure that fits the policy objectives has been proposed and job descriptions for department and units have been drafted and endorsed (MoH Functional Review 2016).

Decentralization and fragmentation and implications for the health sector: The decentralization policy is widely supported throughout the country. However it continues to face significant challenges, due both to limited local capacity and the unfinished Federal system. State boundaries are not clearly defined and administrative issues are a major challenge. In Puntland the capacity of the public sector has relatively improved over the last five years. Support is needed from the Federal MOH to strengthen institutions at regional and state levels, many of which have been seriously crippled by armed conflict.

Emergency preparedness: National policy underlines the need to ensure an effective interface between development and humanitarian assistance. Emergency-oriented and humanitarian activities dominate the sector and the burden of large numbers of internally displaced persons (IDPs) remains an overwhelming task for the MOH and health supporting agencies. Effective decentralization in this area is hindered by many factors but is largely due to institutional capacity and instability. Partnership and contracting capacity is lacking and the necessary instruments and skills for managing this governance function are not available. More importantly, weak accountability and transparency in the health sector is among the key challenges facing the sector throughout the country.

Despite substantial progress in governance and leadership, challenges do exist and require further attention. Notable challenges include among others under-resourced Coordination Unit with wide remit. Consequently, linkages between central, regional and district is weak. Health sector local governance structure at municipality level remains non-functional and health facilities planning and management (monitoring and supervision) are infrequently undertaken at central and regional levels. Similarly, governance and leadership management plan has focused on senior and mid-level managers at MoH central and regional staff and needs scaling up to all level of health sector. Adherence to and implementation of procedural guidelines and protocols is weak. Monitoring and evaluation framework for HSSP was under-resourced and produced very little work.

Table 2.10: SWOT analysis for improving governance and leadership of the health system

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT

✓ 2016 Functional Review of MoH provides a clear road-map for ensuring good governance and oversight systems in place during HSSPII ✓ Coordination unit exists ✓ Policies ,strategies, guidelines and protocols have been developed ✓ Inter-Ministerial coordination mechanisms exist and regular meetings scheduled ✓ Senior staff well trained in leadership and governance from variety of sources ✓ Existing policies exist outlining roles and responsibilities of government including decentralisation plans and systems ✓ MOH coordination department ensures inter-departmental coordination is scheduled and followed up ✓ High level of staff retention at central MoH	✓ Coordination unit only exists at central level and is under-capacity (funds and HR) ✓ Lack of adherence to the developed guidelines and protocols ✓ Linkages between district MOH and municipalities remain weak. ✓ To date focus on leadership has been with senior MoH staff and needs to be mainstreamed to all levels within the health system	✓ Donor interest in supporting health coordination systems ✓ Decentralisation process that requires decentralised decision-making	✓ Multiple and duplicate planning and reporting systems among stakeholders and programme ✓ High number of service delivery implementing partners ✓ Weak regulation/registration systems for oversight of implementing partners

2.3.7 HUMANITARIAN RESPONSE AND EMERGENCY PREPAREDNESS

The long, protracted and complex Somali emergency has attracted enormous and intensive humanitarian relief aid, focused on saving lives and alleviating suffering. Support has been through immediate response to the needs of those in directly affected areas. Humanitarian assistance is also delivered to the large and increasing numbers of internally displaced persons (IDPs). This is combined with the challenge of resettling the Somali refugees repatriated voluntarily from neighbouring countries.

Emergency situation of the country has attracted enormous humanitarian aid focused on saving lives and alleviating suffering, through an immediate response to the needs of those in areas directly affected by the recurrent cycles of armed conflict, poverty and natural disasters. Humanitarian assistance is also delivered to increasing numbers of internally displaced persons (IDPs), with the additional challenge of resettling Somali refugees repatriated voluntarily from neighbouring countries.

In 2015 about 3.2 million people were in need of humanitarian aid inside the country. One maternal and 16 under-five child deaths were occurring every two hours respectively, while one quarter of Somali children were acutely malnourished and one third of the population had no access to safe drinking water. During 2015 around 2.8 million people were targeted through planned humanitarian aid, and health relief operations were providing access to

lifesaving essential primary health care services and enhancing resilience during humanitarian crises and emergencies.

Humanitarian Interventions: Humanitarian interventions in the Somalia emergency are being challenged to expand beyond immediate relief work, though substantive achievements were identified by the WHO review (2015), including: ensuring access to essential health services in the conflict affected regions and districts where this assistance remains the major source for ensuring human survival interventions along with food aid, water supply and sanitation and nutrition. Interrupting the indigenous wild poliovirus transmission bringing considerable number of health facilities to their functional status through rehabilitation supporting a large number of health workforce creating in-service skill development opportunities to acquire minimum competence in the delivery of essential services mitigating the effects of major natural and manmade disasters, in the backdrop of the tragic famines witnessed in 1992 and 2011.

A cluster system was introduced in Somalia in 2006, with clusters for health, nutrition, WASH, protection, food security, education and logistics. Health Cluster partners plan to reach about 1.8 million people – or 56 per cent of the people in need – through provision of primary and secondary health care services, focusing on displaced people, host communities, underserved rural and urban areas (including newly-recovered areas), El Niño and drought-affected people. Health and WASH clusters will continue to implement joint strategies to prevent and mitigate the impact of disease outbreaks, particularly seasonal acute, watery diarrhoea (AWD)/cholera.

Healthcare for the most vulnerable people, especially girls, women and boys, is provided through international and national partners, UN agencies, and the Ministry of Health. While the NGOs remain the prime provider of healthcare services in Somalia, all cluster partners provide key frontline health services in targeted geographical areas, including mobile medical units for services in hard-to-reach and overwhelmed areas, camp-based clinics, and support to existing facilities unable to cope with increased demands. These provide life-saving healthcare services for the particularly vulnerable, such as primary health care, emergency reproductive health and nutrition and trauma care. Frontline healthcare providers will need to scale up the availability of life saving interventions to meet increasing needs, complementing and building upon existing national health structures whenever possible.

Child-focused interventions will include emergency immunization campaigns of measles and polio and addressing major causes of new-born and childhood morbidity and mortality. With major outbreaks of cholera occurring frequently, low immunity levels, over-crowding in camps and shelters, and continued displacement, there is a high risk of communicable disease outbreaks, namely measles, cholera, meningitis, acute jaundice syndrome and leishmaniasis. Timely identification, treatment, and case management for communicable diseases and response to outbreaks will be managed through functional early warning system and increased availability of stocks of medicines, vaccines and medical supplies. The Health Cluster will also ensure the provision and continuous supply of life saving medicines, medical consumables, emergency health kits, trauma kits and diarrhoea kits.

The delivery of health services by all those working in the health sector is expected to continue albeit under a more regulated environment and in close consultation and/or partnership with the Government and aligned to the Somali Health Sector strategy and the respective regional Health Sector strategic plans. Cluster activities support and strengthen existing essential public

health services structures in line with the New Compact priorities of expanding health facility coverage and strengthening emergency preparedness and response. The Health Cluster will focus on covering the gaps and addressing urgent humanitarian needs in terms of access to critical services and responding to public health threats to reduce avoidable morbidity and mortality.

In Puntland MoH is actively working with the recently established Puntland Diaspora Office in developing a strategy for mobilizing diaspora assistance. Similarly, emergency preparedness and response plan and a rapid response team have been developed to effectively response to increasing natural and related emergencies. Emergencies responded to include cyclone (2013, 2015), Yemen Refugees (2015), droughts (2016) and recent Mudug region conflict, which resulted in displacement of significant populations of Galkacayo and surrounding settlements (MOH analysis 2016).

Serious challenges remain, including confronting the urgent and increasing demand of linking relief to rehabilitation and development to produce better and lasting impact on health, nutrition and WASH services to reduce the risk of a public health emergency; catering to the needs of growing numbers of IDPs; accessing the over two million food-insecure population; responding to persisting security challenges in large areas of the country, and expanding the shrinking humanitarian space for health.

Delivery of life-saving medicines and medical equipment has been irregular due to insecurity, road inaccessibility, electricity and fuel shortages, and rupture of the cold chain. Access to essential health services is an immediate need for some 3.27 million people, with health capacities severely overburdened, stocks diminished and services disrupted especially in conflict, drought and flood-affected areas, especially for IDPs.

Compounding the above challenges are a lack of an emergency preparedness and response plan; lack of MOH and personnel capacity in this area; weak surveillance, early warning systems; limited logistic capacity and lack of 'buffer' stocks to supply emergencies.

Table 2.11: SWOT analysis for Enhancing health emergency preparedness and response

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Puntland Humanitarian Emergency coordination body (Humanitarian Affairs and Disaster Management Agency – HADMA) is functional ✓ Emergency preparedness and response plan exist ✓ Rapid Response Teams (RRT) are trained and deployed during emergencies ✓ Functional Emergency Cluster at central	✓ No resources to effectively plan beyond training and surveillance ✓ Limited capacity to respond emergency situations ✓ Limited emergency response funds(Puntland no longer has priority of SHF and CERF funds) ✓ Majority of facilities do not have capacity to respond to emergency situations	✓ Linkages with the WHO EMRO Emergency Response Preparedness and Response department ✓	✓ Fragile environment: Disaster Natural (droughts,cyclones) manmade(conflicts and wars) ✓ Potential for conflict/instability

✓ Early warning system and established links within communities in place ✓ Key identified staff trained in emergency and disaster management ✓ Rapid mobilization of mobile teams possible			

2.12 INEQUALITIES (SOCIAL DETERMINANTS OF HEALTH)

While health outcomes for the country as a whole are poor, some groups (e.g. women) and areas (e.g. isolated rural areas without healthcare providers) have significantly worse outcomes.

Many of the factors – or determinants – that affect people's health are outside the health sector's remit (such as income, education, rural isolation, gender, disability, access to potable water and sanitation).). However, there is much that the health sector can do to tackle these issues and help to reduce inequalities. Access to and use of reliable data disaggregated by factors such as age, sex and location is critical to ensuring inequalities between groups and areas are reduced. Having accurate data helps with targeting of resources to areas that need them most as well as determining the success of efforts to reduce inequalities, Meaningful engagement of civil society – including women and representatives of the most vulnerable groups – in planning, delivery and review of services is important in ensuring services effectively meet the needs of all. Working across all sectors with an impact on health – such as education, transport, water and sanitation, economic development – can multiply the impact of health sector efforts.

The WHO review noted that the Somali people currently have some of the lowest development and humanitarian indicators in the world, and inequalities across different social groups, a major driver of conflict, have been widening. It points to the fact that the conflict has further deteriorated the determinants of health such as political instability, population displacement, unemployment, weak health and educational institutions, environmental effects, gender disparity and food insecurity. Impact of these determinants on the conflict-stricken society includes lack of social cohesion, fear and insecurity, distress and increasing mental disorders due to social upheavals. The review recommended augmenting and aligning efforts in cross-cutting areas of gender, FGM/C, WASH and other social determinants having direct impact on the health outcomes.

The WHO review (2015) highlighted the comparative advantage of the health sector interms of coordination, saying that it is among the very few sectors that pursue the principles of partnership, although challenges such as limited ownership, inclusiveness of all partners and weak accountability and transparency are still hampering progress in this area. In Puntland, inter-ministerial coordination arrangements, such as CARMMA, SUN exist, along with a Communication for Development policy. While health outcomes for Puntland as a whole are poor, some groups (e.g. women) and areas (e.g. isolated rural areas) have significantly worse

outcomes. For example, female genital mutilation/cutting (FGM/C) can have serious implications for safe childbirth and maternal mortality.

The Somali Health Policy notes the following for inclusion in relation to promoting action on social determinants of health and health in all policies. While many of these elements are crosscutting, the key strategic objective where these are addressed is indicated:

- Promoting **action on the social determinants of health** (SDH) (addressing health concerns related to environmental sanitation and waste disposal; food safety; injury prevention; poverty alleviation, gender equity, occupational safety; school health, water and sanitation and substance abuse) (see SO 1 – essential health services)
- Promoting **intersectoral collaboration for developing public policies that create synergies and mutual gains for health** (see below, SO9)
- Promoting **policy interventions particularly to benefit the disadvantaged Somali nomadic population** (see SO 1 – essential health services)
- Endorsing the concept of **health impact assessment** (HIA) to estimate possible adverse health implications of all development interventions (see SO 5–health information system)
- Building the **health workforce capacity about the SDH and health equity** and on the value of collaborating with other sectors (see SO2 – health workforce)
- **Promoting research on the relationships between social determinants of health and health equity**(see SO 3 – health information system)

For activities on meaningful engagement of communities in planning, delivery and review of health services, see SO 3, leadership and governance.

