Somaliland National Quality Policy and Strategy (NQPS)

2026–2030

Somaliland Ministry of Health Development

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King's Global Health Partnerships in Somaliland

KING'S College LONDON

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Global Health Partnerships FORMERLY THET

World Health Organization

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Abbreviations

COVID-19: Coronavirus Disease 2019

DQA: Data Quality Assurance

ELMIS: Electronic Logistics Management Information System

EMRO: Eastern Mediterranean Regional Office (of WHO)

EPHS: Essential Package of Health Services

FCV: Fragile, conflict affected, and vulnerable

HAI: Healthcare-associated infection

HMIS: Health Management Information System

HNQIS: Health Network Quality Improvement System

HSSP: Health Sector Strategic Plan

IOM: Institute of Medicine

IPC: Infection Prevention and Control

IPCHS: Integrated People-Centred Health Services

IPCAF: Infection Prevention Control Assessment Framework

KGHP: King's Global Health Partnerships, King's College London

KII: Key Informant Interviews

LMICs: Low and Middle-Income Countries

MCH: Maternal and Child Health

NCD: Non-communicable diseases

NDP: National Development Plan

NGO: Non-Governmental Organisation

NHP: National Health Priorities

NHPC: National Health Professions Commission

NQP: National Health Quality Priorities

NQPS: National Quality Policy and Strategy

MoHD: Ministry of Health Development

ODK: Open Data Kit

PHU: Primary Health Units

PGME: Post Graduate Medical Education

PPE: Personal Protective Equipment

PSFHF: Patient Safety Friendly Hospitals Framework

PSI: Population Services International

PVS: People's Voice Survey

QuEST: Quality Evidence for Health System Transformation

SDGs: Sustainable Development Goals

SOPs: Standard Operating Procedures

THET: Tropical Health and Education Trust (now known as Global Health Partnerships)

TOR: Terms of Reference

TWG: Technical Working Group

TB: Tuberculosis

UHC: Universal Health Coverage

UN: United Nations

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

WHO: World Health Organization

Foreword

The Ministry of Health Development (MoHD) aims to provide high quality, accessible, and equitable essential health care services in Somaliland. Despite the multifaceted challenges that the healthcare system faces, the MoHD is determined to develop and adopt innovation to improve quality and safety through the development of the National Quality Policy and Strategy (NQPS).

Guided by the National Health Policy, National Health Sector Strategic Plan, situational analysis of current quality across the health system including the population's perspectives of quality collected through the People's Voice Survey (PVS), stakeholders came together to develop the NQPS for 2026-2030.

This national policy and strategy not only explains the underlying challenges for delivering safe and high-quality services, but it explicitly presents a new direction by defining quality priorities, objectives and interventions and mapping out an implementation plan to improve quality over the next 5 years.

The NQPS development and the subsequent implementation over the next 5 years will be an opportunity to strengthen the MoHD focus on the quality and safety of healthcare, as well as on improving data for quality measures and engagement of communities in improving healthcare services.

On behalf of the MoHD, I am pleased to present the Somaliland NQPS 2026-2030 to all stakeholders and partners. We have taken an inclusive and participatory approach that seeks to provide a framework to all stakeholders to implement quality improvement in different services and across different delivery levels. I urge all stakeholders to align with the strategy and to ensure priority interventions and activities are fully implemented.

Finally, I would like to thank everyone who participated in the NQPS development. We appreciate MoHD staff for their dedication and valuable input. And we are grateful to our health partners for their valuable contributions throughout the process.

H.E Hussein Bashir Hersi
Minister of Health Development
Republic of Somaliland

Acknowledgements

The development of the Somaliland NQPS 2026-2030 has been consultative and participatory, involving technical working groups, MoHD departments, MoHD Partners and stakeholders across the health sector.

We express our sincere gratitude to all those who made significant contributions over the last three years and value their commitment to implement the new strategy. Special appreciation goes to Dr Khalid Ali Ahmed Balayah (Director of Planning, Policy and Strategic Information), Mr Mohamed Abdi Hussein (Former Director of Planning, Policy and Strategic Information), Mr Abdirahamen Hassan Ibrahim (Former Director of Health services and Hospitals) for their leadership and oversight of the development process.

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Technical design and review of the document was provided by the Technical Working Group for Quality of Care. This was made up of representatives from World Health Organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Population Services International (PSI), Save the Children, Global Health Partnerships (formerly THET) and the following MoHD departments: Planning and Policy, Health Services and Hospitals, Community Health Services and Human Resource. We thank this group for their valuable technical support.

We thank Qatar Charity for their financial support to the National Healthcare Quality Improvement Programme, under which this policy and strategy were developed.

Dr Ahmed Mohamoud Jama
Director General
Ministry of Health Development
Republic of Somaliland

Executive summary

The Somaliland National Quality Policy and Strategy (NQPS) 2026-2030 outlines a framework to