The SOMALI HUMAN RESOURCES FOR HEALTH DEVELOPMENT POLICY 2016-2021

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'The Somali Human Resources for Health Development Policy 2016-2021'

Produced by:
Ministry of Health, Federal Government of Somalia
Ministry of Health, Puntland; and
Ministry of Health, Somaliland

Approved by:
Somali Health Advisory Board (HAB)

Consultancy support:
Dr. Khalif Bile Mohamud

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Contents

ACRONYMS

ACMWs	Assistant Community Midwives
CHWs	Community Health Workers
CBFHWs	Community Based Female Health Workers
CMWs	Community Midwives
CPD	Continuing professional development
CSC	Civil Service Commission
EPHS	Essential Package of Health Services
HAB	Health Advisory Board
HBCs	Health Professional Councils
HCs	Health Centers
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HPAs	Health Professional Associations
HPC	Health Professional Council
HPTIs	Health Professional Training Institutes
HRH	Human Resources for Health
HSC	Health Sector Committee
HSSPFG	Health Sector Strategic Plan Financiers' Group
JHNP	Joint Health and Nutrition Programme
JPLG	Joint Programme on Local Government
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOH	Ministry of Health
M&E	Monitoring and Evaluation
NGOs	Non-Government Organizations
PHUs	Primary Health Units
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
WHO	World Health Organization

FORWARD

The formulation of Human Resources for Health (HRH) development policy is a major milestone providing an opportunity to develop this important component of the health system. The dismal Somali health indicators alongside the glaring HRH disparities between the urban and rural areas are factors substantiating the magnitude of the challenges being faced. The latter is exacerbated by the absence of comprehensive HRH information system profiles, offering credible processes for data collection, management, and use. The labour intensive nature of the health sector requires the deployment of a well-trained, skilled and motivated health workforce. This policy is specifically aimed with a focus on priority HRH domains that range from planning; training and production; deployment; leadership development, utilization and management; HRH information system and financing and retention, while recognizing the need to build partnerships for its successful implementation. Additional HRH anticipated challenges related to policy implementation include the very small proportion of resources allocated to the health sector out of the already low government budgetary outlays; the limited or lack of public sector health training institutions; the absence of a comprehensive HRH plan for implementation and the weak institutional framework for building HRH partnerships and coordination. To tide over these challenges, the HRH development will require a strong health sector commitment, strategic coordination among partners, and the building of innovative and collaborative HRH endeavours with a view to accelerate progress towards universal health coverage and the attainment of the post 2015 health related sustainable development goals. The HRH policy is aimed at triggering the development of a workforce strategic plan that will translate the agreed policy aspirations into action. The policy emphasizes on the production and supply of health workers that are aligned with the HRH goals of the health system, as outlined in the programme of Essential Package of Health Services (EPHS), thus forming the basis for improving the promotive, preventive, curative and rehabilitative services of the health system, during the ensuing rehabilitation and development phase of Somali health systems. In this endeavour, we take this opportunity to thank all the institutions and partners who assumed strong roles in the HRH assessment and policy formulation processes and generously donated their time and effort to this important undertaking. On behalf of the Somali Health Authorities, we invite all the relevant public and private sectors, civil society organizations, UN agencies, international NGOs and donor partners to extend their full support to the implementation of this policy and actively engage in the HRH development process.

H.E. Minister of Health
Federal Government of Somalia

H.E. Minister of Health
Somaliland

H.E. Minister of Health
Puntland

ACKNOWLEDGEMENTS

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The Somali health authorities gratefully acknowledge the contribution of the different senior professionals representing universities, United Nations agencies and international and national NGOs who participated actively in these policy discussions. We are grateful also, for the involvement of the Regional Medical Officers and the health sector senior staff that played a significant role in HRH data collection and led the different sessions of the policy development process. We also note the important contributions provided by the large number of health professionals and experts and partner organizations who shared their comments and offered their valuable technical support along the process. The Somali health Authorities realize and acknowledge the growing threats to health and that health workforce development affords a real opportunity to respond, hence the solidly shared commitment to build a workforce driven by their desire to make a positive difference to the domains of equity, social justice, and the right to health.

1. INTRODUCTION

The Human Resources for Health (HRH) is the driving force for any meaningful improvement in the health status of a population. A well-trained and motivated workforce forms the critical pathway towards universal health coverage (UHC) and is a key to the attainment of the post-2015 health related sustainable development goals (SDGs) and targets. The Somali population has transitioned from decades of complex emergency and civil conflicts that inflicted a significant damage to the health system with substantive destruction of the services delivery network infrastructure and a large number of health training institutions. The health workforce is the backbone of the health system and often constitutes the most significant element in the provision of essential and lifesaving health services to the population. The existing grave shortage of qualified health professionals, especially those in reproductive, maternal, new-born and child health, has restricted the progress in reducing maternal, newborn, and child mortality and rendered the Somali health system unable to provide the necessary care to its populations, particularly those residing in the rural and hard to reach geographical areas. During the extended Somali conflict, over 600 medical doctors, qualified nurses, midwives, and skilled health technicians have migrated overseas, depleting the health workforce assets, a matter compounded by the clustering of the majority of the limited number of available health professionals in the major urban cities. Based on the current health status of the Somali population, the health system has clearly missed the Millennium Development Goals (MDGs) by a large margin, and will have a challenging road to meaningfully embark on the post-2015 development agenda, unless the existing health workforce gaps are effectively addressed.

The World Health Organization (WHO) defines Human Resources for Health as "all the people engaged in actions whose primary intent is to protect and improve health"[1]. According to this definition, health workers include: a) those delivering direct services to a target population and are hence denoted as "health service providers" and b) those not directly engaged in the provision of services, but providing managerial and support inputs to the national health system. The HRH domain also incorporates the technical skills and expertise that health workers apply when performing the promotive, preventive, curative and rehabilitative services of the health system. The Somali health workforce crisis being the most critical issue facing the health care systems, demands the strongest political commitment for emergency response actions that address the underlying causes of this severe health workforce scarcity. The HRH policy deliberations will be strongly aligned with the stipulated Somali health policy directions and are also in line with the Somali New Deal Compact strategy that will support the Somali health care system. There is no doubt that through multi-stakeholder partnerships and coordination, HRH development will become one of the key