Table 2.13: SWOT analysis for Promoting action on social determinants of health and health in all policies

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Inter-ministerial coordination (CARMMA,SUN approach) exist ✓ Communication for Development policy exists ✓ Community and civil society linkages in health services have been improved ✓ Frequent inter-ministerial dialogues to ensure linkages across ministries on all relevant health issues ✓ High level of support for health promotion activities within sector and communities	✓ Behaviour Change Communication(BCC) messages are not harmonized ✓ No clear guidelines on health promotion or messaging ✓ Limited resources for development and analysis of communications messaging ✓ Many vulnerable and under-served populations that do not access EPHS services	✓ Calendar of Global Health events to promote key health promotion messages ✓ Sufficient media and telecommunication companies to deliver messages to communities ✓ New generation of workforce highly skilled in communications and information technology ✓ Introduction of the DFID CHANGE programme focused on demand creation and behaviour change	✓ Lack of research around health seeking behaviours ✓ Taboos, social norms in proper messages to the communities ✓ Political instability and conflict

2.3.1 HEALTH INFRASTRUCTURE

Physical infrastructure of public health facilities refers to the state of the buildings, water, electricity and communications technology available, the quality of access roads, and the availability of equipment (both medical and non-medical) in working condition. Delivering healthcare above a certain level of complexity is difficult in the absence of good infrastructure. Shelter for patients and staff, drinkable water, toilet facilities, and a source of electricity for, among other things, refrigeration for vaccinations are fundamental for the safe provision of healthcare. A working communications mechanism is necessary for the functioning of a referral system, as well as to enable the provision of support services (such as laboratory services) to the facility.

Many specialized projects have not achieved their targets because of the poor infrastructure in which services are delivered. Poor infrastructure has been shown to significantly affect patients' perception of quality of care and has a significant effect on health professionals' satisfaction with their working conditions. The 2016 Service Availability and Readiness Assessment (SARA) report and complimentary Health Infrastructure Assessment that was commissioned by WHO and UNOPS will be finalised and endorsed by the second quarter of 2017 and will provide a template for each state to develop a specific infrastructure improvement plan and budget.

The 2016 Service Availability and Readiness Assessment (SARA) findings has made it clear that both the extent and condition of the country's infrastructure are poor. Limited funding is available for infrastructure from development partners and the Government does not have a budget line for infrastructure development. There is no database of facilities or policy and plan for improvement of infrastructure or medical equipment based on population need. Infrastructure based on population need can help contribute to reducing inequalities by improving access, for example by providing services (and healthcare worker housing) for rural populations, separate toilets for male and female patients and staff, or access for people with physical disabilities.

The WHO review (2015) noted poor infrastructure as a problem in a number of situations, such as challenges in delivering professional development without adequate infrastructure. It states that although the EPHS strategy says clearly that the focus will be on quality not quantity, there is no quality assurance standards/programme, and there is an absence of patient safety and infection control norms, outdated infrastructure and insufficient maintenance. Limited funding is available for infrastructure from development partners and the Government does not have a budget line for infrastructure development. There is no database of facilities or policy and plan for improvement of infrastructure or medical equipment based on population need.

The infrastructure of health facilities across the country is considered poor because not only is the *condition* of the infrastructure poor, it is also *inadequate* for the needs of the populations served. Both of these problems need to be addressed in the HSSP II. One aspect is to ensure that infrastructure is of good quality, and the other is to plan infrastructure development to better meet the needs of the population. Good data is essential for both of these tasks. It will be important to have disaggregated population data that looks at factors such as gender, age, location and disability. This can help ensure access for all that can contribute to reductions in inequalities through, for example, the availability of toilets for male and female staff and patients, beginning to work towards access for people with physical disability, facilities for healthcare workers and their families in rural areas, or access information for people who cannot read.

The collection of infrastructure data, especially that relating to the conditions of physical infrastructure and equipment may require specialist skills. However, it is necessary to collect and review such information regularly because buildings and equipment deteriorate over time.

Table 2.14: SWOT analysis for improving health sector physical infrastructure.

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
✓ Health facilities exist at all levels within the EPHS framework ✓ Piloting of renewable energy sources (solar lighting) proved impressive long term returns on investment ✓ Baseline mapping of all facilities completed	✓ Infrastructure is very old and not suited for health service delivery ✓ Maintenance of equipment and lack of technical staff remains a consistent issue ✓ Recent mapping does not provide data on all facilities. Further mapping required	✓ Availability of external resources allocated toward infrastructure development and refurbishment ✓ Community support for infrastructure improvement ✓ Health facility infrastructure survey provides clear priorities for development of a refurbishment plan	✓ Lack of basic services at facility level - electricity, water, drainage etc. ✓ Disasters: natural (e.g. cyclone) and man-made (e.g. wars) ✓ Overall poor infrastructure and inaccessibility of areas

Section 3: Strategic Directions

The Puntland vision, mission and goal are derived from the Somali Health Policy: The Way Forward[29] (2014) and the National Development Plan[30] (NDP) 2017- 2019 for the Federal Government of Somalia (FGS). They aim is to contribute to achievement of national development goals as well health-related SDGs.

Vision

The Somali people enjoy the highest attainable standard of health and quality of life and have universal and equitable access to essential quality health services with a priority focus on maternal, neonatal and child health and nutrition, and on the prevention and control of high burden diseases and related risk factors.

Mission

To provide equitable, efficient and affordable quality essential priority health services as close to the communities and families as possible based on the EPHS and primary health care approach.

Goal

Improve the health status of the population through health system strengthening interventions and provide quality, accessible, acceptable and affordable health services that facilitate moving towards universal health coverage (UHC) and accelerate progress towards achieving the health-related SDGs.

Targets

1. By 2021, reduce maternal mortality ratio from 732/100,000 in 2015 to less than 400/100,000
2. By 2021, reduce <5 mortality rate from 137/000 in 2015 to less than 100/1000 live births
3. By 2021, reduce Infant mortality from 85/000 in 2015 to less than 70 per 1000 live births
4. By 2021, reduce neonatal mortality from 40/000 in 2015 to less than 35 per 1000 live births
5. By 2021, reduce the number of children who are stunted by 15% from 12%
6. By 2021, reduce incidence of TB from 285/100,000 per year to less than 250/100,000
7. By 2021, increase the coverage of Pentavalent 3 from 43% in 2014 to 80%
8. By 2021, increase skilled birth deliveries from 33% in 2014 to 55%
9. By 2021, reduce child wasting from 14% to less than 10%
10. By 2021, increase contraceptive prevalence rate (CPR) to >15%
11. By 2021, increase TB case detection rate and treatment success rate from 42% to >70%
12. By 2021, increase in per capita expenditure on health from ~$12 per person per year in 2015 to $23 per person per year; with share of Government Health Expenditure (GHE) increased to 12% of the total expenditure on health through public sector.

Strategic Objectives(SOs)[31]

[29]Somali Health Policy: The Way Forward. Prioritization of Health Policy Actions in Somali Health Sector. Approved by the Health Advisory Board September 2014.

[30]Federal Government of Somalia. (2016)National Development Plan Final December 2016

[31] For full details of wording of policy priorities, see section 5 and Annex XX, Operational plans.

1. **Essential health services**: Scaling up of essential and basic health and nutrition services (EPHS)
2. **Health workforce**: Overcoming the crisis of human resources for health
3. **Leadership and effective governance**: Improving governance and leadership of the health system
4. **Availability of essential medicines, vaccines and commodities**: Enhancing the access to essential medicines and technologies
5. **Health information system**: Functioning health information system
6. **Adequate funds for health**: Health financing for progress towards Universal Health Coverage
7. **Infrastructure**: Improving health sector physical infrastructure
8. **Public health emergencies**: Enhancing health emergency preparedness and response
9. **Social determinants of health**: Promoting action on social determinants of health and health in all policies.

Indicators have been developed for each strategic objective that are specific, measureable, achievable, realistic and time bound (SMART).

Section 4: Health Sector Policy and Priorities

This section covers the nine strategic priority are as outlined in the Somali Health Policy (2014). It includes the background (situation analysis and strengths, weaknesses, opportunities and threats – SWOT – identified in planning sessions), as well as specific objectives and priorities (sub-objectives designed to ensure objectives are achieved) and budgets. Performance frameworks (including target indicators) and operational plans appear in annexes.

Equity – an overarching approach

Based on this plan's guiding principles of universal and equitable access, a gender equity and social inclusion (GESI) approach will be taken. This means taking account of the needs of the population and taking specific steps to reduce inequalities based on factors such as gender, rural isolation, age or disability. This will require integration of a GESI approach across all indicators. Where data do not exist to inform planning, it will be important both to begin to collect such information, but also to increase meaningful stakeholder involvement in planning, delivery and review of services, including with representation of women and most vulnerable communities. Even without data it is important to consider equity issues in all aspects of health service planning, delivery and review.

Table below outlines a number of approaches to integrating GESI into HSSP II's strategies and approaches. The content of this plan builds on approaches taken in HSSP I. See also SO 9, below.

Table 4.0: GESI in HSSP II

HSSP II Strategies	GESI component
1. Essential health services	• GESI can be made a criterion when awarding contracts • With EPHS as the platform, equitable service delivery will be made a priority • Strategies tailored to the needs of the population will be adopted - mobile clinics, or using entry points outside the health sector if they are culturally more acceptable
2. Health workforce	• The HSSP will ensure adequate numbers of female service providers • Recruiting staff from clans/groups on equitable basis will be considered as feasible • Job descriptions can be revised to emphasise equitable service delivery and counselling skills • Training and capacity building will emphasise equitable service delivery and counselling skills
3. Leadership and effective governance	• A GESI approach can be incorporated in the next version of the health policy • Build capacity within MoH to understand GESI issues • There will be meaningful community involvement in planning, delivery and review of services, including representation by women and the most vulnerable communities
4. Availability of essential medicines, vaccines and commodities	• The MoH will try to ensure that medicines and consumables which are donated are done so based on need and equitably
5. Health Information	• Wherever possible, data will be disaggregated by gender and location, as well as factors such as age, disability, HIV status where relevant, and used in planning (e.g. to use location data to target resources at areas with greatest need)

	• GESI process indicators will be introduced to M&E systems such as the HMIS • M&E will highlight GESI issues both separately and integrated into all strategic areas • Social audits will be used where possible • Research into barriers and health promotion activities for marginalized and under-served will be undertaken and used to inform planning
6. Adequate funds for health	• GESI- responsive budgeting will be phased in
7. Infrastructure	• GESI-sensitive access issues will be taken into account in infrastructure developments, such as separate toilets for male and female staff and patients
8. Public health emergencies	• GESI issues will be taken into account in planning for humanitarian aid and public health emergencies, such as ensuring private space for women and targeting resources at hard-to-reach areas
9. Social determinants of health	• Develop collaborative approaches to intersectoral working to ensure the determinants of health are tackled in all relevant sectors •

4.1 SO 1: Scaling up of essential and basic health and nutrition services

To improve **access to essential health services** of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under-nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.

4.1.1 Strategic priorities and activities

1.1 Continuation, integration and scaling up of equitable, accessible essential package of health services including mental health as a core component

- 1.1.1 Sustain current EPHS services in four regions including CEMONC
- 1.1.2 Increase the number of Health Facilities providing EPHS services based on prioritisation plan and focused on underserved regions
- 1.1.3 Establish 1 trauma care units in Regional Hospitals staffed with qualified personnel
- 1.1.4 Develop Mental Health Care implementation plan
- 1.1.5 Establish and integrate Mental Health Care services in the health facility providing EPHS health services
- 1.1.6 Implement Mental Health Care Plan including demand creation activities
- 1.1.7 Establish one health and nutrition mobile team per region
- 1.1.8 Strengthen referral system from lower level to higher level EPHS facilities
- 1.1.9 Establish 1 neonatal care units in Regional Hospital staffed with qualified personnel

1.2 Integration of community based health and nutrition services in EPHS

- 1.2.1 Map all community based health and nutrition services
- 1.2.2 Expand Community Based Health Service through the provision FHWs health cadre
- 1.2.3 Expand Community Based Health Service through the provision ICCM
- 1.2.4 Develop a specific strategy to address health needs of nomadic populations (M/F)
- 1.2.5 Start implementation of nomadic health service strategy to address health needs of nomadic populations
- 1.2.6 Implement community based integrated reproductive health outreach services

1.2.7 Implement community based integrated management of acute malnutrition
1.2.8 Implement community-led total sanitation (CLTS) in all regions of Puntland

1.3 Specialised interventions for non-communicable diseases
1.3.1 Develop a national strategy and identify the risk factors for non-communicable diseases (diabetes, hypertension, asthma)
1.3.2 Provide testing and treatment of diabetes, renal disease, asthma and hypertension diseases in regional hospitals
1.3.3 Pilot screening for cervical cancer in regional hospitals (3)

1.4 Improving quality of care/ patient safety
1.4.1 Implement EPHS Compass QA monitoring system including EPHS scorecard
1.4.2 Introduce patient safety and infection control measures in hospitals including waste management system
1.4.3 Increase the number of health facilities with standardised WASH facilities
1.4.4 Regular monitoring and supervision of quality services level to all health facilities

1.5 Demand creation and implementation of BCC strategy
1.5.1 Review BCC strategy and develop a programme of integrated public health messages.
1.5.2 Develop FGM awareness messages for school health targeting adolescents and their parents
1.5.3 Implement mass awareness and behaviour change campaigns for programs including birth spacing, FGM/C, immunization, malaria, TB and HIV
1.5.4 Implement mass awareness and behaviour change campaigns for non-communicable diseases (diabetes, hypertension, and asthma)
1.5.5 Pilot integration of FGM/C service into health facilities (20)

