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FORWARD

By the Hon. Minister of Health

DRAFT

Acknowledgement

Preparation of this document has been accomplished through involvement of different stakeholders namely Donor agencies, national and international partners, NGOs, civil society, Mayors, Parliamentarians, various line government Ministries, Regional Health Boards, Medical Institutions and the Ministry of Health staff in the regions, health facilities and the central level. The involvement included discussions and consultations at different levels over a period of about one year. These discussions and consultations were at times difficult because of the vast knowledge and different opinions on development of the Health Sector among the stakeholders. Divergent opinions and views have helped to refine and strengthen the Policy in the new environment of the changing Public Sector as we move from “quick fix” post-conflict agenda to program and institutional development.

It is for this reason that the Ministry of Health would like to recognize and acknowledge and commend all participants for their contributions towards revising the 1999 Health Policy. The Ministry would also like to register its sincere appreciation to the Honorable Minister of Health for his valuable time and commitment, comments, views, suggestions and recommendations.

The Ministry of Health would therefore wish to take this opportunity to thank all those who actively took part in the revision of the 1999 Health Policy document for the betterment of health development in Somaliland.

Director General
Ministry

of

Health

Acronyms and Abbreviations

CHW	Community Health Worker
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuous Professional Development
DAD	Development Assistance Database
DG	Director General
DHS	Demographic and Health Survey
EPHS	Essential Package of Health Services
FGM	Female Genital Mutilation
HC	Health Center
HLAF	High Level Aid Coordination Forum
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Therapy in pregnancy
IRS	Indoor Residual Spraying
LLIN	Long Lasting Insecticidal Net
MCH	Maternal and Child Health
MENA	Middle East and North Africa
MOH	Ministry of Health
MOI	Ministry of Interior
MONDP	Ministry of National Planning and Development
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
NDC	National Development Coordination
NGO	Non-Governmental Organization
NHP	National Health Policy
NHPC	National Health Professional Council
OPD	Out-Patient Department
PHP	Private Health Practitioners
PHU	Primary Health Unit
PNFP	Private Not For Profit
PPP	Public-Private Partnership
PSI	Population Services International
RMO	Regional Medical Office
RHB	Regional Health Board
SDP	Service Delivery Points
SLMA	Somaliland Medical Association
SLNMA	Somaliland Nursing and Midwifery Association
SPA	Somaliland Pharmaceutical Association
SUFI	Scale Up for Impact
TBA	Traditional Birth Attendant
TCMP	Traditional and Complementary Medicine Practitioners
THET	Tropical Health Education Trust
UNICEF	Unite for Children
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

1. Introduction

1.1 Since independence, Somaliland has committed itself to state building process in a relatively secure and peaceful environment. Since the beginning of the 1990s and thereafter, Somaliland has seen remarkable progress on many fronts: not least a unique reconciliation process, the creation and implementation of functioning governance and judiciary system, and a democratization process that has led to free and fair elections and a multiparty legislative system.

BOX 1

Health Sector Reform is a sustained process of fundamental change in policies and institutional arrangements of the health sector, usually guided by the government. Any meaningful reform process ought to be based on evidence and information about the current state of affairs, and potential effect of alternative policy choices.

1.2 Rationale for developing the second edition of the National Health Policy – henceforth referred to as called NHP II: The Ministry of Health and Labor in 1999 (Now called Ministry of Health) developed the first national health policy. NHP I steered the country from 1999 until 2011 through the immediate post conflict era and following independence. During this period decentralization processes commenced and some functions of the Central Ministry were appropriated to the regions; new partnerships were formed; a series of operational (technical) policies were also drafted; experiences in the establishment of the core functions of the Ministry were gathered; and other significant milestones such as financing options, legal framework, and implementation arrangement options (EPHS, NHPC, new professional schools, new cadre of health workers) were reached during the period. Discussions also commenced on establishment of a Central Medical Stores (CMS) and a Drug Authority, and partners continue to provide drug kits to the health facilities. A national HMIS system was developed and tested. Vision 2030 and the National Development Plan for 2012-2016 were also developed by the Ministry of National Planning and Development. This period also coincided with regional and international milestones that had national rippling effect. For instance, the Paris Declaration (of 2005), the Accra Agenda for Action (of 2008), Abuja Declaration (of 2001) and others focusing on Aid effectiveness (alignment, harmonization, joint analyses, etc.) took place at these times. Polio campaign strategies and Child health Days were also introduced at international level as they continue to have implications at national level.

Hence, NHP II builds on experiences of NHP I and much more; it serves as the point of departure and framework for investment in national stability and development framework contrary to the past post-conflict transition strategy. It seriously considers decentralization of authority and responsibility within the context of national decentralization framework. NHP II further sets the agenda for Public Private Partnerships and proposes a feasible organizational structure that can implement the Policy. The new policy proposes concrete ideas for good governance (transparent and

accountable leadership; restructure of Central level MOH and role clarification; clinical leadership in hospital management; the role of Regional Health Committees), quality health care at community, district and regional levels (through conception and adoption of EPHS implementation framework) and service integration, regulatory mechanisms for drugs, supplies and human resources for health, robust quality human resource management, improvement in drug supply chain, innovative mechanisms for financing health services, viable institutional arrangements, a and client charter.

At the international scene, NPH II recognizes the changes that have taken place in Aid environment in the last decade (the Paris declaration of 2005 and the Ghana Agenda for Action of 2008), and references commitments to the Abuja Agenda of 2001.

As documented below, NHP II is based on critical situation analysis of the problems currently encountered at the Central Ministry of Health as well as in the regions, districts and the health facilities.

The NHP II was developed through intense consultative and participatory process. The leadership of the Ministry of Health, Directors and other staff, regional staff, parastatals, relevant Ministries, health development partners and other stakeholders had series of meetings and workshops to review the Situation Analysis conducted, set priorities, develop the vision and mission statements and reviewed what was still useful in the NPH I that could be relevant in NPH II. The success of this NHP II will depend on how far these milestones are implemented and achieved.

BOX 2

The Government of Somaliland is implementing a Health Sector Reform Program which focuses on increased utilization of quality health services especially by people in the underserved area, by improved access to quality and responsive health services, strengthened governance and management in health sector, improved institutional mechanisms for community participation and systems for accountability; and strengthened financial management systems.

2. SITUATION ANALYSIS

2.1 International Context

2.1.1 In the last two decades that the world has been focusing on poverty reduction, there have been considerable improvements in childhood and maternal morbidity and mortality in developing countries. In addition, successes have been made in combating extreme poverty, expanding access to clean water, improving prevention of mother-to-

child transmission of HIV, expanding access to HIV/AIDS prevention, treatment and care, and controlling malaria, tuberculosis and neglected tropical diseases.

However, much more needs to be done in order to fully achieve the MDG throughout regions, countries, districts and communities as progress has been rather uneven. To complicate matters, resurgences of old infections and indeed new infections, increased hunger and malnutrition, low records in achieving environmental sustainability and providing basic sanitation appear to outpace the achievements. Progress has also been slow in reducing maternal mortality and improving outcomes of maternal and reproductive health.

2.1.2 Quantitative investment in health is a major driver that can facilitate the achievement of the MDG by 2015, especially in resource poor environments. In 2001 in Abuja, Nigeria, heads of States and governments in the African region made a commitment on Health Financing for reaching the MDG by pledging to allocate at least 15% of their domestic national budgets to health. This commitment was re-affirmed at a Special Summit on HIV/AIDS, TB and Malaria in 2006 in Abuja and at the 15th Session of the AU Ordinary Summit in 2010 in Kampala. With very little doubt, partnership between the West and the South will facilitate this process.

2.2 National Context

2.2.1 Somalia civil war seriously affected the whole country politically, socially and economically. Health care delivery institutions suffered a lot; hospitals, health posts, MCH Centers and other health institutions were either seriously damaged or completely looted. Trained health personnel in massive number migrated overseas. With all this damage Somaliland succeeded to gain a political shape as “Somaliland” during 1991 with a stable government and considerable level of peace. After that Somaliland started a new national life through rehabilitation of health institutions, calling back migrated trained health personnel and working for other development activities.

2.2.2 Geo-Political, Economic and Demographic Situation. The Republic of Somaliland is situated north of the equator in the Horn of Africa. The total area of the Republic of Somaliland is 137, 600sqkms, and it has a coastline which is 850kms long. It is semi-arid. The average daily temperatures range from 25oC to 35oC. Somalilanders recognize four seasons in the year. The administrative structure of the state consists of three branches: the judiciary, legislative (the House of Elders and the House of Representatives), and the executive arm. The ministers may not be appointed from Members of Parliament. The country is divided into 6 regions, and these are sub-divided into electoral districts. The population of Somaliland was estimated at 3.85 million in 2009 with an annual population growth rate is 3.14%. Life expectancy at birth is between 49 to 60 years. The population consists of nomads (55%) and urban and rural

dwellers (45%). The population density in the Republic of Somaliland was estimated at 28 persons per square km in 2009.

With constant drought and famine affecting man and livestock, poverty and unemployment are widespread. Over 60% of the population is considered to be below poverty line. The backbone and the source of wealth of Somaliland's economy is livestock. About 65% of the population depends either directly or indirectly on livestock and livestock products for their livelihood. Crop husbandry provides subsistence for about 20% of the country's population. Foreign aid and remittances from the Somaliland diaspora also play a major role in the economy of the country.

The current projected income of Somaliland put at \$50 million is optimistically expected to double by next year and then by 2013 to \$160 million (the health sector only receives about 3% of this, although it is expected to double in the coming year). The recent lifting of a ban on livestock exportation on the grounds of fear of Rift Valley Fever by Saudi Arabia has gone a long way to improve the outlook of the economy. International companies such as Coca Cola previously based in Mogadishu are beginning to move to Somaliland thus boosting the country's economy.

2.2.3 Health Status: Somaliland has one of the worst maternal mortality ratios in the world, estimated to be between 1400 and 1000 per 100,000 live births. Life expectancy at birth is between 47 and 57 years. The infant mortality rate is 90/1000 while the under-five mortality is about 145/1000. Fully immunized child is a mere 5%. Environmental sanitation is highly challenged. The top 10 leading causes of morbidity are mainly the preventable and curable infectious diseases.

