THE HEALTH POLICY FRAMEWORK 2012 – 2017

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**THE PUNTLAND STATE OF SOMALIA**

**MINISTRY OF HEALTH**

**APRIL 2012**

# Preface

The efforts deputed by the community and state institutions of Puntland for the restoration of peace, governance and development will need to be reproduced in the health sector, currently facing serious operational challenges, high burden of disease, paucity of resources and shortages of skilled health workforce. It is imperative therefore to revitalize the health system network in Puntland to effectively respond to the urgent and essential health needs and health care delivery expectations of the people. The perennial neglect of the most vulnerable population groups such as nomadic pastoralists and the hard to reach mountainous and distant coastal communities need to be rectified. Through this realization the Puntland Ministry of Health has acknowledged the need to formulate a health policy framework (HPF) that will incorporate the health aspirations of the government and the people and drive the health sector reform and development. The latter will be guided by an assertive commitment in the achievement of health for all and the health Millennium Development Goals (MDGs). The HPF carries forward a vision focusing on maternal, neonatal and child health and on those social groups that are most at risk and as well as on strengthening the health system to enhance the quality and efficiency of health care services. Through this HPF, the health sector will actively promote the effective community participation and intersectoral collaboration in all health interventions, more effectively use the available scarce resources and lend the deserved confidence to publicprivate partnerships to yield greater healthoutcomes. The HPF will predominantly invest on health promotion, protection and education to cost-effectively reduce the burden of disease and malnutrition and build a health care system founded on partnerships and shared accountability and focused on achieving results.

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# Acronyms

|  |  |
| --- | --- |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Care |
| BHU | Basic Health Unit |
| CFR | Case Fatality Rate |
| CHW | Community Health Worker |
| CISS | Somali Health Authorities and Coordination of International Support to Somalis |
| CMW | Community Midwife |
| CRC | C[onvention on the Rights of the Child](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&sqi=2&ved=0CGkQFjAB&url=http%3A%2F%2Fwww.unicef.org%2Fcrc%2Findex_30177.html&ei=2AaAT7WBDOKO4gTTtLGgDg&usg=AFQjCNF_mmhn8-nGOAoFwhSaBhJ-OyV-uw&sig2=BlNSdme16EBnzdXs1-sYuQ) |
| DHS | District Health System |
| DOTS | Directly Observed Treatment, Short-Course |
| EHSP | Essential Health Services Package |
| EmOC | Emergency Obstetric Care |
| EmONC | Emergency Obstetric and Neonatal Care |
| ENT | Ear, Nose and Throat |
| EPHS | Essential Package of Health Services |
| EPI | Expanded Programme on Immunization |
| FHWs | Female Health Workers |
| FSNAU | Food Security and Nutrition Analysis Unit |
| GAM | Global Acute Malnutrition |
| GAVI | Global Alliance for Vaccines and Immunisation |
| GECPD | Education Center for Peace and Development |
| HC | Health Centre |
| HiAP | Health in All Policies |
| Hib | Haemophilus influenzae type b |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health management information system |
| HPAG | Health Policy Advisory Group |
| HPF | Health Policy Framework |
| HSC | Health Sector Committee |
| ICPD | United Nations International Conference on Population and Development |
| IDPs | Internally displaced populations |
| LHWs | Lady Health Workers |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MDGs | Millennium Development Goals |
| MNCH | Maternal Neonatal and Child Health |
| MOH | Ministry of Health |
| NCDs | Non-communicable diseases |
| NGO | Non-Government Organization |
| PHU | Primary Health Unit |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PSC | Parliament Standing Committee |
| RBM | Results-Based Management |
| RHC | Rural Health Center |
| SAM | Severe Acute Malnutrition |
| SHSC | Somalia Health Sector Committee |
| SRC | State Regulatory Council |
| STIs | Sexually transmitted Illnesses |
| TBA(s) | Traditional Birth Attendant(s) |
| UTI | Urinary Tract Infections |
| VCT | Voluntary Counseling and Testing |
| VPI | Vaccine Preventable Illnesses |
| WHO | World Health Organization |

# Introduction

While a large part of Somalia was inflicted by conflicts during the past two decades, Puntland has remained relatively stable, where the traditional leaders and elders have played a key role in maintaining peace. In August 1998 a democratic system of governance was created by the people with the formulation of a single administrative structure that reiterated its strong link with the federal government of Somalia that led to the promulgation of an interim charter and the creation of the legislative, judicial and executive branches of the state. These endeavours reflected the richness of the peace dynamics led by the traditional Council of Elders and Puntland politicians that jointly contributed in restoring a tangible level of trust and confidence in the rule of law and governance system [1]. The efforts deputed by the community and state institutions for the restoration of peace and development were assisted by a large number of national and international partners. In February 2010, the Puntland Constitution was finally approved by the executive and legislative bodied of the state. In these endeavours, a dynamic role was played by the Puntland traditional formal opinion leaders and civil society organizations that included the Development and Research Center creating opportunities for evidence based political and social dialogue among the myriad of stakeholders and interest groups and acted as a catalyst and neutral convener [2]*.* The Puntland State of Somalia is located in the horn of Africa, and has three distinct topographical zones that have their relevance for the establishment of an effective and sustainable health system network, namely a) the torrid narrow coastal strip facing the Gulf of Aden and a similar belt along the Indian Ocean coastline; b) the immediate inland characterized by the hard to reach and less accessible mountainous areas flanking the northern part of coastal strip and c) the large sloping plateau that serves as a grazing lands for the Puntland pastoralist nomads [1]. Although there are no accurate data on the size of the population in Puntland, according to the government approximation, the population is estimated at about 3.9 million. It is estimated also that about 70% of the population are aged 15 years and below, and over 50% are pastoral nomads. It is also estimated that Puntland hosts a large number of IDPs.

# Health Sector Analysis

## Health System organization and Infrastructure

### The Primary Health Unit (PHU)

The Primary Health Care Units (PHUs) operate at the most peripheral level of the district health system network and are staffed by trained and remunerated Community Health Workers (CHWs). Each PHU is supported by a locally constituted Community Health Committee. The major role of the PHU is to provide basic promotive, preventive and simple curative services that include maternal, reproductive and neonatal health, child health, communicable disease surveillance and control, environmental health promotion, first aid and treatment of common illnesses. PHUs also promote nutrition education and the utilization vaccination services

### Maternal and Child Health (MCH) centers

MCH centers are located in urban and rural community centers and receive complementary support in terms of supplies, human recourse remuneration and logistic support from the government health partners operating in the different districts of Puntland [4]. These facilities carry out antenatal care services; assistance during labour and postnatal period; maternal and child nutrition promotion and care, as well as the delivery of child and maternal immunization services and the treatment of minor common diseases and conditions. In many areas the MCH centers are the only reliable facilities that provide MNCH care to the distantly located communities that have limited access to immediate referral support. The specialized nature of these facilities restricts the scope of the PHC service package that they could provide; hence the need to upgrade the most distantly located MCH centers to full-fledged health centers to broaden the range of their service delivery.

### The Health Centre (HC)

The HC is assigned to deliver key programmatic interventions as envisaged in the Essential Package of Health Services (EPHS). The HC offers a facility based service with maternity beds operated by a qualified midwife. Each HC is also staffed by a qualified nurse, auxiliary nurse and a community midwife. HCs also provide facility based vaccination and nutrition promotion services, as well as outreach services to the HC catchment area. Community Health Committees are expected to provide support to the management of the HCs, assisting the health teams in improving service utilization and local resource mobilization and assist in addressing the operational and referral logistic gaps that are identified and communicated by these HCs.

### Referral Health Centres/District Hospitals

The third tier of the service delivery network is the referral Health Center or District Hospital that is connected with the MCH/HC facilities for referral support, training and supervision. Most district hospitals are not sufficiently equipped or have the qualified human resource cadre to attend to MNCH care and to other essential medical and surgical services. In addition to the six core functions set in the EPHS, Referral health centres/district hospitals carry out a range of medical and surgical services, and provide mental health care, treatment of chronic diseases, and dental and eye health. These levels of care carry out comprehensive emergency obstetric and newborn care, with the capacity to perform caesarean sections and reproductive health related surgical services. A district hospital has at least 8 beds maternity ward and an in-patient facility for at least 20 patients. However, some of the above outlined services are executed by accessing specialists through outreach visits performed by the regional team, although currently this relevant support is seldom accomplished. District hospitals are staffed by at least one medical doctor or clinical officer, two midwives, two qualified nurses, an officer for the Expanded Programme on Immunization (EPI) and a laboratory technician and a health/clinical officer. A community based Health Committee is established to provide the necessary support to improve hospital operations as well as to mobilize resources to fill the evolving operational gaps of this facility. The reality on the ground however, reflects a bleak picture with many district hospitals being poorly staffed and functioning at very low performance levels.

### The Regional Hospital

The regional hospitals provide reasonable levels of specialist care, although the service demand overwhelmingly exceeds the capacity and the resources that these hospitals require. Regional hospitals provide medical, surgical, gynaecological and paediatric health care and other specialized services and are staffed by qualified nurses, midwives and doctors who are expected to conduct outreach clinics to RHCs/District Hospitals. In Puntland, the management and coordination of this health system network is directly operated by the Ministry of Health, although the operational support for a tangible number of these facilities is profoundly assisted by international health partners whose contribution is highly valued. The regional EPI central cold chain and regional medical store are other key facilities instituted to support the health system network of the state.

### The Private Sector

The public health sector in Puntland is complemented by a thriving private health sector that ranges from the sale of pharmaceutical products though without having licenses regulating the importation and sale of these products. This sector along with it traditional medicine component has significant impact on the population’s health care seeking behaviour [5]. Moreover, the is a rapidly increasing number of private clinics and hospitals predominantly located in urban areas, hence falling beyond the reach of the poor and vulnerable households of the community. The private sector however, can play a major role in the delivery of health care service in view of the expected significant increases in need and demand for health care services. The private health sector can also help to improve the scope, scale, quality, and efficiency of access to essential services, not only for the urban but also for the rural settings. From this perspective the government of Puntland is acknowledging the positive role of this sector in the delivery of health care services, with a strong desire to engage it as essential partner, while introducing appropriate oversight and regulatory mechanisms to stream line its operations.

## Disease Burden and Nutrition Status

The statistics currently available, although scarce, indicate that acute respiratory infections (ARI) including pneumonia, urinary tract infections (UTI), anaemia, skin diseases and diarrhoea are the main causes of morbidity among the adult and children population, accounting for 61.4% of all the care seeking visits made to the public health facilities of Puntland, while the cumulative share of these health problems among the under-five children is 66.6% [6]**.** The rates of preventable communicable diseases that include acute diarrhoeaordysentery, acute respiratory infections, malaria, tuberculosis, STIs and malnutrition are among the conditions contributing to the high disease burden in Puntland.

### Top Ten Morbidities

Although the health services’ utilization is modest, because of the access challenges facing the distantly located rural communities and the hard to reach nomadic pastoralist communities, the frequent diseases reported through the health information system of the public sector facilities corroborates the above outlined disease burden trend in Puntland. Accordingly, the top 10 morbidities registered by the health sector during 2011 are outlined below.

**Table 1. The Top Ten Morbidities Registered by the Public Sector Network of facilities in Puntland (HMIS 2011)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No.** | **Recorded and reported Morbidities** | **children under five** | **Five Years and Over** | **Total** | **Disease Burden**  **%** | **High Burden Diseases in All Somalia\***  **%** |
| 1 | ARI (excluding Pneumonia) | 24,782 | 26,585 | 51,367 | 18.2 | 18 |
| 2 | Pneumonia | 4,013 | 3,396 | 7,409 | 2.6 | 4 |
| 3 | Acute Watery Diarrhoea | 13,028 | 4,907 | 17,935 | 6.4 | 7 |
| 4 | Anaemia | 5,793 | 24,327 | 30,120 | 10.7 | 12 |
| 5 | Fever of Unknown Origin (PUO) | 2,522 | 2,374 | 4,896 | 1.7 | Reported as others |
| 6 | UTI | 24,758 | 20,754 | 45,512 | 16.2 | 7 |
| 7 | Skin Diseases | 8,561 | 12,103 | 0,664 | 7.3 | 7 |
| 8 | Eye Infections | 7,298 | 8,150 | 15,448 | 5.5 | 4 |
| 9 | Trauma and Burns | 3,804 | 8,036 | 11,840 | 4.2 | 3 |
| 10 | others | 27,093 | 49,640 | 76,733 | 27.2 | 31 |
|  | **Total** | **121,652** | **160,272** | **281,924** | **100** | **100** |

Source (HMIS 2011 report) reported by UNICEF.

\* These data reflect the cumulative HMIS information on the top ten diseases in Somalia and these have reflected the rates of STIs and Malaria morbidities at 4% and 3% respectively.