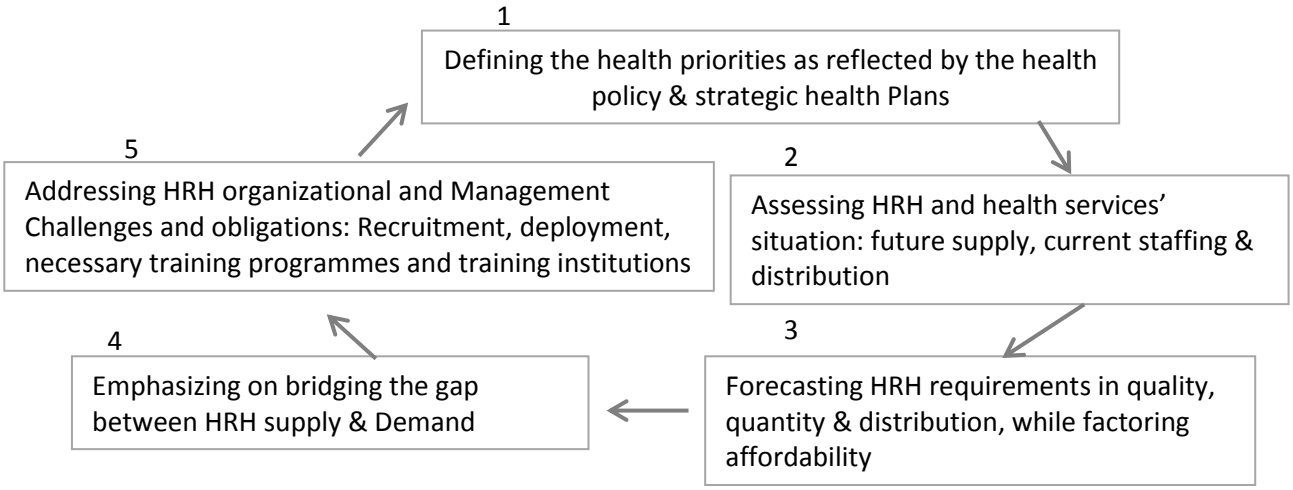
1. The World Health Report 2006 - working together for health. WHO. 2006

success features in the Somali post-conflict social sector recovery with increased provision of community based, universally acceptable, affordable, and accessible essential health care services that are focusing on gender equity and human rights dimensions of health. The HRH policy undertaking is expected to generate a paradigm shift by reversing the existing workforce shortages with scaled up production, equitable distribution, enhanced productivity and an improved working environment.

2. JOINT ACTION TOWARDS ADDRESSING THE HEALTH WORKFORCE NEEDS: POLICY DEVELOPMENT METHODOLOGY AND PROCESS

The health workforce needs to evolve from the demographic, epidemiologic, social and cultural profiles of the population, clients expectations, level of urbanization, technological advances in the health services system and its coverage levels, as well as on workforce conditions of employment and governance modalities that impact on their performance and retention. To address these important dimensions, the HRH policy development process was organized pursuing key principal steps, recognizing first the priorities expressed in the formulated health policy and strategic plans of the different health authorities; assessing the current HRH situation and future requirements; addressing the need to bridge the gap between supply and demand and finally ensuring that sufficient attention is paid to the HRH organizational and managerial challenges that would evolve (fig 1). In the initial HRH situation assessment phase, a literature review was conducted on the health system aspects relevant to HRH training, production, employment, distribution, management and retention. The process fully engaged all the three health authorities and was closely coordinated by the senior leadership of these ministries, with the participation of the locally operating national and international stakeholder partners of the health sector. At the federal MOH and Puntland level, the process was assisted by Benadir University and Puntland Development Research Center respectively, while in Somaliland, the review was facilitated by the then available policy document on the subject. The HRH assessment results indicated the magnitude of the workforce challenges confronting the Somali health system. This was supported by policy analyses of the workforce needs at each health authority level and the prospected relevant interventions for consideration. The guiding principle of this process was the conscious understanding that this joint policy formulation will subsequently lead into the design of HRH strategic action plans for the different health authorities, supporting a specially defined HRH framework of resource mobilization and implementation, as well as a monitoring and evaluation framework for this vital Human Resources Initiative.

Figure 1. Health Workforce Policy Development Process



3. CURRENT PICTURE OF THE HEALTH WORKFORCE

3.1. Training and Production

During the first decade of the civil conflict, almost all public sector higher medical education and mid-level training institutions were destroyed, creating a colossal and acute shortage of qualified health workforce. This challenging situation has led to the rise of a large number of private medical colleges and health professional training institutions and programmes, which were the only viable sources for workforce production. However, these genuine efforts were made without the establishment of regulatory bodies, for regulating norms, accreditation standards and governance control measures. Although commendable efforts were pursued through the international partners' humanitarian health emergency support interventions, this assistance lacked any tangible formal investment in HRH pre-service training or any form of standardized in-service training through continuing professional development (CPD) programmes. This historical absence of public sector support action to address the severe shortage of qualified health workforce was further challenged by vast insecurity that prevailed at the time. This has severely constrained the delivery of quality health services and limited workforce productivity. The disappearance of public sector training institutions was replaced by civil society efforts acting in the public interest, whose actions have led to the revitalization of the health training programmes in different geographical centers. However, despite these notable goodwill programmes, several serious challenges were encountered, which can be summarized as follows:

- Lack of Regulation: These privately owned and managed training institutes though producing similar workforce categories have not pursued any inter-institutional agreement of self-

regulation or public sector authenticated standard curricula, regular teacher training programmes or accredited educational environment.

- Lack of Focus on Mid-level Professionals: The overwhelming majority of these training health programmes are elevated to the university level for the high demand and higher fees they offer. This has affected the recruitment of the crucial mid-level workforce categories, as these graduate professionals have failed to benefit the underprivileged remote geographical areas. Graduates qualifying from these higher educational institutions regularly seek employment in the big urban cities and in the private urban based health sector, while a tangible proportion is getting lost to brain drain.
- Shortage of Faculty development Opportunities: There is a general paucity for training teachers as well as opportunities for public sector support interventions for capacity building and their continuing professional development by formally constituting teaching improvement courses through in-service training programmes
- Disparity between production and demand: the lack of coherent planning and coordination between these professional training institutions and the health authorities has created a major gap between the workforce production in terms of workforce types and quantities to be produced, and the priority health needs of the population. There is an absence or severe paucity of mid-level training programmes for key health workforce categories that are essential for the implementation of the EPHS programme such as Clinical Officers, X-ray Technicians, Anaesthesia Technicians, Optometrists, Mental Health Technicians, Qualified Midwives and Nurses, Mental Health technicians and physiotherapists. Similarly, there is a lack of Community Based Female Health Workers (CBFHWs) at Grass Root Level. In recent years, public sector health authorities contributed to health workforce training and development, often in partnership with the private non-for-profit sector. **Error! Reference source not found.** illustrates the efforts made Puntland, Somaliland and South-Central Somalia.