Maternal mortality is the leading cause of death among women of reproductive age. It is caused mainly by hemorrhage, puerperal sepsis, eclampsia and obstructed labor. Women in Somaliland have a one in 15 risk of dying of maternal-related causes. There are a little over 100 doctors in the country both in public and private sector and about the same number of registered midwives. In the public sector in 2011, there are 15 hospitals, 87 MCH and 165 health posts in the country. All these health indicators reflect the seriousness of the health situation in Somaliland.

2.2.4 Determinants of Health: As a result of prevailing poverty and high illiteracy as determinants of health, many of the common diseases are those of poverty (communicable diseases) as well as those associated with post-conflict situations. Poor hygiene, lack of safe water, poor sanitation and disposal systems as well as unsafe housing environment forms the antecedents of common illnesses. Hence, Diarrhea, Dysentery, Typhoid, Acute Respiratory infections, Tuberculosis, Chronic Bronchitis, ear infections, etc. are in the top causes of morbidity. Low utilization of health care is another cause of poor health as well as occupation. There are the pastoralists and the nomads. Access to health care is a major problem for the nomads. Cultural factors also determine the health outcome. FGM and its attendant long term suffering for its victim is a case in point. Diet, living style (smoking, chewing, injuries, etc.), post-traumatic stress disorder

and lack of physical exercise equally contribute to growing body of non-communicable diseases. This may be more significant as people begin to adjust to the new urban sedentary life and also as people living in the diaspora return home.

In summary, the determinants of health are as follows:

- **Generalized and persistent Poverty**
 - Poor hygiene, lack of safe water, poor sanitation and disposal systems as well as unsafe housing environment forms the antecedents of common illnesses.
- **High illiteracy**, especially in the female population
- **Persistent food deprivation**: Malnutrition (stunting, wasting, low weight)
- **Early age at marriage**
- **Patriarchal society** – limits access to services for women
- **Culture and religion** sometimes limit access to allopathic health care; FGM
- **Sexual abuse and sexual violence**
- **Occupation** – nomadic population and lack of access to health care
- **Inequitable access to services**: Rural dwelling, Nomadic lifestyle
- **Poor health systems response**: Due to shortage of health power, vaccines, drugs
- **Unhealthy lifestyle**: Smoking, lack of exercise, use of hard drugs, car accidents,
- **Post Traumatic Stress Disorder**: Mental illness

2.2.5 Organization and management of the health sector (Governance): The MOH is the public institution responsible for the health care of the nation. It is charged with the overall production, delivery and coordination of the health sector and assuring Somalilanders of good health.

The Ministry of Health is headed by a Minister who is appointed by the President. He is supported by the Vice Minister. Their role is policy formulation, advocacy, external relations and serve as the bridge between the people of Somaliland and the Government. The Ministry is administered by the Director General and has six departments under him namely: Planning, Human Resource Development, Finance and Administration, Health Services, Public Health and Communicable Disease Control. Currently, there is no Health Act for the national health system

Like a few other government Ministries, MOH has been decentralizing its functions and power to lower levels. The country currently has six regions. A Region is headed by a Regional Medical Officer, who is appointed by the DG of MOH. The structure of the regions mimics that of the Central MOH but mainly focuses on support to the district health program. Each region has a Regional Health Board whose composition represents the community. They are usually seven and have oversight functions on all health institutions in the region including the hospitals, the regional health office, health centers, etc. However, they have been known to fully support fund raising, especially for the

hospital. As they are usually from the business community, they are unable to provide clinical oversight required for the hospital's clinical work.

The regional health system is further divided into districts. Districts are governed by the Executive Committee which comprises of an elected mayor and the deputy and an executive secretary that is appointed by the Ministry of Interior. The electoral districts also have elected council members who have been elected since 2003. District Medical Offices are functional in a few of these districts. In general, district management capacity is still very limited in many districts: leadership, management and specialist skills are in short supply at all levels of health care. Community participation is also weak.

Especially at health facility level, there is indiscipline and lack of ethics. Health workers generally work for less than 4 hours before going to their private health facilities..

As contained in Article 17 of the 2001 Constitution, the commitment of the government of Somaliland to sound health and prosperity of its people is unshakable. The MOH is evolving and has come a long way from 1991 when the first post independence government was formed. There is still a dearth of skills for planning, policy development, vision, planning, program formulation, implementation, M&E at all levels. Roles are not clearly defined and these sometimes have led to duplication of efforts, confusion and inefficiency. The organizational structure is still very traditional and unresponsive to existing health management challenges. Although there are no technical guidelines, checklist, or other tools for mentoring regional and health facility staff, however, many technical/operational policies have been drafted and await approval before implementation. Some of these draft policies include: Human Resources, Drug and Reproductive health, etc.

Realizing that medical graduates are not registered, private and public health facilities are not licensed and health training schools are not accredited, a National Health Professional Council (NHPC) has recently been revamped a board of directors formed. The office is not yet fully functional. For instance, it is has no budget of its own and is currently fully supported by an international partner. When fully operational, its role will be to register all medical and allied medical graduates in the country, accredit all health training institutions and license all health facilities (private and public) for medical practice and assurance of compliance with ethics.

Drugs and health supplies are not regulated especially in the private sector but also in the public sector. Importation of drugs by unlicensed traders prevails throughout the country.

In general, there is a general lack of coordination across and within the health sector. Not only is there a lack of coordination of partners working with MOH, there is also a lack of coordination within the MOH structure. The financial system is still weak and would require systems strengthening.

2.2.5.1 Health service delivery: Delivery of health care in Somaliland is comprised of the public sector system of Hospitals, Referral Health Centers, Health Centers and Primary Health Units; and the private sector (for profit) system of pharmacies, clinics, laboratories and traditional medicines. In addition, there are the Private not-for profit hospitals and clinics. Some of them are supported by international organizations and others are owned by individual philanthropists.

As mentioned above, both the private and the public sector participate in the delivery of services to the people of Somaliland. For the public sector, the EPHS framework has been adopted and this package is the official national package for implementation at primary care level.

2.2.5.1.1 The Public Sector delivery system: The public sector health system consists of the EPHS framework which includes the Primary Health Unit (PHU), Health Center (HC), Referral Health Center (RHC) and the Regional hospitals. Furthermore, there are Specialist hospitals (TB, Mental and FGM) as well as the Hargeissa Group Hospital (HGH).

The PHU is the closest facility to the community. It serves a population of about 300 households, approximately 2000 population. It is staffed by at least one trained CHW and supported by a member of the CHC) and provides basic care for prevention and promotion including maternity services to the community. The CHW is not a nurse but is trained to diagnose common diseases, provide antenatal care and also assist in uncomplicated deliveries.

The HC is the first level that has a qualified nurse, midwife and auxiliary nurse and a community midwife. The HC provides outreach support services to the PHU, covers a population of about 5000 people and serves as a referral point for the 2-3 PHU. The HCs receive support from International agencies (drugs and equipment for OPD and maternity as well as incentives for health staff) in addition to regular contributions of the MOH.

There are regional hospitals in the six regions. In addition, there are seven TB hospitals and four TB centers. There is also a Fistula hospital in Buroma and Hargeissa and are supported by South Africa and UNFPA. Several of these regional hospitals are supported by international organizations as they renovate, procure drugs as well as provide incentives to health staff, in addition to government's own contribution that includes standard setting, refresher training, supportive supervision and remunerations. The Hargeissa Group hospital is inefficient in its management, public property is being used for personal gains and there is weak clinical supervision, among others. All these have resulted in loss of public confidence in the hospital.

Like in many resource-constraint regions of the world, referral care in Somaliland is a major challenge. The referral system between various types of health facilities is either non-functional or ineffective. EmOC is missing in practice. Distances are very far apart

making referral a major challenge and there is no transportation. There is a current inability of the system to cater for emergency transport needs of the nomads to hospital. Furthermore, as a result of traditional or cultural barriers, clients usually report as emergency in late stages of disease. However, some hospitals with support of international donors and partners have ambulances and effective communication system for cases of emergency. They are testing out several initiatives worthy of note:

- Referral care logistics through use of Coupons for transport and other innovations
- Risk assessments which can reduce emergency referrals

Lessons are also being learnt from localized experiences of Elders and Regional Health Boards (RHB) on early referral. These lessons are captured, reviewed and being scaled up.

Health services utilization is still limited in Somaliland due to uneven distribution of health facilities especially in rural areas, inadequate supply of drugs resulting in shortages of drugs and other health supplies and the shortage and low motivation of human resource in the public sector. For instance, it is known from surveys that less than 15% of the rural population is able to use the public system for regular complaints as there are major barriers to access and utilization in rural and urban areas.. The functionality of the health system in Somaliland is a challenge and systems strengthening especially at district and community level will be required to effectively deliver services.

The strengths of the health services can be summarized as follows:

- Basic infrastructure and equipment available and in relatively good condition
- Donor support strong in hospitals
- Chronic shortages of drugs not common
- User fees are being used at the point of collection (mainly in the hospitals) for improvements

The weaknesses of the health services can be summarized as follows:

- Health infrastructure is not enough to cover the entire population and respond to their needs. There are less than 300 although the country will require over 1700 units.
- Very poor health indices
- Routine immunization coverage rate is low
- Patient management is poor
- Delivery still takes place at home and by TBAs.
- Preventable diseases account for major causes
- Programs are still very vertical
- No clinical supervision & community outreach
- Consumer knowledge weak
- Health facilities not accredited

2.2.5.1.2 Private Sector: Over 60% of the health market is dominated by the private sector. The private system comprises of the private not for profit organizations (PNFPs), private health practitioners (PHPs) and the traditional and complementary medicine

practitioners (TCMPs). The PNFPs are larger, better organized and with greater structures than the other sub-sectors. They also have better collaboration with MoH. Even though the private sector provides a significant proportion of health services, it is not properly integrated with the public sector to fully take advantage of each other. The non-facility based PNFPs have not been properly harnessed to support health promotion at community level. Improving the partnership at regional level will enhance capacity to provide health promotion and disease prevention, among other services.

The Private not-for-profit subsector (PNFP)

The facility-based PNFPs (such as Edna Maternity, Gargaar and Manhal hospitals) provide curative services while the non-facility based PNFPs (such as CCDRS) mainly provide promotive, preventive, palliative and rehabilitative services. Manhal has its main hospital in Hargeissa and with four branches in different parts of the country while Edna is only in Hargeissa. The Edna Maternity hospital also operates as a health training institution. While Edna is wholly owned and funded by an individual, Manhal receives external support. CCDRS, a NFB-CSO operates at community level in the areas of health education and promotion, counseling, social mobilization and supporting community health workers to promote health at community level. However, this NFB-PNFPs have not been properly harnessed.