### Maternal, Neonatal and Child Health

The Puntland health system as the rest of Somalia is short of offering the required maternal, neonatal and child health (MNCH) care services with only 25% of the pregnant women accessing antenatal care and a far lesser segment of these being assisted by skilled birth attendants during delivery [7]. More than 90% of the women deliver at home, the majority assisted by traditional birth attendants. Moreover, the rural and nomadic populations have virtually very limited access to the direly needed maternal and child health services, especially the emergency obstetric care (EmOC) facilities. The latter is compounded by the limited number of health facilities that can provide basic EmOC, while the access to comprehensive EmOC with blood transfusion and caesarean section surgery are mostly non-existent in the majority of the Puntland district level hospitals. The proportion of complications in the MCH deliveries is estimated at 7% in Puntland, slightly lower than the comparable national rate of 10% [6]. The health system strengthening was envisaged as the only way forward to address these challenges [8]. To address the human resource gaps, the MOH has launched the training of community midwives, where, the first graduating batches were deployed in the rural areas that they were recruited from, with the understanding of serving their communities for a minimum period of one year before receiving their certifications. On the other hand, the referral centers are mostly underutilized with the imperative to improve the staffing and the quality of MNCH services including reproductive health. Although 19% of the eligible women have unmet needs for moderncontraceptive methods, only 1.7% of these are practicing birth spacing [6].

The Limited access and equitable distribution of the health services network has been perpetuated by the high maternal, neonatal and child morbidity and mortality rates, and poor access to reproductive health services **that constitute a** major impediment to achieving the MDGs. The results of the 2009 National micronutrients and anthropometric nutrition survey in Puntland indicated that 20.4% of the children 0-23 months were affected by diarrhoea, 2 weeks prior to the survey, 31.6% of the children 6-23 months of age affected by upper respiratory infections and 24% by fever [9]. The country wide data corroborate these findings as the countdown to 2015 reported that the major contributing illnesses to child deaths in Somalia were pneumonia at 24%, neonatal causes at 23% and diarrhoea at 19% [7]. Tables 2 and 3 illustrates the paucity of MNCH services and corroborates the need for the implementation of wider targeted MNCH interventions [10].

**Table 2. Puntland reproductive health situation analysis of 2011**

|  |  |
| --- | --- |
| **Key reproductive health indicators** | **Puntland base line** |
| Under five mortality rate (per 1000 live birth) | 225 |
| Infant mortality rate(per 1000 live birth) | 81/100 |
| Maternal mortality rate(per 100,000 live birth) | 1400 |
| Delivery attended by skilled birth attendant | 10% |
| ANC coverage | 26% |
| Contraceptive prevalence (% of women 15-49 years of age) | 1% |
| Tetanus Toxoid vaccination coverage | 21% |
| Birth spacing unmet need | 19% |
| Case Fatality Rate (direct obstetric morbidity in EmOC-facility) | 33% |

Source: Puntland reproductive health situation analysis; Feb. 2011

**Table 3. Summary of EmOC Process Indicators in Puntland**

|  |  |  |
| --- | --- | --- |
| **Area** | **Current Status** | **Desired Minimum Acceptable Levels of Performance** |
| Coverage of BEmOC facilities per 500,000 population | 0.5 | 4 |
| % of all births in EmOC facilities | 0.7 | 15 |
| % of expected direct complications treated | 1.5 | 100 |
| % of all births by Caesarean Section | 0.6 | 5-15 |
| CFR of direct obstetric complications | 33.1 | <1 |

Source: Puntland reproductive health situation analysis; Feb. 2011

The routine EPI services in Puntland have shown a commendable performance where DPT3 coverage was estimated at 94% and the Measles coverage at 91%, reflecting an encouraging prospect for the forthcoming Pentavalent vaccine to be launched at the outset of 2013.

The unclassified data by zone, including also the Puntland data and relevant to the diseases and conditions for which families most frequently seek MCH care for the under-five children are led by ARI 24%; acute diarrhoea 12%; skin diseases 7%; anaemia and pneumonia with a rate of 6% each; malaria 3% and bloody diarrhoea and trauma with a rate of 2% each. These morbidity rates will require the stipulation of relevant policy directions that can effectively address the burden of these public health challenges

### Nutrition and Food safety

Malnutrition is of significant public health concern in Puntland as was reflected by the 2009 National Micronutrient and Anthropometric Nutrition survey showing acute malnutrition and severe acute malnutrition rates estimated at 10.7% and 1.3% respectively, while underweight and stunting rates were 12.8% and 16.5% respectively [9]. The latest food security and livelihood based nutrition surveys by Food Security and Nutrition Analysis Unit(FSNAU)showed global acute malnutrition (GAM) rate in West Golis estimated at 22% and severe acute malnutrition (SAM) at 5%. In the Nugal valey, the GAM rate was 23.2% and SAM rate at 6.7%, while in the Sool Plateau, the GAM of 15.9% and SAM of 4% were recorded(Post Gu, October 2011) [9]. Concerning micronutrient deficiency, the study notes that anaemia was quite high at 56.4% and vitamin A deficiency at 24.1 %, both indicative of severe public health concern. Similarly, the prevalence of Iron deficiency in children under five was estimated by the same study at 59.6% and that in Puntland only 87% of the children were ever breastfed, 27% of the infants initiated breastfeeding within the first hour of their lives, only 6.3% exclusively breastfed up to 6 months of age, while, only 11.6% of the infants 6-8 months received complementary feeding [11,9]. In the 2011 MCH HMIS study, the rate of moderate malnutrition in Puntland was estimated at 15%, which was somewhat lower than the national average of 21%. Food safety is another major public health priority as unsafe food can cause many acute diseases ranging from diarrhoea to various forms of cancer. Currently the Puntland government lacksthecapacity to implement and monitor food safetyprotectionsystems for which the right policy directions need to be introduced

## The Health system performance

The public health system network in Puntland is predominantly operated by the Ministry of health, where despite the meagre financial and human resources available to the government health sector, the Ministerial health professionals are deputed to manage and deliver services at all levels of the health system. The Minister, the two Deputy Ministers and the Director General for health operate through the different departments of the MOH and regional Medical Officers the operations and services of the health system. However, to effectively operate the health system network, the government is significantly assisted by a myriad of international NGOs, UN organizations and other development and humanitarian partners who collectively support the provision and access to medical supplies and equipment as well as in granting supplementary remunerations to a large number of the operating health workforce.

The valuable coordination provided by the Somali Health Authorities and International Support to Somalis (CISS) Health Sector Committee (HSC), provides a mechanism that brings together the national health authorities, UN agencies, international donor partners and most international/national NGOs. It offers a platform that promotes partnerships and coherent health sector planning as well as the rational and effective utilization of the resources deputed to this sector. The Nairobi based forum is assisted by similar coordination task forces to be periodically organized in each zone led by the Ministries of Health. The Puntland MOH is fully cognizant of the added value and contribution provided by the SHSC in advancing the health services’ system. These coordination mechanisms have significant bearing on the management of health sector resources. The latter corroborates the need to strengthen the management and leadership capacities at the health authority level to enhance the relevance of and ownership and responsibility for the important decisions made by this coordination system.

### Human Resources for Health: the Paucity of Trained Workforce

Somalia is among the 57 countries experiencing human resource crisis at the global level as reported by the World Health Organization (WHO) and Puntland like the rest of Somalia falls at the lower end of the scale, in view of the country’s historical limited access to development programmes in general and capacity building resources for the health sector in particular. This situation has created a gap between the population health needs and health workforce available for the health system. The recovery and rebuilding of the health system will therefore require a collective national and international partners' effort for the development of a critical mass of health workforce capable to operate the health system network in an efficient and equitable manner and improve the health status of the populations with focus on MDGs. The table below illustrates the paucity of the health workforce estimated at one health worker per 1000 population, falling short of the minimum standards set by the WHO of 2.3 per 1000 population. The Ministry of Health has to design in collaboration with its national and international partners, viable human resource development solutions that competently address the enormous service delivery challenges of the health sector.

**Table 4. Human Resource for Health in the Puntland State of Somalia**

| **Health Workforce** | **Public** | **Private** | **Total** |
| --- | --- | --- | --- |
| Doctors | 41 | 52 | 93 |
| Qualified Nurses | 320 | 200 | 520 |
| Qualified Midwives | 57 | 30 | 87 |
| Auxiliaries/ Technicians | 257 | 393 | 650 |
| CHWs | 500 | - | 500 |
| **TOTAL** | **1272** | **562** | **1834** |

Source: Ministry of Health of Puntland

### Essential drugs

The Puntland Ministry of Health is pursuing a strategic policy aimed at ensuring a high degree of access to essential drugs, vaccines and anti-sera including anti-snake venom serum that are safe, effective, of assured quality and rationally used. Accordingly, the Ministry constituted a State Regulatory Council (SRC) that will have the functions of regulating and registering the services provided by hospitals and pharmacies, allowing the ministry to inspect and control the quality, safety and efficiency of medicines and services and counteract any counterfeit, substandard and unreliable medical services [12]. The SRC will be issuing licenses to professionals and regulate the importation, distribution and management of medicines in Puntland. Currently these functions are partly executed by the international health partners who provide their regular support to the health system network, and partly by the private sector. The latter channels these services through a large number of privately owned pharmacies scattered in the country. However, these retail drug stores lack the required professional staff and have not been abiding by any regulatory norms. The SRC deliberated standards are expected to improve the operational practices in terms of importation, distribution and management of essential drugs in Puntland and eliminate the current inefficient management of essential drugs [13]. The prevailing challenges were preventing the treatment of a range of curable diseases and indirectly contributing to the burden of disease among the poor and rural and nomadic pastoral societies in particular. The irrational drug use has been another major challenge as a large number of unauthorized distributors, prescribers; dispensers led by the poorly staffed private pharmacies recommend and sell medicines to a large proportion of care seekers. The recently approved Puntland state Law Number 6 will strictly control all the transgressions caused by professional health workers, including pharmacists and medical suppliers. Moreover, the existing national pharmaceutical standard treatment guidelines and training manual relevant to the primary health care level of the district health system and supported by WHO and not sufficiently implemented by the health system need to be taken into account[14].

### Health Financing

The public health sector budgetary outlay of about 3% of the modest Puntland government budget has been significantly lower than the needsof theHealthSector. These limitations are posing serious constraints to the public spending on the basic health services to the most disadvantaged populations at district and sub-district level. This will also restrict the operational capacity of the ministry to sustain the PHC network of services and related referral chain at satisfactory functional levels. To bridge this gap the ministry has forged collaborative coalitions and partnerships with national and international partner organizations who have contributed in a laudable manner to the provision of technical, managerial and logistic support inputs to the health system [15]. To sustain the provision of these services and expand the geographical scope of PHC services, the government will develop innovative mechanisms to raise the public sector fiscal contribution to the health sector. Concurrently community co-financing approaches and public private partnership will be explored. The government will promote its coordination role of the national and international efforts for resource mobilization. The latter is exemplified by the envisaged Joint Health and Nutrition Programme support and the GAVI and Global Fund contributions, with the imperative of having effective leadership and management to properly utilize these valuable resources [16, 17, 18]

# The Policy Rationale

The Puntland government has recognized the importance of developing a health policy framework (HPF), where a draft policy was prepared in 2007, reflective the early on policy relevance perceived vision. To translate that vision into reality, the Ministry has welcomed the initiative of the HPF and acknowledged its prerequisite for the health sector to evolve from humanitarian based operation mode to recovery and sustainable development.

The need to develop a HPF at this social and geo-political juncture of Puntland is deemed necessary for the following rationale:

1. An explicit HPF provides the opportunity to define a collectively shared vision for the future which in turn helps to establish targets and points of reference for the health system for the short and medium terms;
2. The HPF outlines the priorities and the expected roles of different groups, that were accomplished through a widely shared participatory process culminating all the relevant stakeholders of the health system, founded on consensus and driven by the key aspirations of the national health system;
3. Given the impending political transition in the country, from the second half of 2012, a HPF will support the growing imperative of rebuilding national health institutions, attempt to rectify decades long inequities related to the unfair provision of health care services to the nomadic populations and to many other rural hard-to-reach communities that were chronically alienated from the benefits of the health system;
4. The deliberations on a health policy framework are indispensable and opportune, considering the envisaged uncertainties that will undoubtedly affect the required, yet scarce public and community based resource mobilization for health and the requisite of attracting a tangible proportion of the international partners’ assistance to the health sector, being conscious of the overwhelming multi-sectoral competing priorities including the cost intensive security and peace building components of the development process and,
5. Finally, the development of short and medium term health sector development plans cannot be sustained without predictable resource allocations, that can only be achieved through the promulgation of a HPF delineating a set of priority health interventions, while focusing on the real health needs of the population, that are equitably executed and operationally viable, with the vulnerable population groups inclusively constituting an integral and vital component of the health system network.

To substantiate these aspirations the HPF was based on wider consultations of the national stakeholders and non-state partners to generate the legitimacy and relevance necessary for its implementation as a real guide for action. The government has conceived the design of this HPF with the solid intention to rectify the critical health system gaps and improve the health status of the population through the establishment of a health system founded on the primary health care values of equity*,* universal access to care and social justice. These values promulgate the delivery of essential health care that is practical, scientifically sound, and socially acceptable, with affordable cost and universally accessible to the entire population, and supported through active community participation and intersectoral action.