Table 1. Health Training Institutions, their Enrolment Status and Production

Type of Academic Training Courses	Offering Institutions	Intake per Year				Currently Enrolled Students				Graduates			
		Central & South Somalia	Puntland	Somaliland	Total	Central & South Somalia	Puntland	Somaliland	Total	Central & South Somalia	Puntland	Somaliland	Total
Medical Doctors	14	890	100	75	1065	1,458	266	429	2,153	214	29	169	412
Dentists	1	-	-	30	30	-	-	78	78	-	-	24	24
Pharmacists	1	20	-	30	50	20	-	65	85	28	-	16	44
Clinical Medicine-DCM/BCM or Clinical Officers	2	100	90	-	190	230	-	90	320	-	-	-	-
Public Health & nutrition	17	380	355	40	775	1,008	824	96	1,928	256	-	-	256
Nursing courses	27	1,240	190	335	1,765	2,966	450	611	4,027	706	642	765	2,113
Midwifery/CMWs' courses	12	45	112	140	297	86	162	151	399	-	45	82	127
Pharmacy tech	2	50	30	-	80	60	-	-	60	56	-	-	56
Anaesthesia	1	-	-	10	10	-	-	4	4	-	-	6	6
Laboratory Technology	12	320	112	105	537	929	92	157	1,178	208	125	34	367
Optometrist	1	-	-	45	45	-	-	37	37	-	-	-	-
Auxiliary nurses	8	20	355	-	375	31	493	-	524	19	-	-	19
Community Health Workers	6	50	50	40	140	45	-	-	45	124	50	39	213
Postgraduate Courses													
Midwifery MSc	1	-	-	25	25	-	-	24	24	-	-	-	-
Public health MSc	3	25	-	10	35	57	-	20	77	10	-	-	10
Health Service management-MSc	1	10	-	-	10	8	-	-	8	-	-	-	-
Gen. & Emergency Surgery	1	10	-	-	10	15	-	-	15	-	-	-	-
Grand Total	110	3,160	1,394	885	5,439	6,913	2,287	1,762	10,962	1,621	891	1,135	3,647

3.2. Deployment and Utilization

Cumulatively the Somali health authorities have a physicians' density of about one per population of 20,000, while the nurses and midwives have a density of about four and one per population of 20,000, respectively.

Table 2. The total number of available human resources for health in the Somali health systems 2014

Human Resource Categories	Central and South Somalia	Puntland	Somaliland	Total
Physicians	339	120	179	638
Dentist Doctors		2		2
Pharmacists	20	6	4	30
Registered Nurses	817	664	1,256	2,737
Registered Midwives & Community Midwives	82	321	344	747
Health allied professionals	508	512	388	1,408
Auxiliary Nurses/ Auxiliary Midwives	1,838	706	1,016	3,560
FCHWs	75	65	39	179
Hospital administrators	34	44	187	265
Grand total	**3,694**	**2,440**	**3,413**	**9,566**

below illustrates the health workforce deployed by the different Somali health authorities. About 60% of the Somali population is either rural or nomadic and 40% resides in urban localities. Urban populations are exceedingly favoured as compared to the rural and nomadic communities as over 85% of the professionally skilled health workforce are located in the urban administrative districts and regional headquarters. This illustrates the urgent need to mitigate the prevailing disparity and bridge the severe lack of health workers in the remote and hard to reach underprivileged rural and nomadic areas. The table briefly illustrates the existing absolute shortage in all the health workforce categories, and the relatively severer deficiency in particular professional groups. Cumulatively the Somali health authorities have a physicians' density of about one per population of 20,000, while the nurses and midwives have a density of about four and one per population of 20,000, respectively.

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3.3. Gender Distribution of the Health Force

Table 3 illustrates the gender distribution of the health workforce operating in the different health authorities for four key health professional categories. Women make up about 42% of the health workforce and their active engagement is indispensable for considerable areas of essential lifesaving interventions where they effectively bridge cultural and religious barriers. Accordingly, female employment in health carries significant technical and socio-cultural privileges for their effective service delivery to the population as care providers. In most social settings, the care seeking behaviour of women and mothers is determined largely by the presence or absence of female health workers in the health facilities. The need for female health workers is imperative when considering key reproductive, maternal, neonatal and child health services including nutrition interventions. Moreover, contrary to the implicit general lower societal prominence of women, the health sector employment provides key social status to women and empowers their family supportive earning capacities. Table 3 shows a conspicuous gender disparity in two of the four health workforce categories, namely the physicians and skilled mid-level technicians, where females account for about 19% in each, while there are also fewer female nurses in relation to male nurses. Gender balance and equality is therefore essential for achieving better health care services and generating employment, especially in the rural and nomadic geographical areas.

Table 3. Doctors, qualified nurses, qualifies midwives and technicians by gender and urban rural 2014

Categories	South Central Somalia			Puntland			Somaliland			Grand Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Doctors	357	74	431	93	27	120	159	38	197	609	139	748
Qualified Nurses	437	380	817	267	397	664	726	530	1256	1430	1307	2,737
Qualified	0	65	65	0	281	281	0	344	344	0	690	690

Midwives												
Skilled Technicians	334	106	440	467	52	519	329	101	430	1130	259	1,389
Total	1,128	625	1,753	827	757	1,584	1,214	1,013	2,227	3,169	2,395	5,564

3.4. Workforce Age Range

Considering the workforce age range, a large number of the senior health workforce staff have reached the retirement age or migrated to settle and work overseas, while many precious health professionals were tragically lost during the two decades of civil conflict. Among the health workforce population 43.3% are of 30 years of age or younger; 26.2% are in the age bracket of 31-40; 20.4% in the 41-50 age bracket; while only 10.4% are over the age of 50.

Table 4. Health Workforce Employed and enlisted by the Somali Health Authorities Categorized by Age 2014

Age Categories	Number of Health Workers Categorized by Age	Central and South Somalia %	Puntland %	Somaliland %	Total %
<- 30	4113	39.2	33.4	50.1	43.3
31-40	2489	27.2	35.3	22.4	26.2
41-50	1910	21.7	22.1	18.1	20.1
>50	988	11.9	9.2	9.4	10.4

3.5. The Striking Paucity of the health workforce

The paucity of the health workforce is conceived by measuring the current level of available doctors, nurses and midwives estimated at the ratio of 0.4 per 1,000 population or 4 for a population of 10,000. These HRH levels are extremely low when compared with the minimum threshold of 2.3 doctors, nurses and midwives per 1,000 population or 23 per 10,000 population, considered by WHO to be the adequate required professional density ratio for these health workforce categories to support UHC and the attainment of MDGs. Considering the observed low ratio, the Somali health

sector falls about seven times short of the minimum threshold mandated by WHO, as shown in **Error! Reference source not found.**. To disaggregate this composite measure for the three categories, the desired ratio between doctors on the one hand and nurses and midwives on the other was approximated at 1:4, while the ratio between the nurses and midwives was expected to be two nurses for every midwife. When considering the EPHS projected ratios, the desired number of doctors was several times lower, while the projected ratio between nurses and midwives was consistent with the above indicated 2:1 proportion. Considering the projected yearly production of the national training institutions, and the minimum WHO required coverage, the current shortage in the three health workforce categories would approximately take about seven years for physicians and nurses and 22 years for the qualified midwives, unless a higher pace of accelerated HRH production is put into action. However, it is important also to note that the Somali population is growing approximately at a rate of about 3%, implying that the population will double in only 23 years, reflecting the enormous number of additional health workforce required in the not too distant future.

