HEALTH SYSTEMS STRENGTHENING FOR THE SOMALI PEOPLE

A WORKSHOP REPORT

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Acknowledgements

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Austen Davis - Health Sector Development Coordinator, UNICEF Somalia
Acronyms

BPHS  Basic Package of *Health* Services
CCM   Comitato Collaborazione Medica
CISP  Comitato Internazionale per lo Sviluppo dei Popoli
COOPi Cooperazione Internazionale
COSV  Committee of the Organisation for Voluntary Service
DfID  Department for International Development
DRC   Democratic Republic of the Congo
EC    European Commission
ECHO  Emergency and Community Health Outreach
EPI   Expanded Programme of Immunisation
GAVI  Global Alliance for Vaccines and Immunization
GFATM Global Fund for AIDS, Tuberculosis and Malaria
GRT   Gruppo per le Relazioni Transculturali
HMIS  Health Management Information System(s)
HR    Human Resources
HR4H  Human Resources for Health
HSC   Health Sector Committee
HSS   Health System Strengthening
JNA   Joint Needs Assessment
KCH   King’s College Hospital (London)
LATH  Liverpool Associates of Tropical Health
MCH   Mother and Child Health Centres
MICS  Multi-Indicator Cluster Survey
MoH TFG Ministry of Health Transitional What-what**
MoH   Ministry of Health
MoHL  Ministry of Health and Labour
MoHL SL Ministry of Health and Labour, Somaliland
MOHPL Ministry of Health Puntland
NGO   Non Governmental Organisation
RCOGIO Royal College of Obstetricians and Gynaecologists International Office
RDP   Reconstruction and Development Plans
SACB  Somalia Aid Coordination Body
SC-UK Save the Children UK
SSS   Somalia Support Secretariat
THET  Tropical Health and Education Trust
UN    United Nations
UNDP  United Nations Development Program
UNICEF United Nations Children’s Fund
WHO   World Health Organisation
This is a report of a workshop on Health Systems Strengthening (HSS) for the Somali people, conceived and realised by officials of the European Commission (EC), representatives from the Ministries of Health, and UNICEF. The purpose of the workshop was to gather together international experts and actors involved in the Somali health sector (representatives of Ministries of Health from Somalia, Puntland and Somaliland, donors, United Nations (UN) agencies, and international and local NGOs), to analyse current challenges facing the health system in Somalia and the impact of systems failure on practical delivery of health care services.

The workshop was developed to launch the UNICEF Lot 3 Health Systems Development Project financed by the EC, which aims to support sector-wide approaches in health over the next two years. The workshop itself was expected to set key objectives and to influence the plan of action of Lot 3.

The aim was to generate an accepted, prioritized list of actions of the most importance in providing practical support to the sustenance of effective and equitable services to the people of Somalia, to be achieved through emergency operations, and more standardised development programmes and/or government-managed services. The intention was to raise issues, collect experiences and generate consensus during an extremely challenging time for Somalia and the health sector in Somalia.

The workshop attained its objectives, managing (through the stamina and crowd-management powers of Rosemary Heenan of the Gedo Health Consortium) to generate consensus around four major developmental focal areas:

- Limited practical support to the various Ministries of Health in the different zones, using modest structures to streamline and enhance their capacity to identify and take responsibility for implementation of a core set of national priorities, above and beyond coordination of international actors.
- Practical support in defining basic cadres of health workers, enhancing production of newly-qualified basic cadres, ensuring they are absorbed back into the workforce of the health sector and managed to ensure productivity.
- Identification of a set of practical, simple standards to define and guide basic service delivery, setting a path for reformation of the basic service delivery sector and improved quality, management and functioning of basic health care services in Somalia.
- An urgent need for information. Many surveys are conducted, but regular and survey information is not collected, analysed or digested in such a way as to feed into decision-making for investment and action in health, and this situation must improve.
The workshop exceeded its original intentions, in developing a further set of outcomes or achievements:

1. In the absence of national plans and/or collectively accepted and used planning documents, the three Ministries of Health gave high quality presentations on activities in their administrative areas, and detailed statements on what they believe to be priority actions. These are important statements of intent by senior representatives of the Ministries of Health and are recorded here in the Annexes (see Annex IV).

2. Realization that the basic platform of service delivery (qualified staff, information, management, supply, communications, norms and standards) was becoming so dilapidated and weakened, that the capacity of humanitarian organizations to swiftly develop and deliver quality services to crisis-affected populations was being threatened. This challenges us to consider that investments in some non-traditional activities might be a critical way to enhance effectiveness and efficiency of all health projects in Somalia, regardless of where or under what conditions they are provided. In particular, availability of qualified staff and the existence of norms and standards endorsed by authorities, means that humanitarian operatives are forced to hire anyone who can read and write, and experience difficulty in assisting them to deliver health care services. Additionally, protracted negotiations over all aspects of programmes (particularly staff entitlements) present such large transaction costs that project effectiveness is significantly reduced.

3. Realization that the Somali health sector was dramatically under-funded, and that existing funding was fragmented, unpredictable and not strategic (i.e. in proportion to priorities), and was failing to produce overall outcomes.

4. Shaping of a community of active partners in health while being increasingly aware that the Somalia health sector is in crisis, requiring urgent action to ensure increased commitment and more effective support beyond specific projects.

5. Exposure of the collective group of actors in the Somali health sector to ideas, innovations and experiences from comparable situations overseas, which left us feeling that we were not alone and that there were new and innovative ideas to be learned from.

Challenges for the future were clear, involving imperatives to:

- Remain focused on practical provision of quality services to as many Somalis as possible.
- Generate new health sector investments in a way that will enforce priorities in service capacity and delivery, as well as sufficient information to allow this.
- Generate new health sector capacities and partnerships in order to start producing outputs not readily achieved through limited, facility-based service delivery projects (particularly training and effective and responsible human resources).
- Generate standards and norms to reduce transaction costs and increase collective efforts and synergies in outcomes from investments in health service delivery.
2.1 Workshop organization, method and objectives

The workshop was held from the 5th – 7th September 2007 in Nairobi, Kenya. Participants included members of the Ministries of Health from all three zones of Somalia, all major health sector donors, The World Bank, major United Nations agencies, the Red Cross and most NGOs active in the health sector, as well as leaders and experts from other countries (see Annex I for a participant list).

The purpose of the workshop was to discuss current challenges facing the health system in Somalia, and the impacts of system failure on practical delivery of health care services.

The workshop included presentations on perceived priorities by the Ministries of Health from all three zones and other actors, followed by break-out discussion groups, plenary sessions and an eventual overall summary and conclusion session.

There were three aims:

1. To share information on the current state of development of health care delivery systems (see Annex II for contents of a binder distributed with key health sector documents).

2. To share information on plans of action for new projects in Somalia and Somaliland.

3. To generate an approved list of prioritized actions important in providing practical support to the creation and maintenance of effective and equitable services to the people of Somalia, achieved through emergency operations and standardised development programmes or government managed services. The intention was to raise issues, collect experiences and generate consensus in the middle of an extremely challenging time both for Somalia and its health sector.

To this end, the workshop was held over three separate days (see Annex III for agenda).

Day 1 - Information sharing – international and Somali experiences.
Day 2 - New programmes, new approaches and working group sessions on priorities.
Day 3 - Generating a future agenda for action.

2.2 Day 1: Information sharing - where we are in Somalia

2.2.1 Opening session

The day was opened by Paula Vazquez Horyaans (EC), who welcomed the group and initiated the workshop.
Dr Mojellid (WR WHO) emphasized the importance of the workshop in the context of making progress on the health of the Somali people and reconstruction of the Somali health system. He emphasized the importance of the Joint Needs Assessment (JNA) process which has resulted in the Reconstruction and Development Plan (RDP) for Somalia. Dr Mojellid emphasized the poor state of the health system, low levels of overall financing and its dependence on international donors for its continued functioning. Dr Mojellid touched on the key areas of financing, workforce development, pharmaceutical procurement and regulation, and the importance of coordination in analysing priorities, ensuring gaps are filled and making progress.

Dr Hassan of the Somali Red Crescent Society pointed out that there was an insufficient Somali presence in the meeting. He underscored the problem of Somalia, with most assistance coming from outside and most management of programmes being in Nairobi. There is a huge challenge to include Somalis, building ownership of national strategies and working together as partners towards the same goals.

### 2.2.2 Main session

Most of the morning was given to the Ministries of Health for the three zones, allowing them to present current situations in their areas of administrative responsibility and their priorities for health sector interventions. Each ministry was asked to prepare a presentation in advance, according to the following criteria:

- Main current and chronic needs
- Opportunities and constraints to respond to the needs
- Resources available to meet current and future needs
- Capacity of the Ministry of Health (MoH) and main gaps
- Capacity of partners and main gaps
- Priorities for system support and development

The positions of the Ministries of Health for the three zones are covered more extensively in Chapter 2.

### 2.2.3 Afternoon session I - External lessons

The session included a brief presentation by Dr Mounir Faraq (WHO) on health systems development and the drafting of the Global Alliance for Vaccines and Immunization (GAVI) HSS proposal for Somalia that began under WHO leadership in July 2007. The presentation expanded on the concept of health systems, reminding attendees to incorporate resources, organization, financing and management in planning, culminating in delivery of services to populations. Dr Faraq defined the six essential building blocks of health systems as governance, financing, human resources, service delivery, health technology support (including medicines and materials) and health information support.

Dr Faraq also reviewed lessons learned from contracting out- and in- services. Contracting out does not mean privatization. Clearly delineated contractual relations around clear deliverables are an effective way to structure some aspects of the health system, but this is a means and not an end in promoting public health outcomes.

Rob Yates of DFID made a presentation on the importance of measurement and data analysis.
feeding into planning and decision making, to enhance overall health sector performance (see Chapter 3).

An important presentation was made by Ahmed Jan Naeem from the MoH Afghanistan and Dr Momin from WHO Afghanistan, on lessons from their recent experience of recovery. These sessions are discussed more extensively in Chapter 3.

2.2.4 Afternoon session II - Somali sector analysis

The final session included a presentation by Dr Suraya Dalil, chief of Health and Nutrition for UNICEF, on findings from the most recent Multi-Indicator Cluster Survey (MICS) survey for Somalia (see Chapter 2).

Enrico Pavignani made a presentation on the Joint Needs Assessment for Somalia (see Chapter 2).

Lastly, there was a presentation by Austen Davis (UNICEF) on behalf of Emmanuel Capobianco of The World Bank, on results of a recent World Bank study on donor financing of the health sector in Somalia (see Chapter 4).

2.3 Day 2: New approaches in Somalia, and setting collective priorities for health sector reform

2.3.1 Session I: New approaches to health sector development in Somalia

Presentations were made on a series of new programmes aiming to take a more systems-oriented approach. Documents and proposals were circulated in the workshop binder (see Annex II for contents).