Private Health Practitioners (PHPs)

PHPs provide mainly primary care services and have a large urban presence. Although existing relevant legislation provides for licensing and regulation of health professionals who engage in private practice, the expansion of private health providers has largely been unregulated and chaotic. The large pharmaceutical (importer) sub-sector is however better regulated. Recently, the Wholesalers have been organized by the MOH for quality control of importation of drugs into Somaliland. The number of pharmacists and pharmacy technicians is low and most people doing pharmacy work are not qualified. There is also a Pharmacy Committee recently established and have done a great job of control of drug purchase such that they only purchase government-backed drugs from Wholesalers.

Traditional and Complimentary Medicine Practitioners (TCMPs)

Approximately 60% of Somaliland-ers seek care from TCMPs (e.g. herbalists, spiritualists, traditional birth attendants and traditional dentists) before visiting the formal health sector. Many traditional healers remain unaffiliated. In the communities, most TCMPs have no functional relationship with public and private health providers.

2.2.6 The Performance of the Health Sector.

2.2.6.1 Child and Reproductive Health: Clinic attendance at Primary level in the public sector is rather low, even though the private sector is flourishing especially in the cities. More deliveries take place at home (31.1%) than at the health facilities (9%). Antenatal clinic attendance (at least four times through pregnancy) is very deflating at 4% and (at least once) 26% respectively. Antenatal care by qualified staff is also less than adequate;

a significant percentage of women are multiparous and use of family planning methods is extremely low. Positive response to ever use of any method of contraception is only 22%. Most of these use the ineffective coitus interruptus or breast feeding according to Islamic law. Very young women who are prime-gravid also pose imminent danger to the attending clinician. With over 80% of women and girls under-going it, the Type III Female Genital Mutilation (FGM) is most commonly practiced in Somaliland. It is also the most harmful as the procedures leave a lifetime of physical suffering for the women. There is a National Network for FGM in Somaliland and the Network has just established the Magan Maternity hospital. Post traumatic surgeries are conducted monthly in addition to counseling. The National Fistula hospital in Boroma has over 30 cases per month for treatment of medical complications.

Routine fully immunized coverage rate for children 12-23 months is still very low at about 5% and measles immunization coverage is 19%. In some regions, DPT drop-out rate is as high as 75%. All these contribute to high VPD. Malnutrition, especially chronic malnutrition, is also a prevailing disease resulting from persistent food deprivation, while exclusive breastfeeding is only 13%. Effective treatment of pneumonia is 33% while effective treatment for diarrhea is a mere 7%.

Service utilization is low, mainly as a result of the poor quality of the service, the lack of health-care facilities, and customer preference for private service providers. Some people live as much as 100 km from the nearest health facilities. Sometimes, these facilities are also poorly equipped in human and material terms and do not have much to offer for the critically ill. Particularly for the nomadic population, access to health care for such emergencies as difficult labor and childhood illness is very poor and could make a difference between life and death.

2.2.6.2 Malaria Although malaria cases appear to be dwindling in some parts of the country, the disease still remains a public health challenge in Somaliland. Both ITN and IRS are being used as preventive approaches in different settings of the country. A combination therapy (Fansidar and Amodiaquine) is also approved for case management. IPTp has been removed from the Malaria policy.

The major challenge for malaria in Somaliland is to effectively balance implementation of strategies for control and sustained control as there is high transmission as well as seasonal transmission in this resource-constraint country. Until local field research suggests that coverage can gradually be targeted to high risk areas and seasons only without risk of a generalized resurgence (Sustained Control), the national program remains in the control phase of the Global strategy.

2.2.6.3 HIV and AIDS: HIV sero-prevalence surveys in Somaliland have consistently shown that HIV is an emerging public health problem as the median prevalence is considerably higher than in other countries in the MENA region. HIV prevalence is also higher among TB and STD patients and indicates that the prevalence may also be higher

among other high risk populations. Therefore, this calls for an urgent initiation and implementation of TB/HIV collaborative activities in the country.

The current level of HIV infection is particularly alarming considering that the usual high risk factors explaining the introduction and the spread of HIV, such as pre-marital and extramarital sex and intravenous drug use, are strongly abhorred in this culturally and religiously conservative society. With high HIV prevalence in neighboring countries, porous borders and consequent cross border mobility, the population of Somaliland will become more exposed and vulnerable to HIV transmission. This vulnerability is further compounded by internal conflict, displacement, food insecurity, and the low level of knowledge on HIV transmission and prevention. It is expedient that aggressive interventions be embarked upon based on clear identification of drivers of the epidemic and communities where HIV vulnerability is highest while there is still a window of opportunity to halt the epidemic.

2.2.6.4 Tuberculosis: The disease is significant and is on the increase in the country as under-nutrition is a significant and enduring public health problem here. Rates of acute and chronic malnutrition have remained persistently high throughout Somaliland with some variation by region and livelihood system. DOTS approach is the current strategy being implemented for case management. Poor hygiene practices, inadequate housing, poor health seeking behaviors and low access to quality health services are some of the factors that propagate TB in the community. Although the social determinants of TB are grounded in the community, the emphasis is still case management at clinic level. There are seven TB hospitals and three Centers throughout the country.

2.2.6.5 Mental Health. Mental illness is a significant challenge to Somaliland. The cause includes depression from the civil war, drug/substance abuse, in addition to anxiety, depression, schizophrenia and organic psychoses.

GAVO, a CSO, has been engaged in advocacy to government and international community and creating internal and community awareness on the situation of mental illness in the country. THET has also been involved in incorporating mental health into training curriculum of a wide variety of health practitioners.

Again, there is an emphasis on hospital admission and treatment without looking at the community that generates these patients due to unhealthy life-style. Community awareness and education will be required if Somaliland would make a concerted effort in reducing this burden of disease.

2.2.6.6 School and Adolescent Health: Not much is being done in the area of school health (oral health, health education, immunization, alcohol and drug reduction program, HIV/AIDS and STD, Communication for Behavior Change, etc.). Many of these lifestyle related illnesses are becoming more common among school, adolescent and youth.

2.2.6.7 Environmental health and Sanitation: This is another major challenge of Somaliland. It is the leading cause of many diseases in the country.

2.2.6.8 Non-Communicable Diseases: Non Communicable Diseases are on the increase. The cause is related to diet, living style (smoking, chewing qat, injuries), post-traumatic stress disorder and lack of physical exercise. This may be more significant as people begin to adjust to the new urban sedentary life and also as people living in the diaspora return home. However, nothing is currently being done about it in terms of awareness creation and education, prevention and promotive care.

2.2.6.9 Occupational Health including Chemical management and Control. The coast of Somaliland is very long and attracts international community to dump chemical wastes and products if not checked. Furthermore, with increased growth of industries in the country, government has to be mindful of chemical hazards and wastes that could result in various skin diseases, respiratory system and other blood disorders. Currently there are no regulations in these areas.

2.2.7 Monitoring and Supervision: The Regional team and the District Health Teams (where they exist) supervise service delivery at government health facilities at the Primary care level. However, challenges exist: supervision and monitoring visits are irregular and poorly documented; there is a lack of tools and human resource to conduct supervision especially in newly created districts; lack of supervisory skills at district and regional levels; lack of transport for supervisory and monitoring visits; and inadequate budgets. Efforts at national level to organize and support clinical supervision of the Regional hospitals have not been very successful. In general, technical supervision is weak and this has affected the quality of service.

The national HMIS unit has developed a HMIS for the country and has been rolled out to the regions. This comprises national guidelines for reporting deadlines and channels, as well as revised and standardized data collection tools. The monthly forms have been implemented in all MCHs and hospitals at regional level. The Health Post level tools are currently under development.

Current challenges faced include:

- The national priority health indicators have not been reviewed
- Different data collection systems proliferated by vertical programs and supporting agencies
- Poor quality of data generated at SDP level mostly contributed by low skill level, low staff morale and lack of data use at collection level
- Available data from MOH not used at any level for decision making
- Lack of proper integration with other systems of data collection in place e.g. Disease Surveillance system
- Lack of other critical sources of complementary information such as: Population & census data at regional and lower levels; Periodic Demographic and Health Survey (DHS) data; Research data

- Private sector not providing periodic service statistics
- Lack of precise demarcations for catchment areas of facilities

2.2.8 Health Infrastructure: The infrastructure of the health facilities appear to be in relatively good working condition although many need some additional refurbishment. At mid 2011, the country has 15 hospitals, 87 MCH and 165 Health Posts. These are grossly inadequate for the 3.85 million population. There is a team of engineers in the central MOH who provide advice on infrastructural design and maintenance. Standards regarding infrastructures and equipment have been developed by them, so also is the mapping to ensure equitable distribution of health facilities by type throughout the country. The challenge in the several years will be upgrading and modifying the health facilities in support of the District-based EPHS framework being implemented by the government and also establishing new health facilities in order to improve access.

2.2.9 Human Resource for Health. Somaliland is in short supply of qualified health professionals as a result of the war and exodus of trained personnel abroad. Currently there are two medical schools, five Nursing Schools and two Schools of Midwifery. These schools are not well coordinated. The curricula used are not well known and approved by the MOH. The total enrollment is still low for the demand in the country and the production is not regulated. Except for the medical colleges, these training schools have not been accredited. The graduates are not registered in accordance with Law No 19 of 2001.

There is no standardized system in place for CPD and criteria are not available to be followed. Distribution of health workers in the country is also skewed in favor of the cities and big towns. Health workers generally work very short hours and attribute this to low wages. Performance assessment is either weak or lacking as there are no clear guidelines for hiring and promotion, or any performance appraisal system, sometimes leading to preferential treatment. However, MOH recently published an Operational Policy and Strategic document which details governance, planning, production of health professionals and continued education. Salaries are extremely low and this has led to employees spending less time at work and looking for additional income in the private sector. A human resource consultant is currently assisting government to develop job description for the leadership including all the directors.