Table 5. Three Key Health Workforce Categories Falling Well Below the WHO Minimum Recommended Staffing and the Projected Period for Bridging this Gap*

Key HRH Categories	CHRH in Service	Estimated Yearly Production	Current Need as per WHO Minimum Standard	Current HRH coverage per 1000 population	Current HRH Gap as per Minimum WHO Coverage	Time projected for bridging the gap in years
Physicians	638	600	5,520	0.4 per 1000 population	4,882	7
Registered Nurses	2,737	1,700	14,720		11,983	7
Registered Midwives	747	300	7,360		6,613	22
Total	**4,122**	**2,600**	**27,600**	**0.4/1,000**	**23,478**	**9**

*The gap is measured for the current population, while the fast growing population at about 3% reflects the high future health workforce demand.

3.6. HRH Planning, Management and Information System

The health authorities have assigned a Regional Health Officer and a District Health Officer for each province and district respectively, whose roles are to manage and coordinate the promotive, preventive, curative and rehabilitative services in their different assigned geographical areas. This

leadership cadre of the health care system directly oversees the operations of the different public sector care providing facilities, and closely liaise with the private sector, other regional and district authorities, local communities and the partner organizations assisting the health sector. Although the different health authorities have functional HRH units or departments, their capacity to managerially relate with their different regional health entities for obtaining information about the status of the health workforce are mostly weak.

To streamline the health workforce development process, health authorities have in coordination with their international partners, worked out mechanisms for standardizing the workforce remuneration, job descriptions and career advancement opportunities. The Health legislation recently deliberated or under consideration by the different health authorities will provide clear guidelines on private practice, fraud elimination and abuse of medical practice by non-licensed individuals. The health authorities have also embarked on the formulation of health professional councils and associations to regulate certification, accreditation, and registration and licensing of the different workforce categories. A tangible proportion of the health facilities are operationally assisted by NGO partners through different mechanisms including the contracting out approach. The NGOs share their HRH planning, and in-service training programmes and supervision with the government, in compliance with mandated partnerships and related accountability. However, an area yet to be addressed is the virtual deficiency of HRH health information system, a subject of paramount importance for an evidence based stakeholder integrated effort for HRH capacity development, remuneration and retention.

3.7. Health Sector Coordination and the Narrow Focus on HRH Development

The coordination of Somali health sector development functions is pursued through a range of institutional arrangements and mechanisms that link the different stakeholders at policy, strategic and implementation level[2]. These include the Health Advisory Board (HAB), a policy and planning forum that brings together the senior heads of agencies and Ministers of the Somali Health Authorities to deliberate on health strategic policies and priorities, and the Health Sector Committee (HSC), a forum that brings together the Somali health authorities and partners to develop policies, strategies and technical interventions for service delivery. Other coordination mechanisms include: the Health Sector Strategic Plan Financiers' Group (HSSPFG); the Health Sector Committee Global Fund Function; the Zonal Health Coordination Forums and the Thematic Working Groups and Task Forces addressing the subjects of Child Health & Immunization; Reproductive Health and Female

[2] Somali Health Sector Coordination: Institutional Analysis of Organisational and Governance Arrangements 13th May 2013. Jack Eldon

Genital Mutilation; Tuberculosis; Malaria; HIV/AIDS and Gender Based Violence. The health sector coordination mechanisms indicated above are expected to interface with the humanitarian cluster system and its 3-year Consolidated Appeals Process (2013-15) to maximize the coherence and effectiveness of health sector interventions.

However, although the HRH development function is central for any meaningful implementation of the priority health interventions, no explicit and tangible focused support was foreseen for HRH pre-service development and production or regular and systematic in-service training. This neglect, though predictable during the extended civil conflict, will now require an accelerated action to develop this vital component of the health system.

3.8. Health facilities, Care Providers and Limited Community Based Interventions

The Somali public health facilities are distributed over the regions, districts and sub-district level rural areas, where health professionals of different categories are assigned by the health authorities for their management and service delivery. **Error! Reference source not found.** illustrates the functional public and private Health facilities administered by the Somali health authorities. The extremely sparse population density of 14.2 persons per square km and the hardly accessed road communication network and poor health seeking behaviours by the communities are major determinants for the low utilization of high-value reproductive health services both at the primary health care level and at the essential referral support level. Despite the genuine managerial and technical efforts made through the EPHS programme, many health facilities face serious shortages of qualified health workforce, while several geographical areas have no functional health facilities in their catchment areas in which the population can access essential health care. Moreover, the engagement of a large number NGOs supporting both the humanitarian and health development management and services of many facilities, though commendable, has limited the establishment of a coherent and coordinated health workforce planning, production, deployment and management framework. Many of these supported facilities lack both the numbers and priority health workforce categories necessary to provide quality and equitable health services to the community, why the health partners' collective and coordinated effort and focus on HRH investment is urgently required and long overdue. Furthermore, to immediately address this critical HRH shortage, the health authorities endorsed the process of scaling up the training and deployment of community based health workers such as Female Community Based Health Workers (FCBHWs), Assistant Community Midwives (ACMWs) and qualified registered midwives and nurse midwives.

Table 6. Reported Functional public and private Health facilities 2015

Health facility type	Central and South Somalia	Puntland	Somaliland	Total
PHUs	244	129	123	496
HC/MCH Centers	169	84	104	357
RHC/District Hospital	87	5	21	113
Regional /Tertiary Hospital	11	8	16	35
Total	**511**	**226**	**264**	**1001**

3.9. HRH Financing, Motivation and Retention Challenges

The extremely modest HRH government budgetary outlay and the workforce general lower pay rates are explained by the severe resource constraints faced by the public health sector. Consequently, some of the payroll staff and others not availing public sector financial support are compensated through the programmatic interventions assisted by the different development partners. On average, the public sector disbursements to the workforce accounts for over 70% of the total health sector budgetary outlays, substantiating its modest but tangible relative importance. There is a growing government demand that the partners' contribution of salary and allowance remuneration be channelled through the Ministries of Health, as this will afford the government and partners to jointly set standard HRH performance appraisals, harmonize staff remuneration packages and effectively coordinate workforce development endeavours. Another major challenge is the delays occurring in the payment of staff remunerations and the occasional abruptly phased out support by some international NGOs due to resource limitations or unexpected facility closures due evolving security challenges that have a direct impact on workforce livelihoods, motivation and retention. The HRH policy will lend the due attention in reforming the HRH development process, with the establishment of regulatory norms that streamline the training, transparent employment, equitable deployment and coordinated and standardized remuneration for effective performance management and retention.