- **COOPi - Lot 1 Hospital and primary health facility support in two regions of Somaliland (Togdheer and Awdal)**

COOPi presented their two-year EC-funded health services strengthening programme in Somaliland. The COOPi programme supports hospitals in Burao and Borama, as well as a network of maternal and child-health clinics. The programme has a long history of involvement in these regions and hospitals, built under the recognition of a long list of constraints to health system development and quality service provision. The primary aim of the programme is to expand access to quality health care through provision of support to salaries, drug supply, recurrent costs and technical capacities of hospitals and MCH management. Programme interventions are designed to sustainably enhance capacity and resources to deliver health services. Reflecting the wide range of constraints, the programme has an extensive broad-based training plan aimed at various cadres of staff. The programme also aims to enhance supervision and management through strengthening of the Regional Health Offices, supporting regional Ministry of Health and Labour (MoHL) staff in leading and managing the regional health system. The programme should work in synergy with the Ministry of Health and Labour (MoHL), the LATH consortium and Lot 3 on different aspects of the same problems, to better address various bottlenecks in the health system. In particular, the programme intends to cooperate with development and implementation of a standard services package, and in developing the Health
Management Information System (HMIS) (Lot 3) while linking on-the-job training to formal training and certification (LATH).

- **COSV – Lot 2** Hospital and primary health facility support in Puntland and Central South Somalia

COSV has been actively working in Somalia since the late 1980s, and in the Lower Shabelle region since 1993. This long history of engagement has given COSV a decisive advantage in operating in the Somali context (i.e. knowledge, relationships and lessons learned).

COSV is the lead implementing agency in a consortium of NGOs providing support to regional health systems in Puntland and Central South Somalia, providing support to hospitals and health systems in Lower Shabelle in:

- 6 districts
- 1 regional hospital
- district hospitals
- TB centres
- 17 health posts

COSV is working to support management and accountability of the health system through formation of a regional health board, district health boards and village health committees. COSV also supports the regional hospital in Jowhar.

CISP provides support to hospitals and primary health facilities in central Somalia, supporting the Eldhore hospital and a network of other health facilities in the region.

Action Africa Help provides support to the hospital and primary health facilities in the Bosasso/Bhari region of Puntland.

The programme aims to develop an essential package of services in all hospitals, with a special focus on obstetrics/gynaecology and mental health services (with assistance from UNA/GRT).

The multi-region programme is managed and overseen by COSV. As the lead agent, COSV seeks to provide greater synergies and learning between the different regions and to work with Lot 3 in providing these.

- **UNICEF – Lot 3 - Health systems development**

UNICEF is the lead agency implementing Lot 3, which is an ambitious programme for total health sector development, conceived and designed in a period when there was greater optimism for a political solution to the problems of Somalia, and plans for a large donor conference to raise significant rehabilitation and reconstruction funds.

Lot 3 was envisaged as a small first step on the path to total system reconstruction, yet has a bold vision of engaging with the main building blocks of the health system in Somalia, i.e. governance and leadership, health financing, human resources, basic service provision, supervision and management, health information systems, and infrastructure and supplies (equipment and pharmaceuticals).

Given the current situation, with no political solution in sight and no major increase of funds foreseen, the Lot 3 project as originally designed has become less relevant. There is a need to re-orient Lot 3 towards a more limited and useful set of actions prioritized by current health actors and their relevance. This workshop has been organized to initiate the Lot 3 grant and to generate a consensus in focusing Lot 3 actions on a shared acceptance of current priorities.

UNICEF would like to make this a participatory process, through listening to authorities, NGOs and health service providers, seeing what can be provided to create an enabling environment allowing
health systems to move forward and produce improved outcomes. That is in part what this meeting was about.

- **LATH – Presentation of the DFID funded consortium (LATH/THET/KCH/RCOGIO/SC-UK/Health Unlimited). Health systems strengthening with an initial focus on Somaliland.**

  The consortium is managed by Liverpool Associates of Tropical Health (LATH) in collaboration with implementing partners. The programme was developed through long experience in Somaliland and consultations with contacts and partners, and was endorsed by the MoHL. It is a two-year programme focusing on institutional development and human resource development, with a strong link to Lot 3. The main foci are to build institutional capacity in training health staff, enhance capacity of professional associations in regulating health professionals, develop capacities and skills of primary health care workers, and develop a programme of health communications.

- **UNICEF – Presentation from the Global Fund (GF) Malaria coordinator on the GFATM R6 plans for development of Health Management Information Systems**

  The GF is a performance-based funding tool. As it requires information to guide investment decisions, the GF wishes to invest in HMIS to increase available information for enhancing needs and performance assessments, and to incorporate HSS components in the GF approach (HMIS identified as a key area for systems development in Somalia).

  The GF has invested funds in HMIS as a means of promoting evidence-based decision making, starting at the basic level of defining data needs and tools, and building data flows and analysis platforms. The programme aims to test HMIS systems in three districts (one in each zone), developing a model system that can be activated after a two-year design and testing phase. If the programme performs, there is a possibility of rolling out the system through training and support.

  The programme supports development of HMIS units and regional capacities in all zones, as well as technical assistance through Comitato Collaborazione Medica (CCM). UNICEF will also have a full time HMIS expert providing leadership to the overall programme, working in close collaboration with the Lot 3 programme.

- **WHO (Dr Mounir Farag) - GAVI HSS Proposal**

  WHO began developing a proposal to GAVI for HSS in July 2007. The purpose of the GAVI HSS funding is to develop national health systems, increase peoples’ access to quality health services, and to expand and sustain vaccination coverage.

  Factors in the successful application for GAVI HSS funds have been political, as well as partner commitment and the use of a broad and inclusive process. Activities have been designed in the context of over-arching national policies and plans aligned to national priorities.
Khadar from the Ministry of Health and Labour Somaliland (MoHL SL) asked for clarification of the process and how local MoHs would be able to participate.

Dr Esse from MoH TFG mentioned how previous processes had been exclusive, establishing priorities not shared by counterparts in Somalia.

WHO and UNICEF representatives pointed out that investments are service-directed and should promote coverage of vaccination and consumption of basic health services.

Imanol from ECHO pointed out that SACB/SSS had been an extremely important technical forum for ensuring process, coordinating diverse partners, managing fund raising and priority setting. MoHs should be aware that significant money was raised only because this mechanism existed and should be protected and not seen as in opposition to their interests.

2.3.2 Sessions II/III/IV: Break-out groups: Priorities for health sector development

The last three sessions were organized into smaller working groups in which participants reviewed key elements of the Somali health system, focusing on:

- Coordination and leadership: authorities, donors, UN, NGOs.
- Health financing (with a focus on equity).
- Human resources – recruitment, training, deployment and salaries
- Basic service provision.
- Health Management Information Systems (HMIS) and information for decision making.
- Supervision and management.
- Supplies – equipment, pharmaceuticals.
- Regulation (protection) and a look at private and public opportunities and threats.

The key discipline suggested to participants was to focus on achievable key actions prioritized over a two year period.

2.4 Day 3: Plenary sessions: Hard choices and feasible priorities

The third day was dedicated to developing a plan of action that was practical, focused, sensitive to difficult contexts and aware of limitations and constraints, yet realistically ambitious.

2.4.1 Session I: Presentations by MoHs - Top priorities (5) for immediate action

The ministries once again presented their focused set of respective priorities for health service and systems development. While it was recognized that the different zones were in different stages of stability and development, it was also remarkable how coherent the priorities were. The priorities of the MoHs are discussed in more depth in Chapter 2.

2.4.2 Session II: Summary session – An overall consensus

Following presentations by the representatives of the three Ministries of Health, the group discussed the outcomes of the two days of work and recommendations. There was a broad-ranging discussion (see Chapter 5).
2.4.3 Workshop Closure by Christian Balslev-Olesen (Country Representative, UNICEF Somalia)

Christian Balslev-Olesen thanked the participants for their energies in confronting such a difficult topic, leading to a successful workshop during which a lot of energy was put into the whole process by many people. The group had to face hard realities and differences of position and opinion, but there was a general common analysis of the challenges faced together. The way forward is further discussed in Chapter 5.
3.1 Major health needs in Somalia today

Suraya Dalil (UNICEF) presented findings of the recent MICS for Somalia, intended to provide quality information for national planning and priority setting both to government and planners, and to track progress towards the Millennium Development Goals.

The MICS 2006 survey is their third since 1990, showing continuing high mortality rates for mothers, children and infants but a significant reduction from previous surveys (conducted using other methods). Under-five mortality is estimated at 135 per 1,000 live births (down from 224 in MICS II in 2000) and infant mortality at 53 per 1,000 live births (down from 132 in MICS II in 2000). Maternal mortality ratios were at 1,044/100,000 live births.

Mortality rates differed by zone, with the highest occurring in central South Zone and the lowest in Somaliland, showing an association with stability, absence of conflict and improved governance.

The MICS 2006 survey also indicated extremely poor coverage of basic high impact public health interventions (exclusive breast feeding, vaccination, Vitamin A supplementation, management of diarrhoea, treatment of fever and pneumonia) as well as high rates of background malnutrition and poor access to potable water, improved sanitation facilities and basic hygiene practices.

This indicates there are major improvements in mortality that can be reached through simple strategies to improve coverage of basic services. Action must occur outside the facility (as there is such poor utilization of public health facilities) and in collaboration with other sectors (food and nutrition, as well as water, sanitation and hygiene).

The health sector partners found the drop in mortality rates hard to explain, but nevertheless found most of the information to be accurate, reflecting their perceptions of the current state of the health sector.

The MoHL in Somaliland endorsed the findings as being very similar to results coming out of their own HMIS system.

3.2 The Joint Needs Assessment (JNA)

Enrico Pavignani (WHO, and a member of the JNA drafting team) presented on the Joint Needs Assessment (JNA) organized by The World Bank and UNDP, which feeds into a possible donor conference pledging large-scale multi-year grants for reconstruction of Somalia. The JNA took place over 18 months, discovering in the process that there was
very little accessible formal information and that much information had to be extracted from recipients either through lengthy interviews or from field reports.

The JNA analysis fed into a process of defining Reconstruction and Development Plans with the various authorities of Somalia. This large and inclusive process was intended to define collectively generated and legitimate national development plans.

The JNA was subdivided into clusters, in one of which health was incorporated as a sub-cluster: “Social services and protection of vulnerable groups”. The sub-cluster report for health was created through an inclusive process of analysis and discussion with Somalis from government, the private sector and international NGOs. The resultant sub-cluster health strategy paper gained broad support from health sector partners and the Health Sector Coordination Committee (despite reservations expressed by the HSC about how the sub-sector report was presented in the JNA).

The health sector is highly fragmented and disorganized. In order to reconstruct the health services and to fashion a coherent, effective, efficient and equitable health system, it would require:

- sustained, collective efforts;
- enlightened leadership; and
- massive resources.

Some of the current main problems are - insufficient information to guide rational decision making and resource allocation; unclear institutional futures; neglect and insufficient support; an unregulated private system; and fragmentation of the international programme of support, both horizontal (area-based) and vertical.

This leads to a vicious circle of insufficient resources, capacity and information, resulting in poor performance. Poor performance leads to under-investment, which perpetuates insufficient resources, capacity and information.