1.6 Effective delivery of disease specific programmes and interventions including AIDS, TB, malaria, polio and vaccine preventable diseases etc.
1.6.1 Sustain TB treatment services (13 TBMU)
1.6.2 Expand TB treatment services with 2 additional centres
1.6.3 Sustain integration of vertical programs within EPHS framework (TB, malaria, HIV)
1.6.4 Establish and staff an MDR treatment centre
1.6.5 Sustain integrated prevention, treatment, and care services for HIV/AIDS patient (6 VCTs)
1.6.6 Implement at least fourrounds of national immunization days (NIDs) for polio
1.6.7 Implement EPI outreach services in 8 priority districts
1.6.8 Implement one round of measles catch-up campaign
1.6.9 Integrated reproductive health outreaches in all regions of Puntland
1.6.10 Nutrition mobile teams to implement IMAM (OTPS) in all regions of Puntland

4.2 SO2: Overcoming the crisis of human resources for health

To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services

4.2.1 Strategic priorities and activities

2.1 Improved Human Resource policy, planning and management

- 2.1.1 Develop equity focused human resource development and management plan
- 2.1.2 Implement GESI-sensitive human resource development and management plan
- 2.1.3 Develop and implement performance appraisal systems
- 2.1.4 Hire HR officers for all regions
- 2.1.5 HRH Rules and Regulations reviewed and finalized and distributed to all regions

2.2 Production of sufficient skilled health professionals and workers (M/F) with equitable distribution to implement health services

- 2.2.1 Training for mid-level workers including lab technicians, anaesthesia technician, pharmacy and radiology technicians, female health workers, community midwives, medical engineering and mental health practitioner In collaboration with training institutions
- 2.2.2 Continue producing nurses, midwives, doctors, neonatologists, clinical officers in cooperation with training institutions
- 2.2.3 Integrate NCD management in curricula of different cadres of health workers including DM, HTN, asthma, cancers, mental health, etc.
- 2.2.4 Assessment on curriculum standardization of health training institutes
- 2.2.5 Standardise curriculum of different cadres across all training institutions
- 2.2.6 Build capacity of tutors and ensure they have up to date knowledge on their areas of expertise
- 2.2.7 Giving additional hardship allowance to professional cadres (M/F), in the rural areas

2.3 Health professionals registered, licensed and accredited

- 2.3.1 Establish electronic employee database
- 2.3.2 Register and license at least 40% of health professionals
- 2.3.3 Establish HRMIS linked HMIS/DHIS2 (disaggregated by factors such as cadre, sex, training institution and location)

2.4 Health workforce at all levels having (on budget) system of salaries, incentives and allowances

- 2.4.1 Identify staffing gaps at all facilities across all levels based on SARA data
- 2.4.2 Review, revise and standardise salaries, incentives, and allowances

2.5 Availability of standardized training guidelines, material, and protocols

- 2.5.1 Develop GESI-sensitive in-service training guidelines, material and protocols and translate into Somali
- 2.5.2 Develop training impact assessment tool and feedback mechanism

2.6 Implementation of in-service training plan

- 2.6.1 Conduct short courses on anaesthesia, ICU, emergency surgery, neonatology, forensic medicine, mental health and NCD management for doctors and nurses
- 2.6.2 Conduct training of first line health workers in line with the training plan, with an emphasis on delivering equitable services
- 2.6.3 Implement internship programme for newly graduated students

2.7 HR monitoring, evaluation, and coordination

- 2.7.1 Supervise health workforce at all levels

2.7.2 Conduct monthly HRH task force meeting

4.3 SO3: Improving governance and leadership of the health system

To build institutional capacity of health authorities at both central and regional levels to provide strong leadership and effective governance, provide core functions of health sector and engage with private sector

4.3.1 Strategic Priorities and Activities

3.1 Development and implementation of Policies, Strategies, and Legal Frameworks

- 3.1.1 Establish calendar of policy/strategy review (mid or end term). Identify TA and budget
- 3.1.2 Review and finalize RH strategy and nutrition
- 3.1.3 Develop nomadic services strategy (see also 1.2.4)
- 3.1.4 Develop private sector engagement strategy and map facilities using recent survey
- 3.1.5 Develop public health administrative law and other acts
- 3.1.6 Review and update leadership, governance and management plan

3.2 Strengthen Zonal Health Sector Coordination

- 3.2.1 Establish health sector coordination board (TOR, clear membership numbers and selection criteria
- 3.2.2 Conduct regular quarterly zonal health sector coordination
- 3.2.3 Recruit Health Sector/Technical Coordination Advisor to support coordination
- 3.2.4 Conduct regular quarterly Technical Working Group meetings prior to Zonal HSC meetings
- 3.2.5 Establish Immunisation Coordinating Committee to feed technical and oversight information and data to the Zonal HSC

3.3 Improved management and institutional capacities with enhanced decentralization

- 3.3.1 Establish regional health management team and build their capacity
- 3.3.2 Conduct workshop to finalize the functional review in 2017
- 3.3.3 Provision of technical assistance in M&E, HMIS, research, policy &planning and community based services with a focus on equity
- 3.3.4 Establish nine regional health boards with clear TORs
- 3.3.5 Establish the operational structure and implementation arrangements at regional level (health facility, regional health board, community committees)
- 3.3.6 Train the regional and district health boards and community health communities in their roles, responsibilities and support available to them from the MoH
- 3.3.7 Strengthen partnership and joint implementation with JPLG districts
- 3.3.8 Produce quarterly management dashboards using data from DHIS2 and EPHS Compass Tools
- 3.3.9 Conduct leadership, management, and governance training for senior managers at central and regional level and RHO/DMO, PHC, health facilities in charge and other mid-level managers

3.4 Develop approaches to meaningful engagement of communities – including women and representatives of vulnerable populations such as nomadic populations – in planning, delivery and review of services as part of effective governance approaches

3.4.1 **Planning**: Develop and implement mechanisms to ensure effective involvement of communities in planning processes (e.g. participatory needs assessment, focus groups)

3.4.2 **Delivery**: Ensure effective representation on CHCs, RHBs, and DHBs of communities including women and representative of vulnerable groups

3.4.3 **Review**: Develop and implement mechanisms for service user and non-user input into review (e.g. complaints procedures, client satisfaction surveys) that are taken into account in formal reviews

4.4 SO4: Enhancing the access to essential medicines and technologies

To ensure the availability **of essential medicines, vaccines and commodities** that satisfy the priority health care needs of the population, in adequate amounts and of assured quality and at a price that the community and the health system can afford

4.4.1 Strategic Priorities and Activities

4.1 Develop import regulations, guidelines, and standards to improve the safety and practices of pharmaceutical sector

4.1.1 Develop standardised guideline for regulating imported medicines and commodities (TA and workshops)

4.1.2 Develop a drug regulation training module and implementation plan (TA and workshops)

4.1.3 Conduct feasibility study on development of registration database of imported medicines and medical equipment

4.1.4 Develop registration system for private sector wholesalers, retailers, and pharmacies

4.1.5 Develop Inspection Plan for public and private sector pharmacies and pilot implementation of the plan

4.1.6 Develop guidelines on good dispensing practices

4.2 Ensure quality supplies (medicines, vaccines, nutrition, and RH commodities) and equipment to all public health facilities)

4.2.1 Re-establish minilabs and undertake refresher training

4.2.2 Conduct spot checks on public and private pharmacies to sample drug and equipment compliance with regulations

4.2.3 Conduct training on rational use of medicines for public sector

4.3 Effective procurement, warehousing, logistics and supply chain system

4.3.1 Procurement of medicines, vaccines and commodities to all health facilities based on EML

4.3.2 Distribution of medicines, vaccines and commodities to all health facilities based on EML

4.3.3 Begin implementation of supply chain Master Plan

4.3.4 Link LMIS and DHIS2 and use data as part of EPHS Compass Performance Management Dashboard

4.5 SO5: Effectively functioning health information systems

To establish an effective **health information system** that provide accurate and timely health data for evidence based planning and implementation, supported by effective monitoring and evaluation (M&E) and by targeted research as a problem-solving tool

Strategic Priorities and Activities

5.1 Effective M&E system to track health system performance disaggregated by gender and location and other factors such as age, disability, HIV status as relevant

- 5.1.1 Conduct Joint Annual Reviews
- 5.1.2 Conduct quarterly monitoring and evaluation visits
- 5.1.3 Conduct quarterly HSSP II review and reporting

5.2. Timely, complete, and accurate HMIS at all levels of health care delivery, disaggregated by gender and location as well as factors such as age, disability, HIV status as relevant

- 5.2.1. Printing and distribution of the revised HMIS registers and reporting forms
- 5.2.2. HMIS training on the revised HMIS tools
- 5.2.3. DHIS2 training to mid-level managers and health partners
- 5.2.4. Rollout of DHIS2 to all Puntland regions
- 5.2.5. Establish and support Information Technology Unit (IT) within the Ministry of Health
- 5.2.6. Conduct quarterly data quality audits to health facilities in Puntland
- 5.2.7. Monthly and quarterly supportive supervisions
- 5.2.8. Conduct quarterly data quality audit feedback meetings and reports
- 5.2.9. Develop data use plan and Organize training on data use to guide decision making
- 5.2.10. Monthly HMIS review meetings
- 5.2.11. Integrate community based service data into the HMIS/DHIS2

5.3 Effective and integrated disease early warning and surveillance system

- 5.3.1 Training for health workers on case management and surveillance system
- 5.3.2 Increase the number of sentinel sites and mobile reporting centres from 61 to 71
- 5.3.3 Develop Link with DHIS2 for data triangulation

5.4 Improved research capacity and implement research and survey plan

- 5.4.1 Revise the existing research agenda and prioritize, including a focus on relationships between social determinants of health and health equity
- 5.4.2 Capacity building on research methodology, data analysis and interpretation to MLM
- 5.4.3 Implementation research for EPI demand creation
- 5.4.4 Implementation research for malaria indicator survey (MIS)
- 5.4.5 Conduct HIV stigma index survey and HIV zero surveillance survey among ANC and STI clients
- 5.4.6 Implement anti-malaria drug efficacy study
- 5.4.7 Planning and coordination of the demographic and health survey (DHS)
- 5.4.8 Collaborate with health institutions/universities on research agendas
- 5.4.9 Technical assistance for research and information management
- 5.4.10 Conduct health workforce survey
- 5.4.11 Step-wise survey
- 5.4.12 Conduct research on mental health problems
- 5.4.13 Conduct health workforce survey

5.5 Establish system of civil registration and vital statistics

- 5.5.1 Technical assistance to support implementation CRVS plan (births and deaths)

5.5.2 Pilot the CRVS tools to one district
5.5.3 Evaluate the system and develop a plan to scale up.
5.5.4 Establish maternal death surveillance and response system
5.5.5 Establish health system observatory website

4.6 SO6: Health financing for progress towards Universal Health Coverage

To raise **adequate funds for health**, protecting the poor and under-privileged from catastrophic health expenditure ensuring that people can access affordable service, therefore moving towards universal health coverage

Strategic Priorities and Activities

6.1 Health financing strategy development and implementation

6.1.1 Review and finalize Puntland Health Financing Strategy
6.1.2 Start the implementation of Health Financing Strategy
6.1.3 Support MOH Health financing unit (Operational support)
6.1.4 Capacity building for MoH relevant department/personnel on applied health economics, health financing and resource management (Puntland MoH, 2016)
6.1.5 Conduct public health expenditure review, including monitoring progress in tackling inequalities
6.1.6 Conduct household health expenditure review - Link with Demographic health survey (DHS)
6.1.7 Conduct cost analysis of health sector and identify health financing gaps
6.1.8 Develop National Health Account (with financial tracking component)

6.2 Sound public financial management and accountability system

6.2.1 Strengthen MOH financial management capacity (financial management training, charts of accounts)
6.2.2 Technical assistance to improve financial control systems (including audits and GESI-sensitive budgeting and review)

4.7 SO7: Improving health sector physical infrastructure

To bridge the gap in the enormous health infrastructure paucity and create the minimum health infrastructure assets, providing the necessary operational environment for effective service delivery

Strategic Priorities and Activities

7.1 Develop and implement health infrastructure improvement plan / standards

7.1.1 Assess health infrastructure based on SARA data
7.1.2 Develop health infrastructure improvement plan emphasising equitable access
7.1.3 Establish neonatal departments in all regional hospitals
7.1.4 Construct and equip operational theatres for ten district hospitals
7.1.5 Install sustainable energy systems for health facilities
7.1.6 Establish fully functional blood bank in Garowe hospital
7.1.7 Establish public health laboratories
7.1.8 Train medical technicians in health facilities

4.8 SO8: Enhancing health emergency preparedness and response

To strengthen the health system and surge its capacity to promote public health and prevent, investigate, mitigate, manage, monitor, evaluate and control public health threats and reach

out to affected communities with integrated effective assistance targeting their specific public health emergencies

Strategic Priorities and Activities

8.1 Strengthen emergency preparedness and response capacity
- 8.1.1 Develop national GESI-sensitive Emergency Preparedness and Response Plan (EPRP)
- 8.1.2 Implement EPRP resource mobilisation plan
- 8.1.3 Preposition supplies including outbreak and trauma kits
- 8.1.4 Training for emergency response teams at all levels

8.2 Effective coordination and linkages with sector coordination
- 8.2.1 Establish national assessment rapid teams at all levels
- 8.2.2 Establish national rapid response teams at all levels
- 8.2.3 Revamp and support emergency coordination clusters
- 8.2.4 Conduct regular cluster coordination meeting

8.3 Basic health and nutrition humanitarian services in non-EPHS areas
- 8.3.1 Support basic health and nutrition services in Sool and sanag regions
- 8.3.2 Integrated Reproductive health outreaches in Sool and sanag regions
- 8.3.3 Nutrition mobile teams to implement IMAM (OTPS) in Sool and sanag regions

4.9 SO9: Promoting action on social determinants of health

To Improve the health of the population and reduce health disparities by addressing **the social determinants of health**, integrating health perspectives into the broader development framework and emphasizing on intersectoral collaboration across all government and other stakeholder partners and building the capacities necessary for its implementation

Strategic Priorities and Activities

9.1 Effective mechanism for intersectoral collaboration ensuring health in all policy
- 9.1.1 Establish inter-ministerial committees (TOR)
- 9.1.2 Conduct inter-ministerial coordination meetings
- 9.1.3 Develop inter-ministerial action plan on SUN and CARMA

Section 5: Consolidated Financial Plan

As noted in Strategic Objective (SO)6, cost estimates links with strategic activities. However, given due consideration to experience and lessons learnt from implementation of HSSP1, and mammoth health service needs in Puntland, the budget is based on per capita cost calculation (US $15). HSSP is calculated using PESS population figures as the basis for the costing of the HSSP. 3% growth rate is factored in to accommodate population growth and 10% increment to factor for inflation and changes in expenses for health sector. This gives a total annual budget for the health sector. Therefore, further exercise is conducted to provide budget Strategic objective (SO). The HSSP puts the highest weight on SO1 for service delivery constantly calculated at 50% across all the five years. This following by medicines and supplies and health infrastructure calculated at 13% and 12% respectively. Strategic objectives for Human resource and health financing are also calculated at 7% and 5% respectively. Governance and leadership, health information and health emergency SOs are calculated 4% per strategic objective. Lastly strategic objective for social determinants of health is gets 1% of the total budget.