4. HRH POLICY FORMULATION

The health sector HRH Policy substantiates the commitment of the health authorities to workforce development in which the related priorities, the strategic courses of action to pursue, and the operational goals to be achieved are clearly spelled out. The HRH policy also outlines the regulatory measures and legislation to be considered and the coordinating mechanism to pursue for its implementation. The policy is aimed at building a national consensus on the critical role of the workforce in scaling up the performance of the health system and encouraging health professionals and health sector stakeholders to rally around the HRH issues. Moreover, the HRH policy will

deliberate on the production, deployment and equitable distribution of the required numbers of qualified and motivated health workers who will effectively perform their functions at the right place and right time.

The HRH Policy needs to outline the national commitment towards this component of the health system and help stipulating the health sector commitment to attainable goals that will guide the development of an HRH strategic plan and workforce action framework. The policy will also outline the HRH vision, mission and the inherent values and principles, as well as the priorities that need to be pursued and achieved to effectively implement the health sector strategic plan and related HRH development interventions. The HRH policy is also aimed to shape the coordination mechanisms to follow, reflecting the partners' direct technical and financial contribution to translate this policy into a strategic development action framework.

4.1. HRH Policy Rationale

The HRH Policy aims at curbing the unacceptable HRH shortage through a development process that provides a set of directions to pursue, and outlines the strategic objectives that incorporate the key prioritized HRH issues and dimensions that include the training, production, deployment, equitable distribution, and improved performance management, motivation and retention. Accordingly, the HRH Policy will deliberate on the key HRH priority attainable goals and outline the vision, mission, principles, objectives and interventions that will guide and revitalize the HRH development process. The importance of HRH coordination will also be emphasized to improve the cost-effectiveness and productivity in health care services.

4.2. Mission, Vision, Principles, Values and Goals

4.2.1. Vision

The Somali population will have access to the essential package of health services approved for implementation, through health systems that are effectively delivered by skilled, motivated and supported health workers, regardless of the geographical location or social status of the community.

4.2.2. Mission

The Somali health authorities will strongly promote, support and launch a wide-ranging action that will effectively address the human resources for health crisis, and develop this vital component of the health system, this being the optimal approach for securing universal health coverage and achieving the post-2015 health related sustainable development goal of ensuring healthy lives and promoting wellbeing for all ages.

4.2.3. Principles and Values of the HRH Policy

- Focus on HRH development: Creating conditions that inspire and motivate the health workforce and engage their full potentials in the delivery of health services to the population
- Integrity, equity and human dignity: Compliance with the highest ethical and professional standards with respect to human dignity and gender considerations, and embracing the best practices in a fair, equitable and collaborative manner
- Quality and responsiveness: Assuming a leadership style that is result-oriented, instils public confidence and pursues high quality outcomes with accountability to the needs of the target population, and where the care seeking clients feel valued and are given the best possible service

4.2.4. HRH Policy Goals

- To plan, produce, deploy, manage and retain the right number of health workforce with the right skills, positioned in the right place, at the right time, that are equitably deployed, motivated and supported to provide essential health services to the people in an equitable and cost-effective manner
- To create an environment where the health workforce is treated, as the most valuable asset and investment of the health system, proactively taking full advantage of their skills and managerial capabilities to produce the best possible health outcomes

4.3. HRH Policy Objectives

i. To define the key HRH priority interventions and related strategic directions that are in harmony with the recently stipulated health policy and with due gender considerations
ii. To establish a network of health authority based coordination mechanisms for HRH development and create the structural and organizational arrangements necessary for their implementation
iii. To develop the relevant legislative and regulatory norms that can improve the health workforce management and the safety of working conditions
iv. To affirm the necessity of government and partners' investment contributions to HRH development, derived from the programmatic commitments, as a way to avert the shortage of the skilled workforce both in quantity and quality that often thwart the translation of these policies into action
v. To develop the key HRH research priorities that correspond to the identified HRH policy concerns, especially in relation to the district health system and higher HRH management levels

4.4. The Essential Package of Health Services and Related HRH Staffing Norms

The EPHS programme was endorsed by the different Somali health authorities, in close coordination with development partners, as the most appropriate need-based approach for the implementation of essential health services to the population. The EPHS recognizes four levels of service provision namely, the primary health unit (PHUs), the health centres (HCs), and referral health centres (RHC) assuming the role of district hospitals and the regional hospitals (RHs). The profiles of service provision and the managerial and HRH support required for each level were also duly standardized. The services provided through the EPHS include six core programmes implemented at all the four levels and four additional programmes that are delivered only at the RHCs and RHs' level. These programmes are further categorized into sub-programmes with standardized interventions supported by a list of essential drugs, supplies and equipment. The six core programmes include maternal, reproductive and neonatal health; child health; communicable disease surveillance and control, including water and sanitation promotion; first aid and care of critically ill and injured; treatment of common illness and control and management of HIV, STIs and TB. The four additional programmes include the management of chronic diseases and other diseases, care of the elderly and palliative care; mental health and mental disability; dental health and eye health.

The EPHS is implemented in the framework of primary health care and is principally aimed to be available to the entire population. The EPHS outlines the minimal HRH norms and standards for its programmatic implementation, where HRH production and supply levels are consistent in the short term with the prospected EPHS operational standards, though yet being lower than the WHO identified minimum workforce density threshold. The HRH policy however, is founded on UHC and on the need to accelerate the rollout of the EPHS programme. The implementation of this policy and envisaged HRH projections need to be carefully reflected in the succeeding health workforce strategic action plans.

5. POLICY INTERVENTIONS

5.1. Human Resource Production and Training

This policy aims to act on the stark HRH shortage, where the cumulative number of doctors, nurses and midwives' density per 1,000 population is about 0.4, falling way short of the WHO set minimum threshold of 2.3 per 1,000 population, which was considered necessary to effectively support the attainment of health related MDGs. In today's public health, and in the context of post-2015 health related sustainable development goals, the earlier set threshold is considered to be in adequate, hence the HRH challenges that lie ahead for achieving UHC.