In order to progress we need to encourage increased investment, prioritize ruthlessly and invest in achievable objectives. Plans must not be comprehensive and complex; they must be simple, direct and flexible in order to respond to experiences and changing conditions. Dr Pavignani suggested a start must be made, so it is important not to be daunted or to give up before the process begins.
There are opportunities to be found during crises, such as freedom to start afresh. It will take a long time, but here is a menu for the first two years:

**Agenda for 1st two years**

<table>
<thead>
<tr>
<th>Financing</th>
<th>HR</th>
<th>Medicines</th>
<th>Infrastructure</th>
<th>Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Health expenditure review</td>
<td>- Establish autonomous certifying body</td>
<td>- Establish independent non-profit purchasing agency</td>
<td>- Assemble database of facilities and their status</td>
<td>- Formulate a BPHS*</td>
</tr>
<tr>
<td>- Establish performing aid tools</td>
<td>- Build database of health workers</td>
<td>- Encourage regional drug supply agencies</td>
<td>- Prioritize rehabilitation agenda</td>
<td>- Conduct study of private providers</td>
</tr>
<tr>
<td>- Inject funds to cover recurrent costs</td>
<td>- Negotiate common salary scale</td>
<td>- Finalise essential drug lists, standardise and introduce treatment guidelines</td>
<td>- Develop standardised blueprints for facilities</td>
<td>- Explore how to serve nomads</td>
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<td></td>
<td>- Negotiate standardised contracts</td>
<td></td>
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<td>- Identify realistic ways to improve quality of services</td>
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<td></td>
<td>- Assess health training network</td>
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<tr>
<td></td>
<td>- Review in-service training activities</td>
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* Basic Package of Health Services

If we had achieved these goals during the first two years, we would now be placed for a leap forward. We would have experience, information, tools and the beginning of a real dialogue on policy.

In subsequent years we need to work on:

**Agenda for 3 – 5 years and beyond**

<table>
<thead>
<tr>
<th>Health information &amp; policy analysis</th>
<th>Policy</th>
<th>Planning</th>
</tr>
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<tbody>
<tr>
<td>- establish an autonomous health policy analysis unit to monitor and learn from lessons</td>
<td>- launch a policy formulation exercise</td>
<td>- design and introduce modern management and regulation systems</td>
</tr>
<tr>
<td>- design a modern HMIS and implement</td>
<td>- negotiate a sustainable and equitable financing strategy</td>
<td>- formulate a health systems network development plan: – staffing management, supply, infrastructure</td>
</tr>
<tr>
<td></td>
<td>- formulate a pharmaceutical policy</td>
<td>- formulate an HR development plan.</td>
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3.3 The Ministries of Health – priorities for the zones of Somalia

The three Ministries of Health (MoH) each presented on the current state of health systems in their areas of administrative responsibility and suggested main priorities for intervention.

The presentations were of a high quality and represent a remarkable outcome of this workshop, i.e. a consolidated analysis of the health sector by the different Somali administrations. Presentations are included in Annex IV.

The MoH TFG Somalia presented an overview of the basic health service network, with facilities, their locations, and human resources by region. The MoH TFG then outlined schools for training of health staff in nursing (nine) and medical schools (three).

The MoH TFG reflected on the poor health status of the population, the frequent epidemics (especially of water-borne and communicable diseases) and high background levels of malnutrition. The health system has very low output and performance levels, and very poor returns on investment.

There is an extreme lack of comprehensive emergency obstetric care (exists in only three towns) available to women. In addition, there is general over-focus on hospital-level care, and lack of access to basic care for poor, rural and nomadic communities.

Health service networks are not managed, in part due to inability to form and support decentralized political administrative platforms.

The MoH TFG concluded that health care is financed via donor programmes and out-of-pocket expenditure. There is no public involvement or influence over financing of health care, which is the most significant challenge and almost matched by the scale of that of human resources. The workforce is old, under-trained, poorly differentiated, unstructured and poorly managed. Furthermore there is a huge amount of reconstruction and rebuilding required to renovate the health services network.

The Ministry of Health Puntland (MoHPL) also discussed the collapse of the State and the subsequent collapse of public services. They described their efforts to regulate and manage the health system, but the complete lack of valid information makes any real planning impossible. Furthermore, lack of governance institutions (especially at the regional level) make it almost impossible to deliver or supervise services.

They have negotiated a regulatory mechanism with the private sector (but it does not function), established rudimentary early warning outbreak and surveillance systems, and adopted decentralized management at the regional level - but none are adequate to create and sustain accessible quality care.

The MoH Puntland admitted that, without basic systems, leadership and partner coordination are meaningless (e.g. drug lists, common procurement processes, HIS, baseline data).

The health system is underdeveloped and referral systems do not function, reducing relevance of the overall system to people’s needs. This is of particular relevance to the poor and women, whose needs are especially dependent on a functioning health and referral system.

There is no real public finance (< 2% of a small national budget) and no public control of financing of the system. Health workers are old, under-qualified and under-managed (certification, job descriptions, salary scales, etc.). There is no HIS, and inadequate quality of basic health care in the lower-level facilities.

The MoHPL reaffirmed their commitment to developing quality health services for all, with a focus on maternal and child health services.
The Ministry of Health & Labour Somaliland (MoHLSL) gave an overview of their demographic situation and administrative structure, starting with a short history. Between 1991-1996 they were still in an emergency phase, with good services provided by international NGOs. It was only after 1998 that they began a process of health sector reform, consisting of transferring responsibility to the Somaliland MoHL. From 1999-2001 was an intense period of systems analysis and development of documents, plans, and strategies, in which outputs were strongly owned by the Somaliland population. There was a pragmatic five-year plan for basic service delivery network development, as well as construction of fundamental support systems (drugs, management, HR). Various statutory bodies were created, and cost recovery systems were introduced as the MoHL began to decentralize to the regions (with plans to further decentralize to districts), but much remained on paper as funding never materialized.

The MoHLSL presented an overview of the health service network and HR base and data on the national health budget and expenditures, as well as financing patterns of major hospitals (including cost recovery inputs). The MoHLSL also presented the bewildering disorganization, assumed high transaction costs and inefficiencies of the international financing of health (in small amounts for short periods, through too many partners).

Key challenges were outlined. The system is under-financed, poorly staffed and very under-utilised, resulting in the majority of the population, especially in rural areas, having no access to, or not using, modern health care. There is almost no referral within the system, leading to major inefficiencies, lower demand and significant challenges facing maternity services.

Weaknesses of the system occur over all aspects: HMIS, financing and accounting, drugs procurement and delivery systems, HR management, infrastructure, supervision, regulation and accreditation.

**Priorities of the three MoHs**

<table>
<thead>
<tr>
<th>TFG priorities</th>
<th>Puntland priorities</th>
<th>Somaliland priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>policy and system design</td>
<td>develop health policy and regulations</td>
<td>human resource development, planning, production and management</td>
</tr>
<tr>
<td>health management structures</td>
<td>develop capacity of system to deliver basic package</td>
<td>establish SL Pharmaceutical Corp (procurement agency)</td>
</tr>
<tr>
<td>sustainable financing mechanism</td>
<td>develop financial and technical assistance</td>
<td>invest in a BPHS</td>
</tr>
<tr>
<td>develop HR4H capacity</td>
<td>support and motivation for HR</td>
<td>develop service delivery management system</td>
</tr>
<tr>
<td>rehabilitation of management and service delivery infrastructure</td>
<td>develop training plan for medical staff</td>
<td>introduce pooled funding to reduce transaction costs of int'l financing</td>
</tr>
<tr>
<td></td>
<td>Improve collaboration with other ministries</td>
<td>develop capacity of MoH to lead</td>
</tr>
<tr>
<td></td>
<td></td>
<td>develop tech and operational capacities of regulatory bodies</td>
</tr>
</tbody>
</table>

*Priorities of MoHs in Puntland and Central South are virtually identical.*
Post-presentation discussions focused on the substantial lack of resources, information and management. In certain regions of Somalia it would be difficult to conclude that there is a health system. Any analysis of needs or gaps in the system throws up more needs than structure. While there are genuine advances, triumphs and opportunities, the scale of needs makes it hard to prioritize or know where to start. Any single investment seems to fail due to inadequacies somewhere else.

The lists of priorities by the Ministries (presented above) could be said to cover most of the “building blocks” of the health system. There is a need to prioritize ruthlessly, with a clear and sequenced plan of action. A debate ensued as to whether this should focus on capacity and institution building, or on providing services to people. The general opinion was “both”, i.e. limited investment in leadership and HR development, with a primary focus on developing the basic means to deliver services, increasing both quality and coverage of services.

*It would be the challenge of the next few days to define with greater precision what is required, in what sequence and with what priority.*
4.1 Effectiveness, Efficiency and Equity – the bottom line

Rob Yates of DFID presented on the importance of using data to drive decision-making on resource allocation in health systems. He argued that the Somali health system was one of the most under- and chaotically-funded health systems in the world, making it all the more important to use scarce resources wisely. He discussed how to measure health sector performance (inputs, process indicators, outputs and outcomes) and argued that it was outcomes that mattered and are of special interest to donors, and must ultimately be taken into consideration.

It is hard to measure actual outcomes and even harder to allocate them to specific interventions; therefore in order to approach an understanding of the efficiency of health investments, we must choose output indicators that are directly related to achieving outcomes, are simple to measure and understandable by a wide user audience (including politicians and donors).

What indicators should we use? Rob presented the use of outpatient utilization rates (overall use and coverage of health system); DPT3 utilisation rates (repeat use indicator); percentage of deliveries attended by skilled personnel or percentage delivered in health facilities; and hospital admission rates.

He then defended these choices with graphs illustrating a very strong association between child mortality rates and number of outpatient visits per year (i.e. effective MCH services are important).

He also argued that to have a better impact we need to increase consumption of quality health services, providing affordable and accessible services to people. This means that health service consumers will shop around for what, in their judgment, is the best deal (quality, cost and ease/pleasantness of use).

Data from Uganda showed the enormous impact of abolishing user fees; utilization climbed steadily over the following five years and overall population-based output figures improved markedly (DPT3).

As outpatient department attendance increased significantly, the overall cost of running the health system also increased, but there was an overall improvement in efficiency and equity. Utilisation rates were so low that staff were under-occupied. When patient numbers increased, staff began to work harder (use more drugs, transport, etc.) so costs increased - BUT there was a much larger return on investment, overall population health improved, and 50% of the benefits of this policy choice were captured by poor people. These improvements in utilization, efficiency, effectiveness and equity of the health system have been seen over and over again in different countries.
when user fees are abolished (examples were given from Zambia and Burundi).

This kind of data is needed in real time, as it is the information that affects major decisions. Comparable data (like district league tables) are needed to be able to compare performance and see input and output differences. Health systems need to be driven by decisions and informed by practical realities.

Project support is far less efficient than health system support, as so much funding is consumed on overheads, technical assistance and grant management, but there are certain conditions for system support.

The presentation showed findings from various evaluations that it is the poor who suffer when user fees are imposed, and that health systems do not raise much revenue from levying them (5–10% of total recurrent expenditure) as well as adopting significant transaction costs in terms of management. The presentation concluded that user fees were inefficient and inequitable and should not be supported. Investments in Somalia must be effective (increase consumption of quality care), efficient (increase outputs for relatively low cost) and equitable (ensure the poor can also meet their needs). In countries like Somalia, where there is almost no financing, what other options are there?