# The Policy Development Process

The HPF assigned terms of reference were shared with Puntland Ministry of Health (MOH) prior to the fielding of the consultant to plan the organization of the consultations considered necessary for this process. The MOH was prompt in preparing the required technical documentations for desk review analysis and in the formulation of a multi-stakeholder Health Policy Advisory Group (HPAG) and scheduled the holding of a range of consultations across the different social and political spectra of the Puntland society. The following contacts were organized during these extensive consultation processes:

* The health Policy Advisory Group: To create an effective dialogue with the different actors in the health sector, the MOH formulated a Health Policy Advisory Group (HPAG) consisting of senior officers from the MOH and members representing international health partners. The forum was chaired by the Vice Minister. The HPAG assumed the role of coordinating the different social groups participating in the policy consultation by having some of its members present in these meetings and by providing their insight about the context and about the actors that would positively influence its adoption and translation into action.
* Parliament Standing Committee for Social Affairs and relevant public sector line departments addressing the Social Determinants of Health: As any policy approval process sequentially moves from the executive body of the government “the Cabinet of Ministers” chaired by the President to the Parliament Standing Committee (PSC) for Social Affairs and finally to the Parliament for its ratification, the meeting with the PSC was an opportunity to provide an early briefing about the direction of the HPF and attain their contributions to enrich its content and provide feedback on its social and contextual relevance. The consolation with PSC also acted as advance advocacy for this envisaged HPF. Separate meetings were also organized with the Ministry of education to substantiate the relevance of school health interventions and with the Ministry of Governance to align the HPF with the national aspirations of good governance. The HPF intent was shared with the line departments and the capacity of the social determinants’ approach to collectively address the complex social and health inequities clearly outlined.
* Health Professional Groups and Representatives of Non-state Actors: The policy consultation has engaged key health professionals that included the Dean of the Medical College of the East African University of Bosasso and the Representatives of Non-state Actors present in Puntland. A structured priority setting exercise was organized both on the burden of disease as well as the demand for health system strengthening.
* Consultation with Puntland Women Association: A HPF consultation was organized for the Puntland Women Association, along with women representatives of other affiliated local NGOs and civil society organizations. These groups emphasized on the negative impact that the paucity of health care services have on maternal and child care and the hazardous health effects of Female Genital Mutilation and violence against women.
* Courtesy calls to the President and Vice President of Puntland: the individual meetings with these national leaders were relevant as they provided the opportunity to brief them on the process of the HPF and its envisaged contents, as well as in seeking the necessary policy support and advisory feedback. The support of these leaders for the HPF was overwhelming.
* Other Consultations: Additional consultations covered the Puntland Development Research Centre, the private pharmacist group and Galkayo medical group and Education Center for Peace and Development (GECPD) for women development and women rights’ support. This and similar NGOs can offer highly catalytic platforms for health action and avenues of mutually rewarding partnerships.

# outputs of the Priority Setting exercize

During the different consultation meetings, several priority setting exercises were carried out, some being formal, where following an initial briefing, the participants were assigned to two consecutive priority setting group exercises. In the first, the disease burden was made the scope of the exercise, where an initial exposure to the quantitative information about the health sector, was followed by a qualitative exercise, where the perceptions of the different groups (two persons in each) presented their consensus priority ranking proposals. A cumulative analysis of these proposals then resulted in setting a final ranking of the disease burden priorities. The second exercise addressed the health system priorities requiring policy consideration and action. A similar analytical approach was applied that produced a sequential list of health system priorities. The final cumulative results of these exercises are outlined in the table below as identified by MOH and the partner organizations and stakeholders:

**Ranking of the identified priority health interventions**

| **Health Priority Requiring Policy Support and Action** | **Identified Priority Interventions for Weak Health System Areas** |
| --- | --- |
| 1. Neonatal, Infant, and child health | * Human resource development with focus on community based workers and mid-level technical staff with effective retention schemes * Regulation of professional associations and the private sector and promote public private partnership and community co-financing schemes * Strengthen HMIS and build health system observatory * Improving the management and leadership capacity of the central MOH and at the regional and district level * Introducing the essential drug list and drug regulation, qualitycontrol and quality assurance and their effective management and rational use * Improve public health sector financing and enhance efficiency and avert duplication of resource allocations * Rehabilitation and reconstruction of the District Health System Network * Introducing the mobile strategy and female health workers to reach out to the nomadic pastoralist communities and eliminate the perennial health neglect * Pursue the integration of the management and implementation of the different priority health programmes to enhance access, equity and cost-effective use * Coordinating and standardizing the multi-stakeholder supported health interventions to avert duplication and improve efficiency * Improving the scope and quality of the health information system and advance operational research for evidence based decision making |
| 1. Casualties and other health problems related to violent civil conflicts and terrorist activities |
| 1. Maternal health and adverse ill-health effects of Female Genital Mutilation |
| 1. Maternal and child nutrition |
| 1. Acute watery Diarrhoea including Cholera and other prevalent communicable diseases |
| 1. Tuberculosis |
| 1. Malaria |
| 1. Blindness |
| 1. Road traffic injuries |
| 1. Mental Health and substance abuse including Khat consumption as a major risk factor |
| 1. HIV/AIDS |
| 1. Oral and dental health problems |
| 1. Scabies ad other skin conditions |
| 1. Hepatitis viral infections and chronic |
| 1. Other non-communicable diseases and the major risk posed by Tobacco use |

At the end of the priority setting consultation processes, a debriefing meeting was organized with the Minister of Health and HPAG. This debriefing was aimed to sum up the collectively envisioned health policy directions and generate the final validating comments of the MOH leadership. The session generated a valuable discussion concluded by the Minister, reiterating the MOH full support to the stated policy directions and making a solid commitment for their translation into action. The Minister also outlined the high and positive participatory nature of this exercise and commended the shared ownership and the wider consensus achieved that would undoubtedly facilitate in the future the translation of this HPF into action.

# Setting the Framework of the Health Policy

## Health and Human Rights Principles of the HPF

The Puntland State has adopted the Primary Health Care principles as the policy model for health for all and for strengthening its health system. The HPF endorses the following public health and human rights principles:

### Commitment to Health for All and Health MDGs

Commitment to the aspirations of health for all, to the Millennium Development Goals (MDGs) and to the C[onvention on the Rights of the Child](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&sqi=2&ved=0CGkQFjAB&url=http%3A%2F%2Fwww.unicef.org%2Fcrc%2Findex_30177.html&ei=2AaAT7WBDOKO4gTTtLGgDg&usg=AFQjCNF_mmhn8-nGOAoFwhSaBhJ-OyV-uw&sig2=BlNSdme16EBnzdXs1-sYuQ) (CRC) and adopts the Primary Health Care principles as the strategic policy model for achieving the health MDGs

### Endorsing the Global Health Definition

The Puntland HPF endorses the global definition of health where this essential human need is perceived as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition qualifies health as an inalienable right of all people regardless of their ethnic, socio-economic status or geographical location, and where health is not only an outcome of development, but a major contributor to socio-economic advancement and stability.

### Government Responsibility for Population’s Health

Subscribing to the national constitutional obligation confirming in article 33 that “The State shall protect public health and promote free medical assistance for indigent persons” and the national Charter reiteration in article 26, that the government is committed to ensure the delivery of essential health services “It shall be the responsibility of the government to protect and provide public health, safe motherhood, child care and control communicable diseases and confirms its support to persons with disabilities”.

## HPF Vision, Mission, Principles and Values, Goals, Objectives and Strategies

### Vision

The vision of the HPF of Puntland is to improve the health and wellbeing of its population with focus on maternal, neonatal and child health and on those social groups that are most at risk and to strengthen the health system to be more responsive to the health needs of the population.

### Mission

To accelerate the provision of health services founded on the principles of PHC, delivered for the achievement of improved health status, made universally accessible to the entire population, with special focus on women and children, where services are of affordable cost and assured quality, with effective community participation and intersectoral collaboration, driven by more effective use of the available scarce resources and by the implementation of health initiatives that involve both public and private partners

### Core Principles and Values

The following principles and values underpin the deliberated HPF:

1. The principles of universal access to affordable, cost-effective and quality health services shall be pursued with upheld social justice and equity
2. The PHC shall constitute the basic strategic framework for the development of the national health system
3. A high level of efficiency and accountability shall be sustained in the management and implementation of the health system strategic and programmatic interventions
4. Effective collaborative partnerships shall be pursued forging alliances between the national public health sector and the various state, non-state national and international partners and organizations, adopting the aid effectiveness principles for these joint endeavours
5. The principle of “health in all policies” shall be pursued through the advancement of inter-sectoral cooperation and collaboration with different health-related Ministries and other national and international institutions and partners
6. The principle of community health action and public participation through advocacy, social organization and mobilization shall be strengthened with the adoption of community based programmes that are fully integrated into the health system network and focused on maternal, neonatal and child health

### Goals

The following three inspirational goals will guide the establishment and development of the healthcare system in Puntland:

1. Improve the health of the population by predominantly investing on the prevention of disease, injury, and disability and reducing the risk and burden of disease and malnutrition
2. Strengthen the health system to reliably provide a standard set of essential primary health care services that ensure universal coverage and efficient enough to drive the nation to the attainment of the health MDGs
3. Build a health care system that is well-coordinated across its state and non-state actors and ensure strong community participation, stakeholder partnerships and intersectoral collaboration

### Policy Objectives

To achieve the above HPF goals, the Puntland government will pursue the set of key policy objectives outlined below, to ensure that the subsequent plans and implementation processes will be successful and the health MDGs will be achieved:

* 1. To work on the gradual transformation of the current predominantly donor-assisted health care system into a self-sustaining, community-based and community co-financed and co-managed system founded on accelerated human resource capacity building with the expansion of the grassroot based health workforce to enhance access to essential lifesaving interventions.
  2. To introduce a Health Sector Reform through greater devolution where the regions will have larger roles in human resource development, in the planning, budgeting, and management of health services through enhanced leadership and governance capacities at all levels, improved health information system, better regulation of essential drugs and broadened scope of resource mobilization with active community participation
  3. To restructure the central Ministry of Health to enhance its capacity and focus on the core directions formulated in this policy framework and on the related subsequent strategic and operational plans, resource mobilization and financing, donor co-ordination, legislation and regulation of professional organizations and the private sector, human resource development, performance monitoring and evaluation and intersectoral collaboration
  4. To put health promotion, protection and disease prevention on the agenda of all sectors and at all levels with active involvement of the community and strengthen the health sector capacity and empower communities to improve their healthy living and working conditions with sustained education and advocacy
  5. To focus attention and action on the health needs of the most vulnerable population groups such as the nomadic pastoralists and the rural hard to reach communities and on adopting the Essential Health Care Package for the greater efficiency and cost-effectiveness of the district health system and promote public-private partnership in the delivery of health care services
  6. To introduce prioritization standards for the rehabilitation and construction of health system infrastructure by focusing primarily on those catchment areas without adequate facilities and resources and where the needs are highest
  7. To streamline nutritional services into the health system interventions and promote the relevant human resource capacities and intersectoral linkages necessary both at the policy and at the operational, and supporting these with the required legislative measures

### Policy Strategy

1. Address the prevailing health inequities between districts and population groups through health promotion, protection and education and recognize the grassroot communities as the main health resource and the essential voice for the promotion of social wellbeing of individuals and families
2. Investing in building the Puntland capacity for strategic planning and management for human resources for health to address the existing workforce gaps in the implementation of priority interventions especially at the community door steps and for the underprivileged and hard to reach community settings and PHC facility outlets
3. Promoting public private partnership ventures to bring about health services’ delivery solutions that address the enormous challenges facing the health sector; enhancing health care financing and advancing intersectoral action to influence the policy choices on social determinants on health and sustained community involvement in the delivery and management of health care services
4. Recognize the public health importance of traditional medicines, as significant numbers of the Puntland population depend on these products and practices for common primary health care ailments and carry out the necessary technical measures to validate the safety and effectiveness of herbal medicines and other traditional healing practices and their regulation.

# Health Policy Framework Priority Interventions

In view of the prevailing socio-economic conditions in Puntland, the HPF will pursue the implementation of the district health system in the framework of PHC, where all efforts will be made to ensure a universal coverage and access to essential promotive, preventive, curative and rehabilitative health care services that are cost-effective, of good quality and of affordable cost and based on equity. The HPF that will be subsequently translated into a health strategy and operational plan will constitute the first point of reference for all actors working in the health sector and encompass the following priority intervention areas:

## Revitalization of the District Health System

Although serious efforts were made by the government of Puntland and its health partners to create a reliable network of health services, the majority of the health system infrastructure requires swift reconstruction and rehabilitation. Similarly, the provided services and human resource capacities are below the satisfactory levels of performance, resulting in serious limitations faced by the underprivileged population groups in accessing basic lifesaving PHC services. To address these challenges the following policy directions are being considered:

### Strengthening the Primary Health Units (PHUs) through the Deployment of Community Midwives

These service outlets, currently staffed by only one Community Health Worker (CHW) need to be upgraded with the support of a locally constituted Community Health Committee and the deployment of a community midwife. Targeting the survival of women and newborn infants and reducing the high maternal and neonatal mortality rates will not only reflect the lives saved but also positively contribute to community behaviour change with regard to service utilization and trust in the performance quality of the health system. An achievement in this regard will catalyze both the health seeking behaviour of the community and the level of their participation and action for health.