The health authorities' government policy commitments to HRH training and production will be substantiated through the following policy directions:

- Encouraging the expansion and consolidation of the existing private-not-for-profit training institutions, introducing contracting arrangements of public private partnerships, whereby the public sector will contract out the training of priority midlevel health professionals' training to selected and accredited health professional training institutes, while offering the necessary technical assistance with focus on courses' standardization; accreditation of teaching environments including clinical training settings, and curricula development; teachers training and the provision of the required learning tools
- Scaling up the public sector role in rehabilitating, rebuilding or establishing health professional training institutes (HPTIs) managed by the health authorities to further increase the workforce production in conformity with EPHS norms and standards
- Substantiating the policy implementation through the development of human resource strategic action plans in which the desired and planned increments of workforce production will be explicitly outlined
- Ensuring the full government support for the training of competent tutors for the different professional health training programmes, through the establishment of post-basic training courses and other targeted training programmes that will develop the teachers' knowledge, skills and educational leadership capacities
- Scaling up the training of Midlevel Health Professionals by targeting the most prioritized health workforce categories that include midwives, registered and auxiliary nurses and midwives, sanitarians and allied health technicians in the fields of laboratory technology, pharmacy, X-ray and anaesthesia, as well as the category of clinical officers that is essential for the effective delivery of district level clinical and public health services of the EPHS framework
- Directing a priority special focus on service provision at the grass roots, through the training of FCHWs and ACMWs or qualified Midwives embedded in their communities and Community Health Workers (CHWs) posted at the PHU facilities and develop regional, local government and community support mechanisms for their remuneration, community action and safety
- The government will mandate for those health workers, whose training was fully or partially sponsored by the government, to sign an affirmation, that upon the successful completion of their training, they will serve the public health sector in their respective localities for a period at least equivalent to the length of their respective training programme
- The health authorities will encourage and support the planning and implementation of E-learning and on-line distance learning, in a manner that is conducive to the context and needs of the health systems' rehabilitation and development, as these opportunities will provide

access to quality learning for health workers living in remote, and hard to reach areas, through the use of IT technologies

5.2. HRH Planning, Deployment, Utilization and Management

The current fragmented status of health workforce deployment, utilization and management and the evident dispersal of accountability will be revised and HRH recruitment and deployment norms and standards established. In this regard, the following policy directions are envisaged for action:

- Promulgating transparent rules and regulations for recruitment planning with transparent selection, hiring and equitable deployment and distribution of health workers in the health system
- Increasing the recruitment and deployment of the urgently needed community imbedded health workforce categories, namely the FCHW and CMWs, Assistant CMWs and prioritized facility based CHWs and midlevel health professionals to address the needs of the underprivileged and hard-to-reach populations
- Introducing skill mix and task shifting norms and standards to resolve the severe shortage of qualified physicians, registered nurses and midwives at district and sub-district level and identifying the necessity of creating new workforce categories that improve the access, quality and cost–effectiveness of health care service delivery
- Bridging the rural urban health workforce imbalance and matching the health workforce production and skills to the population health needs and to the staffing norms required and scaling up the geographical scope of EPHS delivery towards the UHC
- Introducing the systematic implementation of a wide range of capacity building initiatives to improve the HRH governance, leadership and management roles in the health sector
- Improving the workforce management by issuing individual staff contracts that stipulate the terms of employment, posting and remuneration
- Promoting team building and workforce participation in the institutional problem solving and decision making processes and compliance with professional ethics
- Introducing performance management through staff appraisals in order to ensure that health workers are providing efficient and quality services and responding effectively to the health needs of the population

5.3. HRH Financing and Funding Sources' Diversification

A significant challenge facing the Somali health sector is the scarcity of financial resources that cover the HRH employment needs, in terms of salaries and other incentives that are necessary for staff

motivation and retention. To expand the scope of employment, the following policy directions are considered:

- Expanding the service coverage of community based health workers by the creation of multi-source funding for FCBHWs and CMWs/Assistant CMWs through the UN supported local government decentralization initiative and community action for HRH remuneration and for achieving greater productivity, motivation and sustainable retention
- Improving the HRH effective deployment, management and retention, as well as governmental accountability, replacing the current NGOs' direct payment to health workers through alignment with the government systems, by channelling the set standard salaries of Somali health workforce through the government, based on stipulated staff employment contracts
- Increasing the government health sector budgetary outlays to a minimum of 5% of the government annual recurrent and development budget, to be subsequently enhanced, and strengthening accountability systems by matching the earmarked budgetary outlays with actual expenditures for workforce development activities

5.4. Creating Mechanisms for HRH Retention

The skilled Somali health workforce in the prevailing post-conflict environments has been constantly moving from the less secure rural areas to urban localities and from the public to the private sector in search of better financial and professional development opportunities. These imbalances have worsened the existing absolute shortage of the health workforce. To promote the health workforce retention, the following policy directions are considered:

- Supporting the retention of female health workers and protecting their employment from the unexpected frequent partner agencies' workforce downsizing or phasing out of ongoing health programmes for economic or security reasons, to retain their valuable care providing role and maintain their improved social status and earning capacities
- Introducing standardized regular living salaries and special hardship allowances targeted to the staff deployed in remote and hard to reach areas, as well as non-monetary incentives that include developing HRH performance capacities; transparent promotion and career opportunities; availability of equipment and technology; supportive supervision; recognition and awards; workplace safety and security; housing facilities and considerations to personal family and gender related circumstances
- Harmonizing salary remuneration rates for the public sector health workforce to avert fragmentation and promote the efficient use of resources to improve staff retention

5.5. HRH Regulatory Framework

The Somali public health sector will assume a larger role in HRH legislation through efforts aiming at strengthening the capacity of health professional regulatory bodies and health workforce regulatory frameworks. To address this priority health workforce development need, the following policy directions will be pursued:

- Encouraging the formation of health professional associations that liaise with their respective ministries of health, and other relevant authorities in regulating certification, credentialing, registration, accreditation and licensing of health professionals and establishing bye laws, acts and codes of practice, enabling the application of legitimate standards of performance for each professional association and consequently sustain the required levels of professional growth, while building umbrella networks for coordination
- Establishing regulatory Health Professional Councils (HPCs) to operate at the health authorities' level, incorporating representatives from the health professional associations and offering their advisory role to the ministries of health. The HPC functions will include monitoring the performance of educational institutions and the certification, registration, accreditation, and licensing of different professional categories with the requisite of fully aligning with the ethical codes of practice.
- Addressing health professionals' occupational health and patient safety by protecting and promoting the well-being of health professionals and controlling occupational diseases and accidents by creating a healthy, secure and safe working environment

5.6. HRH Information and Research

An effective HRH health information system will require the timely collection, analysis and dissemination of HRH data to all stakeholders for evidence based decision making, aimed at improving the workforce development process and identifying the relevant research agenda. To substantiate this mission the following policy directions are considered:

- Ensuring the timely collection of HRH related relevant data sets from all the health stakeholders and building the capacity and tools necessary, while developing measurable and rational indicators on production, training, deployment and retention
- Establishing a national HRH observatory at each health authority level that will regularly update the HRH information system, following pre-set standard operating procedures for data channelling and ensure their wide circulation to health stakeholder partners for workforce sound planning and management

- Creating a health workforce research agenda producing the necessary evidence based knowledge for future HRH priority areas for action that include the progress made in the accreditation of training institutions; licensing of health professionals; health workforce remuneration system and staff retention and productivity, and the successful implementation and performance of FCHWs' programme at the grassroots level
- Developing the HRH coordination mechanism at the Ministries of Health, coupled with an applied research agenda addressing important human resource issues within the framework of training, financing, performance management, retention and HRH pursued regulations.