*Our programmes must result in increased utility for end users!*

### 4.2 Reconstructing failing health systems – the case of Afghanistan

The Afghanistan case is very famous today, but it is not the only case history – there could be other countries with relevant case histories and perhaps a broader analysis of all countries would be more realistic. Enrico Pavignani and others are busy doing this and a manual is being developed (a draft copy was distributed on disc). In addition, there are increasingly more tools available such as the Benjamin Loevinsohn toolkit presented in the binder (see Annex II).

Ahmed Jan Naeem played a critical role in the reconstruction of Afghanistan’s health system in the period immediately following the fall of the Taliban. In 2003, Afghanistan was emerging from two decades of war. There was no central government, there was brain drain and poor infrastructure, and only isolated instances of health care were provided through cross-border NGO programmes. The public health situation was a catastrophe, with very high maternal mortality ratios, under-five mortality rates, malnutrition and anaemia.

The central government had no norms or standards, no priorities, no framework for providing health services and a failing healthcare network. The health system as it existed composed of a highly centralized MoH, a few hospitals in urban centres and virtually no rural services where they were most needed.

There was a series of high-level donor missions and analyses. The MoH agreed to a role as steward (not primary provider) and began to assemble partners to define a package of essential services focusing on cost-effective basic services that could be extended to rural areas. This BPHS was the core instrument for health systems reconstruction, allowing:

- redistribution of health care resources to rural areas
- a framework for defining priorities and guiding decisions (the decision not to implement left the MoH free to lead decisively), and
- a focus for collective action, channelling the energies of a multitude of partners (MoH, communities, NGOs, donors).

The success of the BPHS was directly associated with major reductions in mortality, as well as increased population confidence in governance and peace. The BPHS allowed everyone to work together effectively
to provide good health services, but it required a lot of support work. Many professionals were recruited from surrounding countries, new cadres were defined and trained, trained staff were supervised in their positions by trainers, curricula were altered to reflect a shift towards PHC, more women were enrolled, yet there is still a human resource problem (a lot of work was needed to make the BPHS a reality).

The above presentation was followed by one by Dr Momin (WHO Afghanistan) on lessons for recovery in post-conflict states.

The first phase of reconstruction was to try and raise pledges for considerable investment funds, spread over an appreciable time frame. The second phase was to organize donors to back a single health strategy.

4.3 Summary of major lessons from overseas

- Investment should concentrate on increasing consumption of quality services by the population.
- All interventions should consider how they contribute to the effectiveness, efficiency and equity of health service provision and consumption.
- Charging user fees is ineffective, inefficient and - worst of all - inequitable.
- If minimum conditions exist, the most efficient investment is to support health systems – not projects or vertical programmes.
- In Afghanistan the MoH decision not to provide services but to act as a steward allowed them to concentrate on a decisive leadership role.
- Exercising this role, the MoH created a framework for action and a set of priorities that promoted effective collaboration and coordination of a diverse array of actors (leading to increased efficiency).
- This decision also promoted the possibility of constructive accountability between MoH and service provider partners.
- Adoption of the BPHS allowed redistribution of resources from hospital level care to more cost-effective basic care from urban to rural areas.
- Increasing consumption of basic services (particularly among the poor) led to dramatic declines in mortality rates as well as increased popular support for sustained peace and government.
- The role of leadership and governance of the MoH was at least as important as service provision – the MoH needs to free up capacity to take this role.
- Government leadership and dynamism was supported by a broader process of public sector reform – without reform of the civil service, government performance cannot improve.
- Performance management was critical to success in contracting-out and contracting-in arrangements.
- Contracting may be used in the short term to rapidly expand access and allow the MoH to focus on leadership and accountability roles; in the longer term, government may be the service provider if public reform is effective.
5.1 World Bank review

A presentation was made on recent funding by traditional donors of the Somali health care sector.

Conventional donor funding grew almost three-fold between 2000 and 2006 ($23 million → $60 million). Per capita funding rose from $3 to $7, representing a shift to a reasonably high level of donor investment in comparison to other, similar contexts.

Distribution of funding was roughly proportionate to population estimates for the three zones. However, the increase in funding over the period surveyed was largely due to major funding increases for polio and from the GFATM. Vertical programme financing increased significantly, while other funding to health systems or public health priority areas either stagnated or declined.

Major public health priority areas neglected in terms of financing were expanded programmes of immunisation (EPI), reproductive health, and nutrition. Major recommendations included increasing overall levels of aid, making them more predictable and more focused, targeting priority public health areas (see Annex V for a summary of research findings).

The presentation raised a discussion about relative levels of financing. The report acknowledges that some resources were not captured in the analysis from NGOs, and that the Somali diaspora and Islamic charities make important contributions to the financing of the health sector in Somalia. Some sources have estimated that 70% of the entire national income is from diaspora remittances, which are used by households to purchase goods and services including health care (mainly from the private sector). There is a booming private sector, in most urban centres at least.

Overall levels of financing feed into the commonly-held opinion that, from a financing perspective, the Somali health sector gets as much as it can expect.

However, it was pointed out that:

1. The transaction costs of providing services in Somalia are enormous, with most agencies supporting administrations in Nairobi and very high transport, logistic and security costs. This means that the comparable value of the $7 per capita is probably halved ($3.5).

2. Funds are provided for the short term, targeted to small scale projects and are not strategically invested. While it is imperative to maintain capacities for flexible and responsive humanitarian interventions, there is a major need to ensure that some funds are spent in a more concentrated fashion, over longer periods and on more strategic priorities (especially addressing public health priorities, HR and information). This would require greater donor commitment, harmonization and alignment as well as an instrument for promoting management of large-scale, sector-wide funds and interventions.
3. Rob Yates of DFID (a health economist) mentioned that his preliminary analyses indicated that the Somali public health system is one of the most under-funded in the world. In addition, the extremely low levels of funding are not used efficiently nor effectively, and therefore expectations of impacts should be modest.

4. Enrico Pavignani mentioned that the value of the dollar had fallen by one third in real terms during this period, meaning that in real terms there was a two-fold rather than a three-fold increase in funding during this period.

Discussions over equity focused on how to finance the health sector. The limited information we have indicates that the cost of accessing services is a major barrier (the other being distance/transport costs).

- With the majority of families receiving some support through remittances from the diaspora, the better-off have discretionary funds and use them to purchase mainly private health services.
- The poor do not use health services.
- As a result the public sector is expensive and massively under utilized, yet the private sector cannot offer services to rural poor or to areas of low population density. These will remain a public responsibility.
- Primary healthcare systems are able to raise a very small proportion of their recurrent costs through cost-recovery mechanisms. The consequences are barriers to use and increased inefficiencies.
- Hospitals can raise a higher proportion of their recurrent costs through cost-recovery, but public hospitals still need to subsidize catastrophic expenditure for the poor and vulnerable.

In conclusion, it would be more efficient, effective and equitable to provide free services at points of use. Nevertheless, in the current financing situation (very low public budget, low levels of conventional international financing, and remittances sent through a relatively small proportion of the citizenry) it is not feasible to abandon cost-recovery (even for BHC). New ways of financing healthcare need to be introduced gradually where possible.

A summary of the ensuing debate made it clear that:

- There is no major surge in funding on the near horizon - we have to be realistic within current financing envelopes (in fact they may decline).
- There is a reasonable level of health care funding but it is poorly invested and has very low return on investment. There is a major need to address how and on what funding is spent.
- Very clear priorities are needed, so future funding may be better-directed.
- There is new funding for some new programmes through Lots 1, 2, 3 and the DFID LATH/THET programme, and some other initiatives. We have to take advantage of what there is and work with it to improve health outcomes for the majority.
- To do this, we must focus on increasing access to BHC for the majority of the population. A genuine commitment to delivering BHC and improved performance is a priority.
- Waiting for major new funding is unproductive. Demonstrating political will and commitment to achieving things now, with available resources, will impress future donors and improve the case for further investment.
- Future investment in health depends on demonstrating improved performance and full accountability. i.e. fund ->deliver->demonstrate->increased funding
The way forward; immediate priorities for intervention at the health sector level in Somalia

6.1 Top five priorities of the three MoHs

The MoHs from Puntland and Somaliland presentations confirmed that they were committed to establishing effective, nationally-led health systems for their people. Both ministries claimed their governments were committed to regulation of the private sector, decentralization of health system of management to regional offices, and increasing health budgets through their national budget processes to 6% in the next three years.

The MoH TFG made similar commitments, but could not commit to an increased budget at the current time as there was no effective national budget.

Each ministry underlined the importance of continuing investment in institutional development to allow them to take up a leadership role, fulfil their obligations to effective regulation and protection of public safety, and set standards for effective coordination. Each ministry understood that for the next few years they would need to rely on the capacity of non-state actors for provision of services. The role of the MoHs was still very much in need of definition - all agreed that the focus must be on providing services to the people, but underscored the need for focused investment in state structures, and enhanced collection of information for effective decision-making, practical coordination and stewardship.

Each MoH was in need of technical assistance and investment in order to fulfil their role, which need to be developed with consideration of public sector reforms managed by UNDP and The World Bank, in collaboration with local counterparts.

Each MoH thanked participants for an important workshop that had assisted them in identifying what is at stake and realizing the scope of the agenda ahead, as well as their roles and responsibilities. They acknowledged the enormity of the tasks, but accepted that a start must be made. Each ministry made a separate summing-up presentation with their most important specific priorities (attached in Annex VI to document MoH positions).
The three MoHs presented the following list of priorities (many with more specific actions under each heading – see Annex VI):

<table>
<thead>
<tr>
<th>PRIORITY</th>
<th>SOMALILAND*</th>
<th>PUNTLAND</th>
<th>TFG SOMALIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Essential package of health services</td>
<td>Health financing</td>
<td>Health financing</td>
</tr>
<tr>
<td>2</td>
<td>Health financing</td>
<td>Human resources</td>
<td>Human resources</td>
</tr>
<tr>
<td>3</td>
<td>Governance</td>
<td>HMIS</td>
<td>HMIS</td>
</tr>
<tr>
<td>4</td>
<td>Infrastructure</td>
<td>Supervision and management</td>
<td>Supervision and management</td>
</tr>
<tr>
<td>5</td>
<td>Supplies</td>
<td>Coordination (of donors, UN and NGOs)</td>
<td>Coordination</td>
</tr>
<tr>
<td>6</td>
<td>HMIS</td>
<td>EPHS</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Coordination</td>
<td>Supplies</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Human resources</td>
<td>Private and public regulation</td>
<td></td>
</tr>
</tbody>
</table>

* Somaliland stressed their list was not prioritized, and had previously stressed that investment in human resources was their No. 1 priority.

6.2 Summing up

The crisis over the past 17 years and lack of governance has left Somalia weak, destitute and prone to natural disasters, external influences and political collapse. Whilst some might benefit from the status quo in the short term, all eventually suffer as the fabric and structure of social life falls apart. No one suffers more in the harsh realities of Somalia today than women and children.

This conference was unusual in view of the current stage of the Somalia crisis; studies show how important it is to plan for future possibilities, even in the midst of war, but this rarely happens. The EC has taken a big risk in adding Lot 3 to their traditional service delivery projects (Lots 1 and 2), but some respondents felt this was a very welcome risk.