**Policy Measures and Decisions**

1. Standardizing CHW Skills: Enhance the training capacity of Community Health Workers operating at the PHU level to enable them perform all the services assigned to this important peripheral service outlet.
2. Deployment of Community Midwives at PHUs’ Catchment Areas: To address this urgent community need, a professional Community Midwife will be deployed in every PHU catchment area, to undertake antenatal care services, refer the high risk pregnancies to centers with comprehensive Emergency Obstetric Care (EmOC) and conduct the maximum number of delivers in her catchment area, while liaising and orienting the community based traditional birth attendants.
3. Strengthening Linkages with Catchment Area Health Facilities: Community Midwives will establish strong linkages with nearby health facilities for the prompt and effective referral of high risk pregnancies and complications; for submitting the monthly report on MNCH activities and for continuing education and capacity building,
4. Birth spacing and Eradication of Female Genital Mutilation: The CMW through her interpersonal communication with mothers and community leaders will be promoting birth spacing by offering safe and effective modern contraceptives and educate women groups and mothers on the eradication of female genital mutilation through awareness building on the serious public health implications of this practice.

### The Health Centre:

The HC is envisaged to provide a range of promotive, preventive and curative primary health care services to the catchment area population. These services include maternal and child care services that comprise all the activities assigned to the stand alone MCH centers.

**Policy Measures and Decisions**

1. Health Centres’ Comprehensive Role: The staffing and support of the HC should be strengthened at all levels as they constitute a critical juncture of the district health system that bridges the community aligned service delivery outlets such as the community imbedded Female Health Workers (FHWs), the PHUs and the district hospital. It is also important to incorporate in the functions of the HC, a fully equipped MCH center staffed by a qualified midwife assisted by a standard MCH support staff
2. Evaluating the MCH Centers Relative to their Geographical Location: Upgrade all the stand alone MCH centers located in remote and hard to reach geographical areas to HCs, to offer an integrated comprehensive PHC services to the catchment area population

### District Hospitals

The District Hospital should provide the necessary first level hospital referral support and be equipped and effectively respond to major common emergency medical and surgical services including EmOC.

**Policy Measures and Decisions**

1. Setting Criteria for Strengthening District Hospitals: Classify the district hospitals to A and B categories as per the accessibility of the referred clients in travel time to the nearest regional hospital to seek specialized medical and surgical care. A category “A” district hospital is the one where the travel with a motor vehicle to the nearest regional referral hospital is more than three hours, and category “B”, a district hospital that is within the proximity of the indicated travel time, and develop specific operating standards for each to ensure the timely provision of emergency lifesaving interventions
2. Using EmOC as Indicator of Hospital Capacity: Provide the first priority for upgradation to the category A district hospital in terms of staffing and establishing comprehensive EmOC services to ensure the effective and rational use of health resources during the forthcoming recovery phase of the health sector, while setting the minimum operating standards for each district hospital

### The Nexus between the District Health System and Regional Hospital

There is a strong nexus between the district health system (DHS) and the regional hospital (RH). The latter is not only a major referral center for the districts of its administrative geographical catchment area, but a hub for providing support to pre-service human resource training, continuing professional development for health professionals and managers and a resource center for the promotion of health research in the region aimed to resolve the various operational challenges confronting the DHS.

**Policy Measures and Decisions**

1. Setting standards for Regional Hospitals: The services, staffing and management capacities of each regional hospital will be standardized, to comply with the district level referral expectations and the envisaged required training capacities
2. Developing the Regional Hospitals as Centers for Learning: Assigning in-service training roles or learning assignments to all the professionals working in the hospital to effectively contribute to human resource development for health in a manner geared to the advancement of the PHC system in the region

### The Essential Package of Health Services

The HPF has adopted the PHC approach for the organisation, coordination, management and implementation of the health system. To substantiate this effort, a major operational direction of the HPF will be the focus on strengthening the six building blocks of the health system. Accordingly, the Essential Health Services Package was envisaged, as a key district health system core policy direction [19]. The EPHS provides to the different national and international health partners, the opportunity to pursue a standard approach that ensures the equitable delivery of essential quality services to the population. The EPHS has also standardized the required essential medicines, supplies and equipment for each level of care. The core interventions in the EPHS include maternal, reproductive and newborn health; child health; surveillance and control of communicable diseases; promoting safe water and sanitation services; provision of first aid and care to the injured and critically ill; treatment of common illnesses; management of chronic diseases; mental health promotion and dental health and eye care.

**Policy Measures and Decisions**

1. Introducing the EPHS: Regulating the EPHS implementation with its set operational standards at all levels of the district health system providing quality and cost-effective promotive, preventive and curative primary health care services, supported by a reliable referral care and effectively enhanced community managerial actions and resource mobilization
2. Integrating the services of FHWs into the EPHS: Integrating the close to the community FHWs’ interventions as an important component of the EPHS and extending their services to the door step of the family, to ensure the widest possible coverage and access to life saving MNCH services
3. EPHS Contributing to Service Quality: Closely monitoring and supervising the EPHS performance to rectify the evolving gaps in the system and improving the PHC network quality by deploying the required workforce at each level and introducing retention mechanisms to maintain satisfactory standards of service delivery

### Maternal, Newborn and Child Health

The insufficient service delivery network, the limited number of qualified health workforce and the geographical distances in Puntland contribute to the unacceptably high maternal, neonatal and child mortality rates. The ability of the health system to provide adequate and comprehensive MNCH services need to be enhanced as well as the access to essential preventive and curative services, substantiated by creating basic and comprehensive EmONC facilities located within reachable distances*.*

**Policy Measures and Decisions**

1. Upholding MNCH Technical Standards: Introducing a quality measure in the DHS network of services, spearheaded by the MNCH service levels and respectively set technical standards of performance, measured by the attainment of the indicators and targets outlined for this programme
2. Aligning MNCH Services: Encouraging the different partners in the health sector to align with the set MNCH policy directions and priorities identified in RH strategy and coherently mobilize the resources necessary for achieving universal access to comprehensive and quality reproductive, maternal, newborn and child health care services
3. Forming Motherhood Action Groups: Strengthening the referral systems for EmONC services and promoting the establishment of women Safe Motherhood Action Groups in all health outlets’ catchment areas for advocacy and support and for increasing the proportion of deliveries attended by skilled birth attendants
4. Preventing HIV Transmission: Improving the access to and utilization of services for the Prevention of Mother-to-Child Transmission (PMTCT) of HIV
5. Seeking the Support of Religious Scholars: Promoting and expanding child spacing as an important maternal and child health intervention and strengthening and expanding adolescent and young adults’ reproductive health services by seeking the endorsement of the local religious scholars

### Nutrition

Malnutrition is acommon problem among women and young children in Puntland. However, the looming political transition that will shift the country to stabilization and recovery constitutes a real window of opportunity for reducing the burden of malnutrition. This subject will therefore constitute a major policy directions for the HPF for which clear measure are stipulated.

**Policy Measures**

1. Improving Nutrition: Improving the district health system capacity to manage maternal and child malnutrition and promoting the appropriate knowledge, attitudes and practices on infant and young child feeding including exclusive breast feeding and complementary feeding
2. Improving the Availability*,* Accessibility andCoverageofMicronutrients: Enhancing the availability, accessibility and coverage of micronutrient supplements and de-worming interventions both for the young and among school going children
3. Promoting Intersectoral Action for Nutrition: Promoting the mainstreaming of nutrition into the national development policy and advancing intersectoral action with relevant line departments for coherent strategic policies and actions

### Control of Communicable Diseases

Communicable diseases are of major public health concern in Puntland with yearly outbreaks of waterborne, vector-borne and vaccine-preventable diseases. The unfavourable hygienic and environmental conditions and the inadequate access to safe drinking water are major factors enhancing the risk of infection and disease. Although Puntland is a seasonal endemic area for Malaria, tuberculosis is highly prevalent and poses a high burden of disease and deaths compounded by its epidemiological interaction with HIV co-infection. Moreover, the high prevalence of hepatitis B and C viral infections account for the overwhelming majority of the widespread chronic liver disease. In view of their significant impact on the population, the surveillance and control of these diseases constitute an important focus of the HPF.

**Policy Measure**

1. **Malaria**
2. Enhancing Preparedness and Response: Building stakeholder strategic partnerships for malaria control interventions and strengthen surveillance and outbreak preparedness and response
3. Using Impregnated Bed Nets: Promoting the interventions of long-lasting insecticide-treated nets, providing rapid diagnostic tests in PHUs and artemisinin-based combination therapy to confirmed malaria cases.
4. Regulating Antimalarial Drugs: Evaluating the imposition of a ban on the sale of oral artemisinin monotherapies and injectable chloroquine to avert their injudicious prescription by care providers
5. **Tuberculosis**
6. Improving TB Treatment Outcomes: Enhancing the government commitment in expanding the DOTS TB control programme to every district with closely monitored laboratory network to steadily increase case notification and improve treatment outcomes
7. Ensuring TB/DOTS Funding: Mobilizing the necessary technical and financial support from the national and international partners; promoting the public private partnership for DOTS expansion and effecting tangible improvement in the DOTS related drug management system and scaling-up MDR-TB and TB/HIV care
8. **HIV/AIDS**
9. Supporting the HIV/AIDS Commission: Consolidating the multisectoral HIV/AIDS Commission for a better coordination and planning of HIV/AIDS control intervention within and outside the health sector
10. Accounting for Social Stigma in HIV Testing: Promoting and facilitating access and use of Voluntary Counseling and Testing (VCT) facilities for HIV, in a manner and in premises fully integrated with the Health Center and MCH and hospital services to account for the existing cultural stigma in the population and to effectively respond to the looming HIV/AIDS epidemic
11. Advocacy Campaigns for HIV/AIDS Prevention: Promoting public education programs on the knowledge of HIV/AIDS and organizing advocacy training for the formal public and private sector intermediate and high schools and graduate training institutions, as well as for the religious, youth and other community social groups
12. Securing Treatment: Providing the necessary support and care to HIV/AIDS patients including ARV treatment as relevant, preventing Mother to Child HIV Transmission and promoting safe blood transfusion and injection safety.
13. **Acute watery diarrhoea including Cholera and other enteric diseases**
14. Preventing and Preparing for Response: Creating regional and district level health promotion, education and communication units that coordinate community action for adopting preventive behaviours as well as preparedness and response interventions for the control of acute water diarrhoea including Cholera and other enteric diseases through treatment and care, personal and environmental hygiene promotion, safe drinking water, proper sanitation, waste disposal and food safety
15. Setting Early Warning System: Ensuring the regular provision and timely use of rapid diagnostic tests for cholera and other common communicable diseases, improved surveillance for their early detection with the setting of early warning systems and rapid response
16. Prepositioning Supply Stocks: Improving the DHS capacity for proper case management with sufficient pre-positioning of medical supplies and relevant emergency medical kits
17. Food Surveillance: Promoting laboratory-based surveillance of priority food-borne diseases in humans and animals and the monitoring of these pathogens in food, while introducing food safety policies and actions from importation and production to consumption levels of the food chain in collaboration with relevant public and private sector institutions.
18. **Expanded Programme on Immunization (EPI) and Polio Eradication**
19. Raising EPI Coverage: Ensuring the universal immunization of all children and pregnant women through the EPI, this being a priority health policy direction aiming to reduce child mortality and promoting measles and neonatal tetanus elimination, while considering the EPI coverage rate as an indicator of health system performance for each district and region. The EPI coverage was significantly and cost-effectively enhanced by the successfully mobilized Child Health Days [20].
20. Utilizing the Evolving Opportunities for Effective Outreach Services: the community based FHWs initiative that will soon be launched will bridge immunization gaps through EPI outreach services and through the direct involvement of these workers in community mobilization and organization of vaccination sessions and also acquiring skills to independently perform these upon improved access to cold chain facilities
21. Creating a role for the Private Sector: Increasing the role of the private health sector by mandating its participation in the organization of EPI services in all the privately owned health outlets to avert the current lost opportunities for the large number of children and pregnant mothers seeking care in these facilities
22. Sustaining Polio Eradication Campaigns: Scaling up the sustained efforts for polio eradication and the achieved success of interrupted polio transmission by maintaining the political and operational commitments of the government of Puntland to Polio eradication campaigns
23. Managing the Cold-Chain: Promoting the vaccination of all eligible infants, children and pregnant mothers and supporting the establishment of a well maintained and monitored cold chain that have the required capacity to preserve the quality of vaccines and sustain the necessary regular outreach immunization services to the rural, nomadic and hard to reach communities
24. Integrating Disease Surveillance: Establishing an e[pidemiological surveillance](http://en.wikipedia.org/wiki/Epidemiological_surveillance) system, integrated with the disease control programmes, with a distinct management system, whose reports are being promptly shared with all health partners to set off a coordinated joint preparedness and response actions
25. **Prevention and Control of Hepatitis B and C Viral Infections**

Somalia is a country with hepatitis B and C high endemicity that have created a large pool of chronic liver disease with unaffordable treatment costs, corroborating the prevention to be the only viable cost-effective strategic policy for the control of these silent killers.