In summary, the strengths of the Human Resource department are as follows:

- A Human Resource policy available
- Relatively good work environment for staff by INGOs working there
- Increasing number of Health Training schools and health graduates
- Some HRM tools have been developed
- HR management database has been established
- Standardized RN/RM, MD, NTT curricula are now available
- Head count assessment of all MOH completed
- ID for all health personnel partially also completed

The weaknesses are as follows:

- Shortage of qualified human resources
- Insufficient medical teachers
- Lack of training needs assessment
- No selection criteria for staff development
- No coordinated CPD
- No uniform staffing patterns at health facilities
- Unusually short working hours
- Poor performance of health staff, absenteeism
- Mal-distribution of trained staff

The opportunities availed are as follows:

- Training schools are supported by government and stakeholders
- There are 2 Medical schools; 5 SON, 2 SOM
- Availability of trained Diaspora and willing to come back
- Internship and national service program in existence

2.2.10 Drugs, food and Pharmaceutical safety and Supplies In the public sector drugs are provided by donors and partners. These drug kits for PHC arrive in country and are stored in the Central Medical Stores in advance for distribution to health facilities. There are frequent shortages because drugs are distributed quarterly and are never enough to cover the three months. The kits are prepared outside the country and sometime do not reflect what is in the essential drug list of Somaliland. Especially in the private sector, there are still problems with drug safety, counterfeited drugs and proper storage. There are problems with irrational use of drugs.

The weaknesses are the following:

- There are no systems for drug registration
- There is no quantification done
- There is no procurement procedure in place
- Irrational drug use rampant
- Public has unlimited access to all types of drug
- Licensure mechanisms for all private health outlets not in place
- Same drug kits given to all PHC (PHU or MCH)

The prevalence of diarrhea, dysentery and typhoid fever are an indication of microbial food poisoning and lack of food safety. Food premises are not licensed and food handlers are not certified by the MOH.

In general, the opportunities availed to Somaliland in the area of drug control are the following:

- A Pharmaceutical Steering Committee is being negotiated. There will also be a Wholesalers Union. This group will assist with Quality Control for imported drugs

- The Drug Kit and other drug donation will serve to build lasting national system
- An Investment Plan of Action has been submitted to a donor for possible funding as seed money for initial procurement for the DRF drug.

2.2.11 Health Care Financing. Financing for Health continues to be an important challenge. The state allocation to the health sector doubled in 2011 in absolute terms but still remains at 3% of the national budget. This is about 1.25 USD/capital/year. These mainly support salary and maintenance. Other sources of revenue for financing health care at service delivery points include: user fee, Diaspora contributions, community philanthropists; municipality contributions (from taxes, etc.), and donor financing. Government is largely dependent on donors and international partners to conduct its activities. Sustainability of the entire health sector continues to be an issue for debate in high level circles.

As a result of all of the above, a major funding gap for program development and scaling-up of priority public health interventions exists in the sector. At the same time the increase in personnel emoluments have not risen to the point where the salaries in the sector are comparable with those in similar settings in other countries. Hence, a good size of resources from partners are used for salary top ups as well.

Collection of user fees has been dwindling in recent times, especially where partners are supporting hospitals. Where user fees are collected, they are generally used at the point of collection for infrastructural improvement, including payment of volunteer workers such as CHW. Active implementation of exemption strategies is yet to take place.

In general, Concept of co-management and co-financing relatively are well developed and functional for Hospitals; Contributions from the Diaspora is uniquely innovative; RHB able to raise funds locally and also from the Diaspora for programs; and Some community members and the Elders make substantial in-kind contributions to the health sector.

However, there is no health financing policy; Government allocation very low at 3%; Public expenditure on health is less than \$5 per capita, compared to the recommended \$40 by WHO; Councils are unable to contribute because the taxes are centralized; Strategy for efficient revenue collection from private health facility not been fully developed; and MOH has not taken advantage of the full range of financing options. The opportunity here is that EPHS provides a good opportunity to experiment with innovative approaches to financing the health system through various models for cost sharing and cost recovery

2.2.12 Partnership for Health: Partnerships between and among government Ministries, donors, charity organizations, private for-profit, development partners, NGOs and the

community remain critical to the achievement of health and development goals of the country.

At the international level in Nairobi, new donor partners are expressing interests in supporting Somaliland. However, all donor meetings continue to be held in Nairobi and not in Hargeissa. At the MOH level, a quarterly National health and nutrition coordination meeting is in existence and brings donors, partners and government to dialogue on planned and completed activities. Similar meetings take place at the regional level as well. Some technical Working Groups have also been started and are on-going.

An NGO Act was passed by the Parliament (Law No. 43/2010) and signed into a Presidential decree No 82/112010 in November 2010. A Development Assistance Database (DAD) has also been developed by MoNPD and distributed to INGOs to complete. Currently, there is no forum for inter-sectoral collaboration in Somaliland.

2.2.13 **Research:** Research agenda for health service, epidemiological and biomedical research are not currently available. Universities are probably involved in some forms of epidemiological research but are not coordinated and government is not fully aware of these events. There are no priority research agenda and capabilities are not determined. Even so, data is not available for planning.

2.2.14 Opportunities: There is a new government that has promised to provide good governance with astute values. A new law has been passed that defers the responsibility of the PHC system to the Councils. This could encourage the participation of the Councils in primary health care. Furthermore, an NGO Law is now in place and ratified by Parliament. The AID instruments such as the Vision 2030, National Development Plan 2012-2016 and the National Aid Coordination Policy are all opportunities provided by government outside the MOH to “speak up” to the donors.

With regards to the health services, EPHS framework provides opportunity to take control of the health service delivery systems; there are also opportunity for service delivery options through results from existing projects of local and INGOs; and finally, nomadic orientation challenges the current health system mode to be creative.

3. Policy Context

3.1 Historical context. At independence in 1991, government committed itself to delivery of quality health care for the nation. This is well articulated in article 17 of the 2001 Constitution. Since the start of the implementation of the Health Sector Reforms in Somaliland in 1996, primary health care has been the cornerstone of the reform process. The two main pillars of this PHC system are decentralization of the health system to the regions and the districts and community participation in the management and financing of the services.

NHP II has been largely informed by the National Development Plan 2012-2016 (NDP) which serves as a guide for development resource allocations for the Somaliland Government and its development partners in a strategically consistent manner. The main response strategies to the NDP on the part of Somaliland's development partners—the United Nations Transition Plan (UNTP); the Joint Strategy Paper of EC, EU countries, and Norway (JSP); and the World Bank's Interim Strategy Note (ISN)--were the first attempts to align international donor support to national priorities. The NDP explains how economic development exemplified by, for example, reduction in prevalence of poverty can be achieved. Economic development is dependent on social and human development. Improvement of people's health is both an outcome and a cause of economic development. The NDP prioritizes the implementation of the EHPS. The NHP II has also been formulated within the context of the provisions of article 17 of the Constitution of the Republic of Somaliland (2001) which decentralized governance and service delivery. Following this, the MoH has delegated responsibilities to the regions for them to manage the delivery of health care.

3.2 *The Vision and Mission Statement*

Vision: For all the citizens of Somaliland to attain the highest quality health status and social wellbeing equitably and sustainably.

Mission: To create an enabling environment for the provision of socially acceptable, affordable, accessible, equitably distributed essential package of quality health care that responds to the need of the community, with special attention to the most vulnerable in the population and delivered in a sustainable way through a decentralized health system within Somaliland.

This mission may not be met without the following assumptions: public private partnership; resource mobilization from the community; community participation in the management and financing of health services; and the reduction in the dependency of the health system on external finance through an increase in the Government contribution to the health sector.

3.3 *Policy Objectives*

The following policy objectives have been set up in order to achieve the mission of the Ministry of Health:

- I. To improve the governance functions for the health care system;
- II. To improve the quality of services provided at the health facility level (including referral care and client charter) and expand service delivery options.
- III. To enhance the quality, quantity and spread of human resources in the health system;
- IV. To expand the options available in financing health care;
- V. To improve the control and distribution of drugs, supplies and consumables;
- VI. To improve physical access to health facilities;
- VII. To strengthen the national HMIS system;

3.4 The objectives of the health policy will be achieved by emphasizing the following core values and Guiding Principles:

Core values:

This policy puts the patient and community in the forefront and adopts a ‘client-centered’ approach and it looks at both the supply and demand side of health care. The following social values, as detailed in the Constitution of the Republic of Somaliland and the Patients’ Charter, will guide the implementation of this policy: **Integrity; ethics; equity; gender-sensitivity and accountability.**

Guiding Principles:

The National Health Policy shall be guided by the following principles:

- The implementation of the NHP II shall be ‘evidence-based’ and ‘forward-looking’, as has been the development of this policy.
 - The NHP II shall be based on sustainability. To ensure that the inputs of today can be sustained over a longer term, beyond the life of donor funds
 - Integrated quality care that is socially acceptable, affordable and accessible, and supporting continuum of care.
 - Efficient utilization of health care at all levels.
- NHP II shall be pro-poor oriented and shall provide a policy framework that shall support SERVICE FIRST within sustainable development approaches.
- PARTNERSHIPS with other government ministries, institutions and the private sector.
- PHC shall remain the major strategy for the delivery of health services in Somaliland. PHC, based on the district health system, explicitly recognizes the role of hospitals as an essential part in a national health system.

- Accreditation of all service delivery points. The private sector shall compliment the public sector for improving geographical access to health care and options provided.
- In order to address the burden of disease in a cost-effective way, services included in the EPHS shall be provided in phases. Various scenarios will be used to ensure that all sectors of the public are covered, based upon equity and efficiency considerations, including the need for special attention to the nomadic population. However, private health practitioners shall be expected to provide services not included in the minimum package.
- In line with the PHC strategy and current and projected resource envelope restrictions, greater attention and support shall be given to the health promotion and disease prevention interventions as defined in the EPHS and empowerment of individuals and communities for a more active role in health development.
 - Communities shall be encouraged and supported to participate in decision making and planning for health services provision through Community Health Committees.
- Government facilities shall offer curative, preventive and promotive services in an integrated manner. Government shall explore alternative, equitable and sustainable options for health financing and health service organization targeting the poor and other vulnerable groups.
- A gender-sensitive and responsive national health delivery system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programs.
- Health shall be mainstreamed in all relevant policies and MoH, as lead advisor to Government on health issues, shall provide advice to other government ministries and departments and the private sector.
- The Ministry of Health shall strengthen the development and implementation of efficient, sound and transparent financial management, accounting and procurement methods that can ensure the effective implementation of planned activities and achievement of strategic objectives.
 - Continuous improvement through periodic review and update of the Health Policy
- In order to minimize health risks in Somaliland, the Government shall play a pro-active role in initiating cross border initiatives in health and health- related issues.