5.0: Summary of Population projections

Population 2016 figure = 2565794.89		**Cost per capipta = 15 USD/Person**				
2016	**Year**	**2017**	**2018**	**2019**	**2020**	**2021**
2,565,795	Population (3% Increment)	2,642,769	2,722,052	2,803,713	2,887,825	2,974,459
Cost/capita (15)	Total Budget	39,641,531.05	40,830,777	42,055,700	43,317,371	44,616,892

5.1: Summary of HSSP Budget per SO

STRATEGIC AREA	**% per SO**	**2017**	**2018 (10% increment)**	**2019 (10% increment)**	**2020 (10% increment)**	**2021 (10% increment)**	**Total**
Health Service Delivery	51%	20,090,172	22,701,894	23,583,853	24,311,458	25,042,811	115,730,188
Human Resource for Health	7%	2,686,446	3,035,684.33	3,153,619.32	3,250,914.35	3,348,710	15,475,375
Governance and Leadership	4%	1,442,721	1,630,274.92	1,693,610.38	1,745,861	1,798,382	8,310,849
Health Information	4%	1,492,470	1,686,491.29	1,752,010.73	1,806,064	1,860,395	8,597,430
Medicine and Supplies	13%	5,323,144	6,015,152.28	6,248,838.28	6,441,627	6,635,408	30,664,168
Health Financing	5%	1,790,964	2,023,789.55	2,102,412.88	2,167,276	2,232,474	10,316,916
Health Infrastructure	12%	4,925,152	5,565,421.27	5,781,635.42	5,960,010	6,139,302	28,371,520
Health Emergency	4%	1,591,968	1,798,924.05	1,868,811.45	1,926,468	1,984,421	9,170,592
Social Determinants of Health	1%	298,494	337,298.26	350,402	361,213	372,079	1,719,486
Total	**100%**	**39,641,531**	**44,794,930**	**46,535,193**	**47,970,891**	**49,413,982**	**228,356,527**

Section 6: Oversight, Coordination and Management of the HSSP

This section presents the implementation plan for HSSP II which builds on achievements so far and provides strategies to consolidate and enhance health system performance in the period 2017 to 2021. HSSP II will therefore guide stakeholders on how best to deliver the EPHS within a framework of systematic health systems development. It is expected to ensure improved health outcomes for all people in Somalia with a special emphasis on the most vulnerable groups. The following will be the key strategies that guide implementation of the plan:

Broad Strategies

1. Delivery of a comprehensive healthcare services using EPHS and PHC approach with an emphases on decentralization and active participation of key stakeholders;
2. Scaling up priority interventions, in an integrated manner to produce targeted outputs and outcomes, with due consideration to resource constraints;
3. Improving quality of care;
4. Improving responsiveness and accountability to consumers so as to enhance utilization of essential services;
5. Explicit consideration of women, children and other vulnerable groups in provision of essential health and nutrition services;
6. Appropriate supervision, monitoring and evaluation framework for the provision of the essential health and nutrition services;

COORDINATION ARRANGEMENTS

During HSSP II, the health sector coordinating mechanism will be strengthened and aligned to the Aid architecture to enable it provide guidance for institutionalized sector partnership and collaboration. This will lay the foundation for broader joint partnership arrangements between the Government and Development Partners including Global Health Initiatives such as GAVI and GFATM and will discourage standalone, vertical programs and projects.

Under the Somalia Development and Reconstruction Facility (SDRF), the Pillar Working Groups are responsible for sectoral and programmatic coordination within the pillars of the National Development Plan (NDP). Development partners will use these groups to present programs at an early stage of development to discuss alignment with NDP priorities, coordinate with key actors, and avoid duplication. The groups will also be responsible for tracking and reporting on progress within their pillars, which will then be compiled by the Secretariat and inform discussions of the Steering Committee. Coordination between the pillar working groups and humanitarian cluster system will be important for ensuring coherence and coordination across the humanitarian-development-peace nexus. Pillar Working groups have a critical role to play in coordinating all activities related to NDP implementation, not only those financed through the SDRF trust funds.

Health and nutrition comes under the Pillar 5- Social and Human development. A sub-pillar working group on health and nutrition will coordinate all related programmes and interventions under the leadership of Federal Ministry of health and with support from donors, UN agencies and NGOs. Implementation of HSSP II through partnership will promote the role of government as the overall steward in provision of health services in Somalia and the coordinator of all stakeholders' efforts. This will enable efficient and equitable utilization of all resources while minimizing duplication and overhead costs

MONINTORING, EVALUATION AND REPORTING ARRANGEMENTS:

The HSSP II has been developed in line with the Somali health policy, NDP and SDGs. As such, the HSSP II monitoring framework will be developed to ensure achievement of the HSSP II objectives and targets. In the same manner, HSSP II indicators and targets have been set in line with the NDP indicators and targets. The monitoring and evaluation framework will be inclusive and participatory, using joint reporting, monitoring and evaluation mechanisms.

Health sector performance will be monitored using a set of agreed indicators whose selection takes cognizance of indicators contained in the WHO Toolkit for health systems strengthening and the SDGs. Due consideration will be given to ensuring regular (preferably annually) availability of data for these indicators. The HSSP II indicators with baseline values and targets are shown in annex I

In addition to the national level indicators, program, district and hospital level indicators will be developed to facilitate regular performance assessment at the various levels and to provide an opportunity for comparing entities at these levels.

Sources of Information for Monitoring HSSP II

HMIS is the major tool for collecting information for monitoring the HSSP II. In this regard, strategies will be employed to strengthen HMIS to enable it to play its role effectively in monitoring of the HSSP II. In addition, information from other sources will be used.

Surveys commissioned by the MOH, which may be carried out directly by programs within the MOH or contracted out. They are planned to include:

- ✓ Population-based surveys such as DHS or MICS
- ✓ Health facility survey and service availability mapping to determine geographical access to health services;
- ✓ Health Facility Assessment (HFA);
- ✓ Use of burden of disease or other appropriate methodology like comprehensive sentinel surveillance sites;

Surveys in other institutions, including national household surveys will be used to provide up-to-date and representative data for key HSSP II indicators. In addition, studies in the health sector will be commissioned to address appropriate issues including support supervision reports for the different levels of care.

HSSP II Reporting Arrangement

Quarterly and Annual Health Statistical Reports: These reports will be compiled from the periodic statistical reports submitted through the Health Management Information System (HMIS). The quarterly and annual health statistical reports provide ample attention to data quality issues, including timeliness, completeness and accuracy of reporting, as well as adjustments and their rationale. The HMIS officers will be responsible for compiling and disseminating these reports.

Quarterly Performance Review Reports

Quarterly sector performance review reports will be presented by the various sector technical working groups during the sector quarterly review meetings. Quarterly state level performance reports will be presented and discussed at the quarterly review meetings attended by the key implementers in the states.

Annual Health Sector Performance Reports

The Annual Health Sector Performance Report (AHSPR) will be institutionalized during HSSP II to highlight areas of progress and challenges in the health sector. The review process will include all levels and all health services nationwide. Review reports will be used by all levels to assess performance, following which they will be submitted to the national level for compilation of the AHSPR by the end of October each year. AHSPR will be HSSP II performance report for use by all stakeholders. The AHPSR will be developed through a jointly agreed process that will be validated through a Joint Review Mission to be held in November each year and launched in the Pillar working group each year. This cycle will form an integral part of the national coordination mechanism for the implementation of the HSSP II.

The HSSP II Monitoring and Review Processes:

The framework for reviewing health progress and performance covers the M.E process from routine performance monitoring, quarterly reviews, annual review and evaluation of all the HSSP indicator domains. Specific questions will have to be answered during the different review processes, especially the annual reviews, but also the performance monitoring.

Health progress and performance assessment will bring together the different dimensions of quantitative and qualitative analyses and will include analyses on: (i) progress towards the HSSP goals; (ii) equity (iii) efficiency; (iv) qualitative analyses of contextual changes; and (v) benchmarking.

Table 4: Monitoring, Review and Evaluation Processes

Methodology	Frequency	Output	Focus	Level
Performance review meeting	Quarterly	Quarterly progress reports;	Done by Joint (Government/ Partners). A review of progress against targets and planned activities.	Inputs, process, and output
Joint annual review and planning	Annually	Annual progress reports,	Done Jointly with development Partner, key stakeholders, and planning entities as from district level onwards. A review of progress against set target outcomes	Input, process, output, and outcome levels
Mid Term Review	Half-way	Midterm review report	Done by sector review progress against planned impact	Input, process, output, outcome and impact levels
End Term Evaluation	At end of HSSP II	Final evaluation report	Independent review of progress, against planned impact	Input, output, outcome and impact levels

Joint Annual Review

The JAR is a national mission for reviewing sector performance annually. The annual reviews will focus on assessing performance during the previous fiscal year, and determining actions and spending plans for the year ahead (current year+1). These actions and spending should be addressed in amendments to the HSSP II. Annual Sector Reviews should be completed by the 30th September each year, to ensure that the findings feed into the planning and budget

process of the coming year. The annual review shall be organized by the MoH (Department of Planning& Policy) in collaboration with Development Partners. The proceedings of the JAR will be documented and signed by the MoH and DPs.

Programs/Projects Reviews

Detailed program/project specific reviews shall be linked to the overall health sector review processes and contribute to it. Program/project specific reviews should be conducted prior to the overall health sector review, and help inform the content of the health sector review in relation to that specific program/project area. It is important that the specific program/project reviews involve staff and researchers not involved in the program/project itself to obtain an objective view of progress. Progress review reports shall be submitted to the MoH (Department of Planning and Policy) in order to inform quarterly and annual sector reviews as well as evaluation exercises.

Performance Monitoring and Review of Implementing Partners

Implementing partners contribute significantly to health service delivery in the country. Most times their input and attribution to health outcomes is not captured in the sector performance reports. In order to measure their contribution to the overall sector performance they will be required to report to MOH (Department of Planning & Policy).

Performance monitoring and review for global health grants

Under the Global Health Initiatives, the health sector is supported through initiatives like the Global Fund for Tuberculosis, HIV/AIDS and Malaria (GFTAM) and Global Alliance for Vaccines and Immunization (GAVI) which provides funds based on performance. There are other sector support programs/projects which also disburse funds such as Change and Shine Programmes. The M&E plans of those programmes shall be carried out in line with the M&E framework and plan of the health sector using tools that consider outputs and indicators to be drawn from approved work-plans and budgets for the HSSP II.

Performance Monitoring and Review for Civil Society Organizations and Private Sector

CSOs and the private sector contribute significantly to health service delivery in the country. Most times their input is not captured in the sector performance reports. In order to measure their contribution to the overall sector performance they will be required to report to the relevant sector entities.

HSSP II EVALUATION

Programme/Project Evaluation

A number of health sector investment and intervention projects will be undertaken during the period of the HSSP II 2017-2021. All projects will be subjected to rigorous evaluation. The type of evaluation to be planned for and conducted should reflect the nature and scope of the investment. For example, pilot projects that are being conducted amongst a random group of participants shall be selected for impact evaluation to determine whether or not the investment should be scaled up. As a minimum requirement, each project in this category will be required to conduct the following:

1. A baseline study during the preparatory design phase of the project or the program;
2. A mid-term review at the mid-point in the project to assess progress against objectives and

provide recommendations for corrective measures;

3. A final evaluation or value-for-money (VFM) audit at the end of the project. A VFM audit will be carried out for key front-line service delivery projects where value for money is identified as a primary criterion. All other projects will be subjected to standard rigorous final evaluation.