5.7. Monitoring and Evaluation

Monitoring and Evaluation (M&E) is a useful tool to assess the course of HRH performance management interventions and feed these results back into HRH planning in order to adapt to the changing needs of the health system. To consolidate the M&E managerial capacity the following interventions are considered:

- Establishing the M&E system as a managerial tool to be established at the ministries of health both at central and regional level, to evolve the capacity to track the HRH development process and assess whether the planned interventions are being pursued and effectively contributing to the equitable and quality service delivery
- Developing a critical set of indicators for close monitoring and periodic evaluation that includes HRH leadership development; skill mix levels measured by the distribution of different health workforce categories; rural and urban distribution; gender aspects; HRH coordination functionality; compliance with educational institutions' accreditation norms; relevance of in-service training programmes to population health needs; licensure of health professions etc.
- Conducting yearly internal reviews on the implementation of HRH policy deliberations and addressing the challenges being faced

5.8. Policy Aspects Related to HRH Institutional Framework

A wide range of institutions have a direct role and exert influence on the framework of the HRH development process from planning, resource mobilization, training, performance monitoring, coordination and managerial support that are critical to the delivery of health care services. These institutions and their required HRH policy roles are outlined below:

5.8.1. The Health Sector: Building HRH Governance, Capacities, Partnerships and Coordination

A major component of the policy focus is to strengthen the health ministries' capacities in the area of human resources planning and management. The current understaffed HRH departments need to

be consolidated through strengthened HRH management, leadership, assessment and research capacities to effectively address and resolve the health workforce challenges in the areas of recruitment, deployment, performance quality, HRH information system, productivity, motivation, career advancement and retention. HRH departments will coordinate their functions with their respective government civil service commissions for mutual support and accountability. To assume this important role, the following policy directions will be pursued:

- Strengthening HRH departments to enable them perform all the HRH development and managerial functions, and creating regional HRH focal units responsible for managing the workforce recruitment, deployment, performance, in-service training, retention and career development
- Building partnerships with the different stakeholders both at national and international level to generate the necessary support for the planning and management of the HRH operational roles at all levels of the service delivery network to improve productivity and retention
- Establishing HRH coordination mechanisms, for which the health authorities will invite all the national and international health sector stakeholder partners to jointly extend their collective support to scale up HRH development and guide the workforce planning, resource mobilization and implementation
- Developing HRH leadership capacities through the establishment of intersectoral linkages that are related to social determinants of health and substantiating the vision of Health in All Policies to produce an integrated response action

8.5.2. The Civil Service Commission

The Civil Service Commission (CSC) is a vibrant institution mandated to reform the civil service and improve public service competences in the different government sectors. The CSC performs these functions in line with the existing civil service legislation. The CSC has also the responsibility of delineating transparent standards for recruitment and remuneration. Considering the labour intensive nature of the health sector and its close interface with the CSC, the following HRH policy directions were considered:

- Involving the CSC in aligning the HRH recruitment norms and standards of the health sector with those pursued by the CSC to ensure that the health sector is compliant with public sector employment practices, which is a measure to protect the workforce minimum remuneration rights and mandated professional development opportunities

- Negotiating with the CSC on pursuing a special grading system for specific health workforce categories that would not closely fit the general categorization of the civil service workforce to sustain the desired levels of motivation and retention of these priority health professionals

8.5.3. The Health Professional Associations

Health professional associations (HPAs) are operational in the different health authorities; however, their role in promoting the standards of practice and professional regulations in coordination with the ministries of health has been insufficient. To revive and somewhat redefine the role of the different health professional associations, the following policy directions are being considered:

- Encouraging and supporting the different health professional organizations to engage actively in their mandated roles of protecting the public wellbeing by offering the highest possible standards of health services' provision, while preserving the ethical norms of practice
- Creating partnerships with different professional associations in introducing and consolidating the HRH regulatory norms related to certification, accreditation, registration and licensing
- Liaising with professional associations in the development of different training programmes of their respective academic expertise and participating in the advancement of priority academic courses that are essential for health system development

8.5.4. The Association between Higher Education and the Health Sector

The government ministries responsible for the higher education are coordinating the educational policies and plans of a number of government supported educational institutions and a large number of universities established by the private sector during the past two decades with diverse medical and other health professionals training programmes. To expand the health training institutions and promote the quality of their programmes, the following policy interventions are considered:

- The health sector will closely coordinate with the government ministries responsible for higher education on all issues related to the regulation and accreditation of health training institutions and programmes to improve the quality of their production
- The health sector will engage the Health Councils to create partnerships between the ministries of health, the education sector and HPAs to establish a joint task force for standardizing the health courses' educational curricula, the academic environment and evaluate and support capacity development for the teaching staff

8.5.5. Ministries of Finance

During the ensuing recovery and reconstruction phase of Somali public sector institutions, the Ministries of Finance are expected to oversee civil servants' payrolls. However, in view of the prevailing financial limitations at the macroeconomic level with scarce revenues, the government will not have the necessary resources to match its human resource employment ambitions. In this context, the following HRH policy directions will be pursued:

- The public health sector will closely negotiate with government financial institutions to recognize the significant role that the health workforce is playing, in meeting the essential healthcare needs of the population and consequently, the need for scaling up the health sector budgetary outlays
- The health sector will seek the support of their respective ministries of finance and Social Affairs' Parliament Committees to earmark a proportion of the taxation on cigarettes and *Khat* for the health sector to finance the delivery of priority HRH capacity development interventions that curb major disease risk factors

8.5.6. UN Joint Programme on Local Governance and Decentralized (JPLG)

The JPLG aims to strengthen local governance and promote service decentralization through a partnership between the government, five UN agencies and a range of other stakeholders that include development partners and the private sector. JPLG will engage in eight programme areas of work that include municipal, finance, local economic development, service delivery such as health, solid waste management, water and sanitation and social accountability, all being issues of significant relevance to the delivery of essential health services. Considering the potential of this programme, the following HRH policy directions are considered:

- Pursuing the local government employment of the trained community based health workers comprising of FCHWs and ACMWs through the JPLG decentralization initiative
- Negotiating with partner UN agencies to consider the local employment of these predominantly female health workers through the JPLG and selectively earmarking the necessary remuneration co-financing for this vital gender sensitive health intervention
- Support the construction of MCH and health centers and maternal waiting homes in remote and hard to reach rural areas to expand healthcare access into the rural areas