There is a total lack of health care financing. Without adequate funding, not much can be initiated, steered, investigated and/or reformed. In addition to the low financing levels that condemn the Somali health system to inadequacy, inefficiency, ineffectiveness and inequality, financing is poorly targeted, unpredictable and ineffectively used. Very little is achieved with existing funding, which does not inspire donors to give more.

The health sector is trapped in a vicious circle of limited finance poorly targeted, resulting in poor outcomes, leading to reduced confidence which further limits financing. The only people who can reverse this trend are those working in the health sector. They must enhance leadership, coordination, realistic planning, dedicated supervision and evaluation and demonstration of successes.

None of this is possible without a shared vision of the way forward and a sense of responsibility. This can only be effectively generated by government. The Ministries of Health need to take this role and to execute it authentically, prioritizing their leadership role over all others and generating a sense of mission and responsibility in providing services to the people of Somalia behind which the community of actors can organize.
Government leadership is the sine qua non for improvement to occur and for increased levels of predictable funding, reduced investment in vertical projects and agency self-promotion.

Donors have made it clear that there are no major new investments on the horizon. All are aware that the health system is critically under-funded, but a certain level of funding exists and it is the collective responsibility of the health sector to demonstrate that it can work and that there is a vision and a framework to invest in the future. If that is done, donors will perhaps begin to support the health sector more constructively.

This implies that there is a great need for invigorated coordination able not only to raise funds, but to channel and smooth funding to increase involvement and coherence of action, and reduce institutional self-interest.

There is a desperate need for effective staff to remain in the health sector in Somalia. All institutions (Somalia and international) must try to put such staff in place and encourage them stay. We must also produce information to prove better performance and enhance decision making.

Do not start from scratch. Build on what exists locally and is successful, and locally accepted.

6.3  A final agreement

The participants agreed on a limited set of actions for the next two years, focusing on (i) specific actions in the development of central institutions, (ii) development of human resources for health, and (iii) delivery of basic services.

The first step in this process would be to develop a BPHS on which all other human resource development and service delivery initiatives will depend. Much has already been developed, and there is no need to reinvent the wheel (there are other country packages to draw from, as well as past work from the Somali sector). What is needed is technical assistance to consolidate past work, generate consensus, and a path for implementation (involving some work on costing).

The second greatest area of need outside service delivery, is investment in human resource development, but this has to be expanded to incorporate other cadres (not just medical doctors and nurses), ensuring that these trained staff enter the public network with realistic salary scales and certification, can be managed, and to incorporate women in the health workforce.

Attention was also paid to cross-cutting issues of financing, information and coordination, all of which must be revitalised in order to make collective advances. Coordination has to work to make disparate investments more holistic and synergistic. The participants of the workshop agreed to forward the following common prioritized agenda:
6.4 Closing the workshop

Christian Balslev-Olesen said it was a privilege to attend the workshop, where he had seen the intensity of input and feeling by the participants and had begun to understand the deep commitment of so many partners and the problems facing the sector.

He mentioned that no-one had wanted to take on the EC-funded Lot 3 fund, which was a huge challenge. UNICEF had tried in the past and all plans had been dashed by the vagaries of the Somali situation and shifting commitments of donors and actors, resulting in UNICEF itself not wanting to manage this programme, although he recognized it was needed.

Someone has to address the task of creating foundations for emergence of an effective health system, and for the people of Somalia (especially the women and children) there is no time to waste. Christian was pleased to see such a positive start, and had found new hope in this collective spirit and sense of commitment to what is possible. He felt the key message was that each partner must make pragmatic commitments and then stick to them.
Annex

List of Participants

Afghan MoH
Ahmad Jan Naim

AMREF
Donald Odhiambo
Nzomo Mwita

COOPI
Paola Grivel
Gemma Sanmartin
Dr. Ahmed Askar
Annita Owino

COSV
Francesco Metti
Dr. Alberto Leone
Dr. Mohiddin Gure

DFID
Rob Yates
Rachel Drew

EC
Paula Vazquez-Horyaans
Manfred Winnefeld
Andrea Berlofa
Edda Costarelli

ECHO
Imanol Berakoetxea

SSS - HSC/HSS WG
Rosemary Heenan -Gedo Health Consortium

Italian Cooperation
Renato Corregia

LATH
Angela Brown
Sheila Waruhiu

MoH Somalia North East
Abdullahi Yusuf Ismail
Abdi Ibrahim Warsame
Abdikafi Shire Mohamed

MoH Somalia North West
Khadar Ahmed.
Hon. Abdi Abdillahi Ali

MoH Somalia South Central
Dr Esse Weheliye Malin (Vice Minister)
Dr Mohamed Hersi Duale (Perm. Sec.)
Dr Abdi Awad (WHO technical advisor to the MoH)

RED CROSS
Dr Ahmed Hassan – SRCS
Ed Cooper - IFRC

SC UK
Dr Nadeem Jan

THET
Karen Peachey
Catherine Novi

UNICEF
Christian Balslev-Olesen
Siddharth Chatterjee
Suraya Dalil
Austen Davis
Awil Haji Ali Gure
Abdirahman Yusuf Muse
Willis Ouma
Tanya Shewchuk

USAID
Connie Davis

WHO
Dr Fouad Mojallid
Dr. Enrico Pavignani
Dr Mounir Farag
Dr Abdi Momin
Dr Assagid Kabebe
Mark Beesley

World Bank
Sibel Kulaksiz
Wacuka Ikua
1. Somalia Health Systems Documents
A. JNA sub-cluster report on health
B. Health Policy Mapping – JNA summary March 2005
C. Health System Recovery and Development Matrix. SSS: HSS wg 09/07
D. SACB Strategic Framework in Support to the Health Sector

2. New Health Sector Proposals
A. EC Lot 1 Project Documents
B. EC Lot 2 Project Documents
C. EC Lot 3 Project Documents
D. Health Systems Strengthening in the Somali Republic. LATH/King’s College/THET/RCOG Int. Office/SC-UK/Health Unlimited Proposal

3. Health System Capacity Building
A. Identification for Capacity Building Interventions for Local Health Authorities in Somalia. M. Burns 02/04

4. Human Resources for Health
A. Possible Strategies for HR Development in Somalia (SACB 01/02)

5. Basic Package of Health Care
A. BPHS Afghanistan
B. BPHS Hospital Afghanistan

6. Performance Based Service Provision
A. Performance Based Contracting For Health Services In Developing Countries – A Tool Kit. Draft 07/07. B. Loevihnson. World Bank.

7. Health Sector Financing
**Workshop Agenda - Health Sector Development for the Somali People 2007 - 2009**


**Day 1: Wednesday 5th September**  
**Day Chair: Austen Davis**

**Main Objective of the Day: Introduce the concepts and share information**

<table>
<thead>
<tr>
<th>Time</th>
<th>Persons</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.30 – 9.15</td>
<td>Registration and checking in</td>
<td></td>
</tr>
<tr>
<td>9.15 – 9.45</td>
<td>Paula Vazquez-Horyaans (EC) and Dr Fouad Mojellid (WHO Representative)</td>
<td>Welcome and Introduction to the workshop – Objectives and Expected Results</td>
</tr>
<tr>
<td>9.45– 10.15</td>
<td>Meeting Methods Austen Davis</td>
<td>Introduction to participants. Introduction to the agenda and meeting methods. Practical business – notes, minutes, communications, rooms etc.</td>
</tr>
<tr>
<td>10.15 – 11.00</td>
<td>Representative of MoH Somalia</td>
<td>Each Ministry will present an analysis of: main current and chronic needs, opportunities and constraints to respond to the needs, resources available to meet current and future needs, capacity of the MoH and main gaps, capacity of partners and main gaps, priorities for system support and development</td>
</tr>
<tr>
<td>11.00 – 11.30</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>11.30 – 12.15</td>
<td>Representative of MoH Puntland.</td>
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</tr>
<tr>
<td>12.15 – 13.00</td>
<td>Representative of MoH Somaliland.</td>
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<tr>
<td>13.00 – 14.00</td>
<td>Break for Lunch</td>
<td></td>
</tr>
<tr>
<td>14.00 – 14.30</td>
<td>WHO</td>
<td>Introduction to Health Systems.</td>
</tr>
<tr>
<td>14.30 – 15.00</td>
<td>DFID</td>
<td>Lessons for emerging environments – Performance of Health Systems</td>
</tr>
<tr>
<td>15.00 – 15.45</td>
<td>Afghan MoH</td>
<td>From facility support projects to a health sector approach - the Afghanistan experience.</td>
</tr>
<tr>
<td>15.45 – 16.15</td>
<td>Break</td>
<td></td>
</tr>
<tr>
<td>16.15 – 16.30</td>
<td>Suraya Dalil (UNICEF)</td>
<td>The health profile for Somalia – results of MICS III.</td>
</tr>
<tr>
<td>16.45 – 17.15</td>
<td>Enrico Pavignani</td>
<td>Key lessons from the JNA</td>
</tr>
<tr>
<td>17.15 – 17.45</td>
<td>Discussion</td>
<td>Key points to take to Somalia</td>
</tr>
</tbody>
</table>
### Day 2: Thursday 6th September

**Day Chair: Renato Corregia**

**Main Objective of the Day:** To explore new programmes and their contribution to HSD as well as to define priority areas for key actions.

<table>
<thead>
<tr>
<th>Time</th>
<th>Persons</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00 – 09.20</td>
<td>Austen Davis</td>
<td>Presentation of EC funded Programme: Support to Health Sector Development in Somalia- Capacity Building, Strengthening System Coordination and Performance (Lot 3).</td>
</tr>
<tr>
<td>09.20 – 09.40</td>
<td>Angela Brown</td>
<td>Presentation of the DFID funded LATH/THET/Kings programme.</td>
</tr>
<tr>
<td>09.40 – 09.55</td>
<td>COOPI</td>
<td>EC/ IT Lot 1 – HSD Togdheer and Awdal regions.</td>
</tr>
<tr>
<td>09.55 – 10.10</td>
<td>COSV</td>
<td>EC/ IT Lot 2 – HSD in Puntland and Central South Somalia.</td>
</tr>
<tr>
<td>10.10 – 10.20</td>
<td>GF – Malaria (T. Shewchuk)</td>
<td>HIS under GF malaria</td>
</tr>
<tr>
<td>10.20 – 10.30</td>
<td>WHO</td>
<td>GAVI HSS proposal – concept and process.</td>
</tr>
<tr>
<td>10.30 – 11.00</td>
<td>Questions and discussion</td>
<td>To expand on the proposed actions and analyse key gaps</td>
</tr>
<tr>
<td>11.00 – 11.30</td>
<td>Break</td>
<td>Group Facilitators: Rob Yates, Renato Corregia, Imanol Berakoetxea</td>
</tr>
<tr>
<td>11.30 – 13.00</td>
<td>Break out groups.</td>
<td>To work on priority areas for action- governance:</td>
</tr>
<tr>
<td></td>
<td>3 groups:</td>
<td>- Health Financing - equity</td>
</tr>
<tr>
<td></td>
<td>Somaliiland</td>
<td>- Private sector public sector collaboration/regulation.</td>
</tr>
<tr>
<td></td>
<td>Puntland</td>
<td>- Coordination: Donors, UN, NGOs</td>
</tr>
<tr>
<td></td>
<td>Somalia Central – South</td>
<td></td>
</tr>
<tr>
<td>13.00 – 14.00</td>
<td>Break for Lunch</td>
<td>Group facilitators: Rosemary Heenan, Tanya Shewchuk, Ahmad Jan Naim</td>
</tr>
<tr>
<td>14.00 – 15.30</td>
<td>Break out groups.</td>
<td>To work on priority areas for action- design:</td>
</tr>
<tr>
<td></td>
<td>3 groups:</td>
<td>- Essential packages of services</td>
</tr>
<tr>
<td></td>
<td>Somaliiland</td>
<td>- HMIS</td>
</tr>
<tr>
<td></td>
<td>Puntland</td>
<td>- Supervision and management</td>
</tr>
<tr>
<td></td>
<td>Somalia Central – South</td>
<td></td>
</tr>
<tr>
<td>15.30 – 16.00</td>
<td>Break</td>
<td>Group facilitators: Mark Beasley, Enrico Pavignani, Austen Davis</td>
</tr>
<tr>
<td>16.00 – 17.30</td>
<td>Break out groups.</td>
<td>To work on priority areas for action- inputs:</td>
</tr>
<tr>
<td></td>
<td>3 groups:</td>
<td>- Human resources – recruitment, training and retention –</td>
</tr>
<tr>
<td></td>
<td>Somaliiland</td>
<td>- salaries - promotion</td>
</tr>
<tr>
<td></td>
<td>Puntland</td>
<td>- Supplies – medicines, equipment</td>
</tr>
<tr>
<td></td>
<td>Somalia Central – South</td>
<td></td>
</tr>
</tbody>
</table>
**Day 3: Friday 7th September**