4: National Priority Interventions

The situation analysis identified a number of challenges that need to be urgently addressed through policy guidance. Poor governance has retarded the progress of work at the MOH and has not made it to achieve its maximum potential. This has also tricked down to the health facilities including the hospitals. Technical leadership is also lacking in the MOH. Technical guidelines and protocols are either not developed or are not followed at the health facilities. Regular supervision is not conducted either by the

Regions or the Central MOH. Furthermore, there is a dearth of human resource for health as well as financing for health and drug control.

More than 75% of the overall burden of diseases is caused by preventable diseases. Access to safe water, sanitation and living conditions are still poor, especially in rural areas and urban slums, resulting in poor health and high malnutrition levels, especially in under-five children. Unhealthy life styles have led to an increase in NCDs. As the projected resource envelope for service delivery will be insufficient to cover all interventions and services to all people in the foreseeable future, strategic decisions on investing in health shall be made.

The focus of the policy shall be universal provision and utilization of the EPHS to all people in Somaliland with emphasis on vulnerable populations. The selected interventions shall not only to be cost-effective, but also affordable. For many of these diseases, cost-effective and affordable primary, secondary and tertiary prevention interventions and services are available. . They shall therefore constitute the core health interventions in this health policy.

In summary, the top priorities for the MOH in order to achieve the policy objectives are:

- Improve Governance functions at Central and Regional levels, as well as promote best practices in hospital management and clinical leadership
- Improve the expansion and quality of EPHS in order to improve quality of services provided at the health facility level (including referral care and client charter) and expand service delivery options. Promote awareness and contribution to improved personal health care through prevention and health promotion.
- Improve behavior/Social change (including Prevention and Promotion in households
- Establish a concrete Human Resources for Health approaches
- Develop sustainable Health Financing options
- Control Drugs and Consumables and enhance its supply to health facilities
- Improve physical access to quality health services in private and public facilities
- Monitoring and Evaluation

Government shall adopt a decentralized planning and management system in close collaboration with the community. Managerial and administrative capacity will be developed at all levels within the context of decentralization. Government shall design mechanisms to supervise, monitor and evaluate the implementation of the Health Sector Policy with a focus on specified input and process indicators: evaluation will be conducted both internally and externally in collaboration with the Ministry of Health's partners. Finally, the Health Management Information System (HMIS) will be reinforced to better inform decision-making in the health sector.

4.1 Governance

Partnership with the donors shall continue to be strengthened. MOH shall strive to host in Hargeissa Donor meetings hitherto held in Nairobi. The health sector shall continue with the decentralization process that has started and strengthen the Regions and gradually initiate a District Health System (DHS) to manage and deliver quality health services. A lean and efficient organizational structure that is based on core functions of the central MOH will evolve to support and implement the NHP II and prioritize management and technical oversight of the regions (See Appendix 1). Above all, government will not tolerate any act of indiscipline and/or lack of ethics in the health sector. Financial Management system shall continue to be strengthened.

4.1.1 Policy Objective:

The aim of good governance in the health sector is to create an enabling environment that is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of society.

The following are the main objectives of this section on governance in this policy:

- I. Review and implement the structure of Central and Regional MOH levels to ensure efficient and effective management of the health sector
- II. Emphasize Service integration over verticalization of programs;
- III. Inspire confidence in the donor community and stakeholders through demonstration of transparency, accountability, improved Financial Management Systems and effective use of resources; and hence generate additional resources for the sector.
- IV. Re-emphasize its regulatory role through establishment of government parastatal organizations such as NHPC and the National Drug Authority and delegate its Regulatory functions (licensing, registration and accreditation) to these institutions.
- V. Phase out the total control of the management of the hospitals and hand over to a CSO/NGO to manage them along with an independent multi-sectoral hospital management board.
- VI. Improve coordination with partners, donors and other stakeholders

4.1.2 Policy Strategy:

Government shall

- Strengthen the Central MOH to carry out its core functions including Policy formulation; Strategic planning; Resource Mobilization; Monitoring and

- evaluation; External relations (Donor coordination); Legislation and Inter-sectoral collaboration.
- Implement a gradual decentralization of power and authority to the regions and districts to implement the national health policy and strategies;
 - Support the Regional Offices to fully and effectively conduct its core functions including interpretation of policies into actions; establishment of planning, supportive and managerial mechanisms for oversight of District health system; Coordination of disease control program, and provision of adequate training to all the health staff throughout the health region; Provision of technical support to the districts; Supportive supervision and inspection of district health services; Links between Districts and Central Ministry of Health in matters pertaining to standards and quality of health care both public and private.
 - Initiate and support development of the District health system which will be in line with the administrative/political district system.
 - Support the creation of various community committees at different levels: as village, community, PHU and HC levels. Their roles are to:
 - create awareness in the village about available health services and their health entitlements;
 - develop a Village Health Plan based on an assessment of the situation and priorities of the community;
 - maintain a village health register and health information board and calendar;
 - analyze key issues and problems pertaining to village level health and nutrition activities and provide feedback to relevant functionaries and officials; and
 - To present an annual health report from the village to the health authorities
 - Develop strategic integration through team work across departments, divisions, units and programs in order to reduce verticality, fragmentation, duplication and redundancy and increase efficiency and effectiveness.
 - Develop a costed strategic and operational plan for investment in the health sector; and avoid stand-alone, vertical program and projects.
 - Develop a new Financial Monitoring system that will be effective and efficient
 - Put in place an audit system at all levels to ensure transparency and effective management system. To this end, government will muscle all its strength to fight conflict of interest among service providers and ensure zero tolerance to corruption. MOH shall create an Office of Internal Auditor who will audit the entire management system and report to the Office of the Minister.
 - Produce a certified audited annual report
 - Establish National parastatal institutions - NHPC, and Drug Authority and have the following roles:
 - **NHPC:** Standard setting, and Quality Assurance; Licensing of all private and public health facilities; accreditation of health training schools and

4.2.1 Policy objective

- a). To increase access to health facilities for the population
- b). To Increase attendance and utilization of services at PHU and HC by providing a broad range of core services at every service delivery point.
- c). To establish a community component of care that will link communities with the PHUs.
- d). Periodically review the composition of the package to align it with the burden of disease in the country, availability of new interventions to address these conditions, changes in the cost-effectiveness of interventions and the total resource envelope available for service delivery
- e). To increase preventive and promotive health care including self care
- f). Improve timely care for complications through establishment of a referral care system
- g). To restore and improve the quality of care at all levels
- h). To promote Service integration of program and at Service delivery point
- i). To ensure availability of essential equipment, supplies, physical structures and trained Human Resource for Health at every level of care

4.2.2 Policy strategies

In order to achieve this policy objective, Government shall:

- (i) Gradually expand health facilities according to arising needs.
- (ii) Promote routine health facility outreach programs and population-based, high impact interventions for the population
- (iii) Create demand for the community to utilize available health services.
- (iv) Advocate for, design and lead the development of the EPHS framework and encourage its uptake by the regions;
- (v) Include all core primary health care services in all the PHUs and ensure availability of recommended health providers;
- (vi) Ensure availability of equipment, drugs, laboratory supplies and competent health care workers appropriate for the levels of care
- (vii) Initiate a Community-Health facility initiative such that the hard to reach will have a connectivity of basic health and nutrition services with the nearest health facility.
- (viii). Use population based campaigns
- (ix). Use the Child-to-child; Role model mothers; and other types of appropriate models to provide information to care givers.
- (x). Train co-villagers as advocates for, design and pilot the implementation of appropriate service delivery models for specific population groups such as the nomadic population
- (xi) Ensure that at all times adjustments concerning the package necessitated by limitations in the resource envelope for service delivery will be based on the best possible combinations of available options for equity, efficiency and quality of services.
- (xii) Prioritize interventions against diseases internationally targeted for elimination or Eradication, such as measles, polio, etc.

- (xiii) Use Communication for Development including the use of social marketing techniques, to target vulnerable populations regarding the prevention and control of major health problems in Somaliland.
- (xiv) Gradually strengthen self-care, especially at primary care level, for selected health problems and patient categories, possibly through –carefully planned and evaluated- pilot phases.
- (xv) Initiate culturally appropriate referral systems from the community to the health facilities
- (xvi) Provide RHC with ambulances for immediate evacuation of emergencies
- (xvii) Link the health facility structures (including the community) with radio communication system for timely, efficient and effective care for emergencies
- (xviii) Establish and reinforce technical (clinical care management support through
 - development of technical guidelines, supervisory guidelines, professional standards in patient management and introduction of professional registration
 - Mentoring and supportive supervision
 - Clinical audit
- (xix) Develop/review hospital care standards, policies and procedures and implement them within the EPHS context
- (xx) Develop joint needs assessment and plans of action and budget
- (xxi) Conduct joint monitoring visits
- (xxii) Develop national indicators jointly and use one HMIS for data collection
- (xxiii) Emphasis on joint reporting, and
- (xxiv) Inform Partners and donors of GoS plans to conduct integrated programs
- (xxv) Develop service nomenclatures and categorize levels of care with the appropriate equipment, supplies, HRH, etc.
- (xxvi) Develop skills in equipment management at all levels of care
- (xxvii) Conduct regular equipment audit, and repair and/or replace

Child and Reproductive Health. Government will continue to invest resources in key priority areas such as treatment, counseling and care for safe motherhood initiatives, neonatal, infant and child services; care of the adolescence in reproductive health; family planning; sexual abuse; prevention of female genital mutilation; STDs including HIV/AIDS; and female empowerment. Government will ensure health facility delivery with qualified midwives and birth registration of all births.

Government will continue to facilitate the introduction and expansion of Integrated Management of Childhood Illness (IMCI) strategy in all PHC facilities across the country with improved quality care and referral system for childhood illnesses including Acute respiratory illnesses, measles, malaria, diarrhea and underlying malnutrition. Furthermore, government will ensure an uninterrupted, effective and efficient EPI system

whereby all children under two years are fully immunized against all childhood illnesses. Government will support continuum of care.

Nutrition. In order to eliminate childhood and maternal malnutrition and reduce micronutrient deficiencies, government will:

- support the implementation of a Basic nutrition services package including improved dietary habit; breastfeeding; micronutrient supplementation; case management of severely malnourished children and monitoring of children's growth;
- promote Infant and Young Children Feeding (IYCF) as well as food security across sectors
- All these will be done in an integrated fashion with all PHC activities.

Malaria

The national response to Malaria is to ensure that the Malaria technical policy is implemented. This policy supports preventive actions through distribution of LLIN and use of IRS in regions and communities; use of combination therapy in case management for confirmed (use of microscopy or RDT) cases only; and focalized response to outbreaks through prompt surveillance.

