



**SOMALILAND
MINISTRY OF HEALTH**

SECOND PHASE HEALTH SECTOR STRATEGIC PLAN (HSSP II)

2017-2021

FINAL DRAFT

September, 2017-14

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Acronyms and Abbreviations

AHSPR	Annual Health Sector Performance Report
ANC	Antenatal clinic
ART	Antiretroviral therapy
ASRH	Adolescent sexual and reproductive health
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
CBFW	Community Based Female Health Workers
CBHW	Community Based Health Workers
CD4	Communication for Development
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CERF	Central Emergency Response Fund
CHB	Community Health Board
CHC	Community Health Committee
CHW	Community Health Workers
CLTS	Community led total sanitation
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
DoP	Department of Planning
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 Immunisation
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
GBV	Gender based violence
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 center
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
ICT	Information and communications technology
ICU	Intensive care unit
IDP	Internally displaced people/persons
IMAM	Integrated Management of Acute Malnutrition
INGO	International nongovernmental organisation
IP	International partner
IPRSP	Interim Poverty Reduction Strategy Paper
IPV	Inactivated polio vaccine
IR	Implementation research
IT	Information technology
IYCF	Infant and Young Child Feeding
JANS	Joint Assessment of National Health Strategies
JFA	Joint Financing Agreement
JHNP	Joint Health and Nutrition Programme
JPLG	Joint Programme on Local Governance
KAPS	Knowledge, attitudes and practices study
LM&G	Leadership, management and governance
LMIC	Lower and middle income countries
LMIS	Logistics management information system
LOA	Letter of agreement
M&E	Monitoring and evaluation
M/F	Male/female
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and child health
MDR	Multi-drug resistant
MICS	Multiple Indicator Cluster Survey
MIS	Malaria indicator survey
MMN	Multi-micronutrients
MoH	Ministry of Health
MOU	Memorandum of understanding
NCD	Non-communicable disease
NDP	National Development Plan
NERAD	National Environment Research and Disaster-preparedness
NGO	Non-governmental organisation
NHA	National Health Account
NHPC	National Health Professions Council
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
PR	Public relations
PSI	Population Services International
QA	Quality assurance

QC	Quality control
QM	Quality management
R&R	Rules and regulations
RH	Reproductive health
RHC	Referral health center
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
SHINE	Somali Health and Nutrition Programme
SL	Somaliland
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 units
TOR	Terms of reference
UHC	Universal health coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
VCT	Voluntary counselling and testing
VHW	Village health worker
WASH	Water, sanitation and hygiene
WHO	World Health Organisation
WVI	World Vision International

FOREWORD BY H.E MINISTER OF HEALTH

The first Somaliland health sector strategic plan 2013 - 2016 ended in December 2016. MoH has developed the second edition of the Somaliland National Health Policy. The HSSP II has therefore been developed to operationalise the new health policy and the health sector component of the National Development Plan (NDP I) set for 2017 - 2021. The plan details the priority interventions as identified in the national health policy and national development plan. HSSP II acknowledges that resources are limited; hence as was the case in HSSP I, it is focusing on the implementation of the essential package of health services (EPHS) that will be made accessible to all people in Somaliland.

The development of the HSSP II has taken into consideration a wide range of policies, the new emerging diseases, the changing climatic conditions and issues of international health. The process also took into consideration the international treaties and conventions, especially the Sustainable Development Goals (SDGs) and the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness. The aim of reviewing policies and plans during the development of the HSSP II was to harmonise the strategic plan with the other existing sector and inter sectoral documents.

The development process of HSSP II involved the wider stakeholders in the health sector. This consultative and participatory process created the interest of all stakeholders to formalize partnership and contribute optimally in the implementation of the second phase strategic plan for Somaliland for the five years to come.

Most development plans fail because they have been developed simply for having a plan for its own sake, because they do not understand the external environment, because they are too long, complicated, and detailed, and because they have unrealistic goals given level of resources – they try to solve everything. We have avoided these mistakes and I hope that therefore this plan stands a better chance of being accomplished.

Finally, Somaliland Ministry of Health with the support of development partners will explore all possibilities to secure adequate funding and support to HSSP II. We will create an enabling environment for the effective implementation of the HSSP II prior to the realization of the intended objectives and targets set for the five years to come.

Sincerely,

H.E. Suleiman Ahmed Esse
Minister of Health, Ministry of Health, Somaliland

ACKNOWLEDGMENT BY THE DIRECTOR GENERAL

The second phase Health Sector Strategic Plan (HSSP II) 2017 – 2021 is the product of a long and complex process of intensive consultations, team-work on specific assignments, detailed studies and information gathering with the full engagement and participation of all stakeholders.

The Somaliland Ministry of Health is very grateful to everyone who contributed in the successful development of this strategic plan. The concerted effort of all MOH staff and other stakeholders is acknowledged. Special thanks go to Ms Faiza Ibrahim “**Director of Planning, Policy and Strategic Information**”, who was leading the whole process from beginning as overall coordinator of the HSSP II. I am also grateful to all task-force members for their active participation and contributions to HSSP II. Special thanks goes to **Mr. Saeed** who has been an active member of the taskforce.

I would also like to acknowledge the technical support provided by **IRIS Consulting Firm led by Mr. Gordon Mortimore**, who spearheaded the whole process of developing HSSP II and being the main architect and designer of the plan. Similar gratitude goes to WHO in providing the financial and technical support necessary for the development of HSSP II.

Finally, I would like to acknowledge the efforts of all those institutions and individuals who participated and contributed in the development of this document. These include Government Ministries and Agencies at Federal and Federal Members States, Development Partners, UN Agencies, NGOs, Civil Society and Private Sector.

My thanks to you all

H.E. Suleiman Derie Jama
Director General,
Ministry of Health, Somaliland

EXECUTIVE SUMMARY

A new environment is emerging in Somaliland health sector, resulting from the peace dividend along with the investment made by international partners. 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 Somalis 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 vision, the policy set the following mission statement:

“Ensure the provision of quality essential health and nutrition services for all Somali people, 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

- ✓ By 2021, reduce maternal mortality ratio from 732/100,000 in 2015 to less than 400/100,000
- ✓ By 2021, reduce <5 mortality rate from 137/000 in 2015 to less than 100/1000 live births
- ✓ By 2021, reduce Infant mortality from 85/000 in 2015 to less than 70 per 1000 live births
- ✓ By 2021, reduce neonatal mortality from 40/000 in 2015 to less than 35 per 1000 live births
- ✓ By 2021, reduce the number of children who are stunted by 15% from 12%
- ✓ By 2021, reduce incidence of TB from 285/100,000 per year to less than 250/100,000
- ✓ By 2021, increase the coverage of Pent 3 from 43% to 80%
- ✓ By 2021, increase skilled birth deliveries from 33% to 55%
- ✓ By 2021, reduce child wasting from 14% to less than 10%
- ✓ By 2021, increase contraceptive prevalence rate (CPR) to >15%
- ✓ By 2021, increase TB case detection rate from 42% to >70%
- ✓ 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.

The Strategic Plan has nine strategic priorities that need to be addressed to achieve the Mission of the Strategic Plan. These are based on the New Somali Health Policy and the National Development Plan. They are the broad areas of work that need to be addressed to accomplish the Mission. In order of priority, they are:

1. Revitalizing Health Services
2. Overcoming the crisis of human resources for health
3. Improving governance and leadership of the health system
4. Enhancing the access to essential medicines and technologies
5. Developing health management information system and research
6. Health financing for universal coverage
7. Improving health services' physical infrastructure and equipment
8. Health emergency preparedness and response
9. Promoting action on social determinants of health and health in all policies

Budget Summary

	2017	2018	2019	2020	2021
Recurrent	28,980,000	32,900,000	36,660,000	41,030,000	45,860,000
Developmental	49,550,000	34,280,000	60,060,000	66,280,000	71,280,000
Total	78,530,000	67,180,000	96,720,000	107,310,000	117,140,000

SECTION 1: BACKGROUND

1.1 Introduction

This Strategic plan covers the health sector in Somaliland for the next five years. The first Health Sector Strategic Plan (HSSP I) covered the period 2013/2016 and it guided the Somaliland health sector investment led by the Ministry of Health (MoH), Development Partners and other stakeholders over this period. Continuous monitoring through annual reviews were done to assess key achievements and challenges during the implementation of the HSSP I and this formed the basis for the development of the second phase health sector strategic plan (HSSP II) for the period 2017/2021. The HSSP II is developed in line with the Somali Health Policy (2014) and National Development Plan (2017-2019).

The new HSSP will guide the health sector investments for the next five years starting from January 2017 to December 2021. The HSSP II provides an overall framework for the health sector and its major aim is to contribute towards the overall development goal of the health sector of Somaliland by accelerating economic growth to reduce poverty as stated in the National Development Plan (NDP).

The Somali Health Authorities have also developed the first ever Somali National Health Policy (NHP I) endorsed by all Somali health authorities. The HSSP II has therefore been developed to operationalise the NHP I and the health sector component of the NDP I. The plan details the priority interventions as identified in the NHP I and NDP I. The HSSP II acknowledges that resources are limited; hence as was the case in HSSP I, it is focusing on the implementation of the essential package of health services (EPHS) that will be made accessible to all people in Somaliland.

The development of the HSSP II has taken into consideration a wide range of policies, the new emerging diseases, the changing climatic conditions and issues of international health. The process also took into consideration the international treaties and conventions especially the Sustainable Development Goals (SDGs) and the International Health Partnerships and related Initiatives (IHP+) which seek to achieve better health results and provide a framework for increased aid effectiveness. The aim of reviewing policies and plans during the development of the HSSP II was to harmonise the strategic plan with the other existing sector and inter sectoral documents.

1.2 Development Process for the HSSP II

In October 2016, the MoH constituted a Task Force (TF) 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 of the Somaliland MOH. 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. 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 regions within Somaliland. Development Partners, Civil Society and other Ministries were consulted and contributed to the process of developing HSSP II.

The HSSP II consists of seven sections. Section I 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 Somaliland 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.

1.2 Core Values and Principles

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

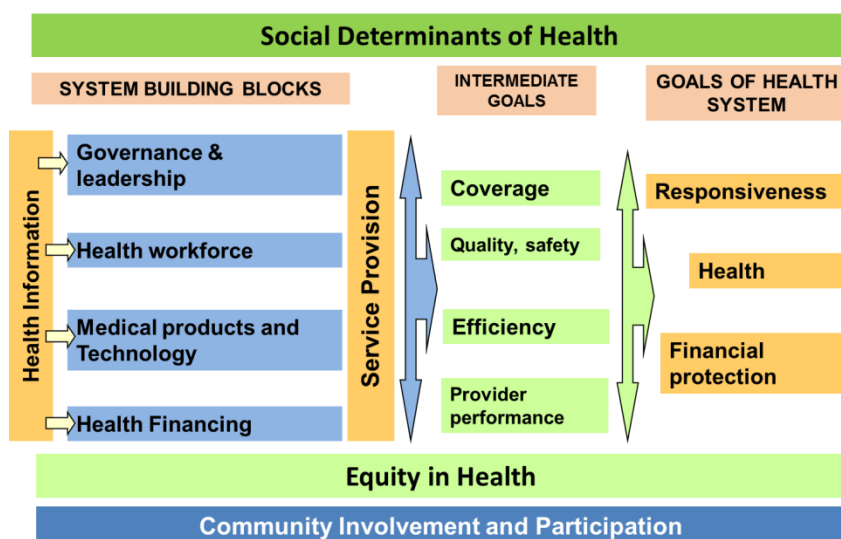
1. Universal and equitable access to acceptable, affordable, cost-effective, and quality health services with maximum impact on Somaliland populations' health to ensure the realization of the right to health
2. Effective, transparent and accountable governance and leadership in managing the different 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 promotes equitable access to priority health services.

1.4 Theory of Change Model

For the development of HSSP I (2013-16), the Health System's Six Building Blocks framework was used. However, to strengthen 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: 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.

Diagram 2: Factors influencing the reduction in child mortality in LMIC between 1990 and 2010



SECTION 2: SITUATION ANALYSIS

2.1 Overview

Somaliland is a low income country with clear disparities between regions, urban and rural communities, the poorest and the relatively rich classes. However, the peace dividend, along with investment by international partners, is bringing about a new environment for the health sector with potential for health improvement. Despite being one of the least developed countries, Somaliland aspires to become a middle income country by 2030. The Somaliland National Development Plan (NDP) (2017-2019) set out to ensure poverty reduction, balanced growth, and environmental sustainability. Priorities include actions that most directly influence the quality of life of poor people in terms of health, education, skill development, water and other social services, and ensuring social protection for vulnerable groups such as children with special needs, people with disabilities, older people, refugees and displaced persons.

The country has a population of about 3.5 million people. Life expectancy is 50 years for males and 55 for females¹. Fifty-five percent of the population is either nomadic or semi-nomadic, while 45% live in urban centres or rural towns, which include the capital city Hargeisa with an estimated population of 0.65 million, along with Burao, Borama, Berbera, Erigabo and Las Anod². The Somaliland NDP (2017-2019) noted that although there were no official population statistics on the percentage of young people, it is estimated that those under 30 constitute about 65-70 percent of the population. The NDP also pointed to high levels of refugees and internally displaced people (IDP).

Somaliland is not currently ranked in the UNDP Human Development Index, but data points to widespread poverty, particularly among certain groups such as IDPs and nomadic populations (HSSP I). Gender disparities, particularly in rural areas, with “extreme”³ gender inequality: limited access to education, early marriage, “universal” prevalence of FGM combined with low contraceptive use and high fertility has resulted in elevated risks of dying in pregnancy. Further factors contributing to poor health outcomes and inequalities include low investment in the health sector, lack of a transport infrastructure, low education levels, poor access to potable water and safe sanitation, poor nutrition, low population density (making provision of static health services costly), and limited health promotion combined with challenging lifestyle factors.

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, natural disasters and health emergencies such as drought and epidemics (WHO 2015).

Health outcomes in Somaliland, as in neighbouring Somalia, are poor (see Burden of Disease, and SO 1, below). 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 and SO 1, below).

¹ Government of Somaliland. Unrepresented Nations and Peoples Organization. 2017. Member profile Somaliland. Last updated: January 2017

² Somaliland government website: 2013 estimate <http://somalilandgov.com/somaliland-culture/>

³ Somaliland. Wasaaradda Caafimaadka. Ministry of Health Final Draft Health Sector Strategic Plan January 2013-December 2016 (Somaliland HSSP I draft)

Security gains have allowed engagement in development strategies and the building of governmental structures and processes (WHO 2015). Several important policies and plans have been developed, supported by development partners. Examples include the Somali Health Policy developed by the Ministry of Health, Somaliland, the HSSP I (2013-2016), and the EPHS Framework. At the same time, there has been 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/ Economic Recovery Plans and the Interim Poverty Reduction Strategy Paper (IPRSP) to ensure the health sector benefits from cross sectoral reforms.

This plan follows Somaliland's Health Sector Strategic Plan I (2013 -2016). In 2014, the Government of Somaliland developed the Somali Health Policy: The Way Forward; Prioritization of Health Policy Actions in Somali Health Sector with the nine policy priorities that inform this plan. The Somaliland NDP also includes guidance on priorities of the health sector. The current mechanisms for health sector coordination⁴ need to be considered in light of developments, ensuring that sector coordination is implemented in a decentralized way and reflects community needs.

Funding of the Somaliland health sector beyond 2016 is uncertain. A drop in overall funding is anticipated, due to the end of the largest health sector development programme, the Joint Health and Nutrition Programme (JHNP), in December 2016. However, funding for EPHS implementation 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 five 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 Health System Strengthening Building Blocks

The following is a brief situation analysis based on the HSSPI (2013-2016) building blocks (services, medicines, people, money, data and leadership) with additional analysis for humanitarian response/emergency preparedness and inequalities.

The situation analysis in this section and in Strategic Directions, below, has been based on participants' input in workshops (e.g. SWOT), the Somaliland Ministry of Health HSSP Review 2015 (Somaliland HSSP 2015)⁵, the WHO 2015 Strategic Review of Somali Health Sector: Challenges and Prioritized Actions (WHO 2015), MoH analysis of HSSP I performance indicators (MoH analysis 2016), Somaliland MoH's Department of Planning's (DoP) consideration of critical success factors and challenges in EPHS Implementation in Somaliland (MoHDoP 2016) and other demographic and epidemiological data and information identified in the text.

⁴The 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

⁵Somaliland Ministry of Health Department of Planning, Policy and Strategic Information (2015) HSSP Review.

Overview: As part of its review of HSSP I, MoH Department of Planning, Policy and Strategic Information identified the following key areas for future development:

- Accelerating the finalization of the National Health Act and enforcement of legislative Public Health acts
- Establishing the District Health Management system
- Strengthening the HR management system to include advancing HR database with linkages to HMIS
- Enforcement of standards for registration, accreditation and licensing of health professionals
- Acceleration of EPHS coverage to all regions
- Development of master plan for national tertiary care services and infrastructure masterplan including maintenance protocol
- Expansion of food-based interventions for under-nutrition high risk populations including the PPP social marketing programmes

2.2.1 Services

Burden of Disease (BOD): Due to decades of civil war, many health indicators are very poor. The BOD in Somaliland is dominated by communicable diseases, reproductive health and under-nutrition. Non-communicable diseases and mental illnesses are also on the rise. The health situation is one of the worst in the world. The country 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 Somaliland and its comparison with the average of Sub-Saharan Africa are presented in table XX.

Table 1: Health and nutrition-related MDG indicators, 2009 – 2010⁶ and 2013-14⁷

Health and Nutrition-Related MDG Indicators	Somaliland		Sub-Saharan Africa	
	2009-10	2013-14	2009-10	2013-14
MDG 1: Poverty and Hunger				
% under-5 children malnourished (underweight)** ⁸	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

⁶Sources for 2009-2010: UNICEF Somalia Statistics (2010); World Bank Millennium Development Goals Global Data Monitoring (2010)

⁷Sources 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)

⁸ ** 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%

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

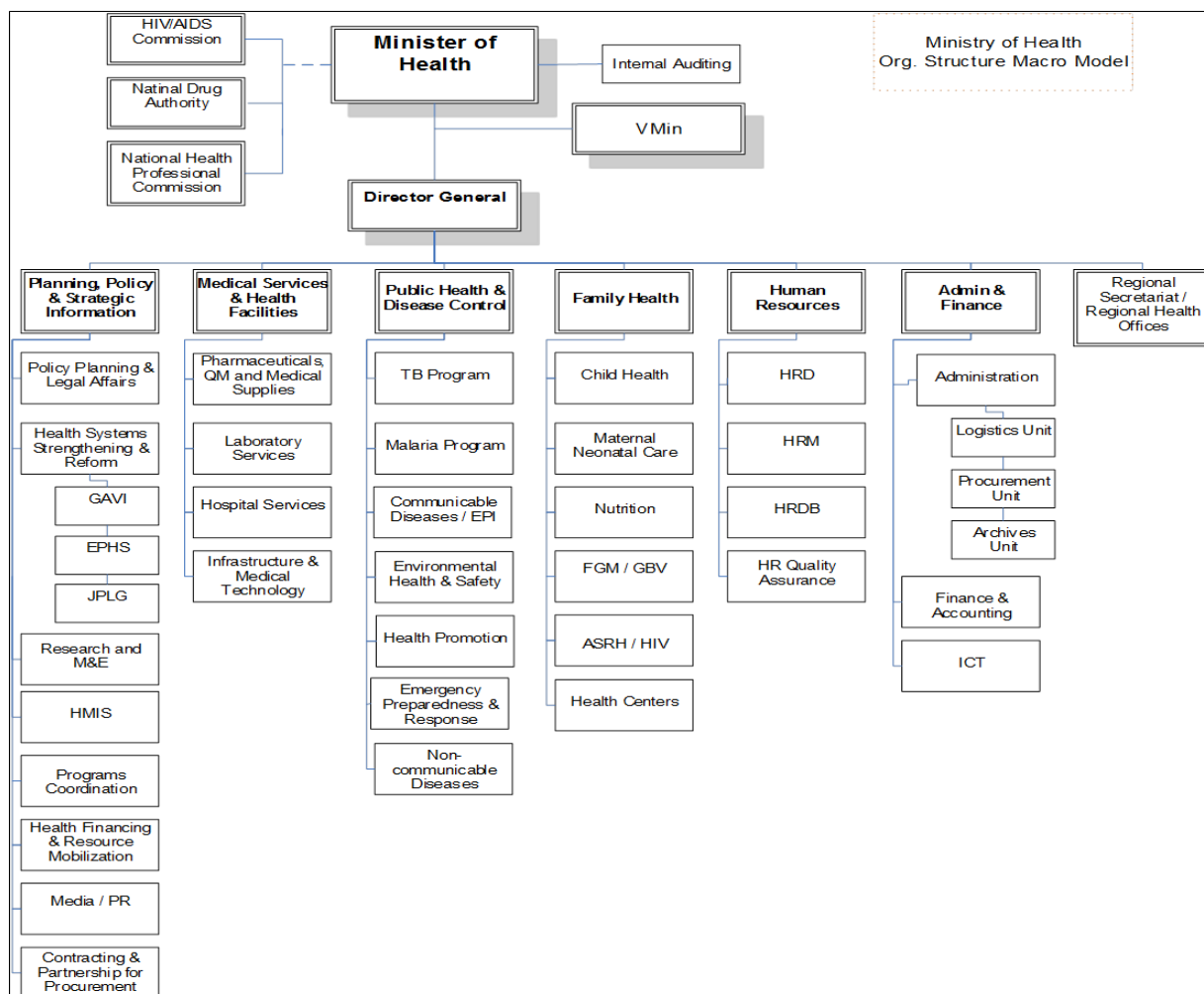
However, a new environment is emerging. Maternal mortality ratio and under five mortality rates, which remained unchanged at a very high level for about two decades are showing slow but persistent declining trends (WHO 2015).

Health service delivery: Health service delivery is structured around the EPHS framework. Implementation of EPHS has not been uniform and covers only four of the six regions, due to factors such as limited resources. Regulatory systems are required to address quality of care and patient safety concerns. Initial actions have been taken to establish national health professions' councils. However, despite challenges, MoH has delivered many improvements, in a relatively short period to improve facilities and standards of staff performance, implement the essential drug list, increase vaccination rates and in-facility deliveries with skilled attendants, which has had a positive effect on maternal, neonatal and young child survival.

In Somaliland, developments in human resources for health (HRH) have included a functional review, an important step in ensuring the MoH is fit for purpose. Figure 1 outlines the MoH organizational structure⁹.

Figure 1 Somaliland MoH Organogram, 2015

⁹ Somaliland. MOH (2015) Somaliland MOH Organizational Manual (Final)



Health infrastructure: The 2016 Service Availability and Readiness Assessment (SARA) findings 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. In Somaliland, achievements include offices have been established at central, regional and HF levels. Cold chain has been established centrally and in three regions. An infrastructure report is available.

2.2.2 Medicines and supplies

Following the fall of Somalia's central government in 1991, public medicine supply systems collapsed. Currently, a range of donors, agencies and NGOs operate parallel supply chains, largely as pre-packed kit systems, but with limited coordination, accounting for only 20–25% of total need (WHO 2015).

Progress: The essential medicines programme is in its infancy and requires a considerable support to establish key components. However, Somaliland has made achievements here including a National Drug Regulatory Authority and an established and functioning central

warehouse. Supply chain management and LMS systems are functional. No vaccine stock-outs were recorded in 2015. Cold-chain equipment has been procured.

Challenges: More support is needed to ensure the safety, quality and efficacy of medical products, particularly in relation to the private sector, a major supplier of medicines. Implementation of the supply chain management master plan needs substantial additional funding. The existing kit-based push system often results in both stock-outs and oversupply of medicines and equipment. Rational use of drugs has not been introduced and over-prescription is widespread. Inadequate procurement, inventory, storage, management and distribution systems, along with lack of accredited training curricula for pharmacists compound the challenges.

2.2.3 Human resources for health

Progress: A skilled workforce is central to effective healthcare. Somaliland has made progress in a number of areas, including improved HR planning and management, development of a five year HR Strategy, a basic HR database although a more advanced HRMIS is yet to be in place, an in-service training plan, standards for health training institutions and curricula have been developed for MBBS, nursing, midwifery and lab staff. Standards for registration, accreditation and licensing of health professionals have been established, although are not yet enforced.

MoH considered that the numbers of skilled health professionals were sufficient to implement the EPHS. Twenty per cent of rural health facilities have skilled Health Workers (HWs) according to data from the Health Worker survey. One nutrition and public health training institutions have been established. Training needs assessment and CPD were underway at time of review, along with development of HR manuals and guidelines. Some skilled health workers (doctors) in rural and nomadic areas receive incentives. All public health sector workers have a contract and a job description. Some staff had annual appraisals. A health workforce survey was undertaken, although data in such surveys are not always up to date.

Challenges: Despite these achievements, challenges remain. The health workforce has shortages in all cadres. There were both low density and numbers of doctors, nurses and midwives, with Somaliland's overall density is under 3 per 10,000 population, much below the threshold level of 23 per 10,000 defined as critical shortage. The overwhelming majority of facility based health personnel are concentrated around urban centres rather than rural and hard-to-reach communities.

Although health professional education capacity is gradually improving and new programmes are being introduced, a lack of on-going professional development for the health workforce, resulting from poor infrastructure and limited faculty capacity, contributes to poor quality services. At the same time, private education institutions are increasing, along with quality concerns due to lack of regulation.

Health expenditure is low and mainly allocated to salaries, which are still not sufficient. Staff retention is problematic due to lower incentives than the private sector. The WHO review (2015) noted the need to increase budgets and fiscal space for salaries of health workers through national and external resources.

2.3.4 Health Financing

Health financing has been extremely limited due to the country's poor economic performance. Health sector resources are mainly through out-of-pocket (OOP) payments,

donor funding and the diaspora. At US\$10-12 per capita, annual public expenditure on health is far below the global standard for health sector investment (WHO 2015), which increases the risk of financial burden, particularly on poor people with higher OOP expenditure.

There has been a significant increase in health sector funding over the past decade, although there are indications of donor fatigue in humanitarian funding. External financing greatly exceeded governmental contributions to the health sector. In Somaliland, government contributions to health sector funding are at five per cent. Although this did not meet the HSSP I target of 12 per cent, the amount of government funding has increased substantially since 2007-09 (WHO 2015). In Somaliland, 11 out of 19 districts have access to basic health services.

The Somaliland review of HSSP I achievements pointed to completion of a PFM assessment and health expenditure review, along with contracting assessment and a costing exercise. MoH finance staff has been trained on health financing. A resource mobilization strategy has been produced.

However, challenges include limited institutional capacity to collect and allocate locally sourced funds to health; a finance gap to ensure service provision to the remaining population, along with mechanisms to reduce OOP health expenditure; lack of up-to-date data on health financing, including OOP expenditure; an urgent need for public financial management (PFM) reforms in the health sector aligned to wider 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). In Somaliland, National Health Accounts are yet to be established and cost sharing and reporting systems are weak.

3.2.5 Health Information and research

Accurate, up-to-date information is essential for planning, delivery and review of effective services. Data disaggregated by factors such as gender, age and location can allow targeted interventions to reduce inequalities. Effectiveness of service provision can be enhanced by involving communities in development of data and information (e.g. through participatory needs assessment). The health information system (HIS) faces enormous challenges but progress has been made.

HMIS: The Somaliland HMIS is functional at central, regional and health facility (HF) levels, staff are trained and HMIS reports are shared regularly to all partners. Reports from health facilities show greater than 90% timeliness and completeness. Integrated Disease Surveillance and Response (IDSR) and nutrition surveillance system are included in the HMIS, but TB is not yet integrated and there is parallel TB and polio reporting by international partners (IPs). Rollout is underway of the District Health Information System (DHIS2), which has been delayed.

National surveys and census: The 2011 multiple indicator cluster survey (MICS) covered Somaliland. 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 analysed.

Independent monitoring and evaluation/ Operational research: An M&E framework and plan for HSSP has been developed and there is improved capacity in the M&E and Research Unit. Quarterly reviews and three Joint Annual Reviews (JARs) have been conducted. A research agenda and committee have been endorsed. An MMR study was conducted in Somaliland in 2013-14.

Births and deaths registration: Standard vital registration (VR) tools and protocols have been developed and implemented in six districts. Somaliland's coverage for birth registration among children under-5 (MICS 2006) was estimated to be seven per cent. VR is not yet integrated into the HMIS.

2.2.6 Leadership and Governance

The WHO review (2015) pointed to leadership strengths, including the Somali Health Policy (2014) and related policies and plans, 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 decentralization at all levels, and insecurity in many regions.

Planning: Somaliland reviewed progress in relation to HSSP I and reported achievements including undertaking drafting of the National Health Act, as well as disease specific plans. The National Health Professions Council (NHPC) Act has been approved and the Public Administration Law drafted. Challenges remain, including lack of capacity and weak decision-making and documentation.

Coordination: Health sector coordination takes place at Nairobi level, and UN, donors and NGOs coordinate activities through regular forums. However, duplication and absence of services are both common due to lack of effective coordination and Government leadership. Health sector coordination has been improving in Somaliland at central and regional level (WHO 2015). The Regional Health Management System (RHMS) has been strengthened with three Regional Health Boards involving local authorities, communities and Community Health Committees (CHCs). Regional coordination units are functioning. District health boards (DHBs) have been established in more than 24 districts. Three JARs have been undertaken and Somaliland conducted a review of HSSP I with the WHO.

Institutional capacity: Somaliland has initiated establishment of a legal framework for health, although the process has stagnated due to lack of capacity and resources. Health regulations remain a major issue. Decentralization is widely supported, but continues to face challenges due to limited local capacity and generally weak administrative systems. Leadership and management plans are included in the HR in-service training plans and 5 year strategy (MoH analysis 2016). Support is needed to strengthen institutions through in-service and on-the-job training in leadership and governance.

Structure: Following review an organizational structure for the MoH that fits the policy objectives has been proposed and job descriptions drafted and endorsed (WHO 2015). However, the functional review undertaken does not reflect regional and district levels and implementation is slow.

Community participation: There has been improvement in citizen engagement in the management and financing of health services. However, there has not been a conclusive report on citizen participation and government legitimacy, nor on diaspora participation (HSSP I performance framework analysis), and implementation of the community strategy is weak.

Emergency preparedness: Emergency and humanitarian activities dominate the sector. Partnership and contracting capacity are lacking. Weak accountability and transparency are among the key challenges of the health sector throughout the country.

2.2.7 Humanitarian response and emergency preparedness

The Somali emergency 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). At present, about 2 million people are in need of humanitarian aid inside Somaliland. During 2015, around 2.8 million people were targeted through planned humanitarian aid, and health relief operations provided access to life-saving primary health care services to enhance resilience during humanitarian crises and emergencies.

Somaliland reports establishment of its emergency preparedness and response unit (NERAD), along with central government commitment and budget allocation. However the Government also reports an ad hoc response, inadequate supplies of safe blood in all regions, minimal sentinel surveillance sites, lack of funding, no reference lab and a lack of emergency buffer supplies in regional warehouses.

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. A 'health cluster' coordination mechanism aims to address needs in health, nutrition, and water, sanitation and hygiene (WASH).

2.2.8 Inequalities

The WHO review noted that the Somali people currently have some of the lowest development and humanitarian indicators in the world, and inequalities across social groups – a major driver of conflict – have been widening. While health outcomes for the country as a whole are poor, some groups (e.g. women) and areas (e.g. isolated rural areas) have worse outcomes. For example, female genital mutilation/cutting (FGM/C) can have serious implications for safe childbirth and maternal mortality.

Many factors – or determinants – that affect people's health are outside the health sector's remit (such as poverty, education, rural isolation, gender, disability, nutritional status, transport infrastructure, access to potable water). However, there is much that the health sector can do to tackle these issues and help to reduce inequalities, including use of reliable data disaggregated by factors such as sex, age and location to target resources to areas that need it most. Meaningful engagement of civil society in planning, delivery and review of services can help ensure services effectively meet the needs of all. Working in partnership across sectors with an impact on health can multiply health sector impact.

Somaliland had established a Communication for Development Unit (C4D) to help coordination of communications, developed a national plan, and has produced an Infant and Young Child Feeding (IYCF) strategy and implementation plan and undertaken a knowledge, attitudes and practices survey (KAPS). However, lack of harmonized messages and guidelines on health promotion, low literacy levels, limited resources and challenging socioeconomic factors are ongoing challenges.

SECTION 3: STRATEGIC DIRECTIONS

The Somaliland vision, mission and goal are derived from the Somali Health Policy: The Way Forward¹⁰ (2014). They aim to contribute to achievement of national development goals as well health-related SDGs. They were developed using the criteria of the Joint Assessment of National (Health) Strategies.

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 137/1000 in 2015 to less than 100/1000 live births
3. By 2021, reduce Infant mortality from 100/1000 in 2015 to less than 70 per 1000 live births
4. By 2021, reduce neonatal mortality from 40/1000 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% in 2015
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% in 2015 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% in 2015 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)¹¹

¹⁰Somali Health Policy: The Way Forward. Prioritization of Health Policy Actions in Somali Health Sector. Approved by the Health Advisory Board September 2014.

¹¹ For full details of wording of policy priorities, see section 5 and Annex 1, 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 (UHC)
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, measurable, achievable, realistic and time-bound (SMART).

SECTION 4: HEALTH SECTOR POLICY AND PRIORITIES

This section covers the nine strategic priority areas 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 annexe

Equity – an overarching approach

Based on the Somaliland NDP's principle of fairness and this plan's vision 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 and information 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 services.

Table 2 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 2 GESI in HSSP II

HSSP II Strategies	GESI component
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1. Essential health services	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • The MoH will try to ensure that medicines and consumables which are donated are done so based on need and equitably
5. Health Information	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • GESI- responsive budgeting will be phased in
7. Infrastructure	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Develop collaborative approaches to intersectoral working to ensure the determinants of health are tackled in all relevant sectors

4.1SO1: Scaling up of essential and basic health and nutrition services

4.1.1 Situation Analysis

Burden of Disease: The Somaliland 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 30,000¹² 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 groups¹³.

Life expectancy is estimated to be 50 for males and 55 years for females¹⁴. One in 7 children dies before their fifth birthday. Infant mortality in Somaliland was 100 per 1,000 live births. 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 (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 births¹⁵ – an improvement since 1990, when the figure was 1210 per 100,000 live births¹⁶, but still poor compared to Kenya (510) or Ethiopia (353) in 2015. Under-5-mortality rate was 137 per 1000 live births¹⁷ 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). Female genital mutilation/cutting (FGM/C) is “universal”¹⁸, 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.

Service Delivery

The way in which health services are organized and managed has a significant effect on how well they serve the needs of the population. Service delivery can be defined as the way that inputs are combined to allow the delivery of a series of interventions or health actions. Service delivery is the chief function that the health system needs to perform (WHO World Health Report, 2000). The service delivery system is where the forces of supply and demand for health care meet, and the point at which all the resources and norms come together to be transformed into curative, preventive, promotive, and rehabilitative services.

¹²<http://www.emro.who.int/som/programmes/tb.html>

¹³http://www.unaids.org/sites/default/files/country/documents/SOM_narrative_report_2014.pdf

¹⁴Government of Somaliland. Unrepresented Nations and Peoples Organization. 2017. Member profile Somaliland. Last updated: January 2017

¹⁵Gavi (2016) Joint Appraisal Report – Somalia 2016

[file:///C:/Users/user/Downloads/Somalia%20Joint%20Appraisal%202016%20\(1\).pdf](file:///C:/Users/user/Downloads/Somalia%20Joint%20Appraisal%202016%20(1).pdf)

¹⁶<http://data.worldbank.org/indicator/SH.STA.MMRT>

¹⁷Inter agency estimates http://www.childmortality.org/index.php?r=site/graph#ID=SOM_Somalia

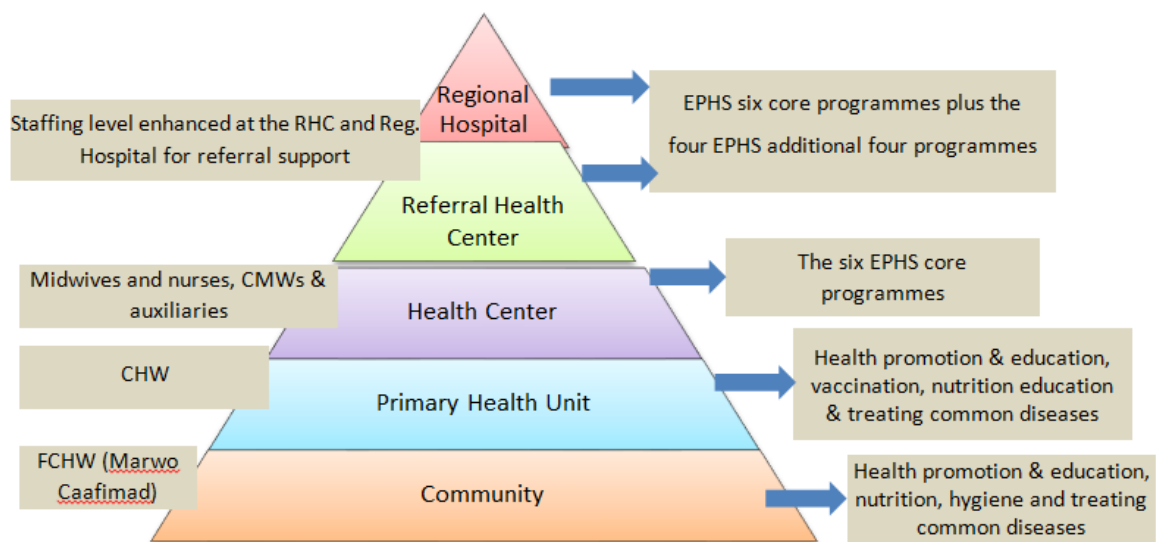
¹⁸ Somaliland Wasaaradda Caafimaadka. Ministry of Health. FINAL DRAFT Health Sector Strategic Plan (January 2013 – December 2016)

Somaliland has established the EPHS as the foundation for service delivery. As well as network of public sector health facilities with defined service packages, guidelines, and protocols at each health facility level exists to meet the health needs of Somaliland's population. This network is structured as a pyramid with referral hospitals at the apex followed by referral health centre, health centres, public health units and community interventions. The health centres, in turn, supervise health posts and community health workers, and other community-based activities.

In addition, at the central level there are specialized programs and technical working groups to provide high-level policy and technical guidance coordinated to further enhance effectiveness of the existing health facility service-provision system. The Ministry of Health's structures and departments oversee and support the different service provision levels to ensure accountability and delivery of real-time, quality health care services.

EPHS: The EPHS programme serves as a foundation of the Somaliland health system. It identifies the effective interventions to be made available at each of the four tiers of the health care system – health posts (Primary Health Unit [PHU]), Health Centres, Referral Health Centres/District Hospitals, and Regional Hospitals. EPHS identifies the cadre of health worker, required equipment and diagnostic services, and medications required to provide the services at each level (MoH DOP 2016). It is divided into 10 programmes¹⁹ of which six are provided at all levels and four are provided only at the referral levels²⁰. All levels should provide some elements of the EPHS, although this is not followed in practice. Figure 1 presents the regional health system (WHO 2015). The MoH Department of Planning has identified use of the EPHS framework to inform all planning as a critical success factor.

Figure 1: The Regional Health System Organization, Staffing and Performance functions



Source: Somali Health Policy, 2014

¹⁹ 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)

²⁰Essential Package of Health Services, 2012. UNICEF. Nigel Pearson and Jeff Muschell

In its 2015 review of HSSP I, the Ministry pointed to EPHS being provided in three out of six regions. By 2016, MoH reported EPHS in four out of six regions – Togdheer, Shali, Awdal and Sanaag – excluding El'afwein, Badan and Dahar, although only core components one and two have been implemented. A referral system has been established, although it is limited. Expanded Programme on Immunization (EPI) outreach ('reaching every district' – RED strategy) has been implemented in regions where there is no EPHS, and the Basic Nutrition Services Package (BNSP) in some non-EPHS areas. Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) and Basic Emergency Obstetric and Neonatal (BEmONC) have been established in regional hospitals and health centres of Sool and Sanaag respectively. CEmONC in Boramahas been significantly delayed. MoH analysis of the HSSP I performance states that the SARA review found 56% of facilities ready and able to provide basic services. The MoH pointed to integration of vertical programmes (HIV and TB) into EPHS.

The Communication for Development (C4D) Unit has been established to support coordinated communication of health messages, and the National C4D and Infant and Young Child Feeding (IYCF) strategy and work plan have been developed, with implementation underway. Food-based interventions for prevention of under-nutrition of high risk populations are in place and the food fortification programme is being implemented, along with social marketing of micro-nutrient rich foods and supplements through the private sector. Integrated school health and nutrition programme (including adolescent SRH) are yet to be implemented in 40 per cent of schools. A KAP Survey has been produced, although there have been delays in follow-up. The Infrastructure Masterplan including maintenance protocol is yet to be completed.

The Emergency Preparedness and Response Unit has been established, although emergency response strategies (including emergency medical services and referral health centres) remain ad hoc. There are inadequate supplies of safe blood in all regions. The Environmental Health Unit is not fully operational, but MoH reports that through the waste management policy, local governments are making improvements.

Regulation: Quality and patient safety concerns have highlighted the need to establish regulatory systems. Initial actions have been taken to establish national health professions councils, while developing policies and systems to regulate health professionals. Immediate challenges are to build institutional capacities, adopt policies, and registering and licensing all health professionals (WHO 2015).

Service density: the WHO review (2015) found that across Somaliland, health facilities density is 1.1 and average hospital bed density is also 1.1 per 10,000 population. Available data suggests under-utilization of facilities. It is estimated that 5% of people living with HIV/AIDS are on ART (2013, HMIS) and the success rate for smear positive TB treatment cases is 89% (2013)²¹.

Table 3: Distribution of the health facilities in Somaliland²²

²¹Somalia Health Sector Situation Analysis, WRO Somalia, 2015

²²WHO 2015. Based on calculations from different sources

	Somaliland	
	#	per 10,000
Health post	164	2
MCH	109	3
Hospitals	23	15
Total	269	1

Community Level Services: There are 2only community health cadres recognised by the community health strategy (e.g. female health workers [FHWs], CHWs)²³, – with its a framework, job descriptions, training curricula and administrative systems and therefore have the highest potential to grow and provide forthcoming 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 (WHO 2015).

Private health care: The private sector is a key player in the health sector, having grown significantly over the past two decades at all levels. Many donors channel their health sector contributions through an implementing partner, usually by contracting private providers to deliver EPHS. 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).

Conclusions: Challenges to implementation of EPHS in Somaliland include its high intervention cost and the fact that its delivery remains largely dependent on external donor resources without a long term plan for sustainability. Delays and gaps in implementation of service contracts exist between UN and implementing partners with no government control. There is potential instability in staffing due to funding uncertainty. Supervision is not conducted or inadequately supported. Mobile teams are not adequate and need fully functional clinical teams with wider services than EPI and nutrition. Implementation of the RHC surgical units has not been achieved. Institutional bottlenecks prevent finalizing of planned activities.

In considering key success factors for delivery of EPHS, the Ministry's Department of Planning concluded that in Somaliland, an under-funded, silo approach to implementing EPHS with an incomplete set of interventions undermined the potential of the EPHS pilot rollout (MoH DoP 2016). The analysis also identified flexibility – while remaining in line with the EPHS framework – as critical to achieving maximum impact, taking account of differences in services caused by the status of available health facilities, and cultural and security factors. Flexibility is required in terms of both design and the availability of resources for successful programme implementation and sustainability. It is important to work with RHBs and CHCs to raise community contributions towards health services, developing creative means of income generation from services and health facility premises. Working with local actors (e.g. TBAs as MNH promoters) using a variety of community activities can create awareness of and demand

²³Somali Community Health Strategy. WHO Ref Number 2014/413682-0. 2014

for services. Working with local community groups can help to address GESI issues to build on the framework of EPHS services (MoH DoP 2016).

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 services²⁴. Such assessments are also a reflection of people's low level of expectations (WHO 2015).

Key challenges identified in the WHO report include:

- Despite the EPHS focus on quality, there are no quality assurance standards, 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, uncoordinated MoH community level services resulting in overlapping or gaps in services
- Current broad-scope community health cadres are not sustainable. It is important to apply the standardized approach that will provide cost effective services for women and children particularly in underserved districts
- Ongoing training is needed for CHWs 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 the MoH.

Table 4: SWOT analysis for SO1 Scaling up of essential and basic health and nutrition services (EPHS)

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ Four out six regions implementing EPHS framework (excluding El'afwein, Badan and Dahar) ✓ Integration of BNSP/EPHS ✓ Integration of vertical programmes (HIV/AIDS & TB) into EPHS ✓ CEmONC & BEmONC established in RHs & HC in Sanaag/BEmOC in Sool ✓ BNSP implemented in some districts where there is no EPHS ✓ EPI outreach (RED Strategy) implemented in regions where there is no EPHS 	<ul style="list-style-type: none"> ✓ Tertiary care services implemented in ad-hoc fashion ✓ Integrated schools health and nutrition programme (including adolescent SRH) yet to be implemented in 40% of schools ✓ Delays in follow-up KAP Survey (2015) ✓ Referral systems weak if at all established ✓ Supervision not conducted and/or inadequately supported ✓ EPHS not fully implemented ✓ Only implemented core components 1 and 2 	<ul style="list-style-type: none"> ✓ Plans underway for EPHS rollout to Sanaag & Buhoodle ✓ Mother and child services free for clients ✓ Partial expansion and operationalisation of PHUs ✓ Utilization of Community Health Committees and RHBs ✓ Increased facility based deliveries and larger service utilization ✓ Human resource development and expansion including 	<ul style="list-style-type: none"> ✓ EPHS largely dependent on external donor resources without long term sustainability plan ✓ High intervention cost of EPHS ✓ Delays and gaps in implementation of service contracts between UN and implementing partners with no government control ✓ Potential for large staff resignations

²⁴Review of the implementation of the essential package of health services. Nigel Pearson & Saba Khan. 2013

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ A master plan for national tertiary care services underway ✓ KAP Survey published ✓ Food based interventions for the prevention of under-nutrition high risk populations ✓ Food fortification program implemented ✓ Social marketing of micro-nutrient rich foods and supplements through private sector 	<ul style="list-style-type: none"> ✓ Mobile teams not adequate and need to be fully functional medical/clinical mobile teams with wider services than EPI and nutrition ✓ Implementation of the RHC surgical units not done ✓ CEmONC not implemented in Borama: significantly delayed ✓ EPHS largely dependent on external donor resources without long term sustainability plan ✓ Institutional bottlenecks in finalizing planned activities 	<ul style="list-style-type: none"> trainings and remuneration packages for support ✓ Referral system established although limited 	<ul style="list-style-type: none"> due to lack of funding

4.1.2 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

4.1.3 Strategic priorities and activities²⁵

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 Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) and expand EPHS into the remaining two regions.
- 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 Implementation 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

²⁵Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

- 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 Somaliland
- 1.3 Specialised interventions for non-communicable diseases (see also SO9.2)**
- 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 standardized 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 (see also SO 9.2)**
- 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 programmes including family planning, FGM, 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 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 in one other region
 - 1.6.5 Sustain integrated prevention, treatment and care services for HIV/AIDS patient (6 VCTs)
 - 1.6.6 Implement at least 4 rounds of national immunization days (NIDs) for polio
 - 1.6.7 Implement EPI outreach services in 19 districts
 - 1.6.8 Implement two round of measles catch-up campaign
 - 1.6.9 Integrated reproductive health outreach in all regions of Somaliland
 - 1.6.10 Integrated health & Nutrition mobile teams to implement IMAM (OTPS) in all regions of Somaliland

4.2 SO2: Overcoming the crisis of human resources for health

4.2.1 Situation Analysis

A skilled workforce is central to effective healthcare. Despite formidable challenges in human resources for health, Somaliland has made progress in a number of areas. In its analysis of achievements during HSSP I period MoH pointed to improved HR planning and management and development of a five year HR Strategy. In terms of staffing levels, MoH considered that numbers of skilled health professionals were sufficient to implement EPHS. Twenty per cent of rural health facilities have skilled Health Workers (HWs) according to data from the HWF survey.

There is an in-service training plan, and standards for health training institutions and curricula have been developed for MBBS, nursing, midwifery and lab staff. One nutrition and one public health training institution have been established. Training needs assessment and CPD were underway at time of review, along with development of HR manuals and guidelines. Standards for registration, accreditation and licensing of health professionals have been established, although are not yet enforced. Some skilled health workers (doctors) in rural and nomadic areas receive incentives.

There is a basic HR database, although a more advanced HRMIS is yet to be in place. A functional review of the SL health workforce has been completed. All public health sector workers have a contract and a job description. Some staff had annual appraisals. A health workforce survey was undertaken, although due to delays, data in such surveys are not always up to date.

Despite these achievements, challenges remain. The health workforce is characterised by serious shortages for all cadres, including specialist physicians (WHO 2015). There were both low density and numbers of doctors, nurses and midwives, with the overall density remaining at 3 per 10,000 population, much below the threshold level of 23 doctors, nurses and midwives per 10,000 population, defined as critical shortage (see table 5). As noted in SO 1, above, there is an unsustainably large number of cadres at community level.

	Somaliland	
	Number	Density/10000 pop
Doctors	111	0.3
Nurses	789	2.2
Midwives	165	0.4
Total	1,065	3

Source: estimates from MoH 2014 (WHO 2015)

Although limited in scope and numbers, health professional education capacity is gradually improving and new programmes are being introduced. However, a lack of on-going professional development for the health workforce, with poor infrastructure and limited faculty capacity, contributes to poor quality services. In Somaliland, numbers of enrolled students were 429 medical, 395 nursing and 151 midwifery (WHO 2015). At the same time, private education institutions are increasing, although the lack of regulation of these has raised quality concerns. In Somaliland, the MoH does not recognize private training institutions and does not employ their graduates. Dual practice is common and the private sector offers additional job opportunities for public sector health workers, especially for physicians, most of whom engage in private practice during office hours with a high level of absenteeism.

The overwhelming majority of facility-based health personnel are concentrated around urban centres rather than rural and hard-to-reach communities. In Somaliland, accommodations and incentive programmes for skilled HWs in rural and nomadic areas have not been established, although some skilled health care workers (e.g. doctors) in rural and nomadic areas do receive incentives.

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 low and often released after long delays. Posts provided by the civil service commission are generally not sufficient to employ all available trained health professionals. The MoH of Somaliland did not receive any new posts from the Civil Service Commission in 2015. 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 for expatriate physicians risk a dependency on external resources, reducing the involvement of MoH in decision-making, and sustainability concerns.

Table 6: SWOT analysis for SO2 Overcoming the crisis of human resources for health

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ Improved Human Resources Planning and Management ✓ Sufficient number of skilled health professionals to implement EPHS ✓ Basic HR management system established ✓ In-service training policy underway: Training needs assessment and CPDs inclusive ✓ Development of HR Manuals and guidelines underway ✓ Functional Review of SL Health workforce completed ✓ Standards for health training institutions and curricula for key programmes developed (MBBS, nursing, midwifery, lab) ✓ 1 Nutrition and 1 public health training institution established ✓ Some skilled health workers (doctors) in rural and nomadic areas receive incentives ✓ 20% of rural health facilities have skilled HWs (conclusive data in the just completed HWF survey) ✓ Standards for registration, accreditation and licensing of health professionals established ✓ Civil servant volume increased and salaries increased by 10% by 2017 	<ul style="list-style-type: none"> ✓ Advanced HR database yet to be established ✓ Not all public-sector health workers have contract/JD/ receive annual staff appraisals ✓ Staff incentives and allowances are not harmonised across programmes ✓ Registration, accreditation and licensing standards for health professionals not yet enforced ✓ Inadequate ratio of doctor and midwives ✓ Lack of mid-level training opportunities at regional 	<ul style="list-style-type: none"> ✓ Large pool of skilled civil servants ✓ Disbursed manpower across the country ✓ NHPC and association bodies available ✓ Universities and training institutions available 	<ul style="list-style-type: none"> ✓ Limited implementation of appraisal and motivational opportunities ✓ Brain-drain and loss of skilled manpower ✓ No pension scheme ✓ No occupational health programme ✓ Staff retention problematic especially in rural and hard to reach areas

4.2.2 SO 2: Overcoming the crisis of human resources for health

To develop a **health workforce** that addresses the priority health needs of Somaliland population, which is adequate in number, well trained, equitably distributed and

motivated to provide essential health services

4.2.3 Strategic priorities and activities²⁶

2.1 Improved Human Resource policy, planning and management

- 2.1.1 Implement equity-focused Human Resource In-service Development and Management Plan
- 2.1.2 Develop GESI-sensitive performance appraisal systems and implement
- 2.1.3 Hire HR officers for the 19 districts
- 2.1.4 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, midwives, medical engineering and mental health practitioners 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 Enhance electronic employee database
- 2.3.2 Register and license at least 50% of health professionals
- 2.3.3 Strengthen HRMIS and ensure linkage to HMIS/DHIS2 disaggregated by factors such as gender, cadre, location, training
- 2.3.4 Health workforce at all levels having (on budget) system of salaries, incentives and allowances
- 2.3.5 Identify staffing gaps at all facilities across all levels based on SARA data
- 2.3.6 Review, revise and standardise salaries, incentives and allowances

2.4 Availability of standardized training guidelines, material and protocols

- 2.4.1 Implement in-service training guidelines, material and protocols and translate into Somali
- 2.4.2 Develop training impact assessment tool and feedback mechanism

2.5 Implementation of in-service training plan

- 2.5.1 Conduct short courses on anaesthesia, ICU, emergency surgery, neonatology, forensic medicine, mental health and NCD management for doctors and nurses
- 2.5.2 Conduct training of first line health workers in line with the training plan

²⁶Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

2.5.3 Implement internship programme for newly graduated students

2.6 HR monitoring, evaluation and coordination

2.6.1 Supervise health workforce at all levels

2.6.2 Conduct monthly HRH task force meeting

4.3 SO3: Improving governance and leadership of the health system

4.3.1 Situation Analysis

Governance refers to —strategic policy frameworks that are combined with effective oversight, coalition building, regulation, attention to system design, and accountability—and the provision of appropriate regulations and incentives. Although there have been important achievements, such as the Somali Health Policy (2014), capacity building and improved coordination, major challenges remain. These include limited institutional capacity, a weak culture of accountability and transparency, limited capacity for ensuring effective decentralization at central, regional levels, and insecurity in many regions.

Policy and planning: The WHO review (2015) pointed to leadership strengths including development of the Somali Health Policy (2014) by the Ministries of Health in Somaliland. In addition Somaliland produced the HSSP I (2013-2016), with strategic objectives and high-level indicators for review, and emergency preparedness at the centre of plans. The HSSP is functionally linked to the Somali Compact and New Deal through the Somaliland Special Arrangements (SSA), with efforts placed on aid effectiveness. Somaliland reported partial achievement of HSSP I policy and planning goals, including undertaking drafting of the National Health Act, as well as disease specific plans. The National Health Professions Council (NHPC) Act has been approved and the Public Administration Law drafted. Legal affairs have been integrated with the DOP policy and strategy section.

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.

Coordination: Well established coordination of the health sector takes place at Nairobi level and going forward the coordination will take in Somaliland (in country structure). 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.

There is active health sector coordination in Somaliland (WHO 2015), with MoH reporting good links from central to regional level. The Regional Health Management System (RHMS) has been strengthened with three Regional Health Boards (RHBs) involving local authorities, communities and Community Health Committees (CHCs). Coordination units have been established and are functioning at regional level. District health boards (DHBs) have been established in more than 24 districts. In its identification of critical factors for success, the MoH DoP said that the involvement of the Regional Health Office (RHO) and RHBs was a very important factor that generated a lot of support from these and other governmental offices, health workers and communities. There was meaningful participation by the RHO, RHBs and CHCs in planning and making important decisions. Terms of reference (TORs) of health boards and committees have

been reviewed and applied at all levels. A Joint Annual Review has been conducted and Somaliland conducted a review of HSSP I with the WHO.

There is an annual calendar of coordination activities with development partners. Standard letters of agreement (LOAs) are signed with all partners.

Institutional capacity: Developing a legal framework for health has been initiated in Somaliland, although the process has stagnated due to lack of capacity and resources. Regulating health professionals and facilities and enforcement of health regulations are almost non-existent although significant efforts have been made in Somaliland. Public health laws are outdated and have not been reviewed for more than 25 years (WHO 2015).

Leadership and management plans are included in the HR in-service training plans and 5 year strategy (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 and a structure that fits the policy objectives has been proposed and job descriptions for department and units have been drafted and endorsed (WHO 2015). However, the functional review undertaken does not reflect regional and district levels and implementation is slow. The ministry is planning to establish district health management teams as there are no district infrastructure or management teams currently. Regional health teams are not fully staffed.

Governance structures in the health sector distinguish between (1) central and local administrative structures with constituency representative functions and (2) implementing agencies, responsible for providing health services to the population. The various levels of the health care pyramid are thus governed by the formal structures shown in Table 40.

Table 7 . Governance structures in the health sector

LEVELS	ADMINISTRATIVE STRUCTURES	IMPLEMENTING AGENCIES
National	Government / Ministry	Ministry of Health
Region	Governors	Regional Medical Officer
District	District Councils / Executive Committee / District Health Unit	District Medical Officer / Hospital Board
Health Facility	Elected councils / Executive secretary and staff	Health Centre / Health Centre Committee
Primary health unit	Elected councils / Executive secretary and staff	Health Post / Community Health Worker
Village	Community Health Committee	CHW

Community participation: The Somaliland National Development Plan (2017-2021)²⁷ places very strong importance on the involvement of the population in government. The first of its guiding principles is that “All citizens must participate in the development and political process, and the government will ensure and facilitate such participation”. There has been improvement in citizen engagement in the management and financing of health services, with Community Health Boards (CHBs) undertaking fundraising and community engagement activities. However, there has not been a conclusive report on citizen participation and government legitimacy, nor on diaspora participation (HSSP I performance framework analysis), and implementation of the community strategy is weak.

Decentralization and fragmentation and implications for the health sector: The decentralization policy is widely supported throughout the country and is seen as an opportunity in Somaliland. However, it continues to face significant challenges. Boundaries and roles are not clearly defined and administrative issues are a major challenge. In Somaliland the capacity of the public sector has relatively improved over the last five years. Support is needed from 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.

Table 8: SWOT analysis for SO3 Improving governance and leadership of the health system

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ Regional and central capacity stable and growing ✓ Guiding policies and strategies including Health Policy, HSSP, disease specific plans ✓ Good links from central to regional level ✓ Regional Health Boards with local authorities and communities and CHCs ✓ Undertaken a functional review of MoH to guide planning ✓ Improving citizens' engagement in the management and financing of the health services 	<ul style="list-style-type: none"> ✓ Informal approaches to decision making and lack of systems to document implementation of decisions ✓ Regional Health Teams not fully staffed ✓ No district infrastructure or management teams. ✓ DHIS2 not functional ✓ Only 3 RHBs functioning (50%) ✓ implementation of the community strategy weak ✓ Functional review does not reflect regional and district levels ✓ Lack of internal communication and sharing of strategic documents 	<ul style="list-style-type: none"> ✓ Effective decentralisation strategy and identified gaps in overall framework of decentralisation relating to all sectors including health 	<ul style="list-style-type: none"> ✓ Implementation of the functional review is slow and no leadership plan exists at all levels for implementing

²⁷ Somaliland. Ministry of National Planning and Development (2011) National Development Plan (2012-2016)

4.3.2 SO 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

4.3.3 Strategic Priorities and Activities²⁸

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
- 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 in-country health sector coordination

- 3.2.1 Establish in-country health sector coordination mechanism(TOR, clear membership numbers and selection criteria)
- 3.2.2 Conduct regular quarterly 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 National HSC

3.3 Improved management and institutional capacities with enhanced decentralization

- 3.3.1 Strengthen regional health management team and build their capacity
- 3.3.2 Conduct workshop to launch 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 19 district health boards with clear TORs
- 3.3.5 Strengthen the operational structure and implementation arrangements at regional level (health facility, regional health board, community health committees)
- 3.3.6 Train the regional and district health boards and community health committees 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 (LM&G) training for senior managers at central and regional level and RHO/DMO, PHC, health facilities in charge and other midlevel managers

3.4 Improved engagement and involvement of communities (including women and representatives of vulnerable groups) in planning, delivery and review of health services

- 3.4.1 Planning: Develop and implement mechanisms to ensure effective involvement

²⁸Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

- 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 representatives of vulnerable groups
 - 3.4.3 Review; Develop, implement and review 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

4.4.1 Situation analysis

The essential medicines programme in Somaliland 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.

In Somaliland, a National Drug Regulatory Authority has been established and is functional. Cold chain equipment has been procured and distributed to health facilities (HFs) and regions.

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. A Master Supply Chain Management Plan has been developed in Somaliland and the supply chain management and logistics management information system (LMIS) are established and functional (SWOT). 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, although in Somalia in 2015, no vaccine stock-outs was recorded. 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. (WHO 2015)

There is a national warehouse in Hargeisa but there are no regional warehouses. Across the regions medicines are often poorly managed and stored at facility and central warehouse level without a proper inventory system but standard operating procedures (SOP) for warehouse management and storage practices have been introduced. Essential medicine kits are limited and not supported in non-EPHS areas.

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, with additional quality testing performed in Kenya's National Quality Control Laboratory (NQCL). A system for sending Alert Warnings on Withdrawn Medicines is also in place.

Medicines therapeutic committee have been established to ensure oversight by ministry of health of essential medicines related activities; a medicines policy has been developed and endorsed. However, pharmaceutical unit at ministry level is not in place and is 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 widely spread. 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 9: SO4: Enhancing the access to essential medicines and technologies

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ National Drug Regulatory Authority established and functional ✓ Master Supply Chain Management Plan developed ✓ Supply chain management and LMIS established – fully functional ✓ No stock-out on vaccines recorded in 2015 ✓ Cold chain equipment procured and distributed to HFs and regions ✓ Physical structures developed: National warehouse in Hargeisa, ICU at HGH 	<ul style="list-style-type: none"> ✓ Essential medicine kits limited and not supported in non-EPHS areas ✓ No regional warehouses (x6) ✓ Master Supply Chain Plan not funded ✓ No national reference lab 	<ul style="list-style-type: none"> ✓ Access and security to all regions good 	<ul style="list-style-type: none"> ✓ Opaque and unaccountable procurement process

4.4.2 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

4.4.3 Strategic Priorities and Activities²⁹

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

²⁹Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

- 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 availability of 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
- 4.2.4 Effective procurement, warehousing, logistics and supply chain system
- 4.2.5 Procurement of medicines, vaccines and commodities to all health facilities based on EML
- 4.2.6 Distribution of medicines, vaccines and commodities to all health facilities based on EML
- 4.2.7 Begin implementation of supply chain master plan
- 4.2.8 Link LMIS and DHIS2 and use data as part of EPHS Compass Performance Management Dashboard

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

4.4 Improved / rational use of drugs

- 4.4.1 Re-distribute rational drug use policy to all facilities
- 4.4.2 Develop rational drug use guidelines
- 4.4.3 Conduct training on rational drug use to facility heads

4.5 SO5: Effectively functioning health information systems

4.5.1 Situation Analysis

The health information system (HIS) in Somaliland faces enormous challenges in terms of overall functioning, performance and institutional frameworks, capacity and mechanisms to support information use for decisions.

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.

It is also important to ensure meaningful input by communities into collection of information to inform planning and review of services (including by 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.

Health Management Information System (HMIS)

The Somaliland HMIS is functional at central, regional and health facility (HF) levels, including an Integrated Disease Surveillance and Response (IDSR) and nutrition surveillance system. HMIS reports are shared regularly to all partners. The staff at the HF, regional and central levels have been trained in data collection, analysis and dissemination.

The sector has improved reporting compliance for the HMIS to nearly 100 percent (thanks in part to PBF incentives) and addressed issues of data quality by introducing a standardized data quality assessment methodology at national and district levels. Over the past few years. Reports from health facilities show greater than 90% timeliness and completeness. Analysis of the HSSP I performance data shows 100 per cent reporting by MCHs, and 97 per cent by HPs with computerised systems. However, HMIS is non-existent in most of the districts. Rollout is underway of the District Health Information System (DHIS2), which has been delayed.

TB is not yet integrated into the HMIS and there is parallel reporting by implementing partners (IPs) notably for polio and TB. ISS tools and guidelines have been validated. There is a basic MoH website with the aims of linking DHIS2 to this website.

The challenging issue of data use is compounded by the fact that there is not yet a formal data sharing in place and information systems are only now shifting over to web-based platforms, which can be accessed more widely—both at central and peripheral levels. Most routine information systems report data up, but have limited feedback reporting or mechanisms to support local data use.

On the data quality front, many of the remaining issues relate to a system that overburdens health workers with the collection of too much data of uncertain utility, overly complicated or poorly designed recording and reporting tools, and the lack of quality population denominator data for health facility catchment areas at the various higher levels.

National Surveys and Census

A 2011 multiple indicator cluster survey (MICS) covered Somaliland. A SARA review has been conducted. There are ongoing discussions on conducting regular MICS and Demographic Health Survey (DHS). 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.

Independent monitoring and evaluation (M&E) and operational research

An M&E framework and plan for HSSP has been developed in Somaliland and there is improved capacity in the M&E and Research Unit. Three Joint Annual Review and quarterly reviews have been conducted. A research agenda and committee have been endorsed and TOR validated. An MMR study was conducted in Somaliland in 2013-14.

Births and deaths registration

Standard vital registration (VR) tools and protocols have been developed and VR implemented in 6 districts. The coverage for birth registration among children under 5 years old (MICS 2006) in Somaliland was estimated to be 7%. VR is not yet integrated into the HMIS.

Conclusions: Despite much progress, major challenges in information systems include questionable quality of data reported through HMIS; no national household level health survey have been conducted in last decade; vertical programme HIS and surveillance systems are

not integrated with HMIS. A system of Civil Registration and Vital Statistics (CRVS) is not fully in place.

Table 10: SWOT analysis for SO5 Effectively functioning health information systems

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ M&E framework and plan for HSSP developed ✓ Improved capacity of the M&E and Research Unit ✓ Joint Annual Review and quarterly reviews conducted ✓ >90% timeliness and completeness of reports from HFs ✓ HMIS functional at central, regional and facility levels ✓ Research agenda and committee endorsed & TORS developed and validated ✓ ISS tools and guidelines developed and validated ✓ Integrated Disease Surveillance and Response (IDSR) integrated into HMIS ✓ Nutrition surveillance system integrated into the HMIS ✓ Nutrition dashboard established ✓ Vital registration implemented in 6 districts ✓ Standard VR tools and protocols developed ✓ Skilled, trained staff at HF, regional and central for data collection, analysis and dissemination ✓ MoH website developed ✓ HMIS reports shared to all partners regularly 	<ul style="list-style-type: none"> ✓ Vital Registration not yet integrated with HMIS ✓ Implementation of DHIS2 delayed and lacking local server ✓ Inadequate, irregular support of data recoding tools to HF ✓ TB not yet integrated with HMIS 	<ul style="list-style-type: none"> ✓ DHIS2 rollout underway ✓ Continued support from Global Fund (and other partners) for HMIS 	<ul style="list-style-type: none"> ✓ Parallel reporting from IPs and notably TB and polio programmes

4.5.2 SO 5: Effectively functioning health information system

To establish an effective **health information system** that provides 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

4.5.3 Strategic Priorities and Activities³⁰

5.1 Effective M&E system to track health system performance, disaggregated by gender, 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
- 5.1.4 Establish routinely produced information products such as feedback reporting and periodic health bulletins, and align reporting calendar of the Ministry
- 5.1.5 Develop a Resource Tracking Tool (RTT)
- 5.1.6

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

- 5.2.1 Printing and distribution of the revised registers and reporting forms for DHIS2
- 5.2.2 Training on the revised HMIS tools to all facilities
- 5.2.3 Roll out of DHIS2 to all Somaliland regions

³⁰Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

- 5.2.4 DHIS2 training to mid-level managers and health partners
- 5.2.5 Strengthen the Information Technology Unit (IT) within the Ministry of Health
- 5.2.6 Conduct quarterly data quality audits to health facilities in Somaliland
- 5.2.7 Monthly and quarterly integrated 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
- 5.2.12 Capacity building to institutionalize data use for decision-making at all levels

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 a step-wise survey
- 5.4.11 Conduct research on mental health problems

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 Evaluate the system and develop a plan to scale up
- 5.5.3 Expand the CRVS tools to one other district
- 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

4.6.1 Situation Analysis

Recognizing the important role of financing, in 2001 African heads of state committed themselves to allocate at least 15 percent of their national annual budgets to improving the health sector. In May 2005, the 58th World Health Assembly adopted a resolution that urges member states to ensure that health financing (HF) systems include a method for prepayment of financial contributions for health care, to promote sharing risk among the population and avoiding catastrophic health-care expenditures and related impoverishment of care-seeking individuals (WHO 2005).

Health financing has been extremely limited as the country's economic performance is poor. Health sector resources are mainly from out-of-pocket payments or through donor funding. Health expenditure is difficult to quantify as it is channelled mainly through humanitarian routes, mainly disbursed through the Common Humanitarian Fund (CHF) or Central Emergency Response Fund (CERF) either to the three key UN agencies in health (UNICEF, WHO and UNFPA), or international organizations and NGOs. 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. This increases the risk of financial burden, especially on poor people with higher out-of-pocket (OOP) expenditure. (WHO 2015)

The Ministry of Health is guided by a number of principles in the development and implementation of the Health Financing Policy: (a) equity, risk-sharing, and solidarity; (b) efficiency, evidence-based decision-making and result-based financing and management, transparency and accountability; and (c) ownership, empowerment and participation, and partnerships.

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.

Current funding approach: The past decade has seen a significant increase in funding for the health sector across Somaliland. Financing from conventional donors increased by 180%, from US\$53.6 million in 2005, to US\$103 million in 2009,³¹ and approximately US\$150 million in 2014.³² 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. While US\$150 million was invested in 2014, Somaliland's budget contribution to health for the year was US\$7.1 million compared to US\$1 million during 2007- 2009. (WHO 2015)

Funding of the Somaliland health sector beyond 2016 is uncertain. A drop in overall funding is anticipated, due to the end of the largest health sector development programme, the JHNP, in December 2016. However funding for the implementation of the Essential Package of Health Services (EPHS) will continue under different implementation arrangements. Through SHINE, DFID will contribute a total of GB£92 million for 5 years up to 2021. 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.

³¹World Bank, 2010, A decade of AID to the health sector in Somalia (2000-2009)

³²WHO 2015 Mission estimates

External financing greatly exceeds government contributions to health: altogether governmental funds constitute less than 5% of the allocation through the public health sector (see table 11).

Zone	MoH Budget	Total Budget	% share of health
Somaliland	\$7.1m	\$156m	4.5% ³³

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.

Somaliland achievements and challenges: The Somaliland review of HSSP I pointed to completion of a PFM assessment and health expenditure review, along with contracting assessment and a costing exercise. MoH finance staff have been trained on costing and had two phases of health financing training. A resource mobilization strategy has been produced.

Although Somaliland government had aimed to increase the percentage contributed to health expenditure by 12 per cent for five years, but only increased its national contribution to 5 per cent. National Health Accounts are yet to be established with cost sharing and reporting systems are weak. In reviewing implementation of the EPHS in Somaliland, the MoH DoP considered sustainability. It noted that given the unrecognised status of the Somaliland government and the immediate post-conflict status of the other states of Somalia, generating revenue to fund the running of public services including health/EPHS beyond the cycles of donor funding is an obvious challenge. The MoH DoP called for discussion between donors and governments so that capacity is developed and made functional through time. It is important not to require NGOs to develop sustainable programmes when the regional governments are not yet there to takeover project initiatives.

Conclusions: Strengths of the current health finance systems include that access to basic health services (both through development and humanitarian investment) is ensured to nearly two-thirds of the population. Rationalized humanitarian assistance means more focus on conflict-affected areas and de-funding the stable/ post-conflict areas (WHO 2015).

Major challenges across 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 50% of the population, along with pre-payment mechanisms to reduce catastrophic/OOP health expenditure; lack of 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).

Table 12 SWOT analysis for SO6: Health financing for progress towards UHC

³³Note: MOH analysis of HSSP I performance indicators states that 5% has been achieved.

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ PFM assessment & health expenditure review conducted ✓ Contracting assessment conducted ✓ MoH finance staff trained on two phases of health care financing ✓ Costing exercise and training conducted ✓ Resources mobilisation strategy developed 	<ul style="list-style-type: none"> ✓ National budget allocation for health not yet increased from 4% ✓ Preliminary NHA (including humanitarian funding) yet to be established ✓ Implementation of cost sharing weak ✓ annual cost sharing reporting system weak 	<ul style="list-style-type: none"> ✓ National health budget proposal submitted but awaiting approval ✓ Increasing resources from community, diaspora 	<ul style="list-style-type: none"> ✓ National budget allocation for health not yet increased from 4% ✓ Joint Financing Agreement (JFA) for HSSP yet to be conducted

4.6.2 SO 6: Health financing for progress towards universal health coverage (UHC)

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

4.6.3 Strategic Priorities and Activities³⁴

6.1 Health financing strategy development and implementation

- 6.1.1 Review and finalize Somaliland 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 (Somaliland 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

4.7.1 Situation Analysis

In order to improve access to and coverage of EPHS services, the MoH and stakeholders will construct health facilities, This will help to ensure that the majority of Somaliland population live within an 10 kilometers radius of a health facility Infrastructure systems include the fixed assets like buildings, as well as their control systems and software required to operate, manage, and

³⁴Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

monitor them. They also include communication facilities, plants and vehicles and other utilities.

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.

Although there has been no systematic study on the conditions of Somaliland's public health infrastructure poor infrastructure has been cited in a number of studies, conducted primarily in middle and low income countries, as undermining health service delivery. 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 the country to develop a specific infrastructure improvement plan and budget.

Somaliland MoH has established offices at central, regional and HF levels, including management offices. An infrastructure report was available (2016). Cold chain has been established centrally and in three regions. The 2015 MoH review of HSSP I noted that, as part of EPHS provision throughout the regions, there had been infrastructure construction and renovation. Accommodation was not in place for health workers in rural and nomadic areas.

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. Although the EPHS strategy states that the focus will be on quality, 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. In Somaliland, the infrastructure is damaged or old, there is limited infrastructure at district level and there are no prioritization plans.

The infrastructure of health facilities across the country is considered poor because not only is the infrastructure condition poor, it is also inadequate for the needs of the populations served. Both of these problems need to be addressed in the HSSP II: to ensure that infrastructure is of good quality, and 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 13: SWOT analysis for SO7 Improving health sector physical infrastructure

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ Offices established at central, regional and HF levels, including management offices ✓ Cold chain established at central and 3 regions ✓ Infrastructure survey report available 	<ul style="list-style-type: none"> ✓ Damaged and old infrastructure ✓ Limited infrastructure at district level 	<ul style="list-style-type: none"> ✓ Availability of adequate land ✓ Community and partners willing to invest in health infrastructure 	<ul style="list-style-type: none"> ✓ No prioritisation plan

4.7.2 SO 7: 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.

4.7.3 Strategic Priorities and Activities³⁵

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 Burco Regional hospital
- 7.1.7 Establish public health reference laboratories Train medical technicians in health facilities
- 7.1.8 Install and maintain utility systems in existing facilities
- 7.1.9 Rehabilitate and upgrade existing health facilities
- 7.1.10 Construct new health facilities

4.8 SO8: Enhancing health emergency preparedness and response

4.8.1 Situation Analysis

Recently, health disasters in Africa and on other continents have underlined the necessity to remain alert on potential crises and intervene immediately when they occur. The MOH will review and update the Plan for Emergency Preparedness and Response (EPR), covering health related emergencies, epidemics and events with a public health impact and ensure a multi-sectoral approach. Tanzania will establish a permanent coordinating body which will oversee all Disaster Risk Management and Health Risks Management activities in line with the International Health Regulations (IHR) 2005. The MOH will produce and monitor an IHR annual

³⁵Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

action plan, operationalized through Technical Committees at Regional and Council levels, under RHMTs and CHMTs respectively.

Early Warning Institutions (EWI) will inform relevant Ministries regularly, which will take necessary actions for updating and implementing Emergency Plans. The ministry will activate an Emergency Operational Centre when needed for daily monitoring, reporting, and feedback. It will share the reports with stakeholders and will implement corrective measures, including post-disaster support. The ministry will strengthen the electronic Integrated Disease Surveillance and Response (IDSR) system, for immediate action at all levels. Case detection, notification and investigation will be done according to international standards. The sector will set up a mechanism for emergency medical services at all levels including guidelines and protocols for specific situations.

Emerging and re-emerging diseases may cause new epidemics that need to be analysed through molecular technologies. Veterinary experts and molecular biologists will be consulted by the health system. There will be comprehensive training in the different areas of medical care and disaster relief, including the community level. All emergencies will be documented and evaluated and experiences and lessons will be documented to inform future interventions. The MOH will set-up and manage Call Centre(s) for the public to contact the authorities. The MOH will conduct awareness campaigns using modern means of communication, but also local community mobilisers. The MOH will develop strategies for psychosocial support to victims of emergencies.

Somaliland has established the Emergency Preparedness and Response Agency (NERAD), along with central government commitment and budget allocation. However the government also reports an ad hoc response, inadequate supplies of safe blood in all regions, minimal sentinel surveillance sites, lack of funding, no reference lab and a lack of emergency buffer supplies in regional warehouses. 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 2.5 million people, with health capacities severely overburdened, stocks diminished and services disrupted especially in conflict, drought and flood-affected areas, especially for IDPs.

A health sector approach is utilised in Somaliland, with sector for health and nutrition, WASH, protection, food security, education and logistics. Health Sector 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 sector will continue to implement joint strategies to prevent and mitigate the impact of disease outbreaks, particularly seasonal acute, watery diarrhoea (AWD)/cholera.

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 Somaliland Health Sector strategy and the respective regional Health Sector strategic plans. Sector activities support and strengthen existing essential public health services structures in line with the National Development Plan II 2017-2021 priorities of expanding coverage and strengthening emergency preparedness and response. The Health Sector 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.

Table 14: SWOT analysis for SO8 Enhancing health emergency preparedness and response

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ Emergency preparedness and response unit (NERAD) established ✓ Central government commitment and budget allocation 	<ul style="list-style-type: none"> ✓ Ad hoc emergency response strategies in place ✓ Inadequate supplies of safe blood in all regions ✓ Environmental health unit not fully capacitated ✓ Minimal sentinel surveillance sites 	<ul style="list-style-type: none"> ✓ Establishment of sector coordination in the country 	<ul style="list-style-type: none"> ✓ Lack of funding ✓ Lack of reference Lab ✓ No prepositioned emergency buffer supplies in regional warehouses

4.8.2 SO 8: 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**

4.8.3 Strategic Priorities and Activities³⁶

8.1 Strengthen emergency preparedness and response capacity

- 8.1.1 Develop GESI-sensitive multi-sectorial National Emergency Preparedness & Response Plan
- 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 regional and district level
- 8.1.5 Establish call Centre(s) for the public to contact the authorities

8.2 Effective coordination and linkages with sector coordination (cluster)

- 8.2.1 Establish national assessment rapid teams at all levels
- 8.2.2 Establish a coordinating body to oversee all Disaster Risk Management in line with the International Health Regulations (IHR) 2005
- 8.2.3 Revamp and support emergency coordination clusters
- 8.2.4 Conduct regular sector coordination meeting

8.3 Basic health and nutrition humanitarian services in non-EPHS areas

- 8.3.1 Support basic health and nutrition services in Maroodi Jeex, Sool and Sanaag regions

³⁶Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

- 8.3.2 Integrated reproductive health outreaches in Maroodi Jeex, Sool and Sanaag regions
- 8.3.3 Nutrition mobile teams to implement IMAM (OTPS) in Sool and Sanaag regions

4.9 SO9: Promoting action on social determinants of health and health in all policies

4.9.1 Situation Analysis

The major determinants of health in Somaliland include levels of income and education, housing conditions, access to sanitation and safe water, cultural beliefs, social behaviors and access to quality health services. While the proportion of people living below the poverty line has significantly decreased, Somaliland is still a low income developing country with income disparities spread across the country. A direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition and diarrhea as they are more prevalent among the poor than the rich households.

National surveys show that health indicators are worse off among people who have no or little education than those who have secondary school+ level of education. For example, underweight among under five children, the prevalence of diarrhoea and malaria among under five children all decreased the higher the educational level of the mother. These health indicators are also better among the wealthier than among poor people. Improving income and educational levels would therefore lead to improvement in health status. While health outcomes for the country are poor, some groups (e.g. women) and areas (e.g. isolated rural areas without healthcare providers) have significantly worse outcomes.

Many of these factors – or determinants – that affect people's health are outside the health sector's remit (such as poverty, education, rural isolation, gender, disability, access to potable water and sanitation, transport systems). 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.

Somaliland has expressed strong commitment to principles of equity and equality. The Somaliland NDP (2017-2021) included the following as a guiding principle: Fairness: Citizens should be equal before the law and should have equal access to opportunities. The NDP points to the need for gender mainstreaming as well as implementation of the Juvenile Justice Law; development and implementation of a national policy on FGM; implementation of the national gender policy and implementation of the national Gender Budgeting Guideline.

In terms of achievements, Somaliland's C4D unit has been set up to coordinate BCC and health promotion messages. The National C4D plan and Infant and Young Child Feeding (ICYF) Strategy for Somaliland (2012-2016) and work plan have been developed and implementation is underway (SWOT/ MoH HSSP 2015). A monitoring form disaggregated by

gender, age and location was produced in 2013³⁷. A knowledge, attitude and practices study (KAPS) was undertaken on children with disabilities³⁸. Ongoing challenges include lack of follow-up (e.g. for the KAPS), high levels of need and illiteracy, challenging socioeconomic factors, limited resources and a lack of coordination and follow-up.

The WHO review (2015) highlighted the comparative advantage of the health sector in terms 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.

The following elements³⁹ identified in the Somali Health Policy are important 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 SO 9, below)
- Promoting **policy interventions particularly to benefit the disadvantaged Somali nomadic population** (see SO 1 – essential health services and SO 3 –leadership and effective governance)
- 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 5 – 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 15: SWOT analysis for SO9 Promoting action on social determinants of health and health in all policies

STRENGTH	WEAKNESS	OPPORTUNITY	THREAT
<ul style="list-style-type: none"> ✓ Communication for Development (C4D) Unit established. ✓ National C4D & IYCF strategy & work-plan 	<ul style="list-style-type: none"> ✓ Delays in follow-up KAP survey (2015) ✓ Behaviour Change Communications(BCC) message are not harmonized ✓ No clear guidelines on 	<ul style="list-style-type: none"> ✓ Calendar of Global Health events to promote key health promotion messages ✓ Availability of media and telecommunication companies is opportunity to delivery message to 	<ul style="list-style-type: none"> ✓ Lack of research around health seeking behaviours ✓ Political instability and conflict ✓ Socioeconomic factors

³⁷<https://www.humanitarianresponse.info/en/operations/somalia/document/iycf-reporting-template-somaliland>

³⁸CESVI, European Commission, Handicap International (2013) Children with Disabilities in Somaliland: A knowledge, attitudes and practices household survey <https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/assessments/Somaliland%20Children%20with%20Disabilities%20KAP.pdf>

³⁹Ministry of Health and Human Services, Federal Government of Somalia. Ministry of Health Puntland. Ministry of Health, Somaliland (2014) Somali Health Policy

developed and implementation underway ✓ KAP Survey published	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	communities ✓ New generation of work force highly skilled in communications and information technology. ✓ Introduction of the DFID CHANGE programme focused on demand creation and behaviour change	✓ Ingrained harmful behaviours and beliefs such as FGM and khat chewing ✓ High illiteracy rates
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SO 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

4.9.3 Strategic Priorities and Activities⁴⁰

9.1 Effective mechanism for intersectoral collaboration ensuring health in all policies

- 9.1.1 Establish inter-ministerial committees (TOR) including representation from communities
- 9.1.2 Conduct inter-ministerial coordination meetings
- 9.1.3 Develop inter-ministerial action plan on SUN and CARMMA

9.2 Determine priority health promotion, disease prevention and behaviour change programmes (see also SO 1.3, 1.5)

- 9.2.1 Implement the C4D strategy by conduct series of workshops with PSI, other IPs and ministries to develop priorities for messaging and BCC
- 9.2.2 Develop radio script and production
- 9.2.3 Airing of radio programme
- 9.2.4 Oversee implementation

⁴⁰Note: numbering of strategic priorities and activities is in line with numbering in the Operational Plan (annex 1)

Section 5: Consolidated Financial Plan

As noted in SO 6, wherever possible, finances will aim to show – via their link with strategic activities – progress in relation to GESI issues.

Table 16: Budget by recurrent/development costs 2017-2021

		2017	2018	2019	2020	2021	TOTAL
	Budget Estimates (in million US \$)						
A	Recurrent	28.980.000	32.900.000	36.660.000	41.030.000	45.860.000	
1	Employee related expenses	8.600.000	10.100.000	11.500.000	13.600.000	15.700.000	
2	Operating expenses	6.550.000	7.300.000	8.000.000	8.600.000	9.600.000	
3	Coordination	880.000	1.000.000	1.100.000	1.200.000	1.300.000	
4	Medicines, vaccines, commodities and supplies	12.500.000	14.000.000	15.500.000	17.000.000	18.600.000	
5	Repair and maintenance	450.000	500.000	560.000	630.000	660.000	
B	Development	49.550.000	34.280.000	60.060.000	66.280.000	71.280.000	
1	Expenses on physical assets	18.300.000	20.000.000	22.000.000	24.500.000	25.300.000	
2	Policies, plans and legislation etc.	2.300.000	2.600.000	2.600.000	3.000.000	3.500.000	
3	Training (including pre-service and in-service)	10.000.000	11.000.000	12.500.000	13.600.000	15.000.000	
4	Service delivery (excluding salaries & medicines)	15.300.000	16.500.000	18.300.000	20.500.000	22.300.000	
5	Regulatory functions	650.000	660.000	660.000	680.000	680.000	
6	Research and Evidence	3.000.000	3.500.000	4.000.000	4.000.000	4.500.000	
	TOTAL COST (Recurrent + Development)	78.530.000	67.180.000	96.720.000	107.310.000	117.140.000	
	Projected Population (million)	3.516.053	3.618.019	3.722.941	3.830.907	3.942.003	
	Unit cost (\$) per person per year	22	19	26	28	30	

Section 6: 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.

S.N	INDICATOR	BASELINE	TARGET					MOV
			2017	2018	2019	2020	2021	
HEALTH SERVICE DELIVERY								
1	Maternal Mortality Ratio.	732					400	MICS/DHS
2	Under-five mortality rate.	137					100	MICS/DHS
3	Infant mortality rate.	73					60	MICS/DHS
4	Neonatal mortality rate.	40					35	MICS/DHS
5	Total fertility rate.	6.7					6.0	MICS/DHS
6	Prevalence of wasting in children aged 0-59 months (weight-for-height z-score <-2 SD).							
7	Prevalence of wasting in children aged 0-59 months (weight-for-height z-score <-2 SD).							
8	Prevalence of underweight in children aged 0-59 months (weight-for-age z-score <-2 SD).							
9	Pent 3 coverage rate for 1 yr.	43%					80%	MICS/EPI Cluster Survey
10	Skilled Birth Attendant	33%					55%	MICS/DHS
11	Contraceptive prevalence rate (CPR)	6%					16%	MICS/DHS
12	TB case detection rate	42%					70%	MoH Reports
13	TB treatment success rate	87%	90%	93%	95%	97%	99%	
14	% increase in per capita expenditure on health	\$12	\$14	\$16	\$18	\$21	\$23	NHA
15	Share of Government Health Expenditure of total expenditure							NHA
16	No of deliveries conducted in MCH/HC (Institutional delivery)	48,476	55,487	60,922	66,890	73,446	80,646	MICS/DHS
17	No of health facilities providing 24/7 BEmOC	58	36	41	46	49	52	HMIS
18	No. of hospitals providing 24/7 CEmOC	7	7	8	8	8	8	HMIS
19	No. of children <1 yr immunized for Penta III in MCH/HC (Penta 3 coverage)	72,107	77,603	83,130	89,166	95,759	102,966	MICS/EPI Cluster Survey
20	No. of children immunized for IPV in MCH/HC	34,436	38,801	83,130	89,166	95,759	102,966	
21	No. birth spacing client visits in MCH/HC	7,846	10,064	12,140	14,650	17,687	21,363	
22	Number of women attending at least 3 ANC visits	8,794	9,109	9,921	11,490	13,789	15,030	
23	Antenatal care coverage	52%	60%	68%	76%	84%	92%	
24	Number of women attending PNC Visits	72,458	80,789	93,289	107,289	118,450	125,000	
25	Number of malaria cases diagnosed							

S.N	INDICATOR	BASELINE	TARGET					MOV
			2017	2018	2019	2020	2021	
26	Number of clients receiving treatment for malaria as per national guidelines	80%	80%	85%	90%	95%	95%	
27	No. of severely and moderately malnourished children managed in MCH/HC	72864	75481	78208	81051	84015	87105	
28	No. of children born in health facilities and initiated breast feeding	48785	50249	51756	53309	54908	56555	
29	No. of women receiving MMN at health facilities	74983	86760	95436	104979	115477	127025	
30	No. of ARI cases managed in MCH/HC	79534	87487	96236	105860	116446	128090	
31	No. of diarrhoea cases managed in MCH/HC	41463	45609	50170	55187	60706	66777	
32	Number of ANC clients tested for HIV							
33	Number of HIV +ve clients currently on ART							
34	Number of client visits (OP) by service level							
35	Level 1: Primary Health Unit							
36	Level 2: Health Centre	712,000	723,432	754,131	772,222	788,586	832,481	
37	Level 3: Referral Health Centre	10,334	11,984	12,334	13,873	14,491	16,247	
38	Level 4: Hospital	3522	3745	3900	4123	4289	4456	
39	Percentage of health facilities providing EPHS							
40	Level 1: Primary Health Unit	94	95	95	96	97	98	
41	Level 2: Health Centre	57	60	65	68	70	75	
42	Level 3: Referral Health Centre	11	15	17	20	25	35	
43	Level 4: Hospital	4	10	10	10	15	15	
44	Number of Hospitals with functioning Neo-Natal Unit	2	3	3	4	5	6	
45	Number of Hospitals with trauma care unit.	7	8	9	9	10	11	
46	Number of health facilities providing mental health services by level							
47	Level 1: Primary Health Unit	0	0	0	0	0	0	
48	Level 2: Health Centre	0	0	10	15	20	25	
49	Level 3: Referral Health Centre	0	0	2	5	7	10	
50	Level 4: Hospital	0	2	5	6	6	6	
51	Number standardized guidelines and quality monitoring tools developed and adopted	4	4	4	4	4	4	
52	Percentage of health facilities with STG available and used for reference by all staff	100	100	100	100	100	100	
53	Percentage of health facilities meeting all Facility Scorecard Quality Standards	40%	50%	65%	80%	95%	95%	
54	Percentage of health facilities meeting WASH standards	45%	50%	68%	85%	100%	100%	
HEALTH WORKFORCE								
55	Number of health care professionals disaggregated by cadre, sex, facility, district and region	4,202	4,702	5,162	6,112	6,992	7,922	
56	Percentage of functional HR units at regional and district level	60	70	80	90	100	100	
57	Number of health care professionals (disaggregated by cadre, sex, region and type of program) provided in-service training	600	930	1230	1510	1710	1840	

S.N	INDICATOR	BASELINE	TARGET					MOV
			2017	2018	2019	2020	2021	
58	Number health care professionals (disaggregated by cadre, sex and training institution) provided pre-service trainings (Number of new graduates from health training institutions)	970	1050	530	590	640	800	
59	Annual percentage increase in number of health workers on government payroll annually	3	15	15	15	20	20	
60	Number of professionals (disaggregated by cadre, sex and region) registered, licensed and accredited by NHPC (% of health professionals registered and licensed by NHPC)		150	200	250	300	350	
61	Functioning HRMIS		50%	70%	100%	100%	100%	
62	Number of partners adhering and reporting harmonized health workers' incentive scale		5	10	12	15	18	
63	Number of MOH and WHO standardized training guidelines, materials and protocols made available and adhered		10	12	15	15	18	
64	Number of training events		3	5	7	8	8	
GOVERNANCE AND LEADERSHIP								
65	Number of legal documents published	1	2	2	3	4	4	
66	Number of policy and/or disease specific strategies published or renewed	25	28	31	34	34	34	
67	Health coordination structure in place and functioning with ToR and membership criteria	4	In place	In place	In place	In place	In place	
68	Thematic/Technical Working Groups in place with ToR and membership criteria	4	In place	In place	In place	In place	In place	
69	Minimum of 4 HSC meetings conducted annually with minutes/action plans disseminated	4	4	4	4	4	4	
70	Minimum of 4 TWG Meetings conducted annually with minutes/action plans disseminated	4	4	4	4	4	4	
71	Number of training events for senior/middle level managers	40	40	50	50	50	50	
72	MoUs in place with municipalities outlining roles and responsibilities between MoH and local authorities	0	5	10	15	20	40	
73	Number of services formally handed to municipalities under JPLG	0						
74	Number of quarterly meetings with partners	4	4	4	4	4	4	
75	Number of CHC, RHB and DHB established (or % of health facilities, districts and regions with functioning community health boards)		70	100	130	160	190	
MEDICINE AND SUPPLY								
76	Number of licensed pharmacies, wholesalers, retailers.(private sectors) (or % of private pharmacies, wholesalers and retailers licensed)	0	300	600	900	1200	1500	

S.N	INDICATOR	BASELINE	TARGET					MOV
			2017	2018	2019	2020	2021	
77	Number of inspection process performed (once quarterly). At private and public sectors	0	24	48	72	108	132	
78	Establishment of primary quality control system at the entry points(4 mini labs for medicines)	3	4	4	4	5	5	
79	Number of trained staff members on QC/QA each region(minimum 5).	10	10	15	15	20	20	
80	Number of health units reporting stock outs of essential drugs and vaccines (or % of health facilities reporting no stock outs of essential drugs (tracer medicine)	0	< 10%	< 10%	< 10%	< 10%	< 10%	
81	Number of health providers trained on drug use management (rational use of drugs).	0	150	150	150	150	150	
HMIS AND RESEARCH								
82	Percentage of HSSP results-framework indicators reported in the AHSPR	84%	88%	92%	96%	98%	100%	
83	Percentage of planned HSSP reviews that are carried out	50%	75%	100%	100%	100%	100%	
84	HMIS timeliness	86%	88%	92%	96%	98%	100%	
85	HMIS completeness	90%	90%	90%	95%	100%	100%	
86	HMIS reporting rate	95%	95%	95%	95%	95%	95%	
87	Number of a data quality assessment (DQA) was conducted	1	4	4	4	4	4	
88	Number and proportion of regions reporting HMIS data through DHIS2	0	7	7	7	7	7	
89	Number of HMIS reports analyzed and disseminated through DHIS2 and Performance Management Dashboard	0	40	40	40	40	40	
90	Number of community based HMIS reports sent through and linked with the DHIS2	60	160	160	260	260	360	
91	Availability of prioritized national research agenda and costed survey plan	1	1	1	1	1	1	
92	Number of planned surveys and research studies carried out	1	4	6	8	10	12	
93	Number of sentinel sites reporting notifiable diseases	61	71	81	91	101	121	
94	Number of notifiable diseases reported, analysed and disseminated through DHS2	9	9	9	9	9	9	
95	Number of community based Vital Registration sites linked to DHIS2	0	60	160	160	260	260	
96	Number of facility-based Vital Registration sites linked to DHIS2	0	86	96	106	116	126	
97	Number of estimated births reported		126578	130249	134026	137913	141912	
HEALTH FINANCING								
98	Percentage Health sector budget increase (Share of Government budget of total budget)	2.5%	4.0%	5.5%	7.0%	8.5%	10.0%	
99	Resource mobilisation advisor recruited and in place			In place	In place	In place	In place	
100	Resource mobilisation strategy and plan developed and endorsed		In place	In place	In place	Review	In place	
101	Percentage of total funds raised through RM strategy		5.0%	7.0%	15.0%	20.0%	20.0%	

S.N	INDICATOR	BASELINE	TARGET					MOV
			2017	2018	2019	2020	2021	
102	Health expenditure reviews conducted on time	1	1	1	1	1	1	
103	Number of financial management trainings conducted for both management and finance team (number of management and finance staff attended certified financial management course)	0	2	4	3	2	2	
104	Number of Financial audits and spot check conducted (Number of audited reports published)	5	5	5	5	5	5	
105	Number of programs and sub-programs expenditure reports	4	4	4	4	4	4	
106	National Health accounts produced and disseminated			1	1	1	1	
107	EPHS fund management Integrated within MoH and providing reports and deliverables on time as per ToR		In place	In place	In place	In place	In place	
HEALTH INFRASTRUCTURE								
108	Annual costed rehabilitation plan in place by region	0	1	3	6	6	6	
108	Number of new health facilities constructed as per EPHS standard	0	10	10	10	10	15	
110	Number of health facilities upgraded/rehabilitated as per EPHS standard	0	50	50	50	50	50	
111	Number of regional warehouses/offices constructed and functioning	0	2	1	1	1	1	
112	Number of health offices constructed at regional/ district	0	0	1	1	1	1	
113	Number of operating theatres at district level	0	5	10	15	15	15	
114	Number of neonatal units established and functional	0	0	1	1	2	3	
115	Number of health facilities with sustainable energy system installed and functioning	0	65	90	115	14	155	
EMERGENCY PREPAREDNESS AND RESPONSE								
117	Emergency Preparedness Plan in place and regularly updated	0	In place	Updated	Updated	Updated	Updated	
118	Number of Rapid Response Teams trained and in place (Regional Response Teams)	0	9	9	9	9	9	
119	Percentage of regional warehouses with preposition of emergency supplies, based on national checklist.	0	0	15%	30%	50%	50%	
120	Number of emergencies responded in time	2	2	2	2	2	2	
121	Number of cluster meetings conducted	0	4	4	4	4	4	
122	Number of stakeholder mobilized	0	10	15	20	25	25	
123	Number of Emergency Public information and awareness (HADMA and UNOCHA))	0	3	4	4	4	4	
124	Number of voluntary staff pre-registered (Not clear)	0	15	20	20	25	25	
125	Number of health facilities with basic health and nutrition services in non-EPHS areas	9	9	12	15	15	15	
SOCIAL DETERMINANT OF HEALTH								

S.N	INDICATOR	BASELINE	TARGET					MOV
			2017	2018	2019	2020	2021	
127	Inter-ministerial action plan developed and endorsed		In place	In place	Review	In place	In place	
128	Inter-ministerial plan for key social determinant strategies developed (SUN, CARMMA)		In place	In place	Review	In place	In place	
129	Number of inter-ministerial meetings held		4	4	4	4	4	
130	Number of inter-sectoral collaborative activities conducted		2	2	2	3	3	
131	Number of laws to guarantee medical and food care and coverage of social security			1			1	
132	Number of health education sessions conducted at health facilities		400	400	500	600	700	
133	Number of people reached with MNCH messages in the community		50000	100000	150000	200000	300000	
134	Number of integrated public health messages air regularly in public and private media		100	100	100	100	100	

Section 7: 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 Somaliland 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

The current health sector coordination structure is complex and consists of the Health Advisory Board, the Health Sector Committee, the Zonal Health Sector Coordination Forums, Thematic Working Groups, Humanitarian Clusters (Health, Nutrition, WASH), the Global Fund Steering Committee, the JHNP Steering and Technical Coordination Groups. HSSP I proposed a Financiers' Group (HSSPFG) to focus on funding issues whilst the HSC focuses on technical issues.

The Health Advisory Board (HAB) is an important and effective body in political terms. It brings together the Ministers of Health of the Federal Government, Somaliland and Puntland and the Head of Agencies of the Donors and UN. The key challenge for the HAB is how best to link and align to the higher level coordination arrangements such as the New Deal Compact. It has also no link with humanitarian cluster system and with the Global Fund Steering Committee.

The Health Sector Committee (HSC) is the key coordinating mechanism that brings the Somali health authorities together. The HSC decisions are referred to the HAB for review and endorsement. The HSC brings together constituencies to ensure transparent coordination between stakeholders and clear policy guidance for the HAB. However, currently the HSC become an open forum with no clear agenda and policy to guide the health sector coordination leading to overwhelmed discussions and slow pace of decision making. The HSC lacks effective and efficient secretariat to support the overall health sector coordination activities.

Zonal Health Coordinating Forums provide an information sharing and coordination platform for the health sector stakeholders in Somaliland. Zonal Forums have helped to promote Health Authority leadership of the health sector; and provide a constructive platform to address

operational issues, supported by Technical Working Groups (TWGs). However, Zonal Forums are too large and take too long to ensure focused discussion and clear outcomes. They also tend to lack clear accountability channels, with all stakeholders.

TWGs and Task Forces are established to deal with specific issues. They are generally perceived to be more effective and productive than HSC meetings or Zonal Coordination Forums, with a smaller number of members focusing on specific and immediate issues. There is a need and scope to reduce the number of TWGs by combining some of them. TWGs need to be established at Regional level, to support Regional Health Management Teams.

During HSSP II, the health sector coordinating mechanism will be strengthened 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

Implementation of HSSP II through partnership will promote the role of government (MOH) as the overall steward in provision of health services in Somaliland and the coordinator of all stakeholders' efforts. This will enable efficient and equitable utilization of all resources while minimizing duplication and overhead costs. This will be achieved through the following:

1. Health sector compact will be developed to support the implementation of HSSP II;
2. Roles and responsibilities of the government (at various levels) and development partners will be clearly articulated in the health sector compact;
3. Regular assessment of performance against these roles and functions will be carried out (quarterly and annually) and will include expenditure reviews;
4. Coordination and consolidation of activities carried out by different players, with particular effort focused at the district levels;
5. Involvement of the community will be particularly encouraged;

Proposed Coordination Structures

1. Health Sector Coordination Group (HSCG)

The HSCG will be the key coordination mechanism for the health sector. The group will compose senior members from MOH, civil society, development partners, implementing partners as well as representatives from key Government departments. The forum will meet quarterly (four times a year) in Hargeisa.

2. HSSP II Financier Group (HSSPGG)

HSSPFG will be formed of senior representatives of all donors investing more than \$3m annually in the HSSP II, including the UN Office for the Coordination of Humanitarian Affairs, plus Ministers for Health from Somaliland and the Federal Republic of Somalia. Ministries in-charge for Planning and Budgeting will be represented in this forum. Representatives from major financiers must be individuals who are able to make funding commitments. It will meet in Nairobi once a year.

3. Health Sector Committee (HSC)

A completely new HSC will focus on technical issues, not financing. It will comprise representatives of agencies that are providing advice on the design of health programmes, rather than their funding. The Health, Nutrition and WASH Clusters operating under the UN

Office for the Coordination of Humanitarian Affairs should be included on this Committee. The main task of the Committee is coordination – harmonizing programmes that are being supported by all actors, avoiding duplication, preventing geographic imbalances in inputs, avoiding conflicting activities and flagrant inefficiencies. The other work of this committee will be to plan in detail the JAR of the health sector. Finally, it will provide technical guidance to the MOH – for example sharing new global approaches to health issues or new learning from programme experience. The Health Sector Committee will not make any funding decisions. It will meet once every six months (twice a year) in Nairobi.

This structure replaces all existing Committees that are currently involved in the Somalia health sector and a consensus on these new arrangements needs to be facilitated. Terms of Reference and membership for each of the three key committees will then need to be written.

MONITORING, EVALUATION AND REPORTING ARRANGEMENTS:

The HSSP II has been developed in line with the NHP I, NDP I 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 I 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 Section 6.

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 EPHS Compass is the primary tool for capturing all data. The HMIS officers will be responsible for compiling and disseminating these reports.

Quarterly Performance Review Reports

Quarterly sector performance review reports, based on the EPHS Compass, will be presented by the various sector technical working groups during the sector quarterly review meetings. Quarterly 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 using EPHS Compass tools. 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 the HSSP II performance report for use by all stakeholders. The AHSPR 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 Health Review Forum 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 (EPHS Compass) 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) 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) through the EPHS Compass toolkit.

Performance monitoring and review for global health grants

Under the Global Health Initiatives, the health sector is supported through initiatives like the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) 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 the EPHS Compass 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 using specifically adapted EPHS Compass reporting tools.

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 30 months. 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?

Annex 1: Operational Plan 2017

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 & Deliverables	Responsibilities	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
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 Comprehensive Emergency Obstetric and Neonatal Care (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	Director of Planning	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 Implementation Plan including demand creation activities	New			X	X	Mental health implementation plan	Director of Planning	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	New		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
Strategy 1.2 Integration of community based health and nutrition services in EPHS									
1.2.1	Map all community based health and nutrition services	New		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	Ongoing		x	x	x	100 new FHWs are deployed in Togdher and Awdal regions	Director of Planning/HSS unit	UN and INGOs
1.2.3	Expand Community Based Health Service through the provision iCCM	Ongoing		x	x	x	120 iCCM sites in 4 regions of Somaliland	Director of PHC	UN and INGOs
1.2.4	Develop a specific strategy to address health needs of nomadic populations	New		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	New			X	X	Nomadic service delivery plan	Director of Planning	UN and INGOs
1.2.6	Implement community based integrated reproductive health outreach services	Ongoing		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	Ongoing			X	X	Nutrition mobile OTPs	Nutrition unit	UN and INGOs
1.2.8	Implement community-led total sanitation (CLTS) in all regions of Somaliland	Ongoing		x	X	X	CLTS in all regions	Director of Public Health	UN and INGOs
1.3 Specialised interventions for non-communicable diseases (see also SO 9.2)									
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
1.4 Improving quality of care/ patient safety									
1.4.1	Implement EPHS Compass QA monitoring system including EPHS scorecard	New			X	X	EPHS Compass piloted in Karkar 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 standardized 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

1.5 Demand creation and implementation of BCC strategy (see also SO 9.2)										
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 programmes including birth spacing, FGM, immunization, malaria, TB and HIV	New		X	X	X	MoH integrated awareness programme	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	
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)	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 Burco	TB Unit	MoH and WVI	
1.6.5	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	
1.6.6	Implement at least 4 rounds of national immunization days (NIDs) for polio	Ongoing	X	X	X	X	4 NIDs conducted	EPI unit	MoH and UN agencies	
1.6.7	Implement EPI outreach services in 7 priority districts	New	X	X	X	X	regular outreach sessions conducted in 87 priority districts	EPI unit	MoH and UN agencies	
1.6.8	Implement one round of measles catch-up campaign	New			X	x	1 round of measles catch campaign	EPI unit	MoH and UN agencies	
1.6.9	Integrated reproductive health outreach in all regions of Somaliland	Ongoing		x	x	x	3 outreach session (1/quarter for 3 quarters)	RH unit	MoH and UNFPA	
1.6.10	Nutrition mobile teams to implement IMAM (OTPS) in all regions of Somaliland	Ongoing	x	x	x	x	Mobile OTPs in all regions	Nutrition unit	MoH and UNICEF	

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										
	Activities	New/Ongoing	Timeline				Milestones & Deliverables	Responsibilities		
			Q1	Q2	Q3	Q4		MoH Point	Focal	Implementing Agency
2.1 Improved Human Resource policy, planning and management										
2.1.1	Implement equity-focused Human Resource In-service Development and Management Plan	Ongoing		x		x		HRH Team	MoH and partners	
2.1.2	Develop GESI-sensitive performance appraisal systems and implement	New					At least 1 performance appraisal should be conducted for all HWF		MoH and partners	
2.1.3	Hire HR officers for the 7 priority districts	New	x	x			At least 1 HRH focal recruited in 7 districts	HRH Team	MoH and partners	
2.1.4	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	
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 practitioners In collaboration with training institutions	Ongoing	x	x	x	x	At least 30 midlevel 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	New					Assessment report	HRH Team	MoH and partners	
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 (M/F) 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
2.3 Health professionals registered, licensed and accredited									
2.3.1	Enhance electronic employee database	Ongoing	x	x	x	x	HRMIS AND DHIS2 integrated	HRH Team	MoH and partners
2.3.2	Register and license at least 40% of health professionals	Ongoing	x	x	x	x	HRMIS AND DHIS2 integrated	HRH Team	MoH and partners
2.3.3	Establish HRMIS linked HMIS/DHIS2	New			x	x	HRMIS and DHIS2 Integrated and established	HRH Team	MoH and partners
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
2.5 Availability of standardized training guidelines, material and protocols									
2.5.1	Implement 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
2.6 Implementation of in-service training plan									
2.7.5	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
2.6.1	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
2.6.2	Implement internship programme for newly graduated students	Ongoing		x	x	x	80% of graduate students should have completed their internship by the end of the year	HRH Team	MoH and partners
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	Ongoing	x	x	x	x	Meeting minutes	HRH Team	MoH and partners

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									
	Activities	New/Ongoing	Timeline				Milestones & Deliverables	Responsibilities	
			Q1	Q2	Q3	Q4		MoH Focal Point	Supporting Agency
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
3.2 Strengthen in country Health Sector Coordination									
3.2.1	Establish in-country 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 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 National HSC	New		X			National Immunisation Coordination Committee established with ToR, Membership criteria and annual work plan	Director of Planning	WHO
3.3 Improved management and institutional capacities with enhanced decentralization									
3.3.1	Strengthen regional health management team and build their capacity	New		X	X	X	regional health management team Strengthened	Director of Planning	WHO
3.3.2	Conduct workshop to launch the functional review in 2017	New		X			Functional review workshop launched	Director of Planning	WHO
3.3.3	Provision of technical assistance in M&E, HMIS, research, policy & planning and community based services with a focus on equity	Ongoing	X	X	X	X	Technical HMIS, M&E, policy and planning advisors in place	Director of Planning	WHO
3.3.4	Establish 19 district health boards with clear TORs	New	X	X	X	X	District health boards established and their TORs developed	Director of Planning	WHO
3.3.5	Strengthen the operational structure and implementation arrangements at regional level (health facility, regional health board, community committees)	New		X			Regional health system re-structured and Strengthened	Director of Planning	WHO
3.3.6	Train the regional and district health boards and community health committees 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
2.1.6	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 midlevel managers	new		x	x	x	At least 30 mid level managers trained in HRH LM&G	Director of Planning	all partner
3.4 Improved engagement and involvement of communities (including women and representatives of vulnerable groups) in planning, delivery and review of health services									

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 representatives of vulnerable groups								
3.4.3	Review: Develop, implement and review 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 & Deliverables	Responsibilities	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
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	Director of Planning /Partners	
4.1.2	Develop a drug regulation training module and implementation plan (TA and workshops)	New		X			Drug regulation training module	Director of Planning	
4.1.3	Conduct feasibility study on development of registration database of imported medicines and medical equipment	New		X	X		Feasibility study	Director of Planning	
4.1.4	Develop registration system for private sector wholesalers, retailers and pharmacies	New		X			Private registry	Director of Planning	
4.1.5	Develop Inspection Plan for public and private sector pharmacies and pilot implementation of the plan	New			X	X	Inspection Plan for public and private sector pharmacies developed	MOH	
4.1.6	Develop guidelines on good dispensing practices	New			X	X	Guidelines distributed	ALL Directors	
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	Director of Facilities	
4.2.2	Conduct spot checks on public and private pharmacies to sample drug and equipment compliance with regulations	New			X		Spot check conducted	Director of Facilities	

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	Director of Facilities	
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, NGOs and MOH	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	Director of Facilities	UN and NGOs
4.3.3	Begin implementation of supply chain master plan	New		X			Supply chain master plan implemented	Director of Facilities	
4.3.4	Link LMIS and DHIS2 and use data as part of EPHS Compass Performance Management Dashboard	New		X	X		LMIS tools adopted	Director of Planning	UN and NGOs
4.4 Improved / rational use of drugs									
4.4.1									
4.4.2									

SO 5: Effectively functioning health information system									
To establish an effective health information system that provides 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 & Deliverables	Responsibilities	
			Q1	Q2	Q3	Q4		MoH Focal Point	Supporting Agency
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	New				X	JAR conducted annually	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
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	New	X				Print HMIS tools to all Puntland HF's	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 Somaliland regions	New	X				Roll out of DHIS2 to all regions in Puntland implemented and generated HMIS data	HMIS Unit	MoH
5.2.5	Strengthen the Information Technology Unit (IT) within the Ministry of Health	New	X	X	X	X	MoH IT Unit strengthened	IT Unit	MoH
5.2.6	Conduct quarterly data quality audits to health facilities in Somaliland	Ongoing/New	X	X	X	X	4 DQAs conducted and DQAs reported produced	HMIS Unit	MoH
5.2.7	Monthly and quarterly integrated supportive supervisions	Ongoing/New	X	X	X	X	4 quarters ISS conducted	HMIS Unit	MoH
5.2.8	Conduct quarterly data quality audit feedback meetings and reports	Ongoing/New	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	New			X	X	Community service data available	HMIS Unit	MoH
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
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 relationship 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 analyzed	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	Step-wise survey	New		x	x	x	Step-wise survey conducted and reports produced	Research Unit	MoH
5.4.11	Conduct research on mental health problems	New				x	Research on mental health problems conducted and data available	Research Unit	MoH
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	Director of Planning	MoH/WHO
5.5.3	Evaluate the system and develop a plan to scale up	New				x	Evaluation of CRVS system implemented	Director of Planning	MoH/WHO
5.5.2	Expand the CRVS tools to one other district	Ongoing			X	X	CRVS expanded to one other district	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

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

	Activities	New/Ongoing	Timeline				Milestones and Deliverables	Responsibilities		
			Q1	Q2	Q3	Q4		MoH Point	Focal	Implementing Agency
6.1 Health financing strategy development and implementation										
6.1.1	Review and finalize Somaliland Health Financing Strategy	New		x	x		Health Financing Strategy	DoP/Health financing unit	MoH/WHO	
6.1.2	Start the implementation of Health Financing Strategy	New			x	x	Health Financing Strategy	DoP/Health financing unit	MoH/WHO	
6.1.3	Support MOH Health financing unit (operational support)	New		x	X	X	Operational support for HF unit	DoP/Health financing unit	MoH/WHO	
6.1.4	Capacity building for MoH relevant department/personnel on applied health economics, health financing and resource management (Somaliland MoH, 2016)	New				X	20 relevant staff trained on health financing topics	DoP/Health financing unit	MoH/WHO	

6.1.5	Conduct public health expenditure review, including monitoring progress in tackling inequalities	New			x	x	PHER	DoP/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	DoP/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	DoP/Health financing unit	MoH/WHO
6.1.8	Develop National Health Account (with financial tracking component)	New				X	First draft NHA	DoP/Health financing unit	MoH/WHO
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 audits and GESI-sensitive budgeting and review)	New		x	x	x	TA provided	Admin/ Finance department	MoH and partners

SO 7: Improving health sector 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
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	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	Solar energy systems installed for all health facilities	Director of Planning	MoH and UN agencies

7.1.6	Establish fully functional blood bank in Burco Regional hospital	New			x	x	Fully functional Blood Bank established in Burco Regional Hospital	Director of medical service	MoH and UN agencies
7.1.7	Establish public health reference laboratories	New			x	x	Public Health Laboratory Reference 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

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**

	Activities	New/Ongoing	Timeline				Milestones & Deliverables	Responsibilities	
			Q1	Q2	Q3	Q4		MoH Focal Point	Supporting Agency
8.1 Strengthen emergency preparedness and response capacity									
8.1.1	Develop GESI-sensitive 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 regional and district level	Ongoing	X	X	X	X	6 regional teams and 19 district teams trained	MoH	MoH/ Partners
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	Revamp and support emergency coordination clusters	Ongoing	X	X	X	X	Emergency coordination sectors	MoH	MoH/ Partners
8.2.3	Conduct regular cluster coordination meeting	Ongoing	X	X	X	X	Cluster meeting	Director of Planning	MoH/ Partners
8.3: Basic health and nutrition humanitarian services in non-EPHS areas									
8.3.1	Support basic health and nutrition services in MaroodiJeex, Sool and Sanaag regions	Ongoing	X	X	X	X	basic health and nutrition service provided	MoH	MoH/partners

8.3.2	Integrated reproductive health outreaches in MaroodiJeex, 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	Director of Family Health	MoH/partners

SO 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									
	Activities	New/Ongoing	Timeline				Milestones and Deliverables	Responsibilities	
			Q1	Q2	Q3	Q4		MoH Focal Point	Implementing Agency
9.1 Effective mechanism for inter-sectoral collaboration ensuring Health in all policy									
9.1.1	Establish inter-ministerial committees (TOR) including representation from communities	New	X				Terms of reference developed	Department Planning	MoH
9.1.2	Conduct inter-ministerial coordination meetings	New		X	x	X	Meeting minutes	Department Planning	MoH
9.1.3	Develop inter-ministerial action plan on SUN and CARMMA	New	X	X	x	x	Action plan for SUN and CARMMA	Department Planning	MoH
9.2 Determine priority health promotion, disease prevention and behaviour change programmes (see also SO 1.3, 1.6)									
9.2.1	Implement the C4 D strategy by conduct series of workshops with PSI, other IPs and ministries to develop priorities for messaging and BCC	Ongoing		X	X	X	CD4 strategy implemented	Department Planning/Public Health	MoH, PSI, NGO
9.2.2	Develop radio script and production	Ongoing	X	X			Radio script and production developed	Department Planning/Public Health	PSI, NGO
9.2.3	Airing of radio programme	Ongoing		X	X	X	Radio program aired	Department Planning/Public Health	MoH
9.2.4	Oversee implementation	Ongoing		x	X	X	M&E reports	M&E Unit	MoH