**Policy Measure**

1. Scaling up Child Vaccination: Scale up the EPIservicesforchildren that will for the first time include the easy to administer pentavalent vaccine protecting the children for life against five major deadly diseases that include hepatitis B, attained through the support of the Global Alliance for Vaccines and Immunization (GAVI), while at the same time regulating the mandatory vaccination of all health workers against hepatitis B at the time of their induction
2. Improving Blood Transfusion Services: Ensure the provision of safe blood transfusion and safe blood products in all the health system outlets and establish blood banks with the necessary technical capacity to screen and preserve blood donations
3. Safe Injections: Promote the safety of injections and invasive devices and their waste management and safe disposal
4. Promoting Hepatitis Control: Establish a behaviour change communication and Advocacy programme to educate the public about the risks of hepatitis B and C viral infection and the necessary safety measures to pursue
5. Building Capacity: Enhance the health workers’ capacity for the prevention and control of hepatitis B and C viral infections in hospital and health facility settings including the private sector health outlets and pharmacies

### Control of Non-Communicable Diseases

1. **Mental health and Control of Substance Abuse**

Mental health constitutes a major public health problem that affects a large proportion of the general population [21]. Mental disorders have deteriorated as a result of the extended conflict, poverty and the excessive consumption of Khat that contains the psychoactive component “cathinone”, resembling amphetamine in its effects, as well as the lack of appropriate health care services, causing immense suffering to the affected victims and their families and communities.

**Policy Measures and Decisions**

1. Establishing Community Based Mental Health: Developing a community-based mental health services recognizing the social right of people with mental disorders and treating them in a conducive and chain free environment, while promulgating a mental health law that promotes and protects the rights of people with mental disorders
2. Promoting Mental Health and Reducing Stigma: Promoting mental health and preventing mental illness and reducing stigma toward persons with mental illness by raising the awareness of the general public about mental health issues and about the adverse effects of Khat use, this being a major risk factor, hence the need to control its consumption and excessive use as well as the control of other substance use
3. Improving Treatment Opportunities: Strengthening and expanding the capacity of existing inpatient treatment centers, enabling them to provide quality services, while training the required mid-level mental health workforce
4. Interfacing with Traditional Spiritual Healers: Integrating the existing supportive traditional and religious treatment procedures, while exposing to them the capacity of modern psychological and pharmacological therapies and the value of referral support, and communicating the ineffectiveness of the traditionally applied chain system
5. **Prevention of Blindness**

Malnutrition, infectious diseases and other causes of chronic blindness still predominate in Puntland. To reduce the burden of Trachoma infection, vitamin A deficiencies and the other common causes of blindness, the government reflects its commitment in this HPF.

**Policy Measures and Decisions**

1. Promoting Primary Eye Care: Integrating eye care services into the PHC network, where FHWs, CHWs and other members of the health workforce perform primary eye care services for their catchment area populations
2. Training Eye Care technicians: Training eye care technicians that are capable to perform primary prevention and secondary eye care services at district level
3. Building Public Private Partnerships: Establishing public private partnerships to create district and regional referral centers for regularly or periodically organized referral eye care and surgery
4. **Provision of Oral and Ear, Nose and Throat (ENT)** Surgical and Medicare Care **Services**

Promotive, preventive and basic diagnostic and curative services are essential components of the primary health care system and should be streamlined in the provincial and district level interventions.

**Policy Measures and Decisions**

1. Promoting Primary Care ENT Services: Integrating the primary oral and ENT services into the PHC network of services and in the school health programmes educating them to acquire appropriate healthy behaviours that protect themselves from these diseases
2. Creating Outreach Teams: Establishing specialized services at the regional level and organizing mobile team that reach out to district hospitals and rural areas to provide appropriate care for these disease conditions
3. Training Health Technicians: Organizing technical training programmes on oral health and dental care fully assigned to provide the promotive and preventive care services to the community and their school age population
4. **Trauma and injuries**

The periodic armed conflicts that pose security threat to the peace and stability in Puntland, as well as the frequent road traffic injuries result in frequent mass casualties that cannot be handled by the weak emergency medical services of the health system, often resulting in increased morbidity, disability and mortality. The HPF is promoting policy directions aimed to mitigate the impact of this sizeable public health challenge.

**Policy Measures and Decisions**

1. Emergency Medical Services: Organizing emergency medical services at central, regional and district levels and improving the capacity to respond to the large number of casualties including the human caused crimes
2. Establishing Trauma Centers: Establishing trauma centers at the regional level that offer comprehensive emergency care and creating specialized referral hospital units at the central level that manage the most complicated trauma cases
3. Promoting First Aid Training: Promoting community based first aid training and developing health professionals trained on the management of health emergencies both as first responders on the site and as providers of emergency care at the health facilities’ level
4. Addressing the special health needs of people with disabilities by improving their access to quality and affordable health care services, removing the access barriers they encounter and organizing adequate community and facility based care and support for these vulnerable population groups to improve their health outcomes, while training community health workers and health professionals on the required primary and specialized care

### Health Emergency Preparedness and Response

Public Health Emergency Preparedness and response programmes focus respond to the critical events that pose substantial health risks to the population, hence deserving the attention of the HPF. The HPF strongly reiterates the government commitment to sustain an adequate level of preparedness to the natural and manmade related disasters. In pursuing this policy the necessary measures need to be taken to avert the high rates of morbidity and mortality that often result from these adversities.

**Policy measures and Decisions**

1. Strengthening Health Emergency Preparedness and Response (HEPR): Creating central, regional and district level health emergency preparedness and response operational units coordinated by the MOH and its health partners that address the evolving emergency health preparedness and response needs of the population
2. Defining the Scope of HEPR: Ensuring the effectiveness of the health emergency and response interventions by endorsing a policy direction focusing on the priority areas of Maternal, Neonatal and Child Health; immunization of the target vulnerable groups; nutrition promotion and education; control and management of acute and chronic communicable and non-communicable diseases; mental health; hygiene promotion and support for safe drinking water and sanitation
3. Acquiring the Multi-hazard Approach: Pursuing an integrated multi hazard and the whole-of-society approach to reduce the incidence and severity of disasters by linking to the nationally established intersectoral mechanisms for disaster management and establishing coordinated mechanisms for resource mobilization and their effective utilization

### Acting to Reduce Violence against women

The growing violence mostly affecting women and girls including rape is exposing to these victims intense feelings of horror and helplessness that exceed their coping capacities. This violence is compounded by the lack of legal support and high level of impunity for the perpetrators of these crimes. In view of the ill-health consequences of physical and psychosocial mental injuries, the HPF recognizes the need for policy directions that can eliminate these hazardous practices violating the health and human rights of these young girls and women.

**Policy Measures and Decisions**

1. Providing Care: Providing prompt medical and psychosocial support to these victims with the detection and treatment of sexually transmitted illnesses along with the other relevant support measures
2. Offering Forensic Support: Establishing facilities for medico-legal forensic support to validate the occurrence of these violations
3. Linking with Relevant Institutions for Action: Establishing close links with women organizations and law enforcement agencies to substantiate the medico-legal results of these abuses and encourage them to proceed with the relevant legal action

## Special Puntland Public Health Policy Measures

### Pastoralist Nomads Health: Policy Directions

The nomadic pastoralists in the state of Puntland are estimated at over 50% of the population. Although livestock represents a significant component of the state’s economic wealth, these nomads have the lowest access to modern health care services relative to urban and settled rural population. In most cases distance from the nearest health facilities and the demanding pastoral obligations can delay the decision of allowing a sick member of the herding community to travel to seek care. This pattern of delayed care seeking behaviour is more severe during the dry seasons when some of the waterholes begin to dry and when these communities begin their routine migration in search of pasture and water. The cost involved in transporting a sick nomadic patient, the treatment at the heath facility and procurement of drugs and the opportunity cost for time lost by the accompanying family members are some major impeding factor that may restrict the decision to allow the patient to seek care. This social marginalization poses a serious challenge to the health needs of the most vulnerable mothers and children, making it imperative to end this neglect and extend essential PHC services to the nomadic pastoralist population. The Puntland government will introduce the following concrete health policy measures for this priority area of public health.

**Policy Measures and Decisions**

1. Restructuring the Ministry of Health with the creation of a full-fledged department on Nomadic Pastoralist Health Services: To recognize the importance of this policy measure, the government of Puntland is committed to create this structure within the MOH to play a central role in promoting a chain of health services targeting this underprivileged population
2. Organization of PHUs Nomadic Located within Reachable Distances: Despite the seasonal migration of the nomadic pastoralists in Puntland, small village and settlements have emerged in the recent years located on the nomads’ migration crossroads or at the perennial operating boreholes where water for human and animal consumption are obtained from during the dry seasons of the year. PHU will be established in these villages to enable the sick patients seek care from a reliably staffed health facility. In addition to the basic curative care the facility will conduct health promotion and education intervention to enhance the health literacy of these population groups. These PHUs will be an integral part of the Puntland government health system
3. Mobile clinics: To bridge the enormous gap of accessing health care services among nomads as compared to other rural communities, mobile clinics will be introduced to undertake regular rounds of clinical diagnosis and care. Each season the nomadic pastoralists’ migration status will be mapped to use the safest roads and ensure the best coverage of these targeted population groups. For the effective implementation of these mobile services, the health staff must be familiar with the catchment areas to be visited and be aware of the local traditions and customs to effectively perform health education sessions to these nomadic families. The Mobile Health Team will consist of health professionals able to collectively address the MNCH and other public health care needs of this vulnerable population.
4. Training of Nomadic Lady Health Workers: To enhance the effective utilization of the established nomadic PHUs and mobile clinics, the nascent Female Health Workers’ (FHWs) programme envisaged for the settled rural communities will be also launched within the nomadic pastoral communities. Accordingly, nomadic FHWs will be recruited and trained to provide essential MNCH care, promote health education and hygiene, counsel the community to utilize the catchment area PHUs and mobile clinics and refer cases needing more advanced care

### Decentralization to Enhance Local Participation and Accountability

In view of the vast distances between the different districts and the need to have a well functioning and closely supervised network of the health services the MOH will decentralize the operational management of the health services system to the regional and district level authorities. However, the MOH will have the oversight monitoring and evaluation roles on the health system operational plans and implementation processes to ensure equity and performance standards across regions.

**Policy Measures and Decisions**

1. Enhancing Community Role: Creating a legitimate space for community and local government participation in the development of health sector
2. Tailoring Services to Local Needs: Enhancing efficiency and equity in accessing essential health services at the level of the district health system and tailoring the delivery of health services to the local needs, context and operational realities
3. Establishing Health Boards: Assigning direct health supportive roles to the local government and community representatives with access to the decision making and management processes through the establishment of hospital, health center/MCH, Health Posts and grass health management support committees
4. Encouraging Community Co-financing: Mobilizing public support by creating co-financing opportunities, generating local health partnerships and sharing accountability with improved quality of health care services
5. Building the District Health Team: Increasing the learning space and problem solving capacities of the district health team and that of the community and counterpart organizations and introducing local innovative practices to improve performance
6. Providing Capacity Building Support: Ensuring the necessary support to regional and district health entities through capacity building interventions focusing on infrastructure rehabilitation and on the upgradation of technical, logistic and managerial competencies of the respective health teams
7. Coordinating Health Data Analysis: Coordinating health information system data analysis, where the outputs and outcomes attained are promptly disseminated and identified best practices shared across regions and districts, through periodically held regional consultations and exchanged study tours, thus building bridges of cooperation on health system management and on jointly organized epidemic investigations and response interventions.

### The health of the Mountainous and Hard to Reach Coastal Districts of Puntland

Several districts are located in mountainous areas with challenging access to regular health services. These very districts are also difficult to access through the main asphalted road that constitutes the major communication life line for the state. Maternal mortality is a common, as mothers with obstructed labour and with complications have no chance for prompt evacuation to the referral centers as road trips take 6-10 or more hours in these difficult terrains, resulting in excessive maternal death.

**Policy Measures and Decisions**

1. Strengthening the MCH Centers to Better Serve the Mountainous Communities: To encourage the community care seeking patterns and by deploying skilled midwives in these facilities and provided the necessary stockpiles to sustain the MCH critical functions and avert the risk of stock outs, while organizing regular supportive supervisory services to maintain a reliable level of quality services in these facilities
2. Organizing the Training of Locally Selected Females as Skilled Midwives: In view of the limited health workforce willing to serve in these hardship duty stations, the MOH will organize quota seats in all midwifery schools to train girls selected from these hardship areas who will guarantee to return to their native districts for a pre-defined period of time
3. Establishment of Waiting Homes to Reduce Maternal Mortality: to overcome the late transportation of the high risk pregnant women from the mountainous settlements; improve the utilization of antenatal and safe delivery services and undertake the timely referral of high risk mothers, the MOH will encourage the regional and district health authorities to establish Maternal Homes in close proximity to MCH centers. Maternal Homes are rented premises accommodating 5-10 pregnant mothers in their last month of pregnancy or 15 days before their due date. Through the MCH and community support, these mothers will be provided support during their stay and will be covered by antenatal screening. Mothers with potential complications will be referred and transported in time to the district or regional hospitals to access comprehensive EmOC services, while the others will stay in these Waiting Homes and sent back after a safe delivery to their high residential localities. This policy initiative will be carried out in close partnership with local community leaders and district authorities.
4. Improving Health Services for the Deprived Coastal Communities: Another vulnerable group of the Puntland population is the coastal communities that are located far away from the main road communication networks, linking with the main urban cities where trauma care and EmOC services are available. This geographical isolation and the lack of prompt and easy referral transfer of serious patients and pregnancy related complications poses a real challenge to the health system. The MCH centers located in these coastal areas will be strengthened and upgraded on priority basis to Health Centers that are better staffed and able to manage the common health and nutrition problems facing these hard to reach populations. The protective early referral of high risk pregnancies will also be considered.