HIV/AIDS

The National response to the HIV/AIDS epidemic consists of developing strategies to prevent, control and mitigate the impact of the epidemic. The Health Sector will continue to lead the national response on technical issues related to the following:

- Prevention and control of HIV transmission strategies, which include: Sexually Transmitted Infections (STIs) services; Blood safety; Prevention of Mother to Child HIV Transmission; Design, development and distribution of IEC print and electronic messages and materials; Health education and promotion; Voluntary Counseling and Testing (VCT); Care of HIV/AIDS patients at both facility level and community home based care; Provision of treatment for Opportunistic Infections and eventually Anti-Retroviral Therapy;
- Impact mitigation and support to affected and infected individuals and addressing the stigma.
- Management and coordination of the health related technical aspects of the national response.
- Supporting and guiding biomedical and health related research on HIV/AIDS.

Female Genital Mutilation: Government shall

Advocate for sustained commitment of government at all levels to the successful implementation of the policy, as well as to legislation and enforcement; Public enlightenment through an Information, Education and Communication network;

Capacity Building through training of trainers, including peer educators and health workers, as well as ensuring the availability of suitable training packages/information manuals/kits on the dangers and consequences of female genital mutilation; Promote research to generate current information, and to monitor and evaluate intervention programs to determine attitudinal changes; Promote alternative skills acquisition, credit mobilization, and income generation for practitioners of female genital mutilation.

Tuberculosis: Government shall:

Integrate care and control of tuberculosis into the General Health Care Services Scheme based on the Primary Health Care System; Upgrade existing tuberculosis control work through a more efficient organization, provision of uniform guidelines, better training of staff and more intensive supervision; ensure rapid expansion of quality DOTS countrywide as part of the Global Plan to STOP tuberculosis and make standard procedures as simple as possible. Collaborate with National and International training/teaching institutions, as well as research centres for tuberculosis, in various aspects of the disease.

Epidemic Preparedness. Government will build on the existing surveillance system for effective detection of notifiable diseases. Disease monitoring will be strengthened.

School and Adolescent Health:

Because of their population size and vulnerability/influence on health through modern day communication systems, government shall specially focus on the health needs of adolescence and school children and:

- (i) Promote the acquisition of appropriate knowledge on health by adolescents.
- (ii) Train and sensitize adolescents and other relevant groups in the skills needed to promote effective healthcare and healthy behaviours in adolescents.
- (iii) Facilitate the provision of effective and accessible information guidance and services for the promotion of health, the prevention of problems and the treatment and rehabilitation of adolescents in need.
- (v) Facilitate the acquisition of new knowledge concerning interactions between adolescents and those who may provide them with health care or influence their behavior regarding biomedical and psycho-social issues related to the physical, mental and sexual development of adolescents.

In order to achieve the above, government will support the following strategic thrusts:

- (i) Conduct needs assessment surveys, advocacy, basic and operational research, coordination of partnerships between specialized institutions concerned with adolescent issues.
- (ii) Provide comprehensive services, including healthcare, health education and partner with other government Ministries to support personal and job skills training, vocational guidance and training, sport and recreational facilities, and social and legal support to

settings in which adolescents are favorably disposed, with emphasis on promotion of healthy lifestyles and use of positive role models to discredit harmful habits.

(iii) Coordinate school health programs implementation and also to ensure the inclusion in school curricula in the teaching of sexual and reproductive health issues, emphasizing responsible sexual behavior and a positive attitude to sexuality as a means of preventing unwanted pregnancies, drug abuse or avoiding sexually transmitted diseases.

(iv) Provide services in special clinics for adolescents within existing facilities, outreach facilities in schools and other places to which adolescents are attracted.

Mental Health. Government shall:

strengthen public mental health services by integrating into overall health services and strengthening PHC and community level services;

strengthen management capacity of communities and community systems to manage mental illness at family and community levels, which will entail deploying social welfare workers and establishing client groups, associations and networks; and foster inter-sectoral collaboration including NGOs.

Traditional and Complementary Medicine

The role of traditional and alternative health care to Somaliland people is significant. It is estimated that about 60 per cent of the population use traditional and alternative care system for their day-to-day health care. Traditional and alternative healing services and conventional health services are complementary to each other.

Government will continue to recognize the role and contributions of traditional and complementary health care in shaping the health status of the people of Somaliland; the Ministry of Health will ensure that: the Traditional and complementary health practitioners will be accountable for their own prescriptions, remedies and therapies; the Village Community government will appraise, assess and recommend in a particular locality traditional practitioners for registration by an approved authority; government will continue to pursue legislation to provide for regulation of practitioners, therapies and remedies and other related treatments.

Environmental Health and Sanitation

Environmental health and sanitation, is an important area for promotive and preventive health. It is one of the best indicators for measuring social and economic developments which can be achieved by, among other things) enhanced environmental cleanliness, monitoring of water quality and safety, monitoring of food quality and safety of locally produced foods and imported foods at ports of entry, manufacturing, packaging and sales outlets.

Government will achieve these aims through:

- Delivery of health education and promotion at all levels to individuals, families and communities;

- Formulation of guidelines on different aspects of environmental health and sanitation will be given priority.
- Collaboration with other stakeholders and provide guidelines for achieving better environmental health and sanitation.
- Enforce solid and liquid waste management at each health facility.

National Food Hygiene and Safety

Goal: To attain high level of food hygiene and safety practices which would promote health; control food-borne and food-related diseases; minimize and eliminate the risk of diseases related to poor food hygiene and safety.

Objective

- The objective is to prevent illness and diseases attributed to the sale and consumption of unwholesome foods by giving consideration to the intricate network of safe production, distribution and marketing of foods.

Strategic Thrusts

- (i) Advocacy through the mobilization of policy makers and key officials in government and the private sector, opinion leaders and NGOs, including the print and electronic media, to the policy objective.
- (ii) Enactment of current food hygiene and safety legislation, followed by effective surveillance of food, water, food premises, food handlers, etc.
- (iii) License accredit food premises and license food handlers
- (iii) Multi-sectoral collaboration of all relevant government ministries and agencies, NGOs and the private sector in the planning and implementation of programs.
- (iv) Undertaking relevant research in current food hygiene and safety technologies and their application.
- (v) Adoption and implementation of the Hazard Analysis Critical Control Point (HACCP) system in monitoring and evaluating the different aspects of food hygiene and safety from production through processing, storage, transportation, distribution, marketing and preparation for consumption.

Non-Communicable Diseases are on the rise, especially among returnees from the Diaspora. Government will take appropriate measures for prevention, control and surveillance of NCDs including health education and promotional measures to alert the community on prevention, diagnosis and management of such diseases; case detection through mass community services, etc.

These diseases are commonly cancer, diabetes, lung problems, cardio-vascular problems and those associated with tobacco consumption and other toxic abuses, an inactive life style and environmental pollution. Oral health, the prevention of blindness and physical rehabilitation services for the handicapped people will be improved.

Occupational Health Services

Government shall ensure workers' protection against all occupational hazards, which may occur in their work places such as industries, estates, plantations and other high-risk institutions. Government shall ensure that companies employing over 5 people shall offer health information and services to their employees according to guidelines given by the Ministry of Health.

Chemicals Management and Control

Government is responsible for management and control of chemical hazards and contamination of their products.

The priority areas for government intervention shall include:

- Raising public awareness on safe chemicals use and handling;
- Establishing legislation and regulatory instruments to manage chemicals;
- Establishing enforcement structure for the existing legislation and

regulations;

Provision of adequate national capacity to ensure safety through management and control of chemicals and their products;

- Providing guidelines on proper disposal practices of waste/expired chemicals;
- Establishing a national information system for chemicals management and establishing a National register for chemicals.

Medicines and Health Supplies

The shortage of medicine in health facilities constitutes a major problem in improving health care for the people of Somaliland. Currently the drug kits are donated by international partners and the role of government is rather restricted. Hence, drugs are pushed to health facilities as there is no quantification done. Although drugs are bound to be sent to facilities quarterly, there are usually delays and inadequate financing and lack of trained pharmacists/ technicians contribute to this delay. In the course of this NHP II it is the vision of Government to purchase safe, efficacious drugs on international market, locally assemble the drug kits, quantify the health facility consumption, distribute drugs timely to health facilities and ensure timely availability of the medicines and health supplies to health facilities.

There is general widespread use of Sub-standard and expired drugs, propagated by unlicensed and un-professional traders who engage in marketing drugs and pharmaceutical supplies. They sell all sorts of drugs over the counter and that on its own breeds irrational prescription and use and drugs. There is very little awareness on the dangers of consuming drugs. In general, the regulatory environment is at its infancy.

There is a lack of community awareness of their rights to potent, effective and quality drugs as well as lack of consistent implementation of drug policy and procedures

Policy objective

- a). Purchase and safely store efficacious drugs and health supplies
- b). Quantify drug and supply needs at health facilities, giving allowance for emergencies needs
- c). Assemble and distribute drugs and health supplies to health facilities
- d). Gradually initiate a Drug Revolving Fund
- e). Promote rationale use of drugs

Policy strategies

In order to achieve this objective, Government shall:

- (a) Set up a Central Medical Stores as a Public-Private Partnership company where government, private sector including civil society will have shares.
- (b). Purchases will be limited to manufacturers with WHO certification.
- (c). Ensure adequate financing of essential medicines and health supplies in the national budget and gradually reduce donor dependency over time
- (d). Explore opportunities for local production
- (e). Train pharmacy staff in how to conduct a quantification assessment
- (f). Ensure proper management of drugs including stock levels that will inform quantification needs from the lower level health facilities to the national level.
- (g). regularly update the EDL such that the assembly of the drug kits is appropriate to the level of delivery of healthcare
- (h). provide additional funds to cover transport and other contingency needs, in addition to the drug investment funds
- (i). Train staff in the principles/procedure of DRF
- (j). Ensure that money generated from the sale of drugs are re-invested in the purchase of drugs and consumables.
- (k). instruct health facilities to strictly follow the DRF rules, regulation and procedures including the opening of a separate “pharmacy” bank account
- (l). Take into consideration EXEMPTIONS for those who are unable to pay; and cover emergencies through a separate grant
- (m) Promote, support and sustain interventions that ensure rational prescribing, dispensing, better diagnosis and patient compliance in the use of medicines and other supplies;
- (n). Create awareness on irrational use of drugs
- (o). Train the community on the curriculum
- (p). Conduct baseline to generate data on personnel involved in irrational use of drugs
- (q). Continuously promote best practices

4.3 Development and Management Human Resources for Health

The health sector recognizes the critical role of human resource in health in terms of both quality and numbers in the delivery of the quality of health services to the population. There is however, unregulated health training institutions in the private sector, a shortage and mal-distribution of human resource, many staff are poorly trained, poorly motivated, and leadership and management skills are inadequate at management level. There is inappropriate mix of skills and categories for Human Resource for Health. Performance assessment is weak and salaries are extremely low.