Mid - Term Review

A Mid-Term Review of the HSSP II will be done after two and half year. The purpose of the MTR is to review the progress of implementation; identify and propose adjustments to the HSSP II and other government policies as required. The specific objectives of the MTR are to:

1. Assess progress in meeting HSSPs targets and to make recommendations for their adjustment if found necessary;
2. Review the appropriateness of outputs in terms of inputs, processes and desired outcomes;
3. Review the costing and financing mechanisms of the HSSP II; and
4. Coordinate the MTR process with the NDP review.

The MTR shall entail extensive review of documents including routine reports and recent studies in the sector; special in-depth studies may also be commissioned as part of the MTR; and interviews with selected key stakeholders. The MTR is undertaken in a participatory manner involving government line ministries, national level institutions, service delivery levels, DPs, civil society, private sector and academia. The analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the HSSP II indicators. The main result will be a list of recommendations for the remaining HSSP II years.

HSSP II Final Evaluation

The End Term Evaluation will be conducted during the last year of the HSSP II in order to enable the sector to make use of its findings and recommendations for the formulation of the next strategic plan. Like the mid-term review, the analysis will focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes, using the HSSP II indicators. It will focus on expected and achieved accomplishments, examining the results chain, processes, contextual factors and causality, in order to understand achievements or the lack thereof. The evaluation will have to answer questions of attribution (what made the difference?) and counterfactual (what would have happened if we had not done A or B?) and take into account contextual changes (economic growth, social changes, environmental factors etc.), as well as policies and resource flows:

1. **Relevance:** Did the HSSP II address priority problems faced by the target areas and communities?, was the HSSP II consistent with policies of both the Government and Health Development Partners?

2. **Economy:** Have the HSSP II inputs (financial, human, Assets etc) been applied optimally in the implementation process?

3. **Efficiency:** Were inputs (staff, time, money, equipment) used in the best possible way to maximize the ratio of input/outputs in HSSP II implementation and achieve enhanced outputs; or could implementation have been improved/was there a better way of doing things?

4. **Effectiveness:** Have planned HSSP II outputs and outcomes been achieved?

5. **Efficacy:** To what extent have been the achievements of the HSSP II objectives and goal?

6. **Impact:** What has been the contribution of the HSSP II to the higher level development goals, in respect of national development goals; did the HSSP II have any negative or unforeseen consequences?

The evaluation will be conducted by a team of independent in-country institutions in close collaboration with international consultants. The purpose of conducting the evaluation prior to the conclusion of the HSSP II is to generate lessons and recommendations to inform the preparation of the HSSP II.

Section 7: Consolidated Performance Framework and M&E Plan

GESI approach: In line with the guiding principles of universal and equitable access, the performance framework and approach to M&E will emphasise reducing inequalities and will take a GESI approach. Equity and inclusion issues will be highlighted as a separate section, drawing together evidence of progress – and lack of progress – in tackling inequalities based on gender, rural isolation, age, disability, HIV status or other factors. In addition, these issues will be considered in each of the other strategic areas.

In accordance with the Somali Health Policy, health related research should include a focus on the relationships between social determinants of health and health equity, assessing the effectiveness of these policy interventions and disseminating the generated evidence among different sectors for policy consideration and action.

SO 1: Revitalizing health services
To improve access to **essential health services** of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under-nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life

	Baseline	2017	2018	2019	2020	2021	Frequency	Means of Verification
Output Indicators								
No of deliveries conducted in MCH/HC	22,144	25,909	28,520	31,395	34,561	38,047		
No of health facilities providing 24/7 Basic Emergency Obstetric and Neonatal (BEmOC)	62	64	74	83	87	91		
No. of hospitals providing 24/7 Comprehensive Emergency Obstetric and Neonatal Care (CEmONC)	3	3	3	4	5	5		
No. of children <1 yr immunized for Penta III in MCH/HC	42,440	48,806	53,687	59055	64961	71457		
No. of children immunized for IPV in MCH/HC	NA	24403	53687	59055	64961	71457		
No. birth spacing client visits in MCH/HC	8718	9534	12160	15034	18615	23084		
No. of severely and moderately malnourished children managed in MCH/HC	30652	32523	33953	35451	37019	38662		
No. of children born in health facilities and initiated breast feeding	27426	28816	29669	30559	31475	32420		
No. of women receiving MMN at health facilities	51348	56277	61904	68095	74904	82394		

No. of ARI cases managed in MCH/HC	73328	80661	88727	97600	107360	118095		
No. of diarrhoea cases managed in MCH/HC	38488	42337	46570	51228	56350	61985		
No. of mothers screened for HIV during ANC	NA	2591	4385	7107	10124	13674		
No. of health facilities meeting WASH standards								
1.1 Continuation and scaling up of EPHS including mental health as a core component								
1.2 Integration of community based health and nutrition services in EPHS								
1.3 Improving quality of care/ patient safety								
1.4 Effective delivery of disease specific programmes and interventions including AIDS, TB, malaria, polio and vaccine preventable diseases etc.								
1.5 Demand creation and implementation of BCC strategy								
1.6 Specialized interventions for non-communicable diseases including mental health								
1.Number of health facility providing EPHS	76	86	96	106	116	126		
2.Number of hospitals providing CEmONC service 24/7	4	9	14	19	20	20		
3. Number of health facility providing BEmONC service 24/7	76	86	96	106	116	126		
4.Number of deliveries conducted in the health facilities	28,597	33459	39147	45801	53588	62698		
5. Number of children under one year immunized for pentavalent 3	58,520	63201	68257	73718	79615	85985		
6. Number children severely and moderately malnourished children managed in HF	2652	8652	11652	13152	14252	15052		
7. No of children born in HF and initiated breastfeeding	28977	31295	33799	36503	39423	42577		
8. Number of women receiving MMN at HF	78,501	86351	94986	104484	114933	126426		
9. Number of OPD visited by service level	833,298	916628	1008291	1109120	1220032	1342035		
10. Number of hospitals with trauma care unit	0	1	2	3	4	4		

Maternal Health								
Antenatal care (ANC) coverage	52%	60%	68%	76%	84%	92%		
Proportion of deliveries attended by skilled birth attendant (SBA)	38%	41%	44%	47%	51%	55%		
PNC coverage	85%	90%	93%	95%	98%	100%		
Proportion of maternal deaths (institutional)								
Number and proportion of HFs with (CEmONC) services								
Number and proportion of HFs with BEmONC services								
Number and proportion of BEmONC HFs offering 24 hours skilled birth attendance								
Number of women attending ANC visits 3+	54789	62789	70789	80789	93289	107289		
Number of women attending PNC Visits.	82307	#REF!	#REF!	#REF!	#REF!	#REF!		
Family Planning								
Contraceptive Prevalence Rate (CPR) %	2.2	5.2	8.5	11.5	15.2	15.3		
Child Health/EPI								
Number of hospitals with functioning neonatal unit.	1	3	5	7	9	10		
Number of live births (reported at hospitals only)	4244	5344	6544	7854	9259	10809		
Number of still births at the health facility(Reported at hospitals only)	1042	800	750	700	650	600		
Neonatal mortality rate								
Infant mortality rate (per 1000 live births)								
Under-five mortality rate								
Number of children U5 immunised								
Pentavalent immunization dropout rate	11%							

Proportion of children 6-59 months with acute diarrhoea who received ORS and Zinc for diarrhoea	25000	24000	22000	20000	19500	19000		
Nutrition								
Number of moderately and severely malnourished children managed through routine services in MCH/HC	46,596	46,596	46750	45500	44500	44000		
Child malnutrition								
Proportion of malnourished children referred for care								
Number and proportion of children 6-59 months who received Vitamin A								
Number and proportion of children 12-59 months who were dewormed								
Number and proportion of women who received MMN supplements	78,501	78,501	78,501	78,501	78,501	78,501		
Malaria								
Number of malaria cases diagnosed at the OPD	68803	79123	92573	110161	133294	1632951		
Number of patients receiving treatment for malaria as per national guidelines	9207	4607	2307	0	0	0		
HIV/AIDS & STIs								
Number of ANC clients counselled and tested	4204							
Number of ANC clients who are HIV positive								
Proportion of HIV positive ANC clients started antiretroviral therapy (ART)								
Number and proportion of newborn who were given ARVs for prophylaxis								
Number of clients currently on ART								
Number and proportion of pregnant women screened for syphilis during ANC								
TB								
Number of TB cases detected	1723	1522	1500	1000	800	500		
TB treatment outcome (number and proportion)	1229	1300	1200	700	500	300		

Mental Health								
Number of health facilities providing mental health services by level	4	25	35	45				
Number of clients treated	0							
Priority Non-Communicable Diseases								
Number of patients diagnosis and treated with diabetes.	0							
Number of patients diagnosis and treated with hypertension	0							
Number of patients diagnosis and treated with asthma.	0							
1.3 Improving quality of care/ patient safety								
Number standardized guidelines and quality monitoring tools developed and adopted.	0	1	2	2	3			
Number of health facilities with STG available and used for reference by all staff	0	86	96	106	116			
1.7 Demand creation and implementation of BCC strategy								
Number of integrated public health messages air regularly in public and private media.	100	100	100	100	100			
Number of community awareness sessions (Integrated PH Messages}	36	36	36	36	36			

Strategic Direction 2: Overcoming the crisis of human resources for health To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services									
	Baseline	**2017**	**2018**	**2019**	**2020**	**2021**	**Frequency**	**Means of Verification**	**Responsible**
Objectives									
2.1 Improved HR policy, planning and management									

Number of health care professionals disaggregated by cadre, sex , facility, district and region	2,439	2,739	3,039	3,339	3,639	3,939		Health workforce survey, HR database, HMIS reports	HR director
Number of health care professionals (disaggregated by cadre, sex, region and type of programme) provided **in-service** trainings	2214	2260	2560	2860	3160	3460		HR database/ RHO/IP reports	HR director
% of functional HR units at regional and district level	1	9	9	9	9	9		HR report	HR director
Annual increase of number of health workers (M/F) in the government payrolls **(Source: MOH)**	785	885	985	1085	1185	1285		HR database	HR director
2.2 Health professionals registered, licensed and accredited									HR director
Number of professionals (disaggregated by cadre, sex and region) registered, licensed and accredited by NHPC	0	0.2	0.4	0.6	0.8	1		Source: NHPC reports)	HR director
2.3 Health workforce at all levels having (on budget) system of salaries, incentives and allowances									HR director
Number of partners adhering to harmonized health workers' incentive scale	0.8	0.9	1	1	1	1		IP/RHO reports	HR director
2.4 Availability of GESI-sensitive standardized training guidelines, material and protocols									HR director
Number of GESI-sensitive MOH standardized training guidelines and protocols produced/utilized	1	5	10	10	10	10		IP/RHO/ HR reports	HR director
Annual number of training events held	80	95	110	125	140	155			HR director
2.5 Production of sufficient skilled health professionals and workers (M/F) with equitable distribution to implement health services									HR director
Number health care professionals (**Doctors)** (disaggregated by cadre, sex and training institution) provided **pre-service** trainings	140	170	200	230	260	290		Training institute reports, NHPC report, HR database	HR director

Number health care professionals **(Nurse)** (disaggregated by cadre, sex and training institution) provided **pre-service** trainings	664	864	1064	1264	1464	1664		Training institute reports, NHPC report, HR database	HR director
Number health care professionals (**Midwives**) (disaggregated by cadre, sex and training institution) provided **pre-service** trainings	430	530	630	730	830	930		Training institute reports, NHPC report, HR database	HR director
2.6 Implementation of in-service training plan									
Number of training sessions including an emphasis on equitable service delivery conducted for in-service health workers	80	95	110	125	140	155		MOH reports	HR director

Strategic Direction 3: Improving governance and leadership of the health system
To build institutional capacity of health authorities at both central and regional levels to provide strong leadership and effective governance, provide core functions of health sector and engage with private sector

Objectives	**Baseline**	**2017**	**2018**	**2019**	**2020**	**2021**	**Frequency**	**Means of Verification**	**Responsible**
3.1 Development and implementation of Policies, Strategies and Legal Frameworks								MOH reports	Dir. planning
Number of legal documents published	1	2	2	3	4	4	annually	MOH reports	Dir. planning
Number of policy documents published	25	28	31	34	37	40	annually	MOH reports	Dir. planning
3.2 Improved management and institutional capacity									
Number of training event for senior/middle level managers	40	50	60	70	80	90	Annually	MOH reports	Dir. planning
3.3 Effective partnership and coordination								MOH reports	Dir. planning
Number of quarterly meetings with partners	4	4	4	4	4	4	Quarterly	MOH reports	Dir. planning

3.4 Improved community engagement and involvement in planning, delivering and reviewing health services, including women and representatives of most vulnerable groups									
Number of CHC, RHB and DHB established	40	70	100	130	160	190	annually	MOH reports	Dir.planning
Client satisfaction survey	1	1	1	1	1				

SO 4: Enhancing the access to essential medicines and technologies

To ensure the availability of essential medicines, vaccines and commodities that satisfy the priority health care needs of the population, in adequate amounts and of assured quality and at a price that the community and the health system can afford

Indicator	**Baseline**	**2017**	**2018**	**2019**	**2020**	**2021**	**Frequency**	**Means of Verification**	**Responsible**
4.1 Develop import regulations, guidelines and standards to improve safety practices of pharmaceutical sector									
Import regulation and guidelines/standards developed	0	1	2	3	3	4			
Number of licensed pharmacies, wholesalers, retailers (private sectors)	0	300	600	900	1200	1500	Annually	NPHC reports	NPHC
Number of inspections performed (once quarterly)at private and public sectors	0	24	48	72	108	132	Annually	MOH reports	Public Health Dept.
4.2 Ensure availability of quality supplies (medicines, vaccines, nutrition and RH commodities)and equipment to all public health facilities)									
Establish quality control system (4 mini labs for medicines)	3	4	4	4	5	5	Annually	MOH reports	QC/QA Unit