### Effective Traditional Medicine Management

Recognizing the public health importance of traditional medicines where a significant number of people (27-36%) in Puntland are using traditional treatment of herbal products along with religious and other practices for common primary health care ailments, the government will focus on the subject as a priority policy direction to undertake the necessary technical measures to validate their safety and effectiveness and introduce the necessary regulations accordingly [22].

**Policy Measures and Decisions**

1. Creating Medicinal Plants Inventory: Developing an inventory and an assessment of the Puntland native medicinal plants and other plants used by the Puntland population and assess their application, volume and modality of use
2. Seeking Evidence: Documentation of the traditional medicines and practices of proven safety and efficacy in collaboration with WHO and other health partners and share the generated evidence to the public
3. Registering Traditional Practitioners: Registering the Traditional Health Practitioners providing physical, mental and spiritual care and exposing them to the services of the primary and hospital care systems relevant to their practices to build linkages with the formal health sector
4. Setting Guidelines: Introducing the legal and regulatory tools that facilitate the use of products with proven efficacy and safety and discourage or ban those with technical proven harmful effects

### Organizational Changes in the MOH to Scale up Health Promotion

The government of Puntland will establish a full-fledged department for Health Promotion and Education that coordinate across the different health programmes to cost-effectively communicate public health information and education for health and inculcate healthy life skills in the population.

**Policy Measures and Decisions**

1. Reorienting Health Services: Ensuring that all the different health programmes will formulate health education and promotion interventions to be streamlined in the implementations process, stressing on the importance of health and nutrition protection, disease prevention and control to the population wellbeing
2. Integrating Health in Public Policy: Creating strong political commitments to health and equity in all sectors of the government and envisage a Puntland healthy public policy in all sectors of development to build a supportive environment for health
3. Creating Supportive Environment to Health: Developing alliances across sectors to promote action on the social determinants of health with the promulgation of guidelines for action and regulations for implementation
4. Strengthening Community Action: Strengthening community health action and public participation through advocacy, social organization and mobilization with focus on mothers and women groups and promoting the significance of health practices and skills relevant to personal and environmental hygiene, maternal and child nutrition, modifying the care seeking behaviour, promoting best health promotion practices such as immunization and their impact on population’s health security
5. Building alliance with traditional healers and religious leaders to address Health decisions that involve the influence of religion, tradition and morality through health education and promotion strategies to eliminate the stigma and other barriers limiting health services’ utilization

## Development of Human Resources for Health

The HRH constitutes a major component of the health system and a critical element for the efficient and effective delivery of essential health care services to the population. Puntland as the rest of Somalia is facing the challenges of low productivity of skilled health workforce, poor retention capacities and poor working conditions that have collectively weakened the health system and led to an apparent inequity in the distribution of the limited number of health workforce. The Puntland MOH is committed to train adequate numbers of health professionals and improve the effectiveness of their capacity, as they constitute a central pillar for improving the health system performance. This undertaking is constitutes the most critical component of the Puntland HPF.

**Policy Measure**

1. Establishing HRH Coordination Committee: Establishing an interagency HRH Coordination Committee that converges the human resource contributions of the national and international health partners including the Global Health Workforce Alliance, led by the national authority with the role to periodically review and guide the human resource development process in a cohesive manner, consistent with the health sector strategic and implementation plans
2. Launching FHWs Programme: Launching the innovative strategy of Female Health Workers (FHWs) at community level to substantiate a strong promotive and preventive MNCH interventions at the grassroot level
3. Prioritizing Midwifery Training: Initiating a fast track midwifery training programmes in all regional centers to address the shortage and chronic distribution inequity in the rural and hard to reach areas
4. Bridging Gaps in Midlevel Technicians: Train midlevel health professionals to bridge the enormous gaps in the availability of skilled technicians in the different fields of public health as most of the currently engaged personnel are insufficiently trained, while many have aged
5. Improving HRH Data: Creating HRH Observatory that produces / assembles the information necessary for policy and strategic evidence based management decisions on human resource development
6. Envisaging Retention Schemes: Complementing the enhancement of health workforce training and recruitment for the health system with effective retention schemes that consider both financial and non-financial incentives
7. Extending Support to Training Institutions: Providing institutional support to the medical colleges and other health professional training institutions and engaging them actively in the health system to promote community oriented and community based education and engaging them in the training of other professionals including the allied health sciences
8. Restructuring the MOH: Reorganizing the MOH to ensure that its operating departments and units are structured to effectively respond to the health needs of the population, while enhancing the management capacity of the senior and midlevel professionals of the health sector to create the required leadership and governance competencies that are essential for the health system
9. As government health authorities are fully unable to mobilize the necessary resources for employing all the available national health workforce and hence constrained to secure a wider coverage with essential health services , numerous health partners are extending health delivery support to the population but competing for the limited number of trained health professionals. These partners pursue different remuneration criteria that damage coordination and equity in the provision of care, necessitating the formulation of a shared policy direction, whereby salaries and incentives are to be standardized and based on qualification, experience, assigned roles and responsibilities and performance outputs across the health system to promote equity, staff retention and motivation

### Strengthening and expanding health professionals training institutions in Puntland

The significant shortage of health workforce cannot be addressed by the existing training institutions in medical education, nursing, midwifery and other allied health science professionals. Efforts will be made to strengthen these and launch the establishment of additional training institutions both in the public as well as in the private sector to produce the required health workforce.

**Policy Measures and Decisions**

1. Training of Clinical Officers: The Puntland MOH recognizes the vast geographical distances that separate the districts of the same region and the scarcity of medical doctors to serve in district hospitals or in the distantly located health center. To address this challenge the MOH will launch a Medical Officers’ training programme through the collaborative support with regional academic institutions and willing health partners.
2. Scaling up Midwifery Training: Expanding the training of community midwives and scaling them up from the current situation of less than 100 to the longer term goal of 600 midwives that Puntland health system would require
3. Training skilled Mid-level professionals: the government will also encourage the training of skilled technicians in the different health fields i.e. laboratory, dental, environmental, pharmacist, anaesthesia, orthopaedic and other technicians to attain a sufficient level of skill mix for the health services delivery system
4. Motivation and retention schemes: the MOH will create retention schemes where critical staff such as midwives and those deployed in remote and hard to reach areas are provided with special financial and non-training incentives. To motivate the health workforce, career development, continuing professional education and other supportive interventions will also be considered

### Introducing the Female Health Workers’ Programme to Bring Health to the Grassroots

The Somali authorities have endorsed the implementation of a community based primary health care intervention at the grass root level with specific selection training and recruitment criteria and modalities.

**Policy Measures and Decisions**

1. Providing Services at Community Door Steps: Females Health Workers (FHWs) will be selected and trained to deliver essential PHC services to their underprivileged catchment communities
2. Promoting Interpersonal Communication: These FHWs will deliver a package of services dominated by MNCH care, nutrition and health promotion, nutrition education and disease prevention through home visits and interpersonal communication
3. Improving Care seeking Behaviour: These community imbedded FHWs will constitute the agents of change for the health system by stimulating substantial transformations in community practices and improving care seeking behaviour and the utilization of emergency obstetric care referral services of the health sector

## Health Management Information System and Research

The management information system engaging both the public and private health sectors will be strengthened. The data sources will account for population and health facility-based information creating an inventory for all the relevant information for policy, strategic and programmatic decision making. The latter include health surveys and surveillance data, as well as monitoring and evaluation data of the health system. To support the national health system, operational health research needs will be conducted and the necessary coordination forum established.

**Policy Measures and Decisions**

1. Integrating HMIS Data: Improving the capacity of the HIS at central, regional and district levels to inform decision makers and partners, by integrating disease surveillance data, the routinely collected health facility based information and the monitoring and evaluation data reflecting the results attained from the implemented health interventions
2. Using Standard Tools: Standardizing the applied practical tools for the systematic collection of data and their analysis as these are critical for the process of effective decision making for strategic and operational planning and for coordination
3. Promoting Operational Research: Identifying health research priorities that address the effectiveness and progress of major health interventions by pursuing a problem solving approach with focus on the health needs of the vulnerable groups of the society and exploring opportunities to encourage community participation and action
4. MOH and Academic Institutions Task Force: Establishing a knowledge Management and Research Coordination Task-Force (TF): The MOH and Medical Colleges and Health Professional Schools will establish a joint TF whose main roles include: improving knowledge translation strategies aimed at bridging the know-do gap in public health interventions; designing human resource capacity building through the launching of new professional courses or planning the implementation of Continuing Professional Development programmes and identifying key challenges and problems faced at the operational level and prompting research interventions for modelling a solution
5. Building capacity for evidence based management: Enhancing the health managers’ capabilities in recognizing the need for operational research and supporting its implementation, and in acquiring a culture of evidence based decision‐making, focusing on priority issues, using the internally collected data through the health system in addition to research generated information and taking the relevant decisions and actions accordingly
6. Establishing a health system observatory to monitor the ability of health information system to identify problems and needs that influence the evidence based decision making, aimed to improve performance and attain the outputs and outcomes set for the different programmatic health interventions, in terms of better health, equitable and cost-effective distribution of human and financial resources and health services’ infrastructure, as well as enhancing the capacity to negotiate public private partnerships and mobilize community participation and co-financing of service delivery interventions

## Essential Drugs and Vaccines

Essential drugs along with vaccines and technologies constitute a major component of the health system and play a crucial role in the delivery of health care services. The access to Essential Medicines for major priority diseases and conditions need to be made available, affordable, while ensuring their quality and rational use. In this regard efforts will be made to gradually move away from the humanitarian action based exclusive “Health Kit System” to a regular and well-coordinated procurement systems that are responsive to the prevailing burden of disease in each region and to the medicine needs of the health care system. Moreover, the gaps in drug quality assurance systems and the lack or inadequate drug legislation need to be addressed. Despite the Puntland efforts in setting policy guidelines for pharmaceuticals, the health system is seriously exposed to the importation of substandard and counterfeit products compounded by poor storage facilities that can jointly induce potential adverse health effects to the population.

Policy Measure

1. Essential Drug List: Formulating an essential drug list to be applied by the public health sector and build the relevant capacity in collaboration with the international partners to test the quality of drugs to validate their effectiveness and formulate treatment guidelines for common acute and chronic diseases for efficiency and quality that are disseminated throughout the health services’ system
2. Using Generic Drugs: Developing specific strategies to increase the use of generic drugs by the district health system to improve the quality and cost-effective procurement of drugs and scale up their access especially to the rural areas and nomadic pastoral communities.
3. Regulating Drugs: Enabling the ministry of health and SRC to implement the set drug regulatory norms to minimize the harm caused by substandard/adulterated and counterfeit drugs imported and illicitly distributed and sold to the public through the establishment of at least one or two drug quality control centers in Puntland
4. Standardizing Procurement: Designing an effective and sustainable supply chain system for drugs and other essential supplies, with transparent procurement with annual forecasts, good storage, transportation and distribution systems along with capacity building
5. Registering Traditional Practitioners: Registering the traditional healers and promoting operational research interventions investigating the relevance of their therapeutic use and their toxicity and disseminate this information to raise public awareness about their use
6. Capacity Building: Building the human resource capacity in the pharmaceutical field to ensure the employment of qualified professionals for the management of essential drugs both at the public and private sector
7. EPI Acceleration: Promoting EPI as a flagship strategy of the health system reaching out to every child at the right *time* at all levels

## Leadership, Governance and Management

Effective leadership and management are essential components to the success of any health system. This reality was strongly perceived by the national health authorities and their partners through the assessment that was carried out in 2011 in the different Somali zones. Based on this study, a strategic plan for governance, leadership and management was outlined [23]. The strategy framed the need for enhancing the capacity of MOH in policy analysis and strategic planning; human resource development and planning; health financing and resource mobilization; strengthening the health sector related legislative and regulatory system; improving information management and research; enhancing coordination and partnerships and promoting communications, public relations and advocacy. To address these governance and leadership issues, the Puntland MOH has expressed an evident policy commitment and dedication in improving the health system performance by undertaking relevant policy directions and measures.

**Policy Measures and Decisions**

1. Strengthening the MOH Governance Capacity: Enhancing the managerial and leadership capacities of the MOH in health policy analysis, planning, introducing legislative and regulatory reforms, mobilization and management of financial resources, information management and communication and partnership building
2. Creating policy and strategic coalitions: Creating collaborative alliances with relevant sectors to address the social determinants of health like nutrition, safe drinking water, sanitation, education, environment and occupational health
3. Engaging Civil Society Organizations: Creating institutional platforms for engaging civil society and other nongovernmental organizations to play a critical role in the planning, monitoring and equitable implementation of health interventions and scaling up their capacity to mobilize community support and participation in the governance of the health system
4. Mobilizing community support to hospitals and other health facilities: Establishing governing and oversight boards for public sector hospitals and other health facilities that bring together different government and community stakeholders to extend regular and sustained support to the operational strategies and performance of these facilities from the process of problem identification to the planning of solutions for implementation with increased transparency of the efforts deputed by the government and other service providers
5. Developing an adequate number of managers: Training the relevant management cadre for all levels of service delivery by organizing health management courses specifically tailored to the required competencies and needs of the of the health system
6. Organizing public health management Degree Courses: Organizing public health degree courses at country level in coordination and partnership with national and international academic health institutions
7. Improving the working environment: Scaling up the commitment of the health workforce by introducing well communicated policy measures and directions with clear lines of responsibility and accountability, in which performance appraisals lead, when satisfactory to recognition and better remuneration, including career enhancement opportunities

### Professional councils

The absence of legislation regulating the practice of health professionals and related ethical codes are mandating a range of policy directions that will include the establishment of standards enabling the different categories of health professionals to lawfully exercise their obligations to the society and prevent the occurrence of ethical violations. The MOH in partnership with the professional associations will regulate the academic credentials and the accreditation of services both in the public and private sector.