**Day Chair: Rosemary Heenan**

**Main Objective of the Day: Develop a practical plan of action for 2008 and 2009**

<table>
<thead>
<tr>
<th>Time</th>
<th>Persons</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.00 – 09.30</td>
<td>Presentation from Somaliland</td>
<td>Top 5 priorities for action and potential responses from 3 work groups from day 2 – what can we do in the next 2 years that is both critical and realistic?</td>
</tr>
<tr>
<td>09.30 – 10.00</td>
<td>Presentation from Puntland</td>
<td></td>
</tr>
<tr>
<td>10.00 – 10.30</td>
<td>Presentation from Somalia</td>
<td></td>
</tr>
<tr>
<td><strong>10.30 – 11.00</strong></td>
<td><strong>Break</strong></td>
<td></td>
</tr>
<tr>
<td>11.00 – 12.00</td>
<td>Discussion on priorities – feasibility and actions. How to launch this agenda.</td>
<td>To brainstorm as a platform how to move ahead: donors, MOH, UN and implementing partners.</td>
</tr>
<tr>
<td>12.00 – 13.00</td>
<td>Break out groups. 3 groups: Somaliland Puntland Somalia Central – South</td>
<td>To work on priority actions - with defined responsibilities. To write a short plan of action.</td>
</tr>
<tr>
<td><strong>13.00 – 14.30</strong></td>
<td><strong>Prayers</strong> <strong>Break for Lunch</strong></td>
<td></td>
</tr>
<tr>
<td>14.30 – 15.00</td>
<td>Summary of key messages and achievements of the workshop – Renato Corregia - Chairman HSC/ Italian Coop. Sector Specialist</td>
<td>Top priorities for future development of the health sector</td>
</tr>
<tr>
<td><strong>15.00 – 15.30</strong></td>
<td><strong>Christian Balslev Olesen</strong></td>
<td>Closing of the workshop. Thanks and the way forward.</td>
</tr>
</tbody>
</table>

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36
Presentations by the 3 Ministries of Health, Somalia on the Health System and Priorities for Intervention.

A. Ministry of Health TFG Somalia
B. Ministry of Health Puntland
C. Ministry of Health and Labour Somaliland
Situation Report

Somalia has been in conflict for all most 19 years compounded with natural disaster and epidemics (drought, flood, AWD, measles, malaria, etc).

Besides, all these difficult conditions there is still a functioning health service delivering and management systems at different zones and levels with different levels of capacities and performance.

See the next slide.
### Health Facilities in Somalia by zone

<table>
<thead>
<tr>
<th>Health Facilities</th>
<th>North East Zone</th>
<th>North West Zone</th>
<th>Central South Zone</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB Centers</td>
<td>8</td>
<td>7</td>
<td>34</td>
<td>49</td>
</tr>
<tr>
<td>MCH/OPDs</td>
<td>53</td>
<td>74</td>
<td>128</td>
<td>253</td>
</tr>
<tr>
<td>Health Posts</td>
<td>181</td>
<td>154</td>
<td>131</td>
<td>466</td>
</tr>
<tr>
<td>Hospital</td>
<td>15</td>
<td>22</td>
<td>52</td>
<td>89</td>
</tr>
<tr>
<td>Health Centers</td>
<td>4</td>
<td>-</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>VCT</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Private Clinics</td>
<td>-</td>
<td>44</td>
<td>31</td>
<td>75</td>
</tr>
<tr>
<td>Mobile Clinics</td>
<td>-</td>
<td>-</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Outreach sites</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Human Resources in Somalia by zone

<table>
<thead>
<tr>
<th>Human Resource</th>
<th>North East Zone</th>
<th>North West Zone</th>
<th>Central South Zone</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>77</td>
<td>39</td>
<td>94</td>
<td>260</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>14</td>
<td>2</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Midwives</td>
<td>29</td>
<td>55</td>
<td>10</td>
<td>94</td>
</tr>
<tr>
<td>Nurses</td>
<td>167</td>
<td>279</td>
<td>189</td>
<td>635</td>
</tr>
<tr>
<td>Lab Technician</td>
<td>12</td>
<td>18</td>
<td>223</td>
<td>253</td>
</tr>
<tr>
<td>Ass. Lab Tech</td>
<td>29</td>
<td>10</td>
<td>110</td>
<td>159</td>
</tr>
<tr>
<td>X-Ray Tech</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>CHWs</td>
<td>196</td>
<td>700</td>
<td>52</td>
<td>448</td>
</tr>
<tr>
<td>TBAs</td>
<td>447</td>
<td>500</td>
<td>54</td>
<td>1003</td>
</tr>
<tr>
<td>Sanitarians</td>
<td>2</td>
<td>6</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Social Workers</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### MEDICAL AND ALLIED SCIENCES

**Nursing Schools**
- Hargeisa
- Hargeisa (Edna Maternity and Teaching Hospital)
- Burco
- Bessaso
- Garowe
- Lascatrod
- Mogadisho (SOS)
- Mogadisho
- Balass

**School of Medicine**
- Galcaayo school of Medicine  Galcaayo
- Afneux University Faculty of Medicine  Borame
- University of Hargeisa Faculty of Medicine  Hargeisa
If you look to the current health status of Somalia which as follows:

- Life expectancy: 47
- Infant mortality rate: 132
- Under 5 Mortality Rate: 225
- Maternal Mortality rate: 1/100,000
- Immunization coverage of disease preventable in peaceful area: 2 - 5%.

Comprehensive emergency obstetric care can only be in three major towns namely; Mogadisho, Bosaso and Hargeisa.

Which is not affordable nor accessible to poor rural and nomadic communities. Recurrent outbreaks of AWD, Measles, Malaria and other Communicable Diseases.

In addition to that the quality and performance of existing health services is extremely poor with all the generous donor resource Somalia has the worst health indicators on the world.

We highly apologize donor communities for the waste and mismanagement of these resources which are badly needed for the Somalis in these difficult situations with the expertise advice and implementation of highly presidios agencies in health such as; UNICEF, WHO, UNFPA World Bank ICRC and hundreds of International NGOs.

This is unacceptable both to Somalis and international donor communities.
Health Services

The health service is currently administered in Somalia in three zones separately:

- Somaliland and Puntland have zonal administrative set up elected by the communities at district, regional and zonal level which represent decentralizing approach.

- South and central has weak administration and TFG which oversees all existing administrations except Somaliland.

The level of health management in Somaliland and Puntland having zonal management established to some extent. Central and South have no management structures in health, the MoH TFG has established a small office in Mogadisho which limited capacity in terms of infrastructure and human resource which unable to effectively oversee the health services delivery in the country with no national health policy and strategy although we have developed the management structures at all levels roles and responsibilities has to be developed.

Health Care Financing

Currently health care financing is mainly dependent on donor resources and limited local resource based tax revenue and user fees. There is no health financing at moment. Health financing is the major constrain on the current service delivery.
Human Resource

Majority of health professional had left country and those who stay behind are out dated and aged. Very few who are capable of delivering quality service are attached vertical programs for economical purpose. Currently trained health professionals in the country either left the country for economic reasons or joined the private sector. The Public sector remain with poor, unskilled and unmotivated labor.

Infrastructure

Majority of health services infrastructure in the south and central has been destroyed or occupied by IDPs, equipments and supplies has been looted

Priorities and Gaps

- Health policy and system design to be developed.
- Health management structures of different levels (central, regional and district) to be established and support.
- Development of sustainable health financing system.
- Human resource capacity for the health sector all levels and categories to be improved
- Rehabilitation of management and service delivery infrastructures
Governance and Leadership

Problem Analysis

The collapse of the central government in 1991 has led Somalia to a situation of total absence of any kind of public service, institution or authority. No centrally run educational, health or social security system, in a word, there is a zonal administration, therefore, presently, exists in Somalia.

Due to the lack of reliable information about population in Somalia (last census was in 1975) it is difficult to give truthful data of people living in different regions and districts.

The most common source of data currently used for planning purposes is “The JNA Somalia (Sub-Cluster Health report 2006)” for all Somalia.

Leadership / Policy and structure

The health management system, since no public central authority is now present in Somalia, the only way to prepare a possible handover to Somali people is to continue attractive the MoHs for the Health system management through the activities planned in the present situation.
Local health entities are not regularly established

The regulation of local health entities and negotiated, agreed with the private sector (private practitioners and pharmacies) is produced but not functioning.

An Early Warning System for emergency outbreak is not in place in each health local entity with the involvement of the private sector.
Coordination of Implementing Partners

- Absence of a standard drug list and a common procurement system.
- Weakness of the Health Information System (HIS)
- Non-existence of a baseline data and related specific plan of operation with specific target
- Limited general and financial management capacity.
- Absence of coordination among the different health networks and locations.

Policy Status and Frame Work

The Puntland Health System ownership and capacity building, the action will still surely and dramatically need to increase the technical and managerial capacity of the MoH, particularly at decentralised level (regional, district and village).

Supervision and Management

Decentralization

- The Monitoring and Evaluation System is a quite limited with methodological tools and procedures is not well developed yet.
- The setting and implementation of a comprehensive system of referral, monitoring and follow-up is not improved.
Responsibility at levels

The responsibilities and levels of the central, regional and district authorities is under administration of MoH Charts, but the district level is not yet well established.

Community and Business Participation

The community and business participation of health service system is non exist and still need supporting the capacity building and empowerment of civil society.

This impact will translate in more self-reliance, more participation, more decision-making power, more entrance, and advocacy capacity.