Number of trained staff members on QC/QA for each region (minimum 5).	10	10	15	15	20	20	Annually	MOH reports	QC/QA Unit
4.3 Effective procurement, warehousing, logistics and supply chain system									
Number of health units reporting stock outs of essential drugs and vaccines	0	< 10%	< 10%	< 10%	< 10%	< 10%	Annually	MOH LMIS/HMIS reports	QC/QA Unit
4.4 Improved / rational use of drugs									
Number of health providers trained on drug use management.	0	150	150	150	150	150	Annually	MOH reports	QC/QA Unit

SO 5: Developing health management information and research

To establish an effective health information system that provide accurate and timely health data for evidence based planning and implementation, supported by effective monitoring and evaluation (M&E) and by targeted research as a problem-solving tool

Indicator	**Baseline**	**2017**	**2018**	**2019**	**2020**	**2021**	**Frequency**	**Means of Verification**	**Responsible**
Effective M&E system to track health system performance disaggregated by sex, location and other factors such as age, disability, HIV status as relevant									
Percentage of HSSP results-framework indicators reported in the AHSPR	84%	88%	92%	96%	98%	100%	annually	AHSPR	M.E & Research Unit
Proportion of planned reviews carried out	2	4	4	4	4	4	Quarterly	Review Reports	M.E & Research Unit
Timely, complete and accurate HMIS at all levels									
HMIS timeliness	86%	88%	92%	96%	98%	100%	Annually	HMIS Reports	HMIS Unit
HMIS completeness							Annually	HMIS Reports	HMIS Unit
HMIS reporting rate							Annually	HMIS Reports	HMIS Unit
Number of a data quality assessment (DQA) was conducted	1	4	4	4	4	4	Quarterly	DQA reports	HMIS Unit

Number of regions reporting HMIS data through DHIS2	0	7	7	7	7	7	annually	HMIS Reports	HMIS Unit
Number of HMIS reports analyzed and disseminated through DHIS2 and Performance Management Dashboard	0	40	40	40	40	40	Quarterly and Annually	HMIS Reports	HMIS Unit
Number of community based HMIS reports sent through and linked with the DHIS2	60	160	160	260	260	360	Annually	HMIS Reports	HMIS Unit
Improve research capacity and implement research and survey plan									
Development of prioritized national research agenda and costed survey plan, including a focus on equity issues	1	1	1	1	1	1	Annually	Policy and Strategy Documentation Centre	Director of Planning
Number of planned research/surveys implemented/completed	1	4	6	8	10	12	Annually	Research and Survey Reports	M.E & Research Unit
5.4 Effective and integrated disease early warning and surveillance system									
Number of sentinel sites reporting notifiable diseases	61	71	81	91	101	121	Annually	MOH reports	HMIS/CSR
Number of notifiable diseases reported	9	9	9	9	9	9	Annually	MOH reports	HMIS/CSR
Establish system of civil registration and vital statistics									
Number FHW Vital Registration sites	0	60	160	160	260	260	Monthly	HMIS	Dir. Planning
Number of facility-based Vital Registration sites	0	86	96	106	116	126	Monthly		
Number of births/deaths reported annually	0							Monthly, quarterly annual health statistics report (HMIS)	HMIS Unit

SO 6: Health financing for universal coverage
To raise **adequate funds for health**, protecting the poor and under-privileged from catastrophic health expenditure ensuring that people can access affordable service, therefore moving towards universal health coverage

Indicators	Baseline	2017	2018	2019	2020	2021	Frequency	Means of Verification	Responsible
6.1 Health financing strategy development andimplementation									
% Health sector budget increase	2.5%	4.0%	5.5%	7.0%	8.5%	10.0%	Annually		Health financing Unit
Number of programs and sub programs expenditure reports	4	4	4	4	4	4	Annually		Health financing Unit
National Health account reports produced disaggregated by sources and beneficiary and disseminated by quarterly/annually	1	1	1	1	1	1	Annually		Health financing Unit
Health expenditure reviews conducted on time	1	1	1	1	1	1	Annually		Health financing Unit
6.2 Sound Public financial management and accountability system									
Number of financial management trainings conducted to both management and finance team	0	4	2	2	2	2	Quarterly		Health financing Unit
Number of financial audits and spot check conducted	5	5	5	5	5	5	Quarterly and annually		

SO 7: Improving health services physical infrastructure and equipment

To bridge the gap in the enormous health infrastructure paucity and create the minimum health infrastructure assets, providing the necessary operational environment for effective service delivery

Indicator	Baseline	2017	2018	2019	2020	2021	Frequency	Means of Verification	Responsible
7.1 Develop and implement health infrastructure improvement plan/ standards									

Number of new health facilities constructed as per EPHS standard	0	10	10	10	10	15	Annually	MoH annual reports/IP reports and local authority	
Number of health facilities upgraded/rehabilitated as per EPHS budget	0	50	50	50	50	50	Annually	MoH annual reports	
Number of regional warehouses/offices constructed and functioning	0	2	1	1	1	1	Annually	MoH annual reports	
Number of health facilities with sustainable energy system installed and functioning	0	65	90	115	140	155	Annually	MoH annual reports	
Number of regional health offices constructed at regional/ district constructed	0	0	1	1	1	0	Annually	MoH annual reports	

SO 8: Health emergency preparedness and response

To strengthen the health system and surge its capacity to promote public health and prevent, investigate, mitigate, manage, monitor, evaluate and control public health threats and reach out to affected communities with integrated effective assistance targeting their specific public health emergencies

Indicators	**Baseline**	**2017**	**2018**	**2019**	**2020**	**2021**	**Frequency**	**Means of Verification**	**Responsible**
8.1 Strengthen emergency preparedness and response capacity									
Emergency Preparednessand Response Plan	1	1	1	1	1	1	Annually	MOH reports	Dir. Public Health
Number of Rapid Response Teams trained	0	9	9	9	9	9	Annually	MOH reports	Dir. Public Health
Number of timely emergency responses	2	2	2		2	2	Annually	MOH reports	Dir. Public Health
8.2 Effective coordination and linkages with sector coordination (cluster)									
Number of Cluster meetings conducted	0	4	4	4	4	4	Monthly	MOH	Dir. Public Health
8.3 Basic health and nutrition humanitarian services in non-EPHS areas									

Number of health facilities with basic health and nutrition services in non-EPHS areas	9	9	12	15	15	15	Annually	MOH	Dir. Primary Health care

Strategic Direction 9: Promoting action on social determinants of health and health in all policies

To Improve the health of the population and reduce health disparities by addressing the social determinants of health, integrating health perspectives into the broader development framework and emphasizing on intersectoral collaboration across all government and other stakeholder partners and building the capacities necessary for its implementation.

	Baseline	2017	2018	2019	2020	2021	Frequency	Means of Verification	Responsible
9.1 Effective mechanism for inter-sectoral collaboration ensuring Health in all policy									
Number of inter-ministerial meetings held	0	4	4	4	4	4	Quarterly	MOH reports	Dir. Planning
Development of Inter-ministerial action plan	0	2	2	2	2	2	annually	MOH reports	Dir. Planning
Number of inter-sectoral activities collaboratively conducted									

Annex 1: Operational Plan 2017

Puntland HSSP II 2017 operational plan

SO 1: Scaling up of essential and basic health and nutrition services									
To improve **access to essential health services** of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under-nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.									
	Activities	**New/ Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
Strategic Priority 1.1 Continuation, integration and scaling up of essential package of health services including mental health as a core component									
1.1.1	Sustain current EPHS services in four regions including CEMONC	Ongoing	X	X	X	X	4 regions implement EPHS core components	MOH directors	UN and INGOs
1.1.2	Increase the number of Health Facilities providing EPHS services based on prioritisation plan and focused on underserved regions	Ongoing			x	X	4 regions implement EPHS core components	MOH directors	UN and INGOs
1.1.3	Establish 1 trauma care units in Regional Hospitals staffed with qualified personnel	New			X	X	Trauma centre established in Garowe General Hospital	MOH directors	UN and INGOs
1.1.4	Develop Mental Health Care implementation plan.	New		X	X		Mental health implementation plan	MOH directors	UN and INGOs
1.1.5	Establish and integrate Mental Health care services in the health facility providing EPHS health services	New			X	X	Health workers in 25 EPHS facilities trained and supplies provided	MOH directors	UN and INGOs
1.1.6	Implement Mental Health Care Plan including demand creation activities	New			X	X	Mental health implementation plan	MOH directors	UN and INGOs
1.1.7	Establish one health and nutrition mobile team per region	New		X	X	X	9 mobile teams	Director of PHC	UN and INGOs
1.1.8	Strengthen referral system from lower level to higher level EPHS facilities	Ongoing		X	X	x	Referral systems initiated	Director of PHC	UN and INGOs
1.1.9	Establish 1 neonatal care units in Regional Hospital staffed with qualified personnel	New			X	X	1 neonatology centre established	RH Unit	UN and INGOs
Strategic Priority 1.2 Integration of community based health and nutrition services in EPHS									

SO 1: Scaling up of essential and basic health and nutrition services									
To improve **access to essential health services** of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under-nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.									
	Activities	**New/ Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
1.2.1	Map all community based health and nutrition services			X	X	x	Map of ongoing community health and nutrition services	Director of Planning	UN and INGOs
1.2.2	Expand Community Based Health Service through the provision FHWs health cadre			X	x	x	100 new FHWs are deployed in Bari and Nugal regions	HSS unit	UN and INGOs
1.2.3	Expand Community Based Health Service through the provision iCCM			X	x	x	120 iCCM sites in 4 regions of PL	Director of PHC	UN and INGOs
1.2.4	Develop a specific strategy to address health needs of nomadic populations (M/F)			X	X		Nomadic service delivery strategy	Director of Planning	UN and INGOs
1.2.5	Start implementation of nomadic health service strategy to address health needs of nomadic populations				X	X	Nomadic service delivery plan	Director of Planning	UN and INGOs
1.2.6	Implement community based integrated reproductive health outreach services			X	X	X	1 RH outreach/quarter for 3 quarters	RH unit	UN and INGOs
1.2.7	Implement community based integrated management of acute malnutrition				X	X	Nutrition mobile OTPs	Nutrition unit	UN and INGOs
1.2.8	Implement community-led total sanitation (CLTS) in all regions of Puntland			X	X	X	CLTS in all regions	Director of Public Health	UN and INGOs
Strategic Priority 1.3 Specialised interventions for non-communicable diseases									
1.3.1	Develop a national strategy and identify the risk factors for non-communicable diseases (diabetes, hypertension, asthma)	New		X			Communicable disease prevention strategy	Director of Planning	UN and INGOs
1.3.2	Provide testing and treatment of diabetes, renal disease, asthma and hypertension diseases in regional hospitals	New			X	X	Supplies are provided to 5 regional hospitals	MOH directors	UN and INGOs
1.3.3	Pilot screening for cervical cancer in regional hospitals (3)	New				x	HPV testing supplies provided to 3 regional hospitals	RH unit	MOH and UNFPA

SO 1: Scaling up of essential and basic health and nutrition services									
To improve **access to essential health services** of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under-nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.									
	Activities	**New/ Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
Strategic Priority 1.4 Improving quality of care/ patient safety									
1.4.1	Implement EPHS Compass QA monitoring system including EPHS scorecard	New			X	X	EPHS campus piloted in Karkaar regions	MOH	MOH and SCI/PSI
1.4.2	Introduce patient safety and infection control measures in hospitals including waste management system	New				x	30 Health staff trained on patient safety	MOH	MOH and partners
1.4.3	Increase the number of health facilities with standardised WASH facilities	Ongoing	X	X	X	X	30 EPHS facilities provided with WASH facilities	Director of Public Health	MOH and UNICEF
1.4.4	Regular monitoring and supervision of quality services level to all health facilities	Ongoing	X	X	X	X	All health facilities are supervised at least once in 2017	MOH directors	MOH and partners
Strategic Priority 1.5 Demand creation and implementation of BCC strategy									
1.5.1	Review BCC strategy and develop a programme of integrated public health messages.	Ongoing	X	X	X	X	BCC strategy finalized	MOH directors	MOH and partners
1.5.2	Develop FGM awareness messages for school health targeting adolescents and their parents	New			X	X	FGM messages developed	FGM unit	MOH and UNICEF
1.5.3	Implement Mass Awareness and behaviour change campaigns for programs including birth spacing, FGM, immunization, malaria, TB and HIV	New		X	X	X	MOH integrated awareness program	Health promotion unit	MOH and partners
1.5.4	Implement mass awareness and behaviour change campaigns for non-communicable diseases (diabetes, hypertension, and asthma)	New			X	X	MOH integrated awareness program	Health promotion unit	MOH and partners
1.5.5	Pilot integration of FGM service into health facilities (20)	New		X	X	X	20 EPHS facilities provide FGM services	FGM unit	MOH and UNICEF
Strategic Priorty 6: Effective delivery of disease specific programmes and interventions including AIDS, TB, Malaria, Polio and vaccine preventable diseases etc.									