**Policy Measures and Decisions**

1. Formation of Professional Councils: The MOH in collaboration with the professional groups will establish professional health associations for the medical, dental, pharmaceutical, nursing and Midwifery and other paramedical and allied health sciences and enhance their capacity to better understand their roles in the decisions related to recognition of professional qualifications and their subsequent official registration
2. Establishing professional standards: Supporting the institution of professional standards for the health system and that of the health workforce and regulating the professional classification of health practitioners in accordance to qualification and specialization
3. Engaging the associations in establishing and complying with professional code of ethics and in resolving the problems related to any breach or violation of the set ethical norms and professional conduct
4. Introducing the accreditation of public and private health care facilities to ensure that their services meet the priority health needs and comply with the safety and quality standards set for the health system, while encouraging the care providers to constantly review their performance against the standards of practice set by the government

### Emphasis on the Government role as regulator and policy maker: The Ministry of Health and its New Governance Framework for [Improving Health System Perform](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=6&sqi=2&ved=0CGMQFjAF&url=http%3A%2F%2Fgis.emro.who.int%2FHealthSystemObservatory%2FPDF%2FPublications%2FReports%2520of%2520Workshops%2520and%2520Meetings%2FPHP043healthsystemgovernancefinal.pdf&ei=bpaPT8ycHofTrQedvsH7BA&usg=AFQjCNFY6-f-f6mtBJcpW2OZbh8gdgorrQ&sig2=j6OoFc1MgJoJK_euhqzxpQ)ance

During the past two decades, the health system has received increasing attention from a large number of civil society organizations and non-state partners who are engaged in the implementation of a range of priority health interventions that originally constituted an integral part of the primary functions of the government health sector. In view of the operational and resource challenges facing the health system and recognizing the need to sustain these services, the government, in partnership with these stakeholders will pursue a new way of making business with greater emphasis on its role as a regulator and policy maker than the sole predominant health care provider to the public.

**Policy Measures and Decisions**

1. Strengthening the government coordination and oversight role: The government will extend full support to national and international non-state health care providers, who are operationally engaged in the delivery of priority health care services with an oversight of the scope and quality of their performance and compliance with the set standardized regulatory technical and management norms outlined in the technical collaboration
2. Reinforcing the role of non-state actors: The government may outsource the use of public health facilities to non-state actors to operate and finance the health delivery network in the assigned catchment area pursuing the strategic guidelines of the national health system
3. Health Sector Regulation: The Ministry of Health will assume key governance responsibilities that include policy formulation, strategic planning, health legislation, setting implementation standards, coordination, formulating collaborative agreements and intersectoral linkages; monitoring and evaluation of the health system performance; setting the training programmes for human resource development and health research planning and its implementation oversight

### Emerging Role of Academic Health Institutions

The fragile public health system and the scarcity of human resources for health, are mandating national medical colleges and health science training academic institutions the imperative role of building technical partnerships with the ministry of health to jointly pursue a range of shared development policies in human resource training, monitoring and evaluation, operational research and in lending their critical technical support to improve health system capacity and performance.

**Policy Measures and Decisions**

1. Building partnerships: Establishing flexible partnerships between the MOH and medical and other health professional training institutions by creating joint consultation forums that deliberate on human resource strategic policies that respond to the health needs of the population, and hence organize a range of targeted training programmes contributing to health system strengthening by producing the relevant competencies for the health system
2. Improving education Relevance: Promoting the community oriented and community based training approaches to improve the relevance of theoretical and practical academic learning during pre-service training programmes of all health categories, ensuring this policy direction to be pursued by the different public and private academic health institutions
3. Attracting academic expertise to MOH: Acknowledging the value and the necessity of attracting expertise from the different medical and health science training institutions in support of the public health system and creating mechanisms that allow the highly qualified academic health professionals to formally engage in additional managerial or advisory roles to enhance the strategic and operational competencies of the MOH and the health system
4. Bringing evidence into action: Involving the medical and other health institutions in operational research and in the monitoring and evaluation as well as in carrying out assessments that contribute to evidence based decision making of the MOH
5. Continuing education: Promoting continuing medical education and continuing professional development, where training institutions organize learning opportunities in addition to their formal academic programmes to develop the human resource competencies required for the health system

## Health Financing

The health sector financing opportunities are expected to improve through the stipulation of this HPF, whereby the different health partners would better harmonize and align their interventions with the set policy directions. Moreover, the envisaged roadmap to end the political transition in Somalia and embark on a recovery phase of development is expected to generate greater interest and focus on the health sector. In view of the high health illiteracy in the general population and the prominent beneficial externalities of many public health interventions, the role of the government is fundamental in steering the health system towards a universal and equitable access of the poor and vulnerable populations in particular to these vital services.

**Policy Measures and Decisions**

1. Enhancing Government Allocations: Ensuring the allocation of national budgets to the health sector that can substantiate the commitment of the public sector, while undertaking an effective resource mobilization at community level and through the development partners and improve the predictability of health sector financial outlays
2. Aligning with government HPF and plans: Improving the alignment of the different stakeholders’ financial contributions to the priority health policy directions and plans set by the government and encourage efficient resource use in the non-government sector to enhance the overall health system outcome results
3. Promoting Public Private Partnerships: Exploring and encouraging public private partnerships that improve the coverage of the vulnerable populations and the hard to reach communities with essential health care services that are affordable and effective in their implementation
4. Coordinating Resource Oversight: Promoting a coordinated and transparent shared oversight on resource allocation and use and monitoring the attained attributable gains by the health sector
5. Planning Resource Mobilization: Undertaking an effective resource mobilization planning and action through the support of the national and development health partners

# PHYSICAL INFRASTRUCTURE AND EQUIPMENT

The public health physical infrastructure and equipment support are vital constituents of the health system, as properly constructed, maintained and equipped facilities provide the capacity to effectively respond to the health care needs of the population. Although tangible efforts were made by the health authority and its partner organizations, in rehabilitating and equipping the physical infrastructure of the health services’ network, the existing facilities are insufficient to ensure the required coverage and access to essential services. In view of the critical importance of these functions, policy decisions related to the subject are being considered.

**Policy Measures and Decisions**

* 1. Mapping the status of the health facilities’ physical infrastructure and equipment support following a predetermined standard guide, identifying the levels of rehabilitation and reconstructions required and listing the existing geographical access gaps needing focus and action
  2. Introducing physical infrastructure construction and rehabilitation prioritization ranking to ensure that this development function is adequate and responsive to the existing physical infrastructure gaps and population health needs especially at the level of the PHC network and district hospitals
  3. Closely monitoring the rehabilitation of health facilities and their regular maintenance as well as the safeguarding and maintaining the medical equipment provided to each facility level
  4. Developing a Medical Equipment Policy and Guidelines by setting a standard list of equipment for each healthcare level and the minimal technical specifications deemed necessary and healthcare technology management procedures and skills required
  5. Establishing cost-sharing agreements with regional and district authorities and their established institutional boards and communities for the building of new PHC structures and maintenance of existing health facilities to scale up the health system performance

# Consolidating the Private Sector Role in the Provision of Health Care Services

The private health sector partners have assumed a major role in the delivery of health care services during the past two decades and their positive contribution need to be recognized. However, this policy direction has to recognized the challenges facing the private sector is constrained in terms of its limited capacity to engage in the promotive and preventive services of the health system; its unregulated nature that impinges on the service quality and in being predominantly urban based. The government will make all the necessary policy efforts to improve and expand the role of the private health sector by engaging it in shared common health goals with clearly defined roles for implementation.

**Policy Measures and Decisions**

1. Engaging the Private Sector: Bringing the private sector into the mainstream of the district health system by facilitating its expansion and regulating its rules of practice and licensing systems; the quality and safety of its interventions and by sustaining the affordability and availability of its service network for the utilization of the underprivileged strata of the population
2. Promoting Compliance with Standard Service Guidelines: Ensuring the private sector compliance with the nationally set standard preventive, diagnostic and treatment guidelines for key priority disease entities such as the integrated management of childhood illnesses (IMCI), EPI and TB-DOTS, Malaria and HIV/AIDS interventions
3. Establishing public Private Ventures: Establishing public-private partnership that involve the scope of service delivery by the different partner organizations such as in the procurement of essential medicines, addressing specific disease entities or in expanding the access to essential services to remote and hard to reach areas

# Building health partnerships

The HPF will emphasize on partnerships for the health sector through which the national and international stakeholders and relevant civil society organizations will participate in the design of programmatic strategies and operational plans and allow a collective negotiation on how to improve the modalities of engagement in order to support the government in achieving the MDGs. This partnership will allow the sharing of experience and align the different interventions with the stipulated HPF and the national health plans through harmonized resource allocation. The partnership will also contribute in addressing the bottlenecks that hinder the effective performance of the health system.

**Policy Measure**

1. Focusing on MDGs: Providing an umbrella support for setting a single costed national health strategy that directs its commitment on the MDGs 1, 4, 5 and 6 and hence scaling up the health partners programmatic focus and action on nutrition with an emphasis on maternal, and child nutrition and on MNCH care, as well as on the control of malaria, tuberculosis and HIV/AIDS.
2. Applying Shared Indicators: Creating a health sector results framework envisioned in terms of objectives, indicators, outputs and outcomes that will be used to measure the progress towards the attainment of the set health targets such as the health-related MDGs.
3. Establishing a health sector budgetary framework: A singe budgetary framework will have the capacity to harmonize and rationalize the resource mobilization and allocation processes, including the assistance provided by the development partners that will be assigned in accordance with the set health priorities and granted through pooled or jointly coordinated funding mechanisms.
4. Creating a standardized Monitoring and Evaluation Framework: The national authorities and their health partners will work together to develop valid M&E tools for measuring progress in achieving the different strategic and programmatic outputs, outcomes and impact that also promote the strengthening of the health information system
5. Coordinating procurement systems and financial management procedures: These critical managerial systems will be guided by their adherence to transparency and alignment with national plans and M&E systems and by their ability to improve governance and intended results framework
6. To substantiate the aid effectiveness principles, the different international health sector partners will align and harmonize their resource allocations with the government plans and guarantee reliable levels of financial predictability and disbursement, as this will contribute in scaling up the implementation of essential health services for the predominantly vulnerable population
7. Integration of health system operations: The HPF places the emphasis on the integration of various health interventions executed by the different programmes to avert duplication, harmonize their result based orientation and create joint monitoring indicators, supervision and evaluation processes to improve the quality of health care services and the effectiveness of resource utilization.
8. Intersectoral collaboration: The HPF will enhance the collaboration of the health sector with other line ministries whose responsibilities have a bearing on health, such as those responsible for education, water and sanitation, environmental health, women development, labour and local governments. Similarly mutually beneficial linkages may be established with the Puntland Development Research Centre by anchoring health to its research activities and with the Education Center for Peace and Development in Galkayo by integrating health and nutrition literacy programmes to the widely pursued women development interventions

# The Role of Development Partners in Aid Effectiveness

The decades’ long humanitarian concerns about the disrupted health sector have attracted the support of a large number of international partners who were actively engaged in the revitalization of the health system, targeting priority public health interventions. The MOH will expand and bring forward this health system strengthening support.

**Policy Measures and Decisions**

1. Commitment of the Partners to the Health Development Process: To substantiate the aid effectiveness principles, the different international health sector partners will align their resource allocations with government policies, strategies and plans and guarantee reliable levels of financial predictability and disbursement, as this will contribute in scaling up the implementation of essential health services for the predominantly vulnerable population
2. Contributing to the Result Framework: Encouraging the health sector partners to focus on their technical and operational comparative advantages in their support to the national health sector and promoting coherence and synergy in planning and implementation, while avoiding duplication, improving accountability, developing instruments for mutual accountability and producing the programmatically envisaged results framework
3. Improving Predictability of Partners’ Support: Promoting donor partners’ support for enhancing the predictability of their financial contributions to the health sector, to ensure a sustained enhancement of the provision of essential health services to the most vulnerable groups of the population and progress towards the attainment of health MDGs

# Monitoring and Evaluation

The MOH is committed to establish and scale up a unified monitoring and evaluation mechanism that provides evidence based support to the management decision making processes of the health system.