Health Care Financing

Budget Government Resources

According to the budget of Government health is only allocated, the payment of $19 incentives which is less than 2% of the Government budget and there is no health financing policy in Puntland.

Private Contribution

Private sector actors are interested and are willing to participate and collaborate, but the policy and regulations are not in place and developed.
Cost Recovery and Exemptions

One Good example is Bossaso Hospital
Regularly performed the cost recovery system, and others are under process.

Human Resource For Health

There is no enough human resource to enhance health service delivering.

The local staff have quite poor level of knowledge and skill, and a strategy focused on enhancing the local capacity can bring in the future to enable them to run independently the health services.

Health Personnel

<table>
<thead>
<tr>
<th>Description</th>
<th>Number of Staff</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public</td>
<td>Private</td>
</tr>
<tr>
<td>Doctors</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>Qualified Nurses</td>
<td>167</td>
<td>209</td>
</tr>
<tr>
<td>Qualified Midwives</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>Auxiliaries/Assistant Nurse</td>
<td>195</td>
<td>140</td>
</tr>
<tr>
<td>Health Technicians</td>
<td>97</td>
<td>NA</td>
</tr>
<tr>
<td>TBAs</td>
<td>447</td>
<td>NA</td>
</tr>
<tr>
<td>Other supporting Staff</td>
<td>412</td>
<td>NA</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,397</td>
<td>411</td>
</tr>
</tbody>
</table>

*Total number of health staff 519 included Government Payroll*
MEDICAL AND ALLIED SCIENCES

1. Bosaso Nursing Institute
2. Garowe Nursing Institute
3. Lasacanod Nursing Institute
4. Galkacyo School of Medicine

July 28, 2002

MINISTRY OF HEALTH
PUNTLAND

July 28, 2002

- Inadequate provision to standard job description for PHC and Hospitals
- A database of active health workers (personal data, professional qualification, workplace) is not properly placed and women cover at least 30 – 40% of health staff at all levels.
- A common equal salary scale and standard contract format is not available in all levels.
- The curriculum and certification policy of health personnel (Public and private) are not developed.

July 28, 2002

Health Service Packages

- Low observance to Service Package and % to SP possible of PHC facilities and referral hospitals.
- Low number of qualified health staff or re-qualified including the private sector (private practitioners and pharmacists).
- Lack of mental health services effectively working in referral hospitals.
- About less than 2% of the health facilities provide quality monthly reports (HIS standard).

July 28, 2002
All the existing facilities need to be better equipped and furnished and the buildings repaired and rehabilitated in order to be able to upgrade the services given to the community.

Key Priorities and Challenges

Ministry of Health, Puntland State of Somalia has the following key priorities and challenges:

-Developing of Financial and Technical Assistance
-Development of health policy and regulations
-Development of capacity of health system to deliver essential health package
-Provision of support and motivation of human resource
-Improvement of collaboration of other line ministries
-Development of training plan for the medical staff
**Recommendations**

The Government of Puntland State of Somalia/Ministry of Health are committed to provide effective health services in Puntland and to achieving the health-related MDCG specially those aimed at reducing maternal and under 5 mortality.

MoH Puntland recommended:

- Profession of financial and technical assistant to Puntland Government/MoH to develop and integrated and coordinated approach to profession of and on EHP

July 26, 2013
Ministry of Health, Puntland State of SOMALIA

- Strengthen capacity of health system to deliver and EHP
- Support to human resource development
- Support to address the high levels of maternal and newborn morbidity and mortality
- Creation of health capacity unit
- Identification of relevant line Ministries
- Assessment and recruitment of MoH Puntland Staff

July 26, 2013
Ministry of Health, Puntland State of SOMALIA

- Develop health policies and strategy plan
- Improve quality of services and supported health facilities in terms of:
  - Revision of essential Health Package
  - Development of Training plan for medical staff
  - Development of standard job description
  - Implementation of drugs management system
  - Application of health financing procedures
  - Maintain of facilities and equipments

July 26, 2013
Ministry of Health, Puntland State of SOMALIA
SOMALILAND IN BRIEF

Demography/Administrative System

- The population of Somaliland is estimated to 3.3 million. The population in urban areas is increasing and is estimated at 45%, while the nomadic population is 55%.

- Administratively, the government of Somaliland consists of a judiciary, legislative (House of Elders and House of Representatives) and the executive (the President and his Chosen Cabinet).

- It is divided into six regions, 30 districts and about 450 villages/settlements.

- Constitutionally, Somaliland is multi-party system while elected local councils constitute district management structures at local level.
**ECONOMY**

- The economy is largely dependent on pastoral production
- Commerce
- Remittance
- The government mainly gets its revenue from customs on the export charges of livestock products and bi-products, on Qat imports and from docking fees.
- The fiscal policy does not mainly address property and value added tax earnings as the principle sources of the government incomes.

**MILESTONES OF THE HSR INITIATIVE**

- The Somaliland HSR Policy was launched in early 1998.
- Vision:
  - “to attain the highest health status and social well-being of all Somalilanders”
- Mission
  - Create an enabling environment for the provision of affordable, quality, equitable access (access to MESHP) and sustainable health care in Somaliland.
- Health strategic framework (The Blue Book) was developed to guide the reform process.
- HSR secretariat was established, which is the engine driving the reform process.
- Strong will and expression of acceptance of the Somalilanders towards the key elements of the HSR.

**Milestones**

- Establishment of HSR taskforces for health systems' development and documentation
  - Development of five year health strategic plan with investment plan ($12,500,000) 1999—2003.
  - Development of National Drug Policy and Related Documents.
  - Investment Plan for Somaliland National Drug Policy Implementation Program $8,826,917.
  - Development of health care financing guidelines that lead to the adaptation and the costing of the MESHP.
  - Development of Health Sector Staff Establishment based on Minimum Staffing Pattern
Milestones

- Establishment of statutory bodies
  - National Drug Authority
  - National Health Professions Council
  - Professional Health Associations
  - Community Health Boards

- Establishment of health training institutions
  - Institute of Health Sciences-Hargeisa
  - Burao Nursing School
  - Amoud Medical School
  - Hargeisa Medical School
  - Edna Midwifery School

BURDEN OF DISEASES

<table>
<thead>
<tr>
<th>CD</th>
<th>NON-CD/CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Mental Health Problems</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Cardio-Vascular Diseases</td>
</tr>
<tr>
<td>Malaria</td>
<td>Anemia</td>
</tr>
<tr>
<td>UTI</td>
<td>Maternal Health Problems (PPH, Abortion, Eclampsia)</td>
</tr>
<tr>
<td>STI including HIV</td>
<td>Fractures, Trauma related road traffic accidents.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Malnutrition</td>
</tr>
</tbody>
</table>
MINISTRY OF HEALTH AND LABOUR SOMALILAND

MAIN HEALTH CHALLENGES, CONSTRAINTS AND PRIORITIES
### Inequalities in Service Provision

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>WEALTH</th>
<th>SETTING</th>
<th>EDUCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Poor</td>
<td>Rich</td>
<td>Urban</td>
</tr>
<tr>
<td>&lt; 5 mortality (richest 40%/poorest 60%)</td>
<td>140</td>
<td>128</td>
<td></td>
</tr>
<tr>
<td>Child Immunization</td>
<td>9%</td>
<td>54%</td>
<td>49%</td>
</tr>
<tr>
<td>TT Immunization</td>
<td>10%</td>
<td>60%</td>
<td>46%</td>
</tr>
<tr>
<td>Vitamin A Supplement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC</td>
<td>15%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Assisted Deliveries</td>
<td>1%</td>
<td>86%</td>
<td>76%</td>
</tr>
<tr>
<td>Moderate Malaria</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin A &lt;5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin A PP Mothers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved sanitary facility</td>
<td>1%</td>
<td>66%</td>
<td>76%</td>
</tr>
<tr>
<td>Improved drinking water</td>
<td>80%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>ORS treatment diseases</td>
<td>15%</td>
<td>14%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Challenges in the Health Service Delivery System.

- Limited access (Preventive, promotive and curative care)
- Low demand and utilization
- Very poor referral
- Poor quality
- Challenges in the reduction of maternal and child morbidity and mortality rates and communicable diseases (TB, HIV/AIDS, etc)

### Very Weak Health Systems

- Health Management Information System (HMIS).
- Financing and Accounting System
- Drugs and Essential Supplies System
- Human Resource Management and Development System
- Health Infrastructure System
- Supervision, Monitoring and Evaluation Systems
- Regulation and Accreditation System
Critical Shortage of Human Resources

- Doctor population ratio is 1 to 35,000.
- Hospital beds population ratio 1 bed for 1500 population
- Hospital based workloads for nurses 1 nurse into 15 patients or beds in three shifts for each nurse.
- Owing to the population figure, the number of hospital beds required is around 2000 beds, and assuming a nurse will take care 15 beds in a shift, the required number of nurses will be 450 in hospitals alone.
- Midwives: 1 into 400 pregnant mothers/postnatal mothers each shift. The current ratio is 1 to 6102

Challenges Management Capacity

- Lack of Key Skills to Streamline H.S. Development:
  - Health Planning
  - Health Economics
  - Health Management Information System.
  - Education Management
  - Epidemiology
  - Legal Medicine (Forensic Medicine)
  - Public Health

KEY PRIORITIES

- Human resource development, planning, production and management at all levels including the production of skilled female community health workers
- Establishment of Somaliland Pharmaceutical Corporation
- Investment in an integrated basic package of essential health care services through the development of appropriate district health management system
- Development of appropriate health management information system
- Introduction of SWAp in resource mobilization, pooling and spending at all levels.
- Development of the institutional capacity of the Ministry to be competent, efficient and responsive to the public needs & demand
- Development of the technical and operational capacities of the health regulatory bodies including Health Professions Council, Somaliland Food and Drug Authority, etc.
Milestones

- Establishment of statutory bodies
  - National Drug Authority
  - National Health Professions Council
  - Professional Health Associations
  - Community Health Boards
- Establishment of health training institutions
  - Institute of Health Sciences-Hargeisa
  - Burao Nursing School
  - Amoud Medical School
  - Hargeisa Medical School
  - Edna Midwifery School

### BURDEN OF DISEASES

<table>
<thead>
<tr>
<th>CD</th>
<th>NON-CD/CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Infections</td>
<td>Mental Health Problems</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Cardio-Vascular Diseases</td>
</tr>
<tr>
<td>Malaria</td>
<td>Anemia</td>
</tr>
<tr>
<td>UTI</td>
<td>Maternal Health Problems (PPH, Abortion, Eclampsia)</td>
</tr>
<tr>
<td>STI Including HIV</td>
<td>Fractures, Trauma related road traffic accidents.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Malnutrition</td>
</tr>
</tbody>
</table>

### MATRIX OF HEALTH SYSTEM GOVERNANCE

**MANAGEMENT**
- MOHL HQ (HSR SECRETARIAT)
- REGIONAL HEALTH OFFICE
- DISTRICT HEALTH MANAGEMENT TEAM
- HEALTH CENTRE STAFF
- HEALTH POST STAFF

**SERVICE DELIVERY ORGANIZATION**
- NATIONAL REFERRAL HOSPITAL (FCH)
- REGIONAL HOSPITALS CATEGORY (B) HC
- DISTRICT HOSPITAL OR CATEGORY (A) HC
- RURAL HEALTH CENTRE OR CATEGORY (C) HC
- HEALTH POST
Republic of Somaliland
Ministry of Health and Labour

Key Priority Areas

Essential Health Package
• Review and develop EHP focusing on the key feasible and sustainable basic interventions with the highest impact in reducing the maternal, neonatal and child morbidity and mortality as well as reducing the incidence of the communicable and non-communicable diseases with the greatest burden.