The inadequate numbers graduating from training institutions makes it difficult to meet the human resource needs for the delivery of the essential package. Many health workers do not feel accountable to communities.

The vision of Health Resource management in health is to avail the health facilities with well trained, skilled, motivated and sufficient workforce equitably distributed across the country.

Policy Objectives

- a). Increase and maintain rationale production of required quality HRH
- b). Appoint and equitably distribute qualified staff to positions throughout the country
- c). Ensure retention of staff through compensation commensurate with their skills level and career development
- d). Re-introduce Continuous professional training for HRH
- e). Promote a culture of merit-based performance at work
- f). Reinstate discipline and ethics among health workers
- g). introduce Professional registration, licensing and accreditation

Policy Strategies

Therefore, Government shall:

- Invest resources in the training of all health professionals.
- Regulate and strengthen training institutions, including the training curricula and trainers in close collaboration with Ministry of Education (Higher Education Commission) and NHPC. MOH will develop a plan for the production of Human Resource for Health and share with training schools.
- Recruit registered health professionals based on professional qualifications and experiences.
- Ensure a good spread of quality staff in both rural (with appropriate attractive incentives for rural living) and urban areas
- Ensure that all staff in the public sector receive regular salary in line with civil service and living standards

- Develop and implement a human resource retention plan with attractive package for all staff but in particular recognizing experience and location for rural/underserved areas.
- Develop a comprehensive competence/skills in-service training program for both the skilled and unskilled health workers
- Promote a systematic approach for CPD at all levels for health workers and use it as a form of reward for hard and conscientious work;
- Continuously review the relevance of CPD to personnel/professional development
- Introduce annual appraisals and use it to:
 - Identify and reinforce areas for improvement
 - Introduce promotion by merit
 - Gradually introduce continuous learning
 - introduce non-monetary incentives based on performance
- Introduce short courses on ethics and discipline for all staff and ensure that staff enroll in them
- Review Staff Operational manual based on current information on ethics and disciplines
- Enforce ethics and discipline at all times without prejudice
- The HRD will work in close collaboration with NHPC in carrying out its regulatory functions.

4.4 Financing health services

Part of good governance is for government to assume the responsibility of providing quality health care to its population. However, at the moment, government contribution is unable to finance the delivery of such services to its population without additional contributions either from government or elsewhere.

Policy Objective:

- a). To encourage and attract additional government allocation to the health sector so that quality health services can be provided to its population sustainably;
- b). To look for new innovations of attracting funds both from the public and private sources;
- c). To seek additional funds from donors while reducing dependency on them.
- d). To generate contributions from the community and from Somalilanders in the Diaspora;
- e). To levy user fees at the point of service utilization; and
- f). To explore opportunities for possible health and social insurance scheme

Policy Strategy:

It is part of good governance for government to abide by the national constitution and provide free **quality services** for all, as long as there is sufficient revenue to carry out this task. However, given the current fiscal situation in the country, Government will look to fund the health sector for the following financing strategic options:

- (a). Advocate to Parliament and Execute arm of government to increase public funds allocation to the health sector (until it meets and if possible surpasses) the recommended minimum target of 15% of GDP as requested by the Regional African Union agenda (Abuja 2001 target); Per capita public health expenditure in Somaliland is 1%, although WHO stipulates 12%.
- (b). Advocate to Mayors to attract additional contributions from local government and municipals;
- (c). Advocate to Parliament to levy Special Taxes on the public on sale of non-essential commodities such as Tobacco, Qat, cosmetics, etc and, if this is successful, work a mechanism for retrieving the funds with the MOF. The primary focus is to use this penalty to discourage people from unhealthy practices;
- (d). Direct grants from corporations (as part of corporate, social responsibility - PPP)
- (e). Continue to work with MOPD on SWAP;
- (f). Community contributions as well as grants from the Diasporas;
- (g). Generate user fees from Cost recovery/Sharing mechanisms especially at hospitals; At Primary health care level, consultative services will be free for mothers and children under the age of 5 years but they will pay for drugs and laboratory services
- (h). Explore the possibility of Pre-payment scheme/Social (health) insurance at the appropriate time

Basic principles:

The funds raised locally from the communities will be invested locally to improve working environment and client comfort so that communities can see the fruits of their contributions.

As part of sustainability strategy, government shall pay attractive basic salary to all service providers working in Public facilities. Partners /agencies supporting the public health facilities shall be phased out of “topping up” of basic salary and this type of support from the partners will be provided as incentives based on performance/ merit. Government shall gradually study this performance-based system, improve on it and customize it to the local context.

With regards to the EPHS and the issue of government counterpart funding, government shall take into account its pre-EPHS investment in the health sector that allows EPHS to be conceived and considered for implementation “*ab initio*”. This will include the investments in infrastructure, equipment, supplies, past and on-going staff salary and personnel emoluments, etc.

4.5 Partnership

Production and maintenance of the health of the people is a joint effort of all including government, private, CSO/NGOs, faith-based organizations, etc. Hence, partnership is seen as the bedrock of this health policy and total participation of government and non-government forum will be highly preserved. In addition to the Regional and District Health Committees and Boards, this policy supports the emergence of committees for every health facility in the country to ensure their representativeness.

The Vision of the NHP II is to ensure that the interest of communities we serve are well represented and liaise with all partners engaged in the production of quality health care and maximize this relationship.

Policy Objectives

- a). Ensure community involvement, participation and co-management of the health facilities
- b). Provide an enabling environment for private investors to participate in joint ventures with government for the public good.
- c). Encourage, collaborate with and regulate the activities of CSO including NGOs, Voluntary, Religious and Community-Based Organizations, private-for-profit and Professional Associations in the production of health care services in the country;
- d). Enlarge the scope of discussion and inputs of International Agencies, Donors and NGOs on the country program and lead the initiative;
- e). Explore opportunities for inter-sectoral collaboration, including other government Ministries.

Policy Strategy

Government authorities shall:

- Devise appropriate mechanisms for involving the communities in the planning and implementation of services and matters that affect their health
- Promote establishment of various health facility and village health facility management committees;
- Train the committees in the development of annual work plans to input into the health facility work plans;
- Establish PPP ventures such as the CMS stores
- Encourage financially capable Somalilanders utilize quality controlled private services to relief the pressure on public facilities
- License these health facilities and ensure that services provided by these bodies are in consonance with the overall national health policy. The establishment of the NHPC will further enhance this work;

- Promote the optimal participation of these bodies in the planning, organization, operation and management of health programs and services, particularly primary health care;
- Work closely with health professional associations, groups and individuals to strengthen their role in promoting research and other technical disciplines and in improving the quality of health practice and services;
- Facilitate capacity building of the various categories of organizations to play their expected roles effectively and adequately; provide them with relevant information and engage them in dialogue as appropriate
- Collaborate with the MONPD and other government Ministries such as Justice, Interior, Education, Trade and Industries, etc. for proper coordination of the activities;
- Approach Ministries of Planning and Finance, as appropriate, with a view to ensuring that health is accorded a central place in development planning and that health programs receive adequate funding;
- Approach the Agriculture, Housing and public works sectors with respect to guaranteeing food security and appropriate balance between the production of food crops and cash crops, and the provision of safe housing, drinking water and sanitation;
- Request the Education sector to participate in wide-ranging health educational activities, such as curriculum development and teaching and the propagation of health education subjects and issues;
- Provide information and communication skills to Sectors responsible for public works and facilitate the provision of primary health care and enhance the people's access to health services and information;
- Create awareness for measures required to protect the environment from pollution and to prevent occupational diseases and injuries; and shall encourage and facilitate the implementation of such measures;
- Additionally, the industrial sector shall be encouraged to consider the possibility of establishing industries for the production of essential foods and drugs
- Develop modalities and institutionalize appropriate processes for the effective coordination of international agencies and NGOs operating in the health sector;
- Collaborate with United Nations agencies, international, multilateral, bilateral and donor agencies and institutions, regional and sub-regional organizations, to coordinate and optimally mobilize and harness their support and assistance in the health sector;

- Coordinate the planning and implementation of the programs of all international agencies assisting in the health sector to ensure that such programs and operations are in consonance with government's priorities and are designed within the context of government's national and sectoral plans;
- Encourage international agencies to support the national health programs and interventions while discouraging their implementation of vertical programs and interventions;
- In collaboration with the MONPD and Regional Boards indicate sites and locations for the operations of the respective international agencies in the health sector at all Government levels

4.5 Monitoring and evaluation

Government shall continue to develop and operationalize a practical monitoring system in order to demonstrate to stakeholders the achievements and challenges; and thereby continuously improve on the efficiency and effectiveness of the entire health care system. The government shall also recruit competent professionals to support the implementation of the system at all levels of operation (Central, Regional and District). Furthermore, government shall support the training of staff at all levels in the use of the national indicators, the tools and how to analyze data for decision making.

4.5.1 Policy objective

(a) To promote the generation of data and use of evidence for decision making, program development, resource allocation and management.

4.5.2 Policy Strategies

In order to achieve the above objective, Government shall:

- (a) Strengthen the capacity of the MoH and stakeholders to monitor and evaluate all health development interventions;
- (b) Strengthen and ensure support for the HMIS at all levels through increased investments;
- (c) Strengthen disease surveillance at national, regional, districts and community level;
- (d) Increase the training, recruitment and deployment of required human resource for effective data management and dissemination at central, regional and district levels;
- (e) Facilitate the establishment and operation of a community based health information system;
- (f) Ensure dissemination of information to other stakeholders for purposes of improving management, sharing experiences and upholding transparency;
- (g) Generate through periodic surveys, appropriate data for effective planning, management and delivery of health services to people with disabilities;
- (h) Strengthen capacity for coordination and monitoring and evaluation of different stakeholders; and
- (i) Strategy for utilization of data.