8.5.7. UN Agencies, NGO Community and Donor Partners

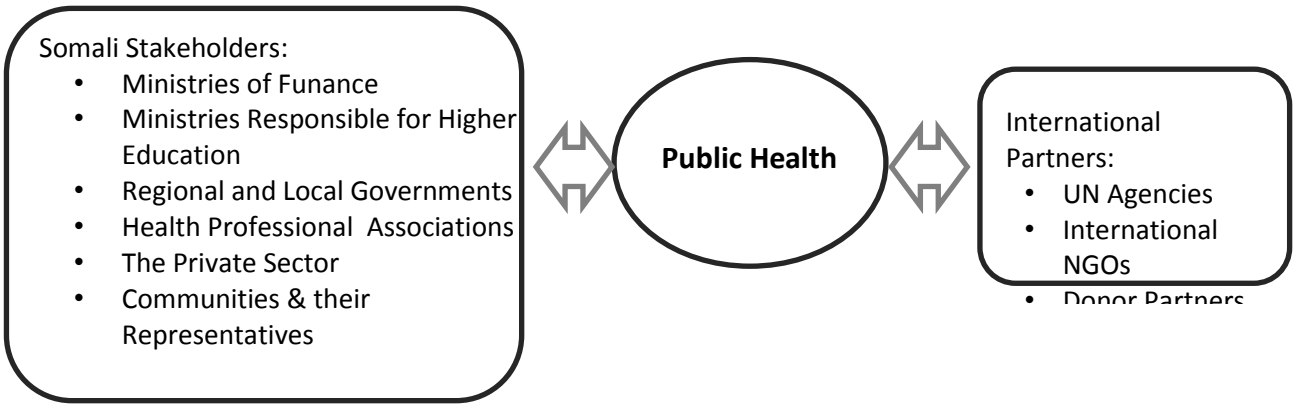
The commendable humanitarian social role of the international partners during the two decades of civil conflict was characterized by the successful provision of health and nutrition services and water and sanitation provision and hygiene promotion. To attract a greater attention from these partners in support of HRH development interventions, the following policy directions are considered:

- The government will encourage the partners' active participation in bridging the severe HRH shortage by mobilizing the necessary technical and financial resources to support priority targeted HRH development interventions in the areas of workforce training, leadership development, production, equitable deployment, management and retention
- The government will encourage the partners to form a high level human resource technical working group that would complement the HRH health authority level coordination mechanism and pursue a workforce centred fast track health system process of development
- The government in cooperation with its partners will incorporate in HRH coordination mechanisms, the harmonization of health workforce planning, development and remuneration systems between the humanitarian and development health interventions to facilitate the transition of the health sector to rehabilitation and sustainable development

6. HRH POLICY IMPLEMENTATION

The HRH policy development has evolved through an inclusive and participatory consultative process at each health authority level and has attracted a large number of stakeholders. To create an appropriate platform for HRH policy implementation, the health authorities will ensure the active involvement and support of all relevant government institutions, the regional and local government entities and the wider spectrum of development partners. The key stakeholders influencing the implementation of this policy are reflected in figure 2, while their roles and responsibilities in the implementation process are briefed outlined:

Figure 2. Health Stakeholders' Partnerships and Coordination



- **Ministries of Health:** the health authorities will be the lead agencies in translating the HRH policy into strategic action plans for its practical implementation. The health sector will coordinate these endeavours with all the relevant stakeholders. To execute these functions the health sector will strengthen its HRH department; establish HRH coordination and facilitation multi-stakeholder committees; build the HRH regulatory bodies and promote public private partnerships to scale up health workforce production. The health sector will conduct HRH policy training briefs for its leadership and management cadres across the health system. Periodic policy implementation reviews will also be conducted to assess progress, respond to local health service delivery conditions and ensure the HRH policy contribution to Improving population health.
- **The Ministries of Finance:** The health sector will closely liaise with the Ministry of Finance to jointly work for earmarking the budgetary outlays necessary for policy implementation through its multi-year strategic plan and related annual work plans.
- **The Ministries Responsible for Higher Education:** The health sector will liaise with its respective ministry on pre-service technical and undergraduate health professional training programmes for their regulation, periodic accreditation and quality improvement.
- **The Regional and Local Government Authorities:** the recently introduced Somali decentralization policy will assign direct responsibilities to the regional and local level institutions to allocate financial resources to support the remuneration of the community based health workers of their administrative geographical areas and contribute to the rural health care facilities' constructions.
- **Health Professional Associations:** the ministries of health will extend full support for the consolidation of professional associations and encourage them to participate in improving and scaling up the HRH pre-service regulation through formal certification, accreditation, registration and licensing
- **The Private Sector:** the private educational institutions are currently the main source for health workforce training and production. Accordingly, the ministries of health will encourage the establishment of public private partnerships for launching courses for the training of the priority midlevel categories that are critical for EPHS programme implementation
- **The Health Partners:** the public health sector will create the necessary environment for effective coordination and partnership building in all HRH development related endeavours for extending the necessary collective support to HRH pre-service and in-service training programmes
- **The community role:** community participation and leadership is paramount for the implementation of community based health interventions that are related to the selection,

training and deployment of FHW, ACMWs and CMWs and facility based CHWs for supporting their field level operations

The successful implementation of this policy provides a credible hope for achieving universal health coverage and the sustainable development goal of ensuring healthy lives and promoting wellbeing for all during the life course, over the medium and long term perspectives.

7. CONCLUSION

The Somali health sector has expressed a desire to articulate a workforce policy framework in which the key priority interventions were outlined. The development of this policy was the result of a series of consultations covering an initial phase of HRH situation analysis followed by discussions and deliberations in the areas of HRH production; planning, deployment, utilization and management; HRH financing and retention mechanisms; HRH regulation, health information and research and M&E as well as the policy aspects related to HRH institutional framework. Accordingly, the HRH policy deliberates on series of interventions that will enable the health sector to minimally conform to the EPHS deployment norms and standards and subsequently achieve staffing norm levels, consistent with the minimum WHO threshold, set for key professional categories. Moreover, the policy clearly spells out the imperative of forging collaborative partnerships that involve both Somali and international stakeholders. Through this policy, the health authorities have also reiterated their commitment to increase HRH budgetary allocations and explore local support through regional and local government ownership and participation, with the long term vision of significantly reducing dependence on HRH external financing. The Somali health authorities emphasize on the significance of HRH profiling and development in the health policy agenda, and scaling up workforce production, addressing both the numerical and capacity shortages that hinder progress towards the attainment of UHC, as well as the ambitions of attaining the post-2015 health related sustainable development goals.