**Policy Measures and Decisions**

1. Strengthening the M&E capacity of the health system: The health system will be enabled to provide quality data for effective decision making that include the burden of disease, disease surveillance, effectiveness of outbreaks’ response interventions, comprehensive health management and information data about the network of health services, human resources management, community based information and compliance with set programmatic standards for implementation, taking advantage of the potentials to be offered by the envisaged health system observatory
2. Following a results based management (RBM) approach: Establishing a monitoring and evaluation system tools to collect and analyze information about the health programmes and improve implementation through the results based management and the logical framework approach
3. Establishing a set of standard indicators: Attaining health partners’ consensus on a primary set of selected input, process, output and outcome indicators for the key health interventions in the health system, their definitions and measurement methods and ensure their practical application
4. Raising staff accountability: Enhancing the monitoring and evaluation skills of the staff to improve performance and raise the level of accountability for data management

# The Clients Service Charter and patient safety

The MOH will endorse the stipulation of a Client Service Charter that frames the establishment of a social pact between the clients and the health system led by the MOH, being the accountable for overseeing the services provided by the different health care providers including the private for-profit sector. In pursue of the Client Service Charter, the MOH will undertake policy decisions to frame operational guidelines that meets the expectations of this social charter to attain the clients’ satisfaction.

**Policy Measures and Decisions**

1. The MOH will undertake the necessary actions to ensure the delivery of quality services to the population following the norms and implementation standards set for all the priority interventions delineated in this policy
2. Promoting patient safety norms and principles by bringing the required changes in the health care system environment and its care providing facilities as well as by improving the technical and Managerial skills of the health teams at all levels of the health care system
3. identifying the potential risks to which the health clients may be exposed and taking the necessary measures to rectify these and eliminate the adverse events that cause harm and suffering to patients visiting health facilities
4. Developing operational guidelines that substantiate the Client Service Charter’s key principles and operation norms and educating the public to improve their knowledge about the service delivery and providers’ response commitments that enhance their care seeking behaviour and improve their health outcomes and satisfaction
5. Creating in all health service outlets, the opportunities for the clients to present or submit complaints, compliments and suggestions about the services rendered with the establishment of health system procedures for investigation, action and feedback

# The Health System Legal Framework

The Ministry of health will develop a set of health system legal framework (LF) measures enabling the public and private health services to function successfully at central, provincial and district levels. This undertaking will cover all the key domains of the health system and ensure equity, safety, quality, efficiency and sound governance.

**Policy Measures and Decisions**

1. The MOH will regulate the roles and responsibilities of each of the three tiers of the health system where the central level will develop the norms and standards to be met in the delivery care, when the regional level will ensure that its decentralization roles and responsibilities are in place and the necessary referral, managerial and other defined support inputs are extended to the district level, while the district health system assumes the most critical role in the delivery of services to its catchment populations in the framework of PHC
2. Promulgating the policy of providing free health care services at all public health sector outlets to the poor, the vulnerable and to pregnant women, mothers and children to significantly reduce the burden of disease and achieve the health MDGs
3. Establishing Health Boards/committees having community representatives to actively participate in the operational oversight and monitoring of hospitals, health and MCH centers, Health Posts and at the FCHWs grassroot level
4. Introducing regulations relevant to professional associations; notification and use of essential drugs’ list and setting dug regulatory norms; regulating traditional medicine and the private practice; proclaiming the notifiable communicable diseases for mandatory surveillance and reporting; endorsing the International Health Regulation and maternal, neonatal and child rights bill and promoting regulations addressing key social determinants of health
5. Developing a systems of internal accreditation of hospitals and quality auditing and certification for the primary health care system as measures for quality assurance and quality improvement of the delivery of care

# Health in All Policies

In the prospective transition and recovery phase, health will undoubtedly become a major objective in the national development process. However, the desired health results would not be attained through the sole contribution of the health sector, why the intersectoral approach is being accepted as the way forward. The latter is substantiated by relevant policy directions acting on the concept of Health in All Policies (HiAPs) and strategically focusing on social determinants of health, as health can be influenced by the policies of these sectors.

**Policy Measures and Decisions**

1. Promoting Intersectoral Action: Breaking the strong nexus between poverty and ill health and promoting intersectoral collaboration by encouraging other sectors to contribute to health and social wellbeing and reduce inequities by addressing the social determinants of health
2. Improving Coordination: Strengthening coordination with national and international partners in promoting the HiAPs approach and the opportunities for mutual gains exploring synergies where the different sectors can achieve more results by working together
3. Introducing Mechanisms to Address Social Determinants: Promoting the development of intersectoral mechanisms to systematically address the health concerns related to environmental and food safety as well as to the work of other sectors such as transport, workplace and occupational health, education and school health, water and sanitation, poverty alleviation and control of Khat and substance abuse
4. Assessing the Health Impacts of Government Policies: Promoting the Health impact assessment policy direction, where the effect of different government development policies on health, will be mandated for consideration to effectively act on the predictable ill-health consequences, and factor these in the health and national development process

# Implementation of the HPF

The formulation of the HPF has emerged as the result of an extensive, inclusive and participatory consultative process involving a large number of national and international stakeholders of the health sector. The policy will cover the period 2012 ‐ 2017 and will be implemented through two cycles of three year strategic plans, each translated into implementation through an annual action plan supported by strong management components. The lessons gained at the end of each strategic plan and the revised socio-economic and demographic situation of the country will allow an effective review of the policy directions outlined in this HPF. Health sector coordination mechanisms will also be established to harmonize the programmatic interventions carried out by the different stakeholders for achieving the objectives of this policy framework. The comparative advantages of the different partners will be defined to improve the cost-effectiveness of the health system and the comprehensive implementation of the EPHS, as outlined for each level of care. The implementation plan will spell out the priority actions indicating the responsibilities assigned, and the timeframe for the completion of key planned interventions. The implementation of the HPF will require:

1. Improving the Organization and Management of the District Health System Network: The organization of the district health system chain of services will start off from the community embedded Female Health Workers offering essential primary health care services at the community level, through the Primary Health Units, MCH centers, Health Centers and District Hospitals. The effective management of this network is expected the delineated package of health services with special focus on maternal and child care.
2. Strengthening the Health System: Strengthening the pillars of the health system with a sharp emphasis on effective service delivery, training, deployment and management of the health workforce, provision of essential drugs, vaccines and technologies, generation reliable HMIS for performance improvement, applying managerial and leadership capacities and pursuing proactive financing strategies for the sector.
3. Implementing the Multihazard Approach to Health Emergency Preparedness and response (HEPR): Implementing an effective system of HEPR founded on the multihazard and whole-of-society approach to prepare for, avert and mitigate the impact of manmade and natural disaster on health
4. Broadening Community Involvement: Promoting community participation at each level of service delivery and building community co-management and co-financing mechanisms and public private partnership to accelerate the attainment of the health MDGs
5. Scaling up Health Promotion and Education: Establishing health advocacy programmes targeting the population in general and mothers, teenagers and youth in particular and promoting health and nutrition best practices and awareness about the risk factors endangerin human health such as tobacco use, consumption of khat and substance abuse

# Public Health and the Collaboration Across Sectors and Partner Organizations

The HPF has clearly illustrated the significance of building partnerships and intersectoral actions to ensure its wide range approval and support and to translate its policy measures into strategic and operational plans for implementation. Accordingly, the MOH will work in collaboration with the health partners on building linkages with other sectors in-charge of public domains related to social determinants of health or other sectors providingadded value for health. This approach is consistent with the endorsed HiAP and will provide impetus to MOH efforts to attain the planned outcomes and development goals of the health sector. The following is an outline of the sectors relevant to the HPF in advancing policy measures that can positively impact upon health:

1. **Ministry Engaged in Women and Youth Development Affairs:** Building partnerships on the promotion of reproductive health rights and services with special advocacy to child spacing and to eradication of female genital mutilation
2. **Ministry of Law:** Assisting the MOH in the development of health legislation for the key public health fields that range from adoption of the international health regulation; promulgation of child and maternal rights; reflection of health as an alienable right in the constitution; promulgation of health professionals’ act, the mental health act; drug abuse prevention and control act, health disabilities’ act, private sector regulation bill and other health related legislation
3. **Ministry of Education** Building partnerships for the promotion of school health education, school health environment and school health services and nutrition with the establishment of school health department at the Ministry of Education to sustain the gains of this endeavour
4. **Ministry of Labour:** Establishing joint collaboration between the MOH and the Ministry of Labour on the promotion of occupational health and safety best practices at the workplace.
5. **Ministry of Transport and Communication:** Forging partnerships for the control of road traffic injuries and introducing road safety measures through policy interventions
6. **Ministry of Sports and Youth:** Organizing joint interventions on the prevention of HIV/AIDS and other sexually transmitted diseases as well as the promotion of health lifestyle and development of better perceptions about health risk factors such as *Khat*, tobacco and substance use
7. **Ministry of Agriculture and livestock:** Promoting technical collaboration on food security and safety and on the control of zoonotic diseases that pose health risksassociatedwithlivestock diseases
8. **Ministry of Religious Affairs:** Establish partnerships on health promotion in all interventions where cultural and religious sensitivities and apprehensions are encountered with the objective to eliminate misconceptions on issues related to reproductive health including FGM, control of HIV/AIDs and other issues of public health relevance
9. **Ministry of Finance:** Establishing a strategic partnership by pursuing a planning process for the allocation of adequate budgetary outlays for the health sector and the mobilization of international support to address the emerging resource gaps in health
10. **Local Government Authorities at Central, Regional and District Level:** Promoting local government support for promoting community action on environmental health and sanitation and in the provision of water supplies and electricity to health facilities
11. **Formal Health partner Organizations**: Establishing formal mechanisms for coordination with international partners, civil society organizations, private sector care providers, teaching institutions etc to harmonize their support to the health sector and achieve better health outcomes including the MDGs
12. **Community Based Organizations:** Establishing local partnerships with community organization to jointly support priority health interventions and advance community co-financing ventures at the grassroot level
13. **Ministry of Foreign Affairs:** Recognizing the relevance of engaging the Ministry of foreign Affairs as the national public health policy is no longer a domestic issue but strongly influenced by the global forces that lie outside the control of a single government, as well as the need to take health to the global development agenda at regional and international level

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# Annex. a summary of the key priority policy directions and their respective SET policy Measures and decisions

|  |  |  |
| --- | --- | --- |
| **No** | **Policy Directions** | **Key policy decisions taken** |
|  | Revitalization of the PHC network | Strengthening the PHC network facilities with equitably distributed universal access to essential services and scaled up district hospitals’ capacities with focus on EmOC services; implementation of the EPHS; upholding MNCH technical standards and its effective provision, including reproductive health and elimination of FGM; accelerating EPI services; integrating nutrition promotion and managing malnutrition at all service levels; Controlling prevalent communicable diseases and NCDs including mental health, blindness, and injuries and trauma; health emergency preparedness and response and reducing violence against women |
|  | Innovative Puntland Health Policy Measures | Introducing health policy directions targeting pastoralist nomads and other hard to reach communities and taking decisions for strengthening MCH centers; introducing mobile health services and communities’ embedded FCHWs; decentralization to improve management and accountability and creating community participatory mechanisms to mobilize support and scale up implementation |
|  | Human Resource for Health | Establishing HRH Coordination Committee comprising all partners for HRH development coherence; launching FCHWs’ training and series of mid-level training courses and Clinical Officers’ training; standardization of salaries and incentives across health partners |
|  | HMIS | Integrating the different HMIS data sets including disease surveillance; promoting evidence based management culture at MOH; establishing Health System Observatory acting as a data bank; building partnerships with academic institutions to generate additional evidence through operational research |
|  | Medicines & Vaccines | Formalizing the Essential Drug List; formulating treatment guidelines for common acute and chronic diseases; Introducing drug regulatory norms and drug quality control centers; registering traditional healers and investigating the relevance of their traditional therapies; promoting EPI as a health sector flagship strategy; |
|  | Leadership,  Governance & Management | Enhancing MOH managerial and leadership capacities on policy analysis and planning; creating training opportunities for managers; establishing professional councils and their operating standards; strengthening government coordination and health oversight role; encouraging public health services’ provision by non-state actors and recognizing private sector contribution and build strategic partnerships with academic health institutions and promoting Continuing Professional Development |
|  | H. Financing | Enhance government allocations; aligning all financial assistance sources with government strategy and action plans; promoting public private partnerships and harmonizing resource mobilization |
|  | Health infrastructure | Mapping the status of the health facilities’ physical infrastructure and equipment support; setting prioritization standards for constructing and rehabilitating facilities; developing Medical Equipment Policy and Guidelines and standards for allocation by service delivery level |
|  | The Role of the Private Sector | Bringing the private sector into the mainstream of the district health system; establishing public-private partnerships to scale up service delivery and apply standard service quality guidelines |
|  | Partnerships | Collective focus on MDGs; establishing a single health sector budgetary framework; standardizing M&E and procurement systems of the health system and supporting intersectoral collaboration |
|  | Aid Effectiveness | Contributing to the Result Framework by focusing Partners’ support on their technical and operational comparative advantages and increasing predictability of their assistance |
|  | M&E | Strengthening the M&E capacity of the health system; pursuing the RBM approach; Establishing and applying a set of standard indicators to raise accountability |
|  | Client Charter | MOH establishing a social pact with clients for providing effective and quality services, promoting patient safety and eliminating adverse events that produce harm and create opportunities for the clients to submit complaints, compliments or suggestions |
|  | Health System Legal Framework | Regulating the roles and responsibilities of each health system level; establishing facility based health boards and introducing supportive legislation for key public health domains |
|  | Health in All  Policies | Introducing mechanisms to address Social Determinants of Health; improving coordination across sectors and promoting health impact assessment policy in all public and private development strategic policies and programmes |