Health Financing
• Analyse the costing of the EHP and develop standard costing pattern.
• Conduct systematic review of the health expenditure with view to developing national health accounts.
• Develop standard planning and budgeting guidelines with weighted criteria for resource allocation based on population, epidemiology, socio-economic to ensure equity.
Governance

- Review and update the national health policy and establish the roles and the linkages between the Ministry, the Community and the Local Governments for the delivery of the EHP.
- Review the management and service delivery structures and develop appropriate organizational norms and job descriptions based on the defined functions and service delivery packages.
- Develop integrated standard supervision tools and plans at all levels.

Health Infrastructure

- Carry out mapping and stock taking of the health infrastructures including private sector throughout the country.
- Establish infrastructure data-bank including information on equipment, furniture and facilities and rehabilitation plan.
- Develop standard layout and guidelines for the construction and rehabilitation of the health facilities.

Drugs and Supplies

- Review and update the Essential Drug List based on the EHP.
- Contract-out the management of the Somaliland Medical Stores to ensure an efficient system of storage and distribution of essential drugs and medical supplies.
- Develop standard procurement and supply management guidelines.
HMIS

• Review the HMIS.
• Develop standard guidelines for data generation, processing, analysis and utilization.
• Pilot the implementation of the HMIS in selected districts by defining the catchment area of each health facility and mapping the target population.

Coordination

• Revitalize and support the work of the Health Sector Reform Secretariat and the taskforces namely (HMIS, HR, Health Care Financing, Drugs and Medical Supplies).
• Strengthen the regional health coordination meetings to be output oriented with concrete topics.
• Establish strong linkage and regular information sharing between Somaliland HSR Secretariat and the Health Systems Strengthening Working Group in Nairobi.

Human Resource

• Establish human resource data-base and projections for the next five years.
• Design human resource development policy and long-term strategic plan.
• Develop standard pattern for staffing based on the EHP.
• Workout improved working conditions incorporating a basic living salary scales; performance-based contractual arrangements, working conditions; disciplinary code of conduct etc at all levels (from training institutional level right through the service delivery level).
Background

The study on the 2000–06 aid flows to the health sector in Somalia is a first attempt to fill a large gap of knowledge in this area. The primary objectives of the study were to assess how levels of donor financing varied over the years; which health interventions were prioritized by donors; and how evenly health sector aid was distributed to the different zones of Somalia. The overall aim of the study was to create evidence for donors, implementers and health specialists involved in allocation of financial resources to the Somali health sector.

The study was conducted in close collaboration with the Health Sector Committee (HSC) of the Coordination of International Support to Somalis (CISS). HSC members were consulted prior, during and after the completion of the data analysis. The HSC endorsed the research protocol in February 2007, provided guidance on the sampling frame, reviewed and discussed the preliminary findings and provided feedback on the draft report.

The results of the study are based on quantitative and qualitative data collected from donor organizations active in Somalia. The study focused on traditional donors, including bilateral, multilateral and others (GFATM and Red Cross/Crescent Movement). Twenty-six agencies were contacted and a response rate of 96 percent (n 25) was achieved. Of the 25 organizations that responded, 88 percent (n 23) provided relevant health sector data.

Key Findings

Conventional donor funding for the health sector grew almost three fold in seven years, passing from US$23 million in 2000 to US$62 million in 2006. The panorama of health donors in the country changed considerably over the years. The contributions of bilateral donors decreased from 63 percent in 2000 to 35 percent in 2006. Multilaterals donors, and particularly the UN, considerably increased their share. New donors appeared on the scene: GFATM contributions increased from 2004 onwards to reach 22 percent of total donor aid to the health sector in 2006.

Per capita aid financing for health grew from US$3 in 2000 to US$7 in 2006. The 2006 figure is conservative and is an approximation based on UNDP population figures. The figure is in line with per capita health aid financing in other fragile states such as South Sudan (US$7) and DRC (US$2–3). Somalia, like South Sudan and DRC, remains an “aid orphan,” despite the increase in funding for health observed in recent years.

Health sector financing for health progressively shifted from horizontal to vertical programs. In 2006, malaria, TB, HIV and the polio programs alone accounted for 50 percent of total aid compared to 25 percent in 2000. The polio program has been the largest funded program in Somalia, accounting for 20 percent of the total health budget over the period 2000–2006; a polio outbreak in 2005 was the trigger for a further increase to polio financing in 2005 and 2006. The large funding for the
The polio program testifies the political commitment of the donor community, but also raises questions about the opportunity costs of the eradication campaign. Other vertical programs have benefited from increased funding provided by the GFATM since 2004. In some cases, for example TB, the large increase in funding does not seem fully justifiable based on program performance.

Within vertical programs, EPI, reproductive health, noncommunicable diseases and nutrition received inadequate funding. Given the high burden of disease and the dramatically poor indicators on EPI coverage, reproductive health and nutrition, additional financial support would be required to reverse the negative trends in these areas.

Support for health system strengthening was relatively large (36 percent of total aid financing over the period 2000–06), declined in 2006, and was generally fragmented. Partners reported lack of coordination in this area and called for more joint planning. Recent initiatives like the development of the Reconstruction Development Plan (RDP) and the creation of a Health System Working Group in the CISS indicate a positive change towards more coordination among stakeholders.

The distribution of aid to the health sector by zones was fairly evenly distributed during the period 2000 to 2006. Sixty-one percent of funding went to South and Central zone (which accounts for 52 percent of the population); 19 percent to Puntland (which accounts for 20 percent of the population); and 20 percent to Somaliland (which accounts for 28 percent of the population).

**Recommendations**

- **Somalia requires increasing and long term financial support for the health sector to address the needs of its population.** Although US$7 per capita aid for the health sector compares favorably with other Sub-Saharan African countries, Somalia’s financial needs for the health sector remain high given the exceptionally low health indicators, and the high operational costs linked both to the difficult logistics of the country, and the reliance on international actors mostly located outside Somalia.

- **More importantly, contributions to the health sector should be made more strategic:** funding gaps in key areas (EPI, reproductive health, nutrition, and noncommunicable diseases) should be addressed as a matter of priority. Needs analysis and data on the burden of diseases are required to guide the prioritization process. However, known but neglected causes of high morbidity and mortality should be addressed without further delay.

- **While supporting thematic interventions, the donor community should invest more in rebuilding the health system.** The findings of the JNA and the RDP represent the blueprint for systemic efforts and should guide future planning and implementation efforts. The recently created Health System Working Group should take the opportunity to lead donors and implementers in the rebuilding process, possibly drawing on the positive experiences of other fragile states (for example, Mozambique, Afghanistan, Liberia, Rwanda).

- **The mix of relief aid and humanitarian assistance should be sustained until the political situation normalizes.** Providing funds for emergencies will serve the immediate.
Top 5 Priorities of the 3 Ministries of Health, Somalia.

D. Ministry of Health Somaliland
E. Ministry of Health Puntland
F. Ministry of Health TFG Somalia
Republic of Somaliland
Ministry of Health and Labour

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TOP 5 MoH Priorities

Somalia Health Sector Development Workshop 5th - 7th September 2007

Overview of Priority Areas

1. Areas For Action Governance

- Health Financing - Equity
- Private and Public sector collaboration/ regulation
- Coordination: Donors, UN, NGOs
2. Areas For Action Design

- Essential packages of services
- Health Management Information system
- Supervision and Management

3. Areas For Action Inputs

- Human resource: recruitment, training and retention, salaries - promotion
- Supplies - Medicines and equipments

MoH Puntland
TOP FIVE Priorities
TOP 5 Priority (1)

- Health Financing - Equity

1. Increasing public financing both Government and Donors and there should be the commitment of Puntland Government regarding on this issue.

TOP 5 Priority (2)

- Human resource

1. Initialising certification of new employees
2. Increasing number of staff in Government payroll
3. Increasing human resource budget
4. Training of health professionals
5. Increasing and equal share of incentives and salaries

TOP 5 Priority (3)

- Health Management Information system - HMIS

1. Integrating Lot 3 and Malaria GF program of MHIS Unit strengthen to MoH development HMIS
2. Improvement of MoH disease surveillance unit
TOP 5 Priority (4)

- Supervision and Management
  1. Strengthen Zonal management with focusing MoH Dept of Planning and Development and M&E Unit.
  2. Joint supervision and Monitoring
  3. Developing standard checklist

TOP 5 Priority (5)

- Coordination: Donors, UN, NGOs
  1. Jointly mission and supervision
  2. Fully participation of partners to MoH internal monthly health meeting
  3. Formulate sector wide approach of quarterly health coordination meeting
  4. Regular coordination with Zonal and Nairobi level

Sub Priority (6)

- Essential packages of services
  - Participatory review of package
  - Improvement of Immunization activities up to 60%
  - Improvement of Infants and young child feeding and Nutrition practice
• Improvement of safe motherhood and Reproductive health
• Strengthen health laboratory services
• Improvement of communicable diseases control
• Strengthen Emergency Preparedness and response Plan

Sub Priority (7)

Supplies - Medicines and equipments
1. Construct central medical store run by MoH
2. Channel drugs through MoH central store
3. Better control of supply chain and consumptions
4. Supply to be demand driven
5. Joint supervision to include checking rational drug use

Sub Priority (8)

Private and Public Sector collaboration
It is very difficult to regulate private sector at moment;

• Some selective contract with private sector
• Priority will be given to Improving Public sector
MINISTRY OF HEALTH TFG SOMALIA

TOP PRIORITIES

Priority 1

Governance

Health Financing

1. Required Institutional building
   Minimal MOH structure at central, regional and district level.

Actions:
   Take corner structure and define roles and staffing plus resources needed for each level
   Circulate for comment and revision (determine between formal professional responsibilities and community).

Central role for immediate period:

- Core policy
- Standard
- Regulation

Regional and district roles:

- Implementation
- Supervision
- Compliance
2. Promote technical support to ministry
Prioritizing resources already available
Better coordination to make support more complete
(fill gaps and overlap)

Priority 2

Human resource

- Assess plus support training facilities
- Define new low level cadres and plan to train
- Develop professional register
- Standardize in-service training—auxiliary/nurses
- Develop salary scales—rural BIAS (with UNDP) civil service commission
- More projects incentives—salaries

Priority 3

HMIS

- Agree GF coordination is focal point
- Analyze current problems to inform new action
Priority 4

Supervision and Management

- Bring together Merlin, Cosv/COOPI etc and GAVI HSS to develop MOH BHC supervision capacity
- Practical hands on experience in partnership with partners –standard model.

Priority 5

Coordination

- Promote zonal, regional coordination linked to Nairobi structures.