SOMALI HEALTH POLICY

The Way Forward

PRIORITIZATION OF HEALTH POLICY ACTIONS IN SOMALI HEALTH SECTOR

Approved by the Health Advisory Board
September 2014

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The *'Somali Health Policy'*:
Prioritization of Health Policy Actions in Somali Health Sector

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FOREWORD

The prioritization of health policy actions in the Somali health sector encompasses a vision and a mission founded on identifying priority policy issues supporting access to essential health care services, aiming to protect and promote the health of individuals and the communities. The policy adopts the six health system building blocks' perspective, yielding a positive impact on the aspirations for universal health coverage, equity in the delivery of health services and in the attainment of health-related Millennium Development Goals (MDGs). In addition; the policy also aims at providing a legitimate space to the population demands in the access to care and participation debate, and creating a health supportive organizational environment at the regional and local government level, offering a reliable degree of diversified governance and financing mechanisms for health services, while keeping the strong leadership and influence of the public health sector. The policy endorses gender aspects of health care, envisaging integration of women's health needs into policy formulation and implementation processes, through promoting gender equity over a range of health indicators. The policy promotes networking and building partnerships with potential health sector's stakeholders including civil society and private sector, with greater coherence among development activities.

Through shared prioritization of health policy actions, the Somali health authorities have realized the need to jointly interface with their international counterparts, through an umbrella course of actions, encompassing their key public health aspirations, and integrating ongoing targeted humanitarian support to the currently pursued focus on health system development paradigm and accelerated progress towards the health related MDGs. The health policy will direct its emphasis on the six health system building blocks as key policy priorities, that include governance, service delivery, human resources for health, access to essential medicines and technologies, health management and information system and health financing. Moreover, the policy will accentuate health infrastructure rehabilitation; health sector partnership and coordination; promoting aids effectiveness and the importance of monitoring and evaluation.

The prioritized health policy directions are fully aligned with the Somali Compact strategy, stipulated within the New Deal framework, planned over three years (2014-2016) aiming to lead the path of recovery, development and durable peace. The strategy represents a commitment to scale-up and expand basic health and social services including health care, nutrition, hygiene, water and sanitation services, to all geographical areas providing a great potential and momentum for the rapid implementation of the settled priorities in the policy. Furthermore, the policy acknowledges the direct impact of the operational choices that have been made by other sectors on the health sector, using the "Health in All Policies" approach in public policies and deliberations. Accordingly, the policy emphasizes the forging of the widest possible partnerships to effectively translate these priority health policy themes into practical implementation.

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Acronyms

ART	Anti-Retroviral Therapy
BEmOC	Basic Emergency Obstetric Care
CHWs	Community Health Worker
CEmOC	Comprehensive Emergency Obstetric Care
CAP	Consolidated Appeals Process
EPHS	Essential Package of Health Services
FCHWs	Female Community based Health Workers
FGM	Female Genital Mutilation
FSNU	Food Security and Nutrition Unit
EPI	Expanded Programme on Immunization
GAVI	Global Alliance for Vaccine and immunization
GAVI-HSS	GAVI - Health System Strengthening
GFATM	Global Fund to fight against AIDS, Tuberculosis and Malaria
HC	Health Centre
HIA	Health Impact Assessment
HMIS	Health management Information System
HSSP	Health Sector Strategic Plan
HIV/AIDS	Human Immunodeficiency Virus Infection/Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
IDPs	Internally Displaced Persons
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illnesses
ITNs	Insecticide-Treated Bed Nets
IVM	Integrated Vector Management
JHNP	Joint Health and Nutrition Programme
JPLG	Joint Programme on Local Governance
LLINs	Long Lasting Insecticide Treated Bed Nets
MNCH	Maternal, Neonatal and Child Health
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
NCDs	Non-Communicable Diseases
NHPC	National Health Professional Council
PHU	Primary Health Care Unit
RHC	Referral Health Centre
RHO	Regional Health Officer
RDT	Rapid Diagnostic Test
RDF	Revolving Drug Fund
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UHC	Universal Health Coverage
WHO	World Health Organization

1. INTRODUCTION

The Somali population has experienced a prolonged conflict spanning over two decades since December 1990, with more than 40% of the population living on less than US$ one dollar a day and 73% on less than US$ two dollars per day (World Bank 2011). The Somali population can be classified into pastoralists, agro-pastoralists, coastal and riverine rural populations, with a third of these residing in urban settings. During this period, much of the public health infrastructure was destroyed with significant deterioration in the delivery of health services, while the sustained international partners' support has significantly contributed in bridging the gap in the delivery of the urgently needed essential health services. Somaliland and Puntland have remained relatively stable, where the peace dividend has mitigated the impact of some of the sizeable challenges encountered by the health system.

The health system support is provided through a two pronged approach, the first is the multi-year Consolidated Appeals Process (CAP) or the humanitarian response plan, aimed to deliver relief operations, currently targeting a population of about 1.1 million internally displaced persons (IDPs) and focusing its planned efforts during 2013-2015 on promoting the recovery and resilience of the health system. These interventions are also designed to deal with future crises, reduce vulnerability and lead to robust resilience building activities, while disaster risk reduction and management will shape the longer term perspective action agenda. The second approach is launched in the framework of a health sector development process, through the implementation of the essential package of health services (EPHS), and health system strengthening, aiming at improving equitable access to acceptable, affordable and quality health services. This developmental health process envisages the scaling up of government leadership, management and service delivery capacity, while sustaining health partners' support, thus averting the transitional funding gap, often encountered during the post-conflict period, when the health system is transiting to recovery, institutional building and development.

Although the prospect of sustaining the targeted humanitarian health interventions in the short and medium terms is essential, yet the foregoing programmatic interventions clearly illustrate the Somali health system's urgent need for a paradigm shift, heading towards a future of continued long term development process, leading to universal health coverage (UHC) and the attainment of health related Millennium Development Goals (MDGs), as well as positioning health in the post-2015 development agenda. To develop the required capacity for the health sector and increase partners' collective support, the Somali health authorities realize the need to jointly interface with their international counterparts, through an umbrella policy, encompassing the health authorities' key public health directions. The policy will illustrate the shared commitment to the post-conflict health development principles of enhanced levels of accountability, reaffirmation of the EPHS programme implementation and strengthening the decentralization and participation processes. It will also aim at scaling up local interventions, promoting human resource and leadership development, building effective partnerships and integrating the ongoing targeted humanitarian support to the currently pursued health system development.

Translating this health policy into action will effectively contribute to health system reconstruction and strengthening and invigorate the government commitment to scale up its budgetary outlays for the health sector. The health policy directions are aligned with the Somali Compact strategy, stipulated within the New Deal framework and planned for three years (2014-2016) which will lead to the path of recovery, development and durable peace. This framework incorporates a commitment to expand basic health, nutrition, hygiene, and water and sanitation services to all geographical areas. Through this new paradigm, the joint health policy will provide a momentum for the public health sector authorities to exert greater legitimacy in the provision of essential services to the Somali population and mobilize civil society organizations and communities to strategically focus their attention on the selected policy directions.

2. BACKGROUND INFORMATION AND POLICY DEVELOPMENT PROCESS

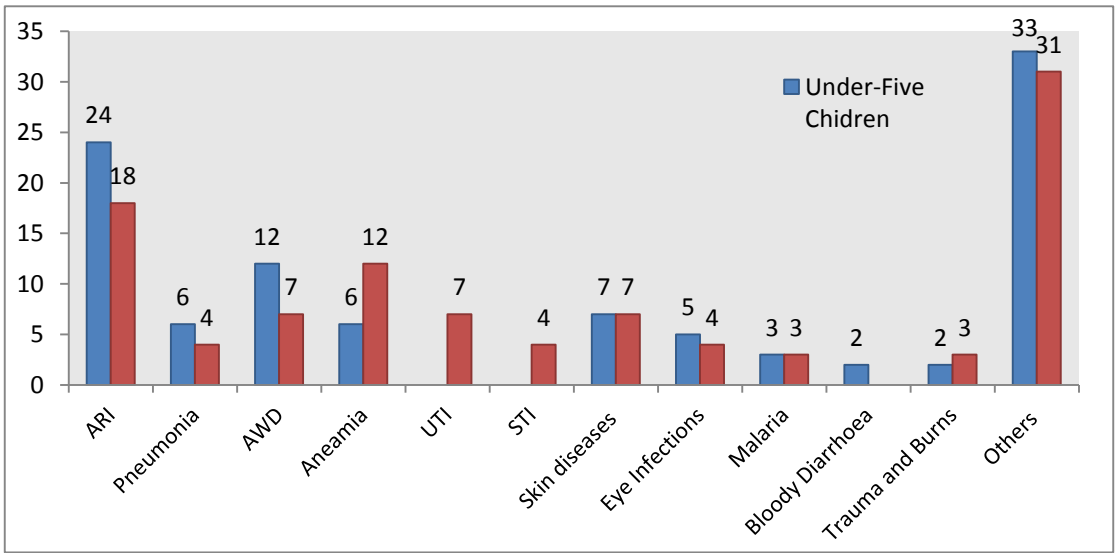
The policy development process was based on extensive consultations organized at each health authority level, led by the Somali Federal Ministry of Health (MOH), the Puntland MOH and Somaliland MOH, respectively. Following the initial high level contacts with the Ministers of Health, consultation workshops were organized and steered by the Director Generals of these ministries and attended by all heads of departments and by the health development partners operating within the framework of the health sector.

WHO/UN offices in the field actively participated and assisted this process, while in Mogadishu and Garowe, the Banadir University and the Puntland Development Research Centre (PDRC) provided additional organizational support to these consultations. The participants gave due consideration to the status, trends, challenges and achievement of the health sector and engaged in an iterative process of plenary and group work sessions and generated through consensus, a range of health policy priority directions. These policy directions were made in coherence with the formulated zonal health strategic plans for their effective implementation. Throughout this engagement, there was a common understanding among health stakeholders that the health policy deliberations will exhibit the vital role of the health sector in the overall socio-economic development and improving the health and well-being of the population.