SO 1: Scaling up of essential and basic health and nutrition services									
To improve **access to essential health services** of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of under-nutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.									
	Activities	**New/ Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
1.6.1	Sustain TB treatment services (13 TBMU)	Ongoing	x	X	x	x	13 TBMU operational	TB Unit	MOH and WVI
1.6.2	Expand TB treatment services with 2 additional centres	New		X	x	x	2 additional TBMU established	TB Unit	MOH and WVI
1.6.3	Sustain integration of vertical programs within EPHS framework (TB, malaria, HIV)	Ongoing	X	X	X	X	Integration of vertical programs initiated	MOH directors	MOH and partners
1.6.4	Establish and staff an MDR treatment centre	New	x	X	x	X	MDR TB centre fully functional in Galkacyo	TB Unit	MOH and WVI
1.6.6	Sustain integrated prevention, treatment, and care services for HIV/AIDS patient (6 VCTs)	Ongoing	X	X	X	X	6 VCTs fully operational	HIV unit	MOH and UNICEF
1.6.7	Implement at least four (4) rounds of national immunization days (NIDs) for polio	Ongoing	X	X	X	X	4 NIDs conducted	EPI unit	MOH and UN agencies
1.6.8	Implement EPI outreach services in 8 priority districts	New	X	X	X	X	Regular outreach sessions conducted in 8 priority districts	EPI unit	MOH and UN agencies
1.6.9	Implement one round of measles catch-up campaign	New			X	x	1 round of measles catch campaign	EPI unit	MOH and UN agencies
1.6.10	Integrated Reproductive health outreaches in all regions of Puntland	Ongoing		X	x	x	3 outreach session (1/quarter for 3 quarters)	RH unit	MOH and UNFPA
1.6.11	Nutrition mobile teams to implement IMAM (OTPS) in all regions of Puntland	Ongoing	x	X	x	x	Mobile OTPs in all regions	Nutrition unit	MOH and UNICEF

SO 2: Overcoming the crisis of human resources for health									
To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services									
	Activities	**New/Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
Strategic Priority 2.1 Improved Human Resource policy, planning and management									

SO 2: Overcoming the crisis of human resources for health									
To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services									
	Activities	**New/Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
2.1.1	Develop equity-focused human resource development and management plan	New		x		x	HRH Plan	HRH Team	MOH and partners
2.1.2	Implement GESI-sensitive Human Resource Development and Management Plan	New		x		x		HRH Team	MOH and partners
2.1.3	Develop performance appraisal systems and implement	New					at least 1 performance appraisal should be conducted for all HWF		MOH and partners
2.1.4	Hire HR officers for all regions	New	X	x			at least 1 HRH focal recruited in each region	HRH Team	MOH and partners
2.1.5	HRH Rules and Regulations reviewed and finalized and distributed to all regions	ongoing		x	x		at least each region should have their HR R&R by the end of the year	HRH Team	MOH and partners
Strategic Priority 2.2 Production of sufficient skilled health professionals and workers with equitable distribution to implement health services									
2.2.1	Training for mid-level workers including lab technicians, anaesthesia technician, pharmacy and radiology technicians, female health workers, community midwives, medical engineering and mental health practitioner In collaboration with training institutions	ongoing	X	x	x	x	at least 30 mid-level health workers from each cadre trained by the end of the year	HRH Team	MOH and partners
2.2.2	Continue producing nurses, midwives, doctors, neonatologists, clinical officers in cooperation with training institutions	ongoing	X	x	x	x	at least 20 doctors, nurses, midwives, clinical officers, neonatologist trained	HRH Team	MOH and partners
2.2.3	Integrate NCD management in curricula of different cadres of health workers including DM, HTN, asthma, cancers, mental health, etc	New			x	x	NCD management integrated in both in-service and pre-service training programs	HRH Team	MOH and partners
2.2.4	Assessment on curriculum standardization of health training institutes						Assessment report	HRH Team	MOH and partners

SO 2: Overcoming the crisis of human resources for health									
To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services									
	Activities	**New/Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
2.2.5	Standardise curriculum of different cadres across all training institutions	ongoing			x	x	all curriculums standardized and finalized and rolled out to all training institutions	HRH Team	MOH and partners
2.2.6	Build capacity of tutors and ensure they have up to date knowledge on their areas of expertise	ongoing			x	x	at least 70% of tutors capacity built	HRH Team	MOH and partners
2.2.7	Giving additional hardship allowance to professional cadres in the rural areas	ongoing	X	x	x	x	at least 50% of rural staff have received hard ship allowances	HRH Team	MOH and partners
Strategic Priority 2.3 Health professionals registered, licensed and accredited									
2.2.1	Establish electronic employee database	new	X	x	x	x	HRMIS AND DHIS2 integrated	HRH Team	MOH and partners
2.2.2	Register and license at least 40% of health professionals	new	X	x	x	x	HRMIS AND DHIS2 integrated	HRH Team	MOH and partners
2.2.3	Establish HRMIS linked HMIS/DHIS2disaggregated by factors such as cadre, sex, training institution, location						HRMIS and DHIS2 Integrated and established	HRH Team	MOH and partners
Strategic Priority 2.4 Health workforce at all levels having (on budget) system of salaries, incentives and allowances									
2.4.1	Identify staffing gaps at all facilities across all levels based on SARA data	New			X	X			
2.4.2	Review, revise and standardise salaries, incentives, and allowances	ongoing	X	X	X	x	standardized salaries, incentives and allowances reviewed and finalized	HRH Team	MOH and partners
Strategic Priority 2.5 Availability of standardized training guidelines, material, and protocols									
2.5.1	Develop GESI-sensitive in-service training guidelines, material and protocols and translate into Somali	ongoing		x	x		all training materials translated and standardized	HRH Team	MOH and partners
2.5.2	Develop training impact assessment tool and feedback mechanism	new			x		at least 1 impact assessment conducted	HRH Team	MOH and partners
Strategic Priority 2.6 Implementation of in-service training plan									

SO 2: Overcoming the crisis of human resources for health									
To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services									
	Activities	**New/Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
2.6.1	Conduct short courses on anaesthesia, ICU, emergency surgery, neonatology, forensic medicine, mental health and NCD Management for doctors and Nurses	ongoing		x	x		at least 2-3 short courses conducted for doctors and nurses by the end of year	HRH Team	MOH and partners
2.6.2	Conduct training of first line health workers in line with the training plan	ongoing		x	x		at least 70% of in service training plan conducted/implemented	HRH Team	MOH and partners
2.6.3	Implement internship program for newly graduated students	ongoing		x	x		80% of graduate students should have completed their internship by the end of the year	HRH Team	MOH and partners
Strategic Priority 2.7 HR monitoring, evaluation, and Coordination									
2.7.1	Supervise health workforce at all levels	ongoing	X	x	x	x	at least 2 quarters of supervisions conducted	HRH Team	MOH and partners
2.7.2	Conduct monthly HRH task force meeting	new	X	x	x	x	Meeting minutes	HRH Team	MOH and partners

SO3: Improving governance and leadership of the health system.									
To build institutional capacity of health authorities at both central and regional levels to provide strong leadership and effective governance, provide core functions of health sector and engage with private sector.									
	Activities	**New/Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	**Q2**	**Q3**	**Q4**		**MoH Focal Point**	**Supporting Agency**
Strategic Priority 3.1 Development and implementation of Policies, Strategies, and Legal Frameworks									
3.1.1	Establish calendar of policy/strategy review (mid or end term). Identify TA and budget	New		X			Schedule of Policy development timeline	Director of Planning	WHO

3.1.2	Review and finalize RH strategy and nutrition	Ongoing		X	X		RH and nutrition strategies reviewed and finalized	Director of Planning	UNFPA/UNICEF
3.1.3	Develop nomadic services strategy	New		X			Nomadic strategy developed	Director of Planning	WHO
3.1.4	Develop private sector engagement strategy and map facilities using recent survey	New			X		Private sector strategy	Director of Planning	WHO
3.1.5	Develop public health administrative law and other acts	New	X	X	X	X	Public health law developed	Director of Planning	WHO
3.1.6	Review and update leadership, governance and management plan	Ongoing	X	X			GLM Plan	Director of Planning	WHO
Strategic Priority 3.2 Strengthen Zonal Health Sector Coordination									
3.2.1	Establish health sector coordination board (TOR, clear membership numbers and selection criteria	New	X	X			Health sector review coordination strengthened and membership TORs develop	Director of Planning	WHO
3.2.2	Conduct regular quarterly zonal health sector coordination	Ongoing	X	X	X	X	health sector coordination conducted on regular Basis	Director of Planning	WHO
3.2.3	Recruit Health Sector/Technical Coordination Advisor to support coordination	New		x			technical Coordination Advisor in place	Director of Planning	WHO
3.2.4	Conduct regular quarterly Technical Working Group meetings prior to Zonal HSC meetings	New	X	X	X	X	Meeting minutes	Director of Planning	WHO
3.2.5	Establish Immunisation Coordinating Committee to feed technical and oversight information and data to the Zonal HSC	New		X			Zonal Immunisation Coordination Committee established with ToR, Membership criteria and annual work plan.	Director of Planning	WHO
Strategic Priority 3.3 Improved management and institutional capacities with enhanced decentralization									

3.3.1	Establish regional health management team and build their capacity	New		X	X	X	regional health management team established	Director of Planning	WHO
3.3.2	Conduct workshop to finalize the functional review in 2017	New		X			functional review workshop conducted and finalized	Director of Planning	WHO
3.3.3	Provision of Technical assistance in M&E, HMIS, Research, Policy & Planning and community based services	Ongoing	X	X	X	X	Technical HMIS, M&E, policy, and planning Advisors in place	Director of Planning	WHO
3.3.4	Establish nine regional health board with clear TORs	New	X	X	X	X	Regional health boards established and their TORs developed	Director of Planning	WHO
3.3.5	Establish the operational structure and implementation arrangements at regional level (health facility, regional health board, community committees)	New		X			Regional health system re-structured	Director of Planning	WHO
3.3.6	Train the regional and district health boards and community health communities in their roles, responsibilities and support available to them from the MoH	New			X	X	Regional health boards and community health committees trained	Director of Planning	WHO
3.3.7	Strengthen Partnership and joint implementation with JPLG districts	Ongoing		X	X	X	Partnership with JPLG districts strengthened	Director of Planning	WHO
3.3.8	Produce quarterly management dashboards using data from DHIS2 and EPHS Compass Tools	New	X	X	X	X	Quarterly bulletin	Director of Planning	WHO
3.3.9	Conduct leadership, management, and governance (LM&G) training for senior managers at central and regional level and RHO/DMO, PHC, Health facilities in charge and other mid-level managers	new		x	x	x	at least 30 mid-level managers trained in HRH LM&G	Director of Planning	All partner

3 Develop approaches to meaningful engagement of communities – including women and representatives of vulnerable populations such as nomadic populations – in planning, delivery and review of services as part of effective governance approaches									
3.4.1	**Planning**: Develop and implement mechanisms to ensure effective involvement of communities in planning processes (e.g. participatory needs assessment, focus groups)								
3.4.2	**Delivery**: Ensure effective representation on CHCs, RHBs, and DHBs of communities including women and representative of vulnerable groups								
3.4.3	**Review**: Develop and implement mechanisms for service user and non-user input into review (e.g. complaints procedures, client satisfaction surveys) that are taken into account in formal reviews								

SO4: Enhancing the access to essential medicines and technologies.									
To ensure the availability**of essential medicines, vaccines and commodities** that satisfy the priority health care needs of the population, in adequate amounts and of assured quality and at a price that the community and the health system can afford.									
	Activities	**New/Ongoing**	**Timeline**				**Milestones and Deliverables**	**Responsibilities**	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
Strategic Priority 4.1 Develop Import regulations, guidelines, and standards to improve the safety and practices of pharmaceutical sector									
4.1.1	Develop standardised guideline for regulating imported medicines and commodities (TA and workshops)	New	X			M/E	Import guidelines	MOH /Partners	
4.1.2	Develop a drug regulation training module and implementation plan. (TA and workshops)	New		X			Drug regulation training module	MOH	

4.1.3	Conduct feasibility study on development of registration database of imported medicines and medical equipment	New		X	X		Feasibility study	MOH	
4.1.4	Develop registration system for private sector wholesalers, retailers, and pharmacies	New		X			Private registry	MOH	
4.1.5	Develop Inspection Plan for public and private sector pharmacies and pilot implementation of the plan	New			X	X		MOH	
4.1.6	Develop guidelines on good dispensing practices	New			X	X	Guidelines distributed	ALL Directors	
Strategic Priority 4.2 Ensure quality supplies (medicines, vaccines, Nutrition, and RH commodities) and equipment to all public health facilities)									
4.2.1	Re-establish minilabs and undertake refresher training	Ongoing		X		M/E	lab. Technician trained on QC/QA	MOH	
4.2.2	Conduct spot checks on public and private pharmacies to sample drug and equipment compliance with regulations	New			X		spot check conducted	MOH	
4.2.3	Conduct training on rational use of medicines for Public sector	Ongoing			X	M/E	Health workers trained on rational use of medicine	MOH/Partners	
Strategic Priority 4.3 Effective procurement, warehousing, logistics and supply chain system									
4.3.1	Procurement of medicines, vaccines and commodities to all health facilities based on EML	Ongoing	X			M/E	Supply procured	UN and NGOs	UN and NGOs
4.3.2	Distribution of medicines, vaccines and commodities to all health facilities based on EML	Ongoing	X			M/E	Supply distributed	MOH	UN and NGOs
4.3.3	Begin implementation of supply chain Master Plan	New		X			Supply chain master plan implemented	MOH/Partners	
4.3.4	Link LMIS and DHIS2 and use data as part of EPHS Compass Performance Management Dashboard	New		X	X		LMIS tools adopted	MOH	UN and NGOs