4.6 Strengthen the National HMIS system

Government shall continue with the expansion and strengthening of the national health information system. It shall be used as a management tool for informed decision making at all levels of health care and related services to:-

1. Assess the state of health of the population, to identify major health problems and to set priorities for action at local, regional and national levels;
2. Monitor progress towards the attainment of the stated goals, objectives and thrusts of health services;
3. Provide indicators for evaluating the performance of health services and their impact on the health status of the population;
4. Ensure that the private health system feeds into the ensuing National HMIS through regular monthly reporting.
5. Provide information to those who need to take action, those who supplied the data and the general public

There shall be five levels of responsibility in the System as follows:

1. Community Level;
2. Facility Level;
3. District Level where the District Authority shall be responsible for:
 - (i) The collection, analysis, utilization and dissemination of data in its area of jurisdiction;
 - (ii) Ensuring timely forwarding/sharing of data to and with relevant departments, agencies and programs operating at the district level;
 - (iii) Ensuring the forwarding of aggregated data and signed prescribed forms to the State level;
 - (iv) Ensuring immediate submission of data in epidemic diseases to the Surveillance Division of the Department of Public Health of the Central Ministry of Health; and
 - (v) Training and supervision of relevant units of the health facilities within its area of jurisdiction.
4. The Regional Level where the Region Health Office shall be responsible for:
 - (i) Collecting and aggregating relevant health data and information from all Districts within the Region;
 - (ii) Ensuring timely forwarding/sharing of data to and with relevant departments, agencies and programs operating at the Regional level;
 - (iii) Ensuring immediate submission of data in epidemic diseases to the Epidemiology Unit of the Department of Public Health of the Central MOH;
 - (iv) Ensuring the preparation of a Regional Health Profile for decision making, dissemination feedback; and
 - (v) Training and supervision of Regional health facilitators and District officials.
5. National Level where the Central Ministry of Health shall be responsible for:-
 - (i) The development, introduction and maintenance of an effective National Health Management Information System (NHMIS);

- (ii) The central coordination of the national health information data;
- (iii) Collecting, processing and presenting relevant and necessary information required, both for national health planning and for monitoring the utilization of resources in accordance with national priorities and objectives;
- (iv) Providing technical and management support to strengthen national HMIS at all levels.
- (v) The flow and feedback paths of health data and information shall be from the community level to the national level; and
- (vi). A minimum of 1.5% of the budgetary allocation to health shall be set aside by all levels of government as support for the development and operations of the NHMIS.

4.7 National Health Research. Government shall promote health research, especially operational research in accordance with national priorities in order to support evidence-based policy and intervention formulation, identification of gaps for improvement and identifying critical factors for special needs for vulnerable groups especially women and children. Particular attention will be given to how research can be used to guide the development and implementation of health promotion, disease prevention and early diagnosis and treatment through data generation, analysis and interpretation.

4.7.1 Policy Objective

To create a sustainable science culture in which health research plays a significant role in guiding policy formulation and action to improve the health and development of our people.

4.7.2 Policy Strategies. In order to achieve this objective the Government shall:

- (a) Put in place a policy and legal framework to ensure effective coordination of research activities.
- (b) Develop and implement a prioritized national health research agenda in a consultative manner and undertake effective dissemination of research findings.
- (c) Ensure adequate allocation of funds to enable the conduct of highly relevant and quality research.
- (d) Promote dialogue and information sharing between the policy makers, researchers, health care providers and communities in order to ensure that research is relevant to the needs of the people and that research findings are utilized by the relevant stake holders, and are consistent with NHP II.
- (e) Develop an ethical code for the conduct of health research in Somaliland, promoting the safety, rights of research participants, as well as the researchers.
- (f) Strengthen the National Health Research capacity in institutions at all levels and develop quality human resource and infrastructure to respond to essential research demands of the country.
- (g) Harness donor funds to ensure funding of prioritized operational research to inform policy and strategy development.

4.8 Health Infrastructure

Health infrastructure comprises of building, plant, equipment (medical devices, other equipment for health facilities and IT equipment) and transport. Government shall provide the necessary resources to ensure provision and maintenance of adequate infrastructure over the next decade, with priority being given to consolidation of existing facilities.

4.8.1 Policy Objective

(a) To provide and maintain a network of functional, efficient, safe and sustainable health infrastructure for the effective delivery of the EPHS, with priority being given to consolidation of existing facilities

4.8.2 Policy strategies

In order to achieve this objective, Government shall:

- (a) Strengthen the Infrastructure Unit with appropriate personnel to plan, procure and maintain health infrastructure.
- (b) As a matter of priority, adequately finance renovations and maintenance programs of existing health infrastructure, in particular PHC facilities, and invest in the construction of new facilities and staff accommodation, targeting underserved parts of the country in accordance with EPHS calendar of events.
- (c) Prioritize investments in buildings, equipment and transport required to operationalize the health sector priorities of this Policy.
- (d) Standardize the medical equipment needs in terms of quantities and specifications for each level of the government health system so that all interventions and services of the EPHS of that level can be provided.
- (e) Plan and procure medical equipment according to the agreed standards of the EPHS.
- (f) Provide the necessary logistical support, including transport, communication and IT equipment, to establish an appropriate and efficiently functioning referral system.
- (g) Promote and increase private sector investments in the provision of health services through infrastructural development based on complementarity.
- (h) Provide the infrastructure, including IT infrastructure, necessary for MoH staff to carry out its functions professionally.

4.9 Client Charter. The role of the Client Service Charter is to ensure the provision of high quality health services that is acceptable to the clients. The Government shall educate clients on how to understand the commitments of service delivery, means of communication, ways of achieving the service standards, means of correction of mistakes and on how to claim their rights.

➤ *The right to highest attainable level of health*

- The Constitution guarantees rights of access for all people in Somaliland to high quality health care services.
- Patients have the right to information about diagnosis, treatment, cost of treatment and consent after obtaining information and protection of privacy.

- Patients are entitled to safety in the public and private health sector. This has implications for treatment protocols, standards of medicines, medical supplies, medical equipment and infrastructure.

Communities are entitled to a healthy and safe environment i.e. access to safe and adequate water supply, sanitation and waste disposal and protection from all environmental dangers.

➤ ***Patients' responsibilities***

- Individuals are ultimately responsible for the lifestyle decisions they adopt. Patients have the responsibility of seeking care and adhering to treatment as prescribed.

➤ ***Solidarity***

- Government will give due consideration to pursuit of national solidarity in a common concern for health-for-all, with special consideration for welfare of the poor, the most vulnerable and the disadvantaged.

➤ ***Respect of cultures and traditions of the people of Somaliland***

- All stakeholders shall respect the promotive health aspects of the cultures and traditions of the peoples of Somaliland.

4.10 Legal Framework. One of the major weaknesses in the health sector today is the non-existence of important health legislation as well as the ambiguities of some existing health laws. Therefore, one important health legislation that government shall undertake is to put in place immediately the National Health Act which shall define the national health system and spell out the health actions of each level of government, among other things. Indeed, such an Act is necessary in order to give legal backing to this Revised National Health Policy.

5: Implementation Arrangements

The government overall strategies for implementing this National Health Policy/Health Sector Reforms will be to:

- (a) Obtain Cabinet approval
- (b) Disseminate the National Health Policy to internal and external stakeholders and customers. (Discuss issues such as strategic alignment, harmonization, joint analyses, management and financing of the health system, etc.)
- (c) Disseminate the National Health policy to the donor co-ordination committee and adopt a Sector Wide Approach (SWAP). *See below for details*

- (d) Articulate a costed Medium Term (five year) National Health Strategic Plan which shall have clear objectives and priorities (as defined in the essential health care package), time frames and performances indicators.
- (e) Train regions in the development of Annual workplans, health accounts, etc.
- (f) Regions develop annual workplans with inputs from the Districts, health facilities and communities
- (g) Annual plans approved and adopted by the Central MOH along with partners and stakeholders
- (h) Implementation, assessments and quality assurance through HMIS, monitoring visits, etc.

SECTOR WIDE APPROACH

Sector Wide Approach will be premised on sufficient commitment to shared health goals by both government and donor community as key players. It will be based on the medium term national health strategic plan and the national health policy on which collaborative program of work will be developed.

Through the concept of joint funding and “basket funding” the government will gradually introduce an integrated common “basket funding” to encourage donors to support the Ministry of Health with “pooled” financial assistance as opposed to technical assistance. This financial assistance will be paid directly into a common basket known as “basket funding” or “budget support”. This provision of “untied” financial support to the Ministry of Health implies that donors will support the Health Sector by financing a single, agreed upon program with a budget administered by the Minister of Health through his Director General.

In order to successfully implement and adopt the Sector Wide Approach, the following policy measures will be implemented by the Government:

- (i) Articulation of a well thought out and costed medium term National Health Strategic Plan;
- (ii) An agreed upon human resource structure to implement the Strategic Plan
- (iii) Reaching an agreement on the prototype “cost-effective essential health package” for Somaliland;
- (iv) Establishment and development of the Resource Envelope and National health Accounts respectively;
- (v) Development and implementation of the Financial Management System;
- (vi) Development and adoption of the common government disbursement, procurement, accounting, auditing and reporting procedures;
- (vii) Adoption of joint evaluation reporting, supervision and monitoring missions by Donors and MOH for appraisal, planning, programming and

reviews; From this, further technical assistance will be identified and requested by the government

- (viii) Consensus by donor community on payment of per diem and honorarium (policy and guidelines to be articulated by government)
- (ix) Introduction of common “basket funding” (joint budget support).

Challenges/Barriers to Implementation of the Health Policy

1. Delays in securing approvals from the Parliament. MOH should be prepared for a longer approval process by the Parliament. This may be due to inability to get a quorum as several parliamentarians may be headed to Mecca for the Eid.

In order to avert these delays, four members of the parliament will join the technical review and thus be aware of the intentions of the MOH and be part of the process in order to facilitate its approval on the floor of the houses.

2. Delay in the development of the Medium term (Strategic) Plan. Securing funds from a partner/donor could lead to delays; identification of a good consultant

To avert this delay, Submit request for support to at least 2-3 partners several months before in advance

3. Training of MOH staff (Central and Regional) in Annual workplan development, health accounts, Financial Accounts Management Systems (FAMS)

Identify appropriate staff and consultants ahead of schedule and ensure that there is no conflict.

4. Several trainings, meetings, workshops, etc. all happening at the same time.

Prioritize the health policy and the MTP as a MAXIMUM alert so that staff are always available for this endeavor.