3. HEALTH STATUS

The epidemiological profile in the different Somali zones is characterized by high maternal neonatal and child mortalities, prevalent communicable diseases, high rates of under-nutrition and a range of other public health problems, while the non-communicable diseases are gaining momentum, although not captured by the current health information system. Table 1 below provides a summary account of the health management information system (HMIS) data collection and analysis. The health system is also faced with a high burden of tuberculosis and malaria, with imminent risk of an explosive human immunodeficiency virus infection/acquired immune deficiency syndrome (HIV/AIDS) epidemic. The figure below illustrates the epidemiological profile, as portrayed by the 2011 HMIS data, reported by United Nations Children's Fund (UNICEF).

Figure 1. Proportional distribution of Health facility visits due to specific diseases as reflected by the HMIS 2011 Report



Source: (HMIS 2011 report) reported by UNICEF

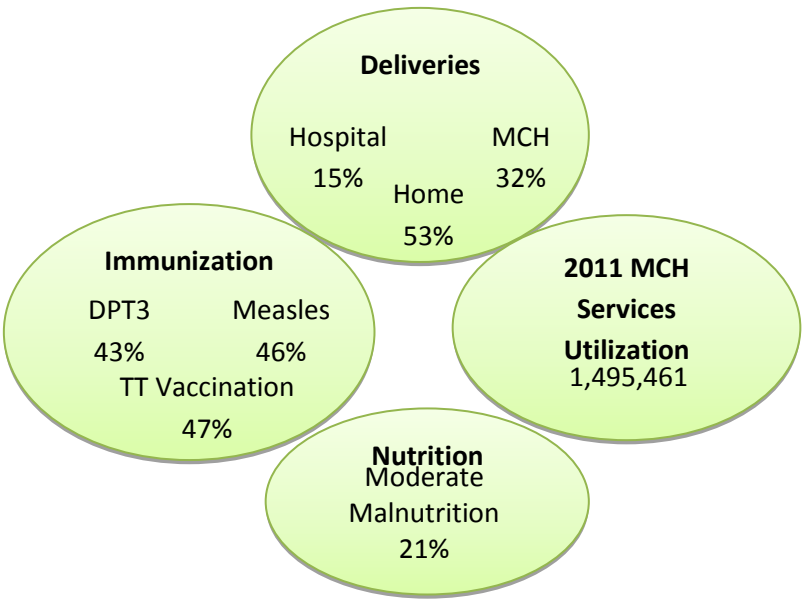
Table 1 shows the status of key reproductive health indicators that puts Somali mothers and children in a highly disadvantaged health condition.

Table 1. Indicators reflecting the poor coverage of Reproductive Health Services

Indicators	Somaliland	Puntland	Central South Somalia	Source
Total fertility rate (TFR)	5.9	6.2	7.1	MICS 2006/ and (WHOSIS) 2008
Modern Contraceptive prevalence rate (%)	4.6	0.1	0.3	MICS 2006
Maternal Mortality Ratio	1044-1400	1044-1400	1044-1400	MICS 2006, MDGs' reports
Ante natal care coverage ANC at least one visit (%) ANC at least 4 visits (%)	 32 10.3	 26 5.8	 24 5.2	HMIS report-UNICEF 2011
Births in a health facility (%)	21	8	6	HMIS report-UNICEF 2011
Births attended by skilled health personnel (%)	21	7	6	HMIS report-UNICEF 2011
BEmOC facilities per 500,000 population	1.1	0.1	1.3	MICS 2006
CEmOC facilities per 500,000 population	1.7	2.2	1.7	HMIS report-UNICEF 2011
Low birth weight prevalence	6	11	21	UNICEF 2008
Reported prevalence of FGM	94	98	99	MICS 2006
Under-five mortality rate per 1000 live births	116	135	200	MICS 2006 & 2011, MDG zonal reports
Infant mortality rate per 1000 live births	73	86	119	MICS 2006, MDGs' zonal reports
Moderate malnutrition rate	10	15	28	MDG reports

The limited access and utilization of essential reproductive health services, low vaccination coverage against vaccine preventable diseases and high rates of under-nutrition depicted in figure 3 below, corroborate the gravity of above indicated underprivileged outcomes of the health system.

Figure 2. Health services utilization and paucity of Service Delivery



Source: 2011 HMIS Updated Report, 2012

The legacy of the past two decades has escalated the burden of communicable diseases, with acute watery diarrhoea and acute respiratory infections being among the top 10 causes of high burden of disease, while tuberculosis is highly prevalent with an incidence estimated in 2011 at 300 cases per 100,000 population of which fewer than 50% are detected, with an MDR of 5.6% among new TB cases and 46% among retreatment TB cases. Malaria is an endemic disease in which the majority of the population is exposed to mesoendemic transmission and the remaining live in hypoendemic transmission geographical areas. The HIV epidemic is also growing with a population prevalence rate of about 1% with significantly higher prevalence seen among the high risk groups, thus constituting an unnoticed threat to the health of the population. Moreover, a number of neglected diseases that include Visceral Leishmaniasis, Schistosomiasis and Leprosy predominate in the riverine areas of South Central Somali, while, intestinal worm infestations are prevalent in all the geographical areas, collectively posing control challenges to the health system. Moreover, there is a noted growing burden of non-communicable diseases (NCDs) especially those related to cardiovascular diseases, diabetes, cancers and chronic pulmonary diseases, while WHO reported mental disorders are considerably high with 33% of the population afflicted by some kind of mental health problem.

4. Overview of Health System Organization and Structure

4.1. The public Sector

The organizational and management structure of the Somali health system comprises of four facility-based health care provision levels and a community based programme, collectively aimed at providing the maximum coverage of health services to the population (figure1). These include the primary health care units (PHUs) located in the most peripheral geographical areas, covering a defined catchment area population with basic promotive, preventive and simple curative services. The PHU is operated by at least one community health worker (CHW), supported by the local leaders in the organization of health services delivery. PHU services are also reinforced by the health centre (HC) outreach support, particularly in services related with the expanded programme on immunization (EPI) and nutrition promotion and education.

The next higher facility based level to the PHU is the Health Centre (HC), operated by qualified nurses and midwives, and nurses particularly trained on EPI and nutrition. Each HC serves the catchment area population of two or more PHUs. A major function of the HC is the provision of basic emergency obstetric care (BEmOC) services supported by a number of delivery beds provided for this purpose.

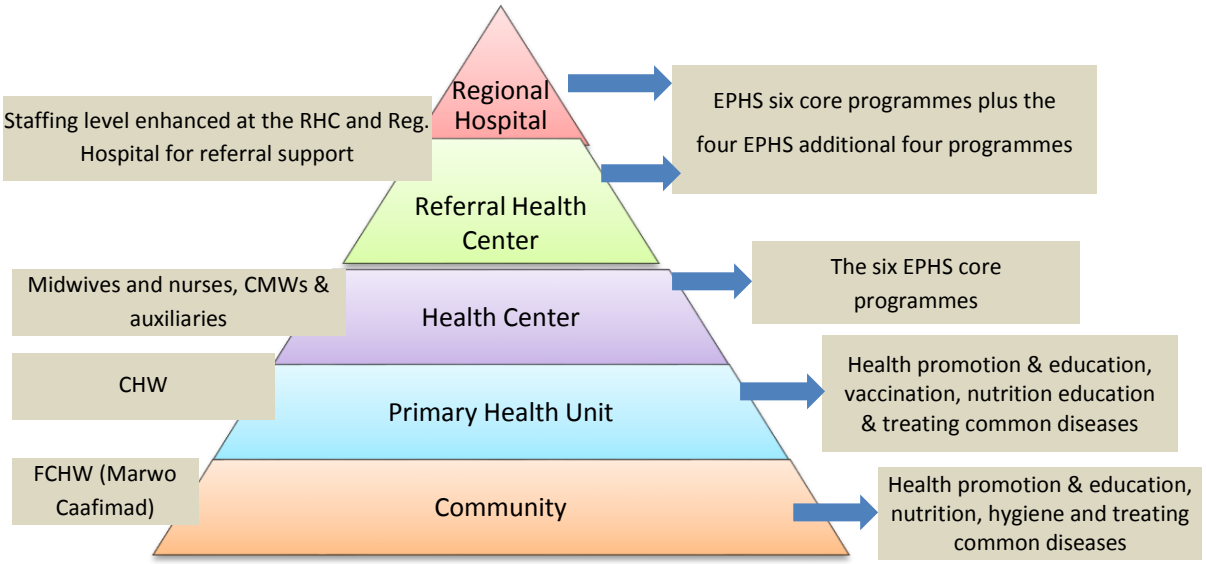
A number of maternal and child health (MCH) care facilities are also operating at district level, where technical capacities for establishing HCs are not available. MCH centres provide a package of services at a lower scale to those delivered by the HC.

The third facility based level is the referral health centre (RHC) or the district hospital. Although there is a lack of accurate estimates of the catchment area population for health facilities, it may be approximated that on average RHCs, HCs and PHUs will serve a population of about 100,000; 30,000 and 5,000 respectively. These facilities are expected to provide important referral support functions that include the comprehensive emergency obstetric care (CEmOC) services, implying the availability of appropriate facilities and trained technical staff. The RHC serves the catchment area populations of several health centres.

The principal referral facility based level is the regional hospital expected to provide major health care speciality services performed by a number of qualified medical and midlevel health professionals and support staff. The PHUs and HCs report to their district health officers, who along with the hospital director report to the regional health officer (RHO). The above multilevel facility

structure was recently supplemented by a community based programme, where trained Female Community Health Workers (FCHWs) named as "Marwo Caafimad" are recruited applying strict selection criteria, with defined age range, education level, residing within their communities and having their acceptance and support. FCHWs operate from their homes and conduct home visits to provide their assigned services at the household doorstep. The FCHWs are supported and supervised by specially trained FCHW supervisors.