SO5: Effectively functioning health information system					
To establish an effective **health information system** that provide accurate and timely health data for evidence based planning and implementation, supported by effective monitoring and evaluation (M&E) and by targeted research as a problem-solving tool.					
	Activities	**New/Ongoing**	**Timeline**	**Milestones and Deliverables**	**Responsibilities**

			Q1	Q2	Q3	Q4		MoH Focal Point	Supporting Agency
Strategic Priority 5.1 Effective M&E system to track health system performancedisaggregated by sex, location and other factors such as age, disability, HIV status as relevant									
5.1.1	Conduct joint annual reviews	New				X	Annual joint review conducted	M/E and Research Unit	MOH
5.1.2	Conduct quarterly monitoring and evaluation visits	New	X	X	X	X	Quarterly M&E visits	M/E and Research Unit	MOH
5.1.3	Conduct quarterly HSSP II review and reporting	New	X	X	X	X	Quarterly Review reports and dashboard	M/E and Research Unit	MOH
Strategic Priority 5.2 Timely, complete, and accurate HMIS at all levels of health care deliverydisaggregated by sex and location as well as factors such as age, disability, HIV status as relevant									
5.2.1	Printing and distribution of the revised HMIS registers and reporting forms	New	X				Print HMIS tools to all Puntland HFs	HMIS Unit	MOH
5.2.2	HMIS training on the revised HMIS tools	New	X				Training of revised HMIS tools conducted	HMIS Unit	MOH
5.2.3	DHIS2 training to mid-level managers and health partners	New		X			DHIS2 training to MLM and health partners conducted	HMIS Unit	MOH
5.2.4	Roll out of DHIS2 to all Puntland regions	New	X				Roll out of DHIS2 to all regions in Puntland implemented and generated HMIS data	HMIS Unit	MOH
5.2.5	Establish and support Information Technology Unit (IT) within the Ministry of Health	New	X	X	X	X	MoH IT Unit Established	IT Unit	MOH
5.2.6	Conduct quarterly data quality audits to health facilities in Puntland	Ongoing	X	X	X	X	4 DQAs conducted and DQAs reported produced	HMIS Unit	MOH
5.2.7	Monthly and quarterly supportive supervisions	Ongoing	X	X	X	X	4 quarters SS conducted	HMIS Unit	MOH
5.2.8	Conduct quarterly data quality Audit feedback meetings and reports	Ongoing	X	X	X	X	4 quarters DQAs feedback meetings conducted and reports produced	HMIS Unit	MOH
5.2.9	Develop data use plan and Organize training on data use to guide decision making	New		X	X		30 people trained on data use	HMIS Unit	MOH

5.2.10	Monthly HMIS review meetings	Ongoing	X	X	X	X	HMIS monthly meeting minutes	HMIS Unit	MOH
5.2.11	Integrate community based service data into the HMIS/DHIS2				X	X	Community service data available	HMIS Unit	MOH
Strategic Priority 5.3 Effective and integrated disease early warning and surveillance system									
5.3.1	Training for health workers on case management and surveillance system	Ongoing			X		50 people trained	HMIS Unit	MOH
5.3.2	Increase the number of sentinel sites and mobile reporting centres from 61 to 71	New			X	X	Number of sentinel sites increased	HMIS Unit	MOH
5.3.3	Develop Link with DHIS2 for data triangulation	New			X	X	Linkage of CSR with DHIS2 implemented	HMIS Unit	MOH
Strategic Priority 5.4 Improved research capacity and implement research and survey plan									
5.4.1	Revise the existing research agenda and prioritize, promoting research on the relationships between social determinants of health and health equity	Ongoing			X		Revised research agenda	Research Unit	
5.4.2	Capacity building on research methodology, data analysis and interpretation to MLM	Ongoing			X	X	40 people trained on research methodology and data analyses	Research Unit	MoH
5.4.3	Implementation research for EPI demand creation	ongoing	x	X	x	X	IR on EPI demand creation conducted and report disseminated	Research Unit	MoH
5.4.4	Implementation research for malaria indicator survey (MIS)	New	x	X	x	X	MIS data available	Research and malaria Unit	MoH
5.4.5	Conduct HIV stigma index survey and HIV zero surveillance survey among ANC and STI clients	Ongoing/New	X	X			HIV stigma index and zero surveillance data available	Research and HIV Unit	MoH
5.4.6	Implement anti-malaria drug efficacy study	New		X	x	X	Anti-malarial drug efficacy report produced	Research and malaria Unit	MoH
5.4.7	Planning and coordination of the demographic and health survey (DHS)	New	x	X	x	X	DHS survey	Director of Planning	MoH

5.4.8	Collaborate with health institutions/universities on research agendas	New		X	x	X	Collaborated Health institutes/Universities	Research Unit	MoH
5.4.9	Technical assistance for research and information management	New		X	x	X	Technical assistance provided to research unit	Research Unit	MoH
5.4.10	Conduct health workforce survey	New			x	X	Health workforce data produced	HR director	MoH
5.4.11	Step-wise survey	New		X	x	X	Step-wise survey conducted and reports produced	Research Unit	MoH
5.4.12	Conduct research on mental health problems	New				X	Research on mental health problems conducted and data available	Research Unit	MoH
5.4.13	Conduct health work force survey	New				X	Survey conducted	HRH Team	IP/WHO/HRH WG
Strategic Priority 5.5 Establish system of civil registration and vital statistics									
5.5.1	Technical assistance to support implementation CRVS plan (Births and deaths)	New		X	X	X	TA Provided to review the CRVS	HMIS Unit	MOH/WHO
5.5.2	Pilot the CRVS tools to one district	New				X	CRVS tools developed and piloted to one district	HMIS Unit	MOH/WHO
5.5.3	Evaluate the system and develop a plan to scale up.	New				X	Evaluation of CRVS system implemented	HMIS Unit	MOH/WHO
5.5.4	Establish maternal death surveillance and response system	New	X	X	X	X	MDSR system established	HMIS Unit	MOH/WHO/UNFPA
5.5.5	Establish health system observatory website	New			X	X	Health System Observatory website established and data availability in the web achieved	HMIS Unit	MOH/WHO

SO6: Health financing for universal coverage.					
To raise **adequate funds for health**, protecting the poor and under-privileged from catastrophic health expenditure ensuring that people can access affordable service, therefore moving towards universal health coverage.					
	Activities	**New/Ongoing**	**Timeline**	**Milestones and Deliverables**	**Responsibilities**

			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
Strategic Priority 6.1 Health financing strategy development and implementation									
6.1.1	Review and Finalize Puntland Health Financing Strategy			X	x		Health care financing strategy	Health financing unit	MOH/WHO
6.1.2	Start the implementation of Health Financing Strategy				x	X	Health financing plan	Health financing unit	MOH/WHO
6.1.3	Support MOH Health financing unit (Operational support)	New		X	X	X	Operational support for HF unit	Health financing unit	MOH/WHO
6.1.4	Capacity building for MoH relevant department/personnel on applied health economics, health financing and resource management (Puntland MoH, 2016)	New				X	20 relevant staff trained on health financing topics	Health financing unit	MOH/WHO
6.1.5	Conduct public health expenditure review including monitoring progress in tackling inequalities	New			x	X	PHER	Health financing unit	MOH/WHO
6.1.6	Conduct household health expenditure review - Link with Demographic health survey (DHS)	New	x	X	x	X	DHS, Household expenditure data	Health financing unit	MOH/UNFPA
6.1.7	Conduct cost analysis of health sector and identify health financing gaps	New			x	X	Unit cost analysis	Health financing unit	MOH/WHO
6.1.8	Develop National Health Account (with financial tracking component)	New				X	First draft NHA	Health financing unit	MOH/WHO
Strategic Priority 6.2 Sound Public financial management and accountability system									
6.2.1	Strengthen MOH financial management capacity (Financial management training, charts of accounts)	Ongoing		X	x	X	30 MOH staff trained on accounting procedures	Admin/Finance department	MOH and partners
6.2.2	Technical assistance to improve financial control systems including auditsand GESI-sensitive budgeting and review)	New		X	x	X	TA provided	Admin/Finance department	MOH and partners

Strategic Direction 7: Improving health services physical infrastructure and equipment.					
To bridge the gap in the enormous health infrastructure paucity and create the minimum health infrastructure assets, providing the necessary operational environment for effective service delivery.					
	Activities	**New/Ongoing**	**Timeline**	**Milestones and Deliverables**	**Responsibilities**

			Q1	Q2	Q3	Q4		MoH Focal Point	Supporting Agency
Strategic Priority 7.1 Develop and implement health infrastructure improvement plan/ standards									
7.1.1	Assess health infrastructure based on SARA data	New	x				Health infrastructure assessment conducted	Director of Planning	MOH and UN agencies
7.1.2	Develop health infrastructure improvement plan emphasising equitable access	New		X			Health infrastructure plan developed	Director of Planning	MOH and UN agencies
7.1.3	Establish neonatal departments in all regional hospitals	New			x	X	neonatal departments established in all hospitals	RH Unit	MOH and UN agencies
7.1.4	Construct and equip operational theatres for ten district hospitals	New	x	X	x	X	Operational theatres constructed and equipped for district hospitals	Director of Planning	MOH, diaspora and UN agencies
7.1.5	Install sustainable energy systems for health facilities	New	x	X	x	X	Solar energy systems installed for all health facilities	Director of Planning	MOH and UN agencies
7.1.6	Establish fully functional blood bank in Garowe hospital	New			x	X	Fully functional Blood Bank established in Garowe Regional Hospital	Director of medical service	MOH and UN agencies
7.1.7	Establish public health laboratories	New			x	X	Public health Laboratory Established	Director of medical service	MOH and UN agencies
7.1.8	Train medical technicians in health facilities	New				X	Medical Technicians in all health facilities Trained	Director of medical service	MOH and UN agencies

SO8: Health emergency preparedness and response.					
To strengthen the health system and surge its capacity to promote public health and prevent, investigate, mitigate, manage, monitor, evaluate and control public health threats and reach out to affected communities with integrated effective assistance targeting their specific public health emergencies.					
	Activities	**New/Ongoing**	**Timeline**	**Milestones and Deliverables**	**Responsibilities**

			Q1	Q2	Q3	Q4		MoH Focal Point	Supporting Agency
Strategic Priority 8.1 Strengthen emergency preparedness and response capacity									
8.1.1	Develop national Emergency Preparedness and Response Plan (EPRP)	Ongoing	X				Emergency preparedness and response plan in place	MoH	MoH/ Partners
8.1.2	Implement EPRP resource mobilisation plan	New	X	X	X	X		MoH	MoH/ Partners
8.1.3	Preposition supplies including outbreak and trauma kits	Ongoing	X	X	X	X	Supplies in warehouse	MoH	MoH
8.1.4	Training for Emergency response teams at all levels	Ongoing	X	X	X	X	215 trainings	MoH	MoH/ Partners
Strategic Priority 8.2 Effective coordination and linkages with sector coordination									
8.2.1	Establish national assessment rapid teams at all levels	Ongoing	X	X	X	X	National assessment teams	MoH	MoH/ Partners
8.2.2	Establish national rapid response teams at all levels	Ongoing	X	X	X	X	National rapid response team	MoH	MoH/ Partners
8.2.3	Revamp and support emergency coordination clusters	Ongoing	X	X	X	X	Emergency coordination sectors	MoH	MoH/ Partners
8.2.4	Conduct regular cluster coordination meeting	Ongoing	X	X	X	X	Cluster meeting	MoH	MoH/ Partners
Strategic Priority 8.3: Basic health and nutrition humanitarian services in non-EPHS areas									
8.3.1	Support basic health and nutrition services in Sool and Sanaag regions	Ongoing	X	X	X	X	basic health and nutrition service	MOH	MoH/partners
8.3.2	Integrated Reproductive health outreaches in Sool and Sanaag regions	Ongoing	X	X	X	X	RH outreach	MOH	MoH/partners
8.3.3	Nutrition mobile teams to implement IMAM (OTPS) in Sool and Sanaag regions	Ongoing	X	X	X	X	IMAM/OTP	MOH	MoH/partners

SO9: Promoting action on social determinants of health and health in all policies.					
To Improve the health of the population and reduce health disparities by addressing **the social determinants of health**, integrating health perspectives into the broader development framework and emphasizing on intersectoral collaboration across all government and other stakeholder partners and building the capacities necessary for its implementation.					
	Activities	**New/Ongoing**	**Timeline**	**Milestones and Deliverables**	**Responsibilities**

			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
Strategic Priority 9.1 Effective mechanism for inter-sectoral collaboration ensuring Health in all policy									
9.1.1	Establish inter-ministerial committees (TOR)	New	X				Terms of reference developed	MoH Focal Point	MOH
9.1.2	Conduct inter-ministerial coordination meetings	New		X	x	X	Meeting minutes		
9.1.3	Develop inter-ministerial action plan on SUN and CARMMA	New	X	X	x	X	Action plan for SUN and CARMMA	MOH	MOH