Figure 3. The Regional Health System Organization, Staffing and Performance functions



4.2. The Private Sector

During the past two decades, a major expansion of the private health sector was witnessed in all the zones, ranging from traditional, private-for-profit and private-not-for-profit health facilities that include training institutions, small scale clinics and diagnostic facilities to full-fledged general hospital settings providing specialized care. This extensive network is more frequently used in the urban areas that account to about 30-35% of the population, relative to the public sector, and a considerable proportion of these services are usually sought in private pharmacies, while the nomadic and rural populations have limited access to this less affordable health care. The import and sale of medicines and technologies is also largely private, apart from those provided to government and international partners' supported health programmes and interventions. The current lack of or weak regulatory norms for monitoring the private health sector is illustrated by the absence of implemented standard guidelines of quality and safety for private health practices and pharmacy and pharmaceutical regulations. On the other hand, there are commendable public private partnership efforts in pre-service education of midlevel categories especially community midwives with the potential to expand access to essential health services. The centuries old flourishing traditional, spiritual and herbal medicine practices often delaying the utilization of modern health services need also to be carefully assessed in terms of efficacy and safety, for their potential mainstreaming in the health care system.

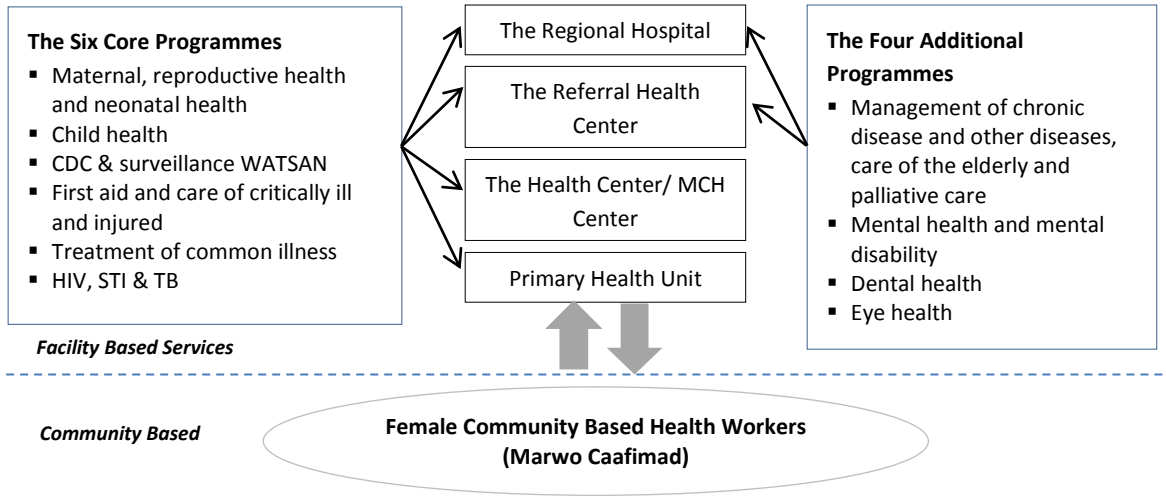
5. The Current Status of Somali Health System

5.1. Health Service Delivery and the Essential Package of Health Services

The EPHS constitutes a fundamental outline and framework for the organization of the Somali health care delivery system. It is founded on a standardized package of health services, comprising of six

core and four additional programmes that need to be delivered in the four health care provision levels (Figure 4). The health workers, the essential drugs and technologies necessary for implementing the EPHS programmatic interventions were also standardized. Although the long term vision of EPHS is to provide UHC to the entire population, its current performance capacity is limited to a number of regions in each zone. The accelerated control of vaccine preventable diseases; the control of major communicable diseases focused on the fight against AIDS, tuberculosis and malaria and the primary prevention and management of non-communicable diseases, particularly mental health disorders, are integral components of the EPHS programme. The provision of effective service delivery is facing many challenges such as inadequate access and underutilization of available services corroborated by the low immunization coverage; poor regional and district leadership skills and managerial capacities; insufficient capacities and resources for supervision, monitoring and evaluation; fragmented multi-stakeholder service delivery with weak mechanisms for coordination and the lack of linkages between the private health sector performance and the public sector EPHS. Moreover, the local communities are not sufficiently empowered to make healthy decisions and actively participate in improving their health status, while cultural and economic factors also contribute to decrease utilization of available health services.

Figure 4. The ten EPHS Programmes implemented at the four health care provision levels and the recently introduced Community Based Level of care



5.2. Human Resources Crisis and the Need for Action

The Somali human resource for health (HRH) crisis is of a highly significant magnitude, ranking among the worst in the world. Considering the global thresholds set by WHO for the collective density of doctors, qualified nurses and qualified midwives of 23 per 10,000 population, representing the minimum coverage level, necessary to support the realization of UHC alongside the attainment of the health related MDGs. The cumulative Somali score ranges between 3 and 4 per 10,000 population. This population coverage level is six to seven times lower than the minimum threshold indicated by WHO, posing a real challenge for expanding the coverage of health services, particularly to the rural areas.

The recent FCHWs integration into the health system network and recognition of the effectiveness of midlevel health professionals may provide a policy window for accelerating the HRH development; contribute to workforce equitable distribution; reduce the glaring rural-urban disparity and improve maternal, reproductive, newborn and child health outcomes.

The salient human resource challenges of the health sector include shortage in the training and production of qualified health workers; the difficulty to realize the desirable workforce skill mix; the lack of uniform standards for workforce training curricula, educational programmes, certification and accreditation systems; inadequate teaching facilities; low and ineffectively harmonized salaries and incentives and poor working environments that have a major bearing on the quality of services delivery, performance, motivation and retention of the health workforce.

5.3. Leadership and Governance

Governance is a major component of health system strengthening, addressing a range of interventions that include the restructuring, setting of regulations and operational procedures and their application, transparency in recruitments with sound leadership at all levels, as well as the building of mechanisms for effective partnerships and coordination. The long term post conflict legacy has posed important challenges to health system governance, from inadequacies in health system infrastructure; weak institutional capacities and lack of explicit strategies for public health sector accountability; inequity in the delivery of health services; lack of inter-sectoral approach for health; weak operational decentralization of health system management and poor regulation of health professions education and absence of standard mechanisms for accreditation, registration, licensing and performance management based on clear job descriptions.

5.4. Essential Drugs and Technologies

Access to essential drugs is one of the key building blocks of the health system. Essential medicines and technologies play a critical role, and when affordable, in good quality and rationally used, can effectively respond to a major part of the health needs of the population. The EPHS has contributed to standardization of medicines supplied to the different levels of care provision, with treatment guidelines available for some of the core programmatic interventions. Although efforts to revitalize the pharmaceutical system were recently initiated by the various health authorities, yet the challenges being faced are characterized by a lack of effectively functioning drug quality control laboratories and medicines regulation and control. The weak medical supply chain management system is another challenging area of concern, while the high prevalence of traditional products and over-the-counter medications and unsafe injection practices are areas that need the requisite policy directions.

5.5. Health Information System

The Health Information System (HIS) is one of the key components of the health system and plays a major role in evidence based decision making, on all aspects related to the other five building blocks of the health system, and particularly, for health policy priority setting. The Somali HMIS data are generated through the analysis of the routinely collected information from the outpatient departments of public health facilities, including hospitals. These data are complemented by the information generated from key vertical programmes and through the disease surveillance system. However, no data are routinely generated from the in-patient facilities or from the other components of the health system, medicines, supplies and equipment and human and financial resources. Frequently cited challenges include limited data base, absence of health research agenda and the inadequate capacity for the timely collection of health data, reporting, analysis, dissemination for evidence based decision making and use of information for planning and implementation.

5.6. Health Financing

The health sector's under-funded budgetary outlays are severely inadequate for covering the basic health services, in terms of procurement and supply of medicines, the purchase of essential technologies and vaccines and remuneration of the health workforce to maintain basic living

standards. The earmarked resources for the health sector range between 3-6% of the modest government budgets in all the three zones, which are significantly short of covering the essential health needs of the population. This evident resource gap in the health sector is partly bridged through the generous contributions provided by the international health partners and through the private health sector services in urban settings and the diverse non-for-profit organizations offering a reasonable range of services to the population. The challenges of health financing include the insignificant government contributions to health; the low pay and incentive packages for health care professionals; total absence of social health insurance systems and heavy reliance for many on out-of-pocket expenditure, that can hinder patients' health seeking behaviour and affordability, thus exacerbating the inequitable access to available essential health services.

6. PUBLIC HEALTH PRIORITY DIRECTIONS:

6.1. The Rationale

The three health authorities have deliberated on their distinct health policy orientations, outlining a wider and ambitious framework of action that will guide their distinctive health development pathways. However, the contributions of the different health authorities and their inevitable joint collaboration with development partners will need to be harmonized through a flagship health policy, addressing the key policy priority directions outlined by each. The shared policy aspiration will reflect the public health unity of purpose, increase coordination and coherently help focus on interventions that have the highest technical and allocative efficiencies by targeting the most cost effective programmes that yield the greatest amount of health improvement in the Somali population.

6.2. Basis of the policy priority directions

The Somali health sector policy priority directions are based on the contextual challenges, efforts and successes pursued for achieving the set health goals. The policy must take into account, the individual health policies, deliberated by the health authorities, and the distinctive successes made in the areas of service delivery of promotive, preventive, curative and rehabilitative health interventions (see annex tables). It is also founded on achieving the basic prerequisites for good health governance, leadership and institutional building; human resource development; taking the first steps towards UHC and the attainment of health related MDGs. The policy endorses the WHO health definition, where health is: "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" and recognizes health as a universal right of every individual and family, regardless of their socio-economic status or geographical location; supports respect to human dignity and social justice and promotes equity paying attention to the needs and rights of vulnerable and hard to reach population groups and those affected by high levels of poverty. Moreover, the policy will give special consideration to forming partnerships with development partners on the basis of Paris Declaration on Aid Effectiveness and at national level, through inter-sectoral actions, mutual accountability, public-private partnerships, and cooperation with CSOs, regional and local government and the community. Lastly, the policy will propagate health as major driving force of human security, sustainable development and peace in a society mostly torn by poverty and violence.

7. THE VISION, MISSION AND GUIDING PRINCIPLES OF THE HEALTH POLICY PRIORITIES

7.1. 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.

7.2. 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.

7.3. Overall Goal

To improve the health status of the population through health system strengthening interventions and providing quality, accessible, acceptable and affordable health services that facilitate moving towards UHC and accelerate progress towards achieving the health related MDGs.

7.4. Core Principles and Values

The following principles and values underpin the health policy priority directions:

- Universal and equitable access to acceptable, affordable, cost-effective, and quality health services with maximum impact on Somali populations' health to ensure the realization of the right to health
- Effective, transparent and accountable governance and leadership in managing the different components of the health system with decentralized management of health care service delivery
- Building effective collaborative partnerships and coordination mechanisms engaging local community, national and international stakeholders and pursuing the aid effectiveness approaches.

7.5. Policy Priorities

The key priorities are outlined below:

i. To improve access to Essential health services of acceptable quality through implementation of EPHS, producing the desired health outcomes in terms of reducing maternal, neonatal and child mortalities, decreasing the rates of undernutrition, controlling prevalent communicable and non-communicable diseases and improving the quality of life.
ii. To develop a health workforce that addresses the priority health needs of Somali population, which is adequate in number, well trained, equitably distributed and motivated to provide essential health services.
iii. To build institutional capacity of health authorities at both central and regional levels to provide strong leadership and effective governance, provide core functions of health sector and engage with private sector.
iv. To ensure the availability of essential medicines, vaccines and commodities that satisfy the priority health care needs of the population, in adequate amounts and of assured quality and at a price that the community and the health system can afford.
v. To establish an effective health information system that provide accurate and timely health data for evidence based planning and implementation, supported by effective monitoring and evaluation (M&E) and by targeted research as a problem-solving tool.

vi. To raise adequate funds for health, protecting the poor and under-privileged from catastrophic health expenditure ensuring that people can access affordable service, therefore moving towards universal health coverage.
vii. To bridge the gap in the enormous health infrastructure paucity and create the minimum health infrastructure assets, providing the necessary operational environment for effective service delivery.
viii. To strengthen the health system and surge its capacity to promote public health and prevent, investigate, mitigate, manage, monitor, evaluate and control public health threats and reach out to affected communities with integrated effective assistance targeting their specific public health emergencies.
ix. Improve the health of the population and reduce health disparities by addressing the social determinants of health, integrating health perspectives into the broader development framework and emphasizing on intersectoral collaboration across all government and other stakeholder partners and building the capacities necessary for its implementation.

8. KEY HEALTH POLICY DIRECTIONS

The health system analyses reflect serious operational and performance gaps and deficiencies in all aspects of the health system. The health aspirations stipulated by the three zonal health authorities encompass the following range of policy directions:

8.1. Revitalizing Health Services

Policy Objective

To provide people-centred essential package of health services with efficient, equitable, culturally acceptable and universal access to promotive, preventive, curative and rehabilitative services that produce the desired health outcomes in terms of reduced morbidity, mortality and improved quality of life and wellbeing.

Priority Policy Directions

a) Strengthening reproductive, Maternal, Neonatal, Child Health (MNCH) and Nutrition

- Revitalizing the EPHS programme implementation in all the four facility based standardized care provision levels of all the regions and districts for an equitable universal access to integrated reproductive and MNCH services and urgently reducing the alarmingly high infant, child and maternal mortality through the facility based, outreach and community based health package.
- Ensuring the widest service network possible for accessing the BEmOC services in all the four facility based care provision levels and CEmOC services in all the regional hospitals and in a large number of RHCs, while integrating the services carried out by the FCHWs into the EPHS programme to increase the coverage and access to these lifesaving MNCH services.
- Eradicating female genital mutilation (FGM) through building public awareness on related serious health and social implications and promoting legislation in collaboration with civil society organizations, local community and religious leaders and women groups and building the necessary information, education and communication network.
- Implementing the Integrated Management of Childhood Illnesses (IMCI) guidelines in all health facilities and at the community level, to scale up children's access to proper assessment and case management from skilled health workers and improve the systems' capacity to support this intervention, inducing the necessary adaptations in its local implementation to the health system in training, supply provision and in expanding its community health practices.

- Ensuring universal immunization of all children and pregnant women through the EPI with the eight vaccines against the major child killer diseases sanctioned by the health authorities, while exploring the introduction of Pneumococcal and Rotavirus vaccines in the medium term through GAVI support; facilitating the involvement of FCHWs and local government institutions, mandating the active participation of the private health sector in EPI services; sustaining the child health days to boost the vaccination coverage with additional interventions that protect children from other preventable diseases and seriously pursuing the permanent interruption of polio transmission and enhancing the integrated surveillance of vaccine preventable diseases.
- Improving the health system capacity to combat maternal and child malnutrition by promoting the appropriate knowledge, attitudes and practices on maternal nutrition, infant and neonatal feeding, including exclusive breast feeding and complementary feeding practices and preventing disease and undernutrition through access to micronutrient supplements, deworming and hygiene and sanitation.
- Promoting patient safety and infection control norms, principles and practices by deploying in each health care provision level, health workers that are competent on the tasks they are assigned to, and treating patients with dignity, respect and compassion, while taking all the necessary measures to improve patient safety and infection control compliance and eliminate the adverse events causing harm to the clients visiting the health facilities.
- Reducing the exposure to non-intentional injuries and violence by adopting safer prevention measures and reducing their severity & consequences by designing emergency medical services.
- Promoting volunteerism, community empowerment and participation in improving public health at community level.

b) Control of Communicable Diseases

Policy objective

To prevent and control the spread of the priority targeted communicable diseases to reduce their burden of morbidity, mortality and disability.

Priority Policy Directions

i. Controlling Acute Watery Diarrhoea, Cholera and other Enteric Diseases

- Engaging the public in the promotion of health, personal hygiene, safe drinking water, sanitation, environmental hygiene, food safety and safe waste disposal.
- Introducing the standardized rapid diagnostic technologies for prevalent communicable diseases and set an active disease surveillance and early warning systems to detect potential disease outbreaks, with pre-positioning of medical supplies and kits to undertake the necessary coordinated rapid response.
- Promoting food-borne diseases' laboratory-based surveillance with the development of food safety guidelines and interventions for action from importation and production to consumption.

ii. Controlling acute Respiratory Diseases

- Introducing safety and infection control guidelines in all health facilities, as infected patients represent the main source of disease, in order to contain the risk of spread of acute respiratory diseases with the establishment of infection control infrastructures and the provision of the necessary case management support.

- Implementing the International Health Regulations (IHR) by contributing to the global effort for the detection and response to international public health risks and potential public health emergencies of international concern.

iii. Tuberculosis Control

- Expanding the Stop TB interventions including enhancing quality TB-DOTS coverage to every district, and integrating the programme interventions into the EPHS four levels of care provision; detecting the missed cases and ensuring that the necessary resources are mobilized and secured for its sustained implementation in collaboration with relevant partner organizations.
- Building the necessary political commitment and technical partnerships to combat the growing multi-drug resistant TB, creating effective diagnostic capacities and supplying the relevant drugs for effective treatment.
- Introducing the active coverage with TB prevention among people living with HIV, as well as the coverage with anti-retroviral therapy (ART) for HIV positive patients that have contracted TB. A TB-HIV policy needs to be framed for screening of HIV patients for TB and vice versa with complete consent, privacy and confidentiality.
- Encouraging and supporting the implementation of operational research on TB to address the local challenges and harness opportunities in the ongoing tuberculosis control programme.

iv. Malaria Prevention and Control

- Understanding the local malaria vector ecology and introducing the integrated vector management (IVM) strategy for prevention and control, considering the elimination of vector breeding grounds, use of larvivorous fish and the use of indoor and space spraying methods as epidemiologically appropriate.
- Fostering the use of long lasting insecticide treated bed nets (LLINs) and promoting their distribution to the target population groups freely or at the lowest possible affordable price according to laid down criteria.
- Developing disease management guidelines and a drug policy to be observed by both the public and private health sector professionals and ensuring the availability of these in all health facilities.
- Ensuring rapid malaria diagnosis by microscopy or through the malaria rapid diagnostic test (RDT) in all patients with suspected malaria attending peripheral facilities, followed by the appropriate management of the disease.
- Educating the public about the causes and methods of malaria prevention and consolidating the malaria early warning system, with a rapid response to possible epidemics, following predefined operational guidelines for action.

v. Fighting HIV & AIDS

- Mounting a high level of political commitment at all levels of the government, recognizing the threat of HIV & AIDS epidemic and building a wider-scale response in which regional, district and community leaders mobilize the necessary support for combating the disease with the due openness and obligation.
- Promoting culturally acceptable public education programs on the knowledge of HIV & AIDS and organizing training activities for different social groups, targeting religious leaders, youth and local opinion leaders on the prevention and control of HIV transmission.
- Strengthening the appropriate care and management of sexually transmitted infections (STI) introducing the relevant preventive interventions and standard syndromic management and care
- Improving the safety and quality of blood transfusion services for non-remunerated blood donor recruitment to avert the transmission of HIV and hepatitis B and C viral infections.

- Promoting the use of Voluntary Counselling and Testing (VCT) for HIV, in premises that are fully integrated into the health system to mitigate the existing cultural stigma in the population, while creating a capacity for HIV & AIDS case management at all levels of the health care system including ARV treatment and promoting the HIV surveillance system.
- Strengthening and supporting the multisectoral HIV & AIDS Commissions to improve the planning and coordination of HIV & AIDS control interventions within and outside the health sector.

vi. Prevention and Control of Hepatitis B and C Viral Infections

- Scaling up the hepatitis B and C prevention through children vaccination against hepatitis B; vaccinating health workers at job entry; health facility infection control; injection safety at all levels of the health system and promotion of safe blood transfusion.
- Establishing behavior change communication through public advocacy and education about the risks of these viral infection and the necessary preventive and safety measures to pursue.

vii. Control of Neglected Tropical Diseases

- Scaling up the control of leishmaniasis, schistosomiasis and leprosy by enhancing access to rapid diagnosis and treatment in all health facilities in endemic areas as integral components of the EPHS programme and sustaining efforts of behavior change communication and active disease surveillance.
- Endorsing the policy of Leprosy elimination by integrating the treatment of the disease into general health services, ensuring early diagnosis and the regular supply of multidrug therapy to reduce the number of cases with grade-2 disabilities (visible deformities), while combating the stigma associated with the disease.
- Introducing the universal policy of Intestinal helminths' free pre-school and school-based deworming treatment, once or twice every year in all the zones and for schistosoma heamatobium only in endemic regions.

c) Prevention and Control of Non-Communicable Diseases

- Operationalizing the WHO Framework Convention of Tobacco Control (FCTC) and introducing tobacco control interventions that prohibit smoking in indoor public and workplaces to reduce the burden of chronic non-communicable diseases.
- Educating the public against the adverse effects of Khat, controlling its consumption and excessive use for being a major risk factor of mental health disorders and other organic diseases and combating other types of substance abuse.
- Promoting a healthy balanced diet intake, and enhanced physical activities to enable communities to reduce the growing morbidity and mortality rates of NCDs.
- Promoting the primary and secondary prevention of NCDs (cardiovascular diseases, diabetes, cancers, chronic pulmonary diseases and mental disorders), as integral components of the health system, pursuing cost-effective policies of early detection and timely treatment of the disease.
- Promoting and raising the awareness of the general public about mental health issues, preventing mental disorders and reducing stigma, discrimination and rights violation, promulgating mental health legislation to respond to the protection and care needed by these vulnerable population groups in a conducive chain free environment and integrating the supportive traditional and religious treatment procedures of mental disorders into the framework of the health system.

d) Injury and Violence Preventions

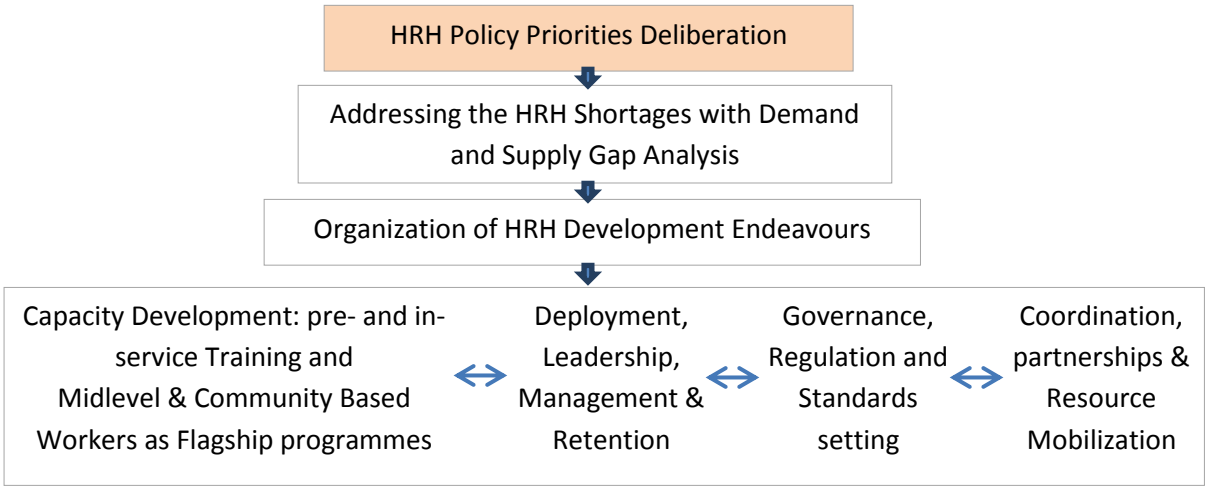
- Raising public awareness about the problems of road traffic injuries and violence, highlighting the crucial role that public health can play in addressing the underlying causes and consequences of these public health challenges, fostering their prevention and control.
- Developing a multisectoral injury and violence prevention plan and strengthening the pre-hospital and regional hospitals' trauma and rehabilitation care, by establishing an Emergency Medical System, setting and providing minimum standards for equipment and building the necessary human resource capacities.
- Enacting legislation on road traffic injuries prevention and control and fostering multisectoral collaboration covering key risk factors from non-adherence to road signs, safety belts, excessive speed and the use of mobile phones while driving, or driving under the influence of drugs.
- Promoting the fight against the gender-based violence that include physical and sexual violence as this constitutes a major public health and human rights problem, and strengthening the health sector response through prevention, treatment and care.
- Developing information systems for injury and violence prevention and establishing an injury surveillance system to assess the scale of injuries and violence and harness this evidence to mobilize public support for action.

8.2. Overcoming the Crisis of Human Resources for Health

Policy Objective

To ensure the availability of the appropriate number of workers with the correct knowledge, skills, attitudes and training that are equitably deployed, fairly remunerated and well managed, supervised and monitored to perform and comply with the tasks assigned to achieve the health outputs and outcomes targeted by the health system.

Figure 5. Addressing the HRH shortages with Demand and Supply analysis



Priority Policy Directions

- Supporting the expansion and consolidation of the existing public sector and privately managed health professional training institutions, with a special focus on accelerating the production of

midlevel health professionals that meet the health needs of the population, with curricula standardization and the development of post-basic tutors' training programmes.

- Accelerating the replication and creation of community based health workforce to fulfil the health system aspirations of UHC through the training of FCHWs, CMWs and ACMWs, and creating local government and community mechanisms for their support.
- Introducing transparent rules and regulations for HRH recruitment, employment and equitable deployment with standardized skill mix, consistent with the EPHS programme, and designing task shifting approaches to expand the HRH capacity and access to essential health care services.
- Improving HRH governance, leadership and management capacities in the health sector; developing staff operating procedures manuals that elucidate contracts, terms of employment, posting and remuneration, task distribution, supportive supervision and performance based management, as well as the compliance with the ethical codes of practice.
- Improving HRH motivation and retention with standardized and harmonized living salaries, hardship allowances and non-monetary incentives and replacing the current NGOs' direct payment to health workers by channelling the jointly stipulated allowance support for the Somali health workforce through the government, with the necessary measures of coordination and accountability, while sustaining gradual increments in the HRH government budgetary outlays.
- Supporting the establishment of health professional associations who will coordinate their efforts with the MOH in the domains of regulation, certification, credentialing, registration, accreditation and licensing of health professionals and in establishing bye-laws, acts and codes of practice.
- Founding Health Professional Councils (HPCs) at the MOH level, for assuming the responsibilities of professional regulation, enhancing the performance capacity of the different professions and organizing CPD and career advancement schemes, while promoting occupational health and patient safety by improving the working environment and controlling the risks of occupational diseases and accidents to the health workforce.
- Improving the HRH information system with the establishment of HRH observatories, collecting all the relevant HRH data sets and developing measurable indicators on production, training, deployment and retention.
- Establishing multi-stakeholder HRH coordination mechanisms to address the planning and implementation of pre-service and in-service workforce training, as well as continuing professional development as an important element of lifelong learning, while supporting HRH performance management at all levels of service delivery.

8.3. Improving Governance and leadership of the Health System

Policy objective

To build an effective leadership for the health system backed up by a good governance foundation to effectively and comprehensively deliver the health sector functions.

Priority Policy Directions

- Strengthening the MOH governance and leadership capacities in setting legislative and regulatory norms and standards for the key functions of the health system and training the management cadre at all levels of the health system on leadership skills and management competencies through capacity building courses specifically tailored to the needs of the health sector.
- Improving public financial management, transparency and accountability in publishing employment information and in the hiring and recruitment processes to enhance the efficiency of health system interventions with the establishment of an effective and efficient internal audit at the MOH to safeguard the assets and resources of the health sector.

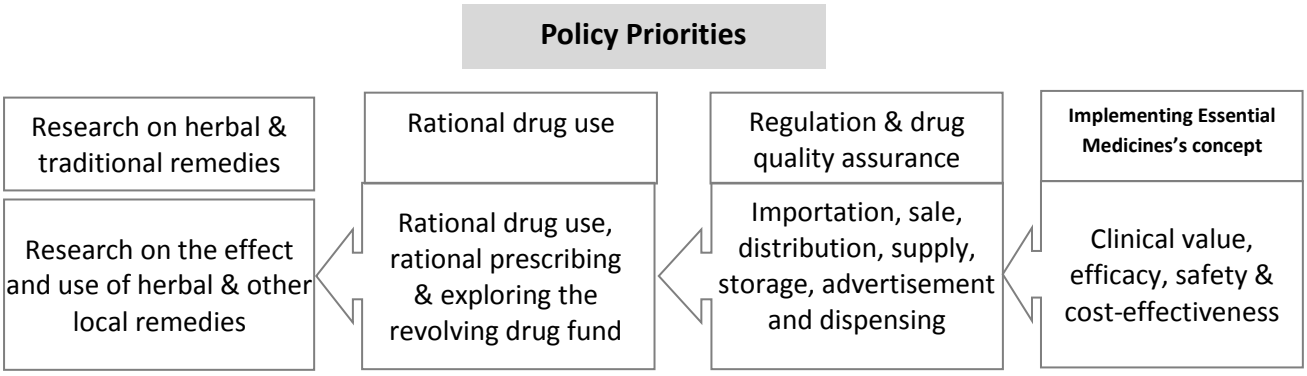
- Developing partnerships and coordination mechanisms founded on aid effectiveness principles of ownership, alignment, harmonization, mutual accountability, and managing for results.
- Developing a health regulatory framework, addressing the major functions related to the six pillars of the health system with focus on medical services, public health and mental health; health professionals; medicine and allied commodities and technologies; food safety; environmental health and sanitation; the health system decentralization and coordination mechanisms and the health care financing and social health protection legal framework.
- Regulating healthcare services, training institutions, the pharmaceutical sector and food and beverages by liaising with the established health professional councils and drug regulatory authorities, Introducing the accreditation system in public and private health care facilities and ensuring compliance with the professional code of ethics.
- Strengthening the ongoing decentralization processes for the regional and district authorities to assume greater role in the delivery, co-financing and management of health services, while promoting intersectoral collaboration to address the social determinants of health.
- Providing clear and comprehensive health information to all clients and their families and disclosing all the necessary information that will allow them to take active informed roles about their health care decisions, while maintaining confidentiality in the health care system.
- Creating in all health service outlets, the opportunities for the clients to present or submit complaints, compliments and suggestions about the services rendered with the establishment of health system procedures for investigation, action and feedback.
- Developing guidelines that substantiate the Client Service Charter's key principles and operational norms and educating the public to enhance their knowledge about the services provided by the health system in order to improve the populations' care seeking behavior.

8.4. Enhancing the Access to Essential Medicines and technologies

Policy Objective

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.

Figure 6. Ensuring equitable access to and rational use of essential medicines



Priority Policy Directions

- Implementing the concept of essential medicines in conformity with priority health care needs, with special attention to their efficacy, safety, and comparative cost-effectiveness to the health

system; standardizing procurement; training the necessary skilled health workforce and developing drug formularies for the public health sector.

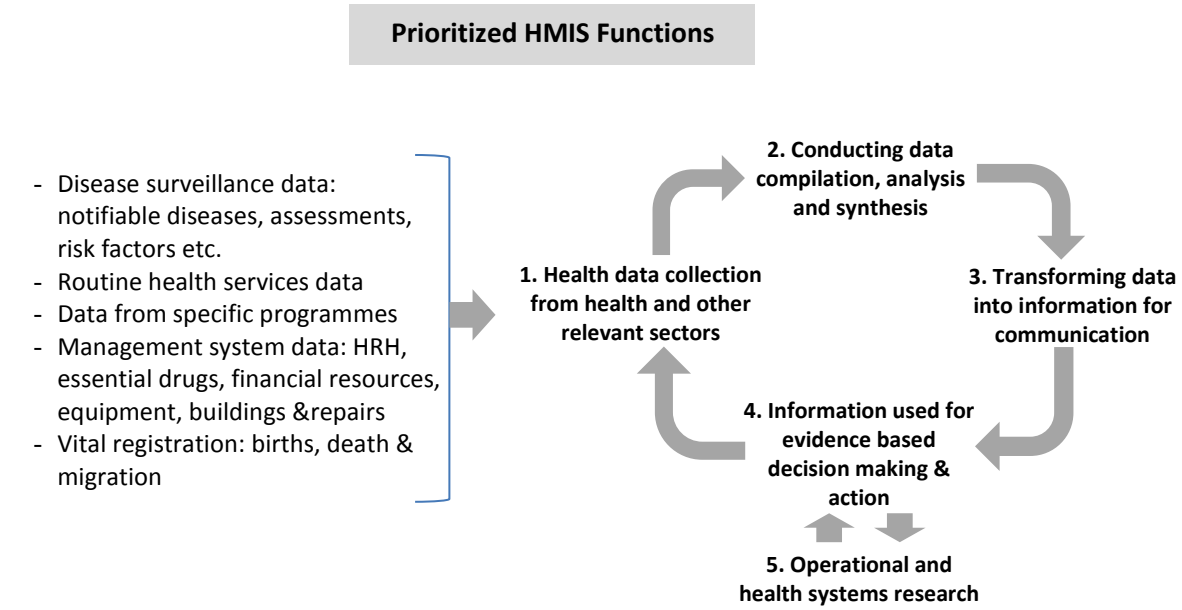
- Developing drug quality assurance systems addressing the import, sale, distribution, supply, storage, advertisement and dispensing, to sustain quality and avert the use of substandard and counterfeit products, while encouraging local manufacturing under stringent regulations.
- Regulating medicines by mandating their formal registration, setting quality guidelines for drug donations, improving storage and distribution systems, promoting essential drug use and rational prescribing and developing clinical practice guidelines for common diseases in the health sector.
- Exploring the relevance of a revolving drug fund (RDF), where following an initial capital investment, drug supplies are replenished from the sales of drugs by the public health facilities and assessing this technique's potential to enhance access and reduce stock outs, with the imperative need of identifying mechanisms for supporting the un-affording poor.
- Undertaking herbal medicines and other traditional remedies' research to identify their beneficial effects and potential harmful impact, thus educating the population about the rationale of their practical use.

8.5. Developing Health Management Information System and Research

Policy Objective

To create a health information system capable to collect and analyse a minimum set of reliable, accurate and timely health system data package, processed to identify health problems and needs, and generate the evidence required to plan cost-effective health interventions and monitor health trends and increase accountability to improve population health outcomes.

Figure 7. The Key HMIS functions and scope of data collection



Policy Directions

- Establishing a health system observatory to timely collect, compile and analyse the various HMIS data sets, integrating health services and management systems' data and transforming them into information for evidence based decision making, helping in identifying the needs and detecting

and resolving the challenges being faced and improving the management and performance of the health system.

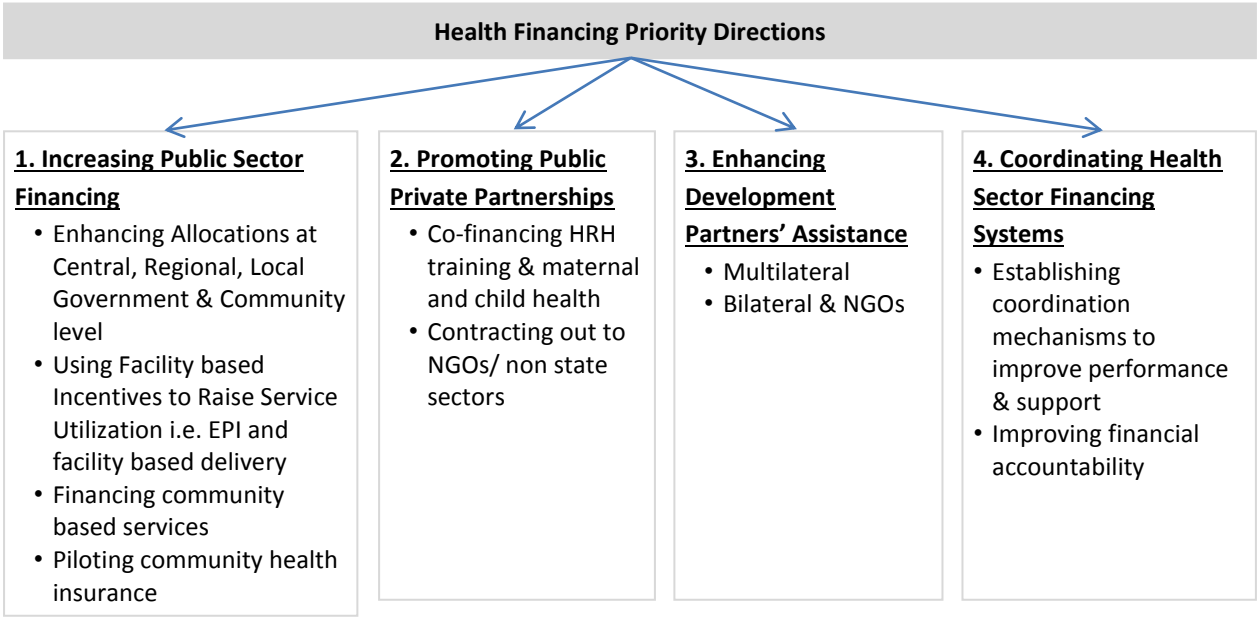
- Revitalizing the neglected HMIS areas for which sufficient information is not available such as in-patient and health system management data and tracking the progress being made in achieving the health MDGs, while improving the collection and reporting of vital statistics.
- Promoting health systems and operational research, with human resource capacity building to assess the progress made in implementing the major health interventions, in identifying the challenges encountered and in introducing the needed problem solving improvements in the organization and delivery of these services, in close partnership with the academic institutions to better address the health needs of the population.
- Building capacity for evidence based management by enhancing the health managers' capabilities in acquiring the culture of using the HMIS data and research generated information for evaluation, planning and health services' implementation.

8.6. Health Financing for Universal Coverage

Policy Objective

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.

Figure 8. Health Financing Priority Directions



Policy Directions

- Increasing government budgetary allocations for health to substantiate the commitment of the public sector, while mobilizing the participation and financial contributions to different health interventions from regions, local governments and grass root communities, supported by transparent collective oversight and monitoring of the resources deputed to the health sector.
- Introducing financial incentives to encourage facility based deliveries and child immunization to scale up demand through voucher based systems or other incentives to bring children for vaccination and pregnant women for antenatal visits.
- Promoting public- private partnership with incentives aimed at harnessing the contribution of the private-for-profit and private-not-for-profit capabilities in the areas of pre-service HRH

development, EPI services and in the control of high burden and high risk communicable diseases.

- Exploring the implementation of community health insurance arrangements to improve financial protection and avert catastrophic expenditures for vulnerable social groups of the population, while the poorest communities require complete public sector subsidization.
- Coordinating the development partners' resource mobilization for health and promoting greater harmonization in programmatic allocations in pursuit of aid effectiveness principles, thus contributing to the predictability of health sector financing.
- Managing the contracting out related decisions when assigning the provision of health services to non-state providers on behalf of the government through detailed memoranda of understanding, and in close coordination with partner organizations, and with joint evaluation of the outputs, outcomes and impacts of the interventions through shared assessment processes.

8.7. Improving Health Services Physical Infrastructure and Equipment

Policy Objective

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.

Policy Directions

- Setting normative standards for the health sector infrastructure encompassing buildings, equipment, technologies and the logistic support system and pursue their rehabilitation through construction, repair, and procurement of equipment, diagnostic technologies and ambulance services for each of the four care provision levels.
- Developing medical equipment policy guidelines in which the standard equipment to be installed in every health care level are reviewed, and the minimal technical specifications required clearly outlined, while training the health workers assigned on their operations to warrant the effective use and quality management of these equipment and ensure patient safety.
- Establishing a management system for health technology assessment, enabling a systematic evaluation of the properties, cost-effectiveness and impacts of the health technologies to be procured on the delivery of health services, as well as the appropriate value they have to patient care; ease of their use and maintenance, while formulating appropriate regulations.

8.8. Health Emergency Preparedness and Response

Policy Objective

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

Priority Policy Directions

- Building the capacity of the health system and creating public health resilience, preparedness and strategic policy operating at central, regional, district and community level with a view to reduce the adverse health effects of these emergencies to the population.
- Introducing the concept of disease and disaster early warning system, disaster risk assessment, management of mass casualties and establishing private ambulance services; closely monitor and

evaluate the impact of these emergencies and define and build the preparedness and response capacities necessary.
- Providing leadership and effective coordination to emergency health response interventions and mobilizing the support of intersectoral capacities and necessary community action.
- Developing the necessary emergency preparedness and response information system with special focus on disease and nutrition surveillance, data and their dissemination to health sector relevant partners.
- Preparing the essential technical emergency preparedness and response guidelines and operational standards, in terms of logistics, health workforce training, pre-positioning of essential drugs and earmarking the required contingency support.

8.9. Promoting Action on Social Determinants of Health and Health in All Policies

Policy Objective

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.

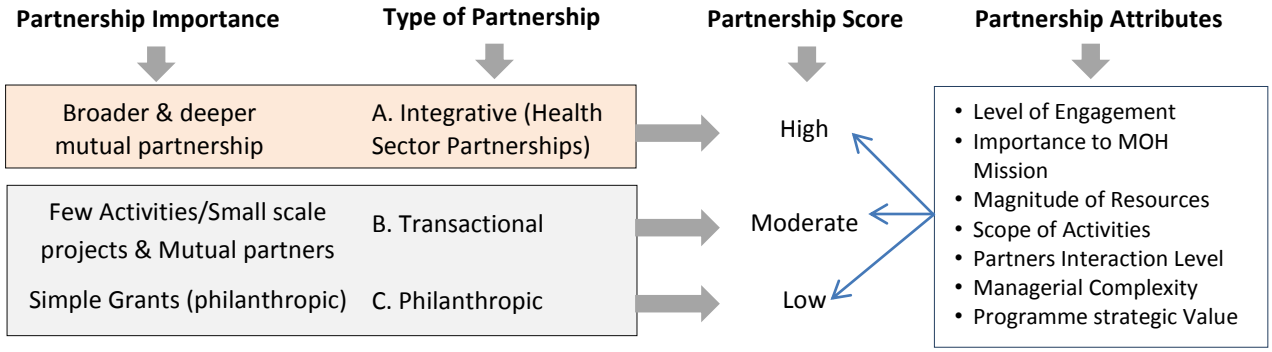
Priority Policy Directions

- Promoting action on the social determinants of health (SDH) with the promulgation of guidelines and regulations for implementation, addressing the 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.
- Promoting intersectoral collaboration for developing public policies that create synergies and mutual gains for health, across different sectors, recognizing their tangible contribution to health and health equity in which the MOH assumes a lead advocacy role.
- Promoting policy interventions particularly to benefit the disadvantaged Somali nomadic population with massive health inequities and addressing their basic development needs through multisectoral collaboration and active community participation.
- Endorsing the concept of health impact assessment (HIA) to estimate possible adverse health implications of all development interventions, allowing the policy makers and development partners to take the health consequences into account and choosing those options inducing the minimum negative health impact to the population.
- Building the health workforce capacity about the SDH and health equity and on the value of collaborating with other sectors for putting this subject high on the government political agenda.
- Promoting research 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.

9. ENHANCING HEALTH SECTOR PARTNERSHIPS AND COORDINATION

In-country Health sector coordination will be strengthened with all partners, to collectively address the complex and challenging public health problems and widen the potential to effectively respond to the health needs of the population and improve their health outcome.

Figure 9. Advancing the Collaboration Continuum Model in Health



Source: Modified from Austin, J. (2000)

- Strengthening health sector coordination mechanisms, involving both the national and international development partners for the shared health goals, through a cooperation led by the national authorities with transparency and enhanced levels of accountability, while promoting aid effectiveness measures of ownership, alignment, harmonization, mutual accountability, and managing for results, to successfully implement and manage the priority interventions of the health system.
- Strengthening and expanding the JHNP and its operational EPHS programme, as a concrete model of collaborative partnership with development partners, and moving towards universal health coverage to significantly reduce maternal, infant and child mortality, in synergy with other collectively implemented health programmes, while integrating operational and health system research into service delivery activities, to improve the outcomes of these health interventions.
- Building partnerships with relevant government institutions, professional associations, civil society organizations, the private sector, the Diaspora and the grass root communities and mobilizing public opinion to maximize their scope and synergy in building the relevant operational scope and responsibility for each stakeholder partner.
- Promoting a single budgetary framework for the public health sector and harmonizing resource mobilization and allocation processes, including those contributed through regional, district and local community support or through development partners' assistance and setting M&E indicators for measuring the progress attained.
- Developing operational guidelines for health sector partnerships and coordination, containing the functions, procedures and roles and responsibilities of the different stakeholders, spearheaded by explicitly defined levels of shared accountability for attaining the full potential of these collaborative partnerships.
- Creating standardized monitoring and evaluation tools for measuring the outputs and outcomes achieved through the different collaborative health interventions with the objective of improving the quality of performance and operational productivity.
- Standardizing and harmonizing public health sector procurement systems with transparent processes, and aligning these with the national mechanisms in pursuit of the government legal framework.

10. STRENGTHENING DEVELOPMENT PARTNERS' IMPORTANT ROLE IN AID EFFECTIVENESS

To enhance the scale and effectiveness of aid for the health sector, the health authorities will facilitate and ensure its full alignment with the health policy plans and implementation procedures, assume the lead in setting the health development agenda, pursue a well-coordinated and gender sensitive practices and effectively manage resources for producing the desired results towards achieving the health related MDGs.

- Promoting the coherence and synergy of health partners' support inputs in planning and implementation, by strengthening the existing mechanisms for coordination and mutual accountability, with clear division of responsibilities, as per the agreed rules of engagement between the partners and health authorities.
- Consolidating the principles of aid effectiveness through national ownership; alignment with health sector policies, and plans and procedures; building mechanisms for mutual accountability; harmonizing partners' collective efforts and managing for results towards the MDGs, while pursuing gender equity perspectives.
- Focusing on the health sector annual working plans in pursuit of the deliberations made by the joint technical thematic working groups, in a manner consistent with the comparative advantages of the different organizations, and with attention to health system strengthening in planning, management and implementation.
- Supporting the evolving public private partnerships led by the government in the areas of human resource development, especially in pre-service health workforce training programmes and in in-service training activities for task shifting and for continuing professional development purposes as well as in the delivery of health care services.
- Harmonizing different aid modalities applied by development partners in their support to health policy implementation and ensuring the predictability of their contributions, while concurrently enhancing government health expenditures and multisectoral collaboration.

11. IMPLEMENTING HEALTH POLICY DIRECTIONS

A major challenge often facing the health sector is the effective translation of these priority health policy themes into concrete steps and practical action. To bring these desired actions to fruition, the wider consultations made with key stakeholders of the health system need to be followed by a similar effort at the operational level, rendering the different envisaged health policy actions consistent with the operational objectives at the field level. It is also necessary to enhance the capacity for policy implementation, motivating the active engagement of health professionals and ensuring the support necessary from the MOH central and regional level and other relevant government institutions, the CSOs, the community and health development partners, while warranting the required technical resources necessary. The policy implementation process also need to address the social contexts within which it will be rendered operational. The stipulated policy measures will be translated into actions through mobilizing the support of all stakeholders, strengthening the health system, progressing towards universal health coverage, eliminating inequities and helping to identify and resolve key policy barriers hindering its successful implementation.

- Improving the governance and organization structures at different levels of policy implementation with shared clarity on the policy measures envisaged for action; forging the necessary partnerships and coordination mechanisms to follow; providing the resources required and pursuing the rules binding stakeholders into a coherent decision-making process leading to development of short and medium term action plans for implementation.
- Strengthening the pillars of the health system with emphasis on service delivery; training, deployment, management and retention of the health workforce; provision of essential drugs,

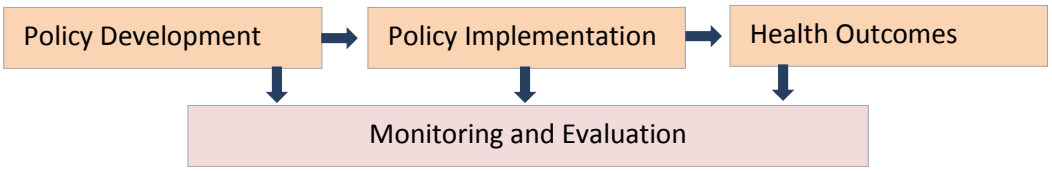
vaccines and technologies; generating reliable data for evidence based decision making; improving governance and leadership capacities and pursuing proactive financing strategies for policy implementation.

- Factoring in local socio-cultural and poverty conditions that would determine the pace and scope of policy implementation and translating the policy legislative measures into applicable rules and guidelines for action, while defining the magnitude of the support required.
- Promoting community participation at all levels of the health system and building community and local government co-management and co-financing mechanisms and public private partnership to accelerate health policy implementation and the attainment of the health MDGs.
- Placing the right health workforce in the right health care provision levels with focus on community based health workers and on the production and equitable deployment of the midlevel health professions in the public sector, with operationally equipped and staffed referral support for effective policy implementation, while taking the necessary measures for licensing and accreditation of health professionals and facilities both in the public and private sector.
- Defining the health partners' core competences and strategic comparative advantages through their partnerships with the health sector, for improving the implementation of the outlined priority policy measures within the framework of expanding the EPHS programmatic interventions.
- Promoting implementation research for defining and understanding the operational challenges compromising the effective execution of priority health policy measures that include a wide range of contextual factors, and introducing continuing adaptation in the implementation process in order to produce the desired health outcomes.

12. MONITORING AND EVALUATING HEALTH INTERVENTIONS

An effective Monitoring and evaluation system will be developed and implemented to regularly assess the progress towards achieving the health policy priority milestones, effectively using the health system generated data for evidence based decision making and measure, whether the intended planned health outputs and outcome are being achieved and induced a positive impact on the health of the population.

Figure 10. The Importance of M&E for Health Policy Development and Implementation



- Establishing M&E as an important health management tool, aimed at collecting and analyzing information about the health programmes and improving implementation through the results based management and the logical framework approach.
- Building the health partners' consensus in selecting a set of input, process, output and outcome indicators for the key health system interventions that are crucial for the implementation of the M&E framework and enhancing stakeholders' perception on the relevance of the M&E management function.
- Enhancing the M&E skills of the staff to improve performance and raise the level of governance and accountability for data management and evidence based decision making.
- Promoting monitoring interventions on the delivery of basic services that enhance community participation and ownership and scale up activities effectively responding to the health needs of the population and meeting the challenges ahead.

ANNEXES

Table 2. Somaliland identified Health Policy Priorities and accomplishments attained

Health Policy Priorities	Accomplishments
Service delivery	
• Expanding EPHS considering mental health as a core programme • Scaling up health education and promotion of NCD interventions • Improving regional and district health care delivery capacity • Promoting health care for adolescents, underprivileged & elderly • Addressing environmental health • Strengthening community based interventions	• Learned lessons from EPHS successful implementation in Sahil region and rolling out in Togdheer and other regions • Maintained Somaliland polio free status • Established MDR Lab • Introduced the first renal dialysis services • Strengthened the MOH by the creation of a Legal unit
Human Resources for Health	
• Promoting job creation; HRH Equitable distribution and effective performance management • Improving HRH retention to bridging and mitigate urban/rural gap • Expanding the training & deployment of FCHWs • Developing specialties for treating NCDs • Preparing HRH development plan	• Developed midlevel training programmes, focusing on female health workers at public, private-non-for-profit and private sector • Launched successfully the training of FCHWs • Linked the establishment of new health related post-graduate courses to prior satisfactory accreditation • Developed HRH management tools
Governance and leadership	
• Developing Health legislation including Legal frameworks and acts • Developing leadership and management capacity • Establishing National Health Professional Council (NHPC) • Promoting transparency in recruitment, promotions and posting • Raising health managers leadership capacity at regions and districts • Improving management systems in HRH and financial practices • Enhancing community role in the health system	• Developed Health policy, health sector strategic plan (HSSP) & annual work-plans • Launched leadership development programmes • Established regional management systems by endorsing the JPLG initiative • Established the NHPC • Created the national drug regulatory authority at MOH
Essential drugs & Technologies	
• Revising and updating Essential drugs' list • Improving supplies management • Scaling up the functions of the recently established medicines' quality control lab • Allocating public funds for procuring essential drugs with phased approach to reduce aid dependency • Developing the rational use of drugs' Act • Revising and updating Standard Treatment Guidelines	• Introduced revolving drug fund (RDF) policy into Hargeisa Group Hospital • Established Minilabs for drugs quality assessment and a Quality Control unit at MOH • Prepared Drug Policy and essential drugs' List
Health Management Information System (HMIS)	
• Creating comprehensive monitoring and evaluation framework and plan and developing indicators to monitor health programmes • Promoting timely and error free reporting and inculcating a culture of data use at all levels • Promoting operational research role in policy implementation	• Developed the HMIS to fully operational scale • Put an active disease surveillance system in place • Engaged research institutions in operational research

Health Policy Priorities	Accomplishments
• Operationalize HMIS at the community and at private sector level	
Financing	
• Increasing government contributions and strengthening financial management systems and control mechanisms • Developing community contributions and pro-poor grants system • Promoting social health insurance and risk pooling methods • Enhancing aid effectiveness • Exploring effective mechanisms for health services' outsourcing	• Enhanced government budgetary allocations and envisaging an approval of higher budgetary share of 6% • Developed a reliable MOH financial management system

Table 3. Central South Somalia Identified Health Policy Priorities and accomplishments attained

Health Policy Priorities	Accomplishments
Service delivery	
• Scaling up the EPHS programme and improving the performance of existing health facilities • Promoting community participation, especially in MNCH, nutrition & control of communicable diseases by expanding community based programmes • Integrating humanitarian interventions into the health service delivery system to strengthen health system capacity	• EPHS successfully implemented in Benadir, Gedo and Galgudud regions • Regional Medical Officers assigned to security-wise accessible regions and constant efforts being made for more regions and districts • Enhanced coordination with health partners
Human Resources for Health	
• Scaling HRH production to reduce shortages • Deploying HRH equitably to bridge the urban-rural gap • Focusing on mid-level professional categories that are in great shortage and community based health workers i.e. FCHWs, CMWs & ACMWs • Encouraging HRH task shifting to broaden the scope of service delivery • Strengthening HRH management & leadership capacity at all levels • Promoting public-private partnership in HRH pre-service training	• Launched successfully FCHWs' training and deployment • Developed HRH policy & strategic plan • Adopted public-private-partnerships for HRH training and production
Governance and Leadership Development	
• Achieving greater role in ownership, governance and leadership in the delivery of health services • Promoting decentralization building capacities for managing health programmes at regional and district level • Strengthen coordination and partnerships at all levels • Building health system governance network, leadership and management capacities	• Formulated health policy framework, HSSP and annual work-plans • Launched MOH leadership development programmes • Policy decisions made at MOH to establish NHPC • MOH deliberated to establish national drug authority • MOH Established the National Institute of Health (NIH) for epidemic investigation and control, laboratory quality control and related research interventions
Essential Medicines and Technology	
• Providing appropriate and sufficient medical products and technologies to regional and district level functional facilities	• Established Minilabs for the quality assessment and drugs quality control at MOH

Health Policy Priorities	Accomplishments
• Revising and updating the essential drugs list • Establishing drug regulatory authority to set rules and regulations	• Revised and updated the essential drugs list and standard treatment guidelines •
Health management Information System (HMIS)	
• Strengthening HMIS for evidence based decision making in planning, management and implementation • Creating an integrated disease surveillance reporting system • Building monitoring and evaluation system supported by operational and health system research to produce evidence for effective decision making	• Established HMIS department at MOH promoting data generation from the health system analysis and dissemination • Created an active disease surveillance system although capacity building efforts are necessary
Health financing	
• Introducing greater public sector resource allocations and community financing in the delivery of health services to expand health services coverage and reduce aid dependency • Aligning donor funding with national systems, plans & programmes • Maintaining high level of accountability in financial management • Piloting community health insurance for implementation	• Established coordination with implementing partners and promoted partnerships that are evolving • Promoted transparency and accountability among all stakeholders of the health system to enhance efficiency and reduce duplication

Table 4. Puntland Identified Health Policy Priorities and the accomplishments attained

Health Policy Priorities	Accomplishments
Delivery of Health services	
• Revitalizing the district health system level of care, focusing on RHCs, HC/MCHs, PHUs and FCHW to bring services as close as possible to the communities and families • Scaling up MNCH, Nutrition, CDC, emergency referral support, emergency preparedness & response and secondary prevention of NCDs programmes to improve health outcomes • Developing mobile clinics strategy to extend services to nomadic, mountainous and costal hard to reach communities • Strengthening community based health interventions through FCHWs, CMWs and ACMWs • Evaluating the health significance of traditional herbal remedies and other kinds of alternative medicine for their possible integration in the health system	• Implemented EPHS successfully in Nugal, Karkaar, Mudug and Bari regions with a planned programme roll-out to other regions • Ensured the delivery of regular health services in the overwhelming majority of health system network facilities • Launched the training of FCHWs and deployed them in the field • Scaled up midwifery training • Maintained Puntland polio free status • supported health integration in the JPLG decentralization development process
Human Resources for Health	
• Scaling up HRH production and equitable deployment to bridge urban-rural disparities • Focusing on community based health workers such as FCHWs, CMWs and ACMWs • Accelerating the training of the different categories of mid-level health professionals that are crucial for the EPHS programme • Developing and implementing HRH regulations and liaising with professional associations • Strengthening HRH management and leadership capacity development at all levels	• Launched successfully the FCHWs programme and Midwives' training • Developed HRH policy and strategic plan • Adopted public-private partnerships in HRH training and production

Health Policy Priorities	Accomplishments
• Standardizing salary scales and establishing HRH information system and • Promoting public private partnership in HRH training and production	
Governance and Leadership	
• Strengthening MOH management structures at central, regional and district level • Consolidating and expanding the attained level of health sector coordination in planning, management and implementation • Promoting and strengthening health partnerships at all levels of the service delivery system • Developing health system managerial and leadership capacities • Standardizing HRH management systems with transparency and accountability	• Mobilized MOH led Successful health partners' coordination, streamlining health services management and implementation • Formulated health policy, HSSP and annual work plan • Took decisions to establish NPHC at MOH • Launched leadership and management capacity building plan
Medicines and technologies	
• Standardizing and coordinating essential drugs procurement system to create an effective medicines' supply chain • Establishing drug regulatory authority to set importation rules and regulations through public private partnerships	• Established Minilabs for drugs quality assessment & Quality Control at MOH in Bosaso • Revised and updated standard treatment guidelines and essential drugs list
Health management Information System (HMIS)	
• Strengthening the HMIS system and reorganizing data collection, analysis and use for evidence based planning, management and implementation • Consolidating the integrated disease surveillance reporting system • Introducing monitoring and evaluation system and operational and health system research	• Successfully piloted an integrated disease surveillance system • HMIS implemented and active HMIS management structures in place
Health financing	
• Increasing government budgetary outlay for health and community financing mechanisms to gradually reduce aid dependency • Aligning donor funding with government systems, plans and programmes • Maintaining high level transparency and accountability in financial management • Coordinating with partners all efforts for resource mobilization and ensuring both allocative and technical efficiency • Promoting public-private partnerships in HRH pre-service training and production • Piloting community health insurance to identify the best practices to follow	• Established well-coordinated partnerships in the delivery of health services • Attained a reasonable level of partners' alignment with government health systems in procurement, distribution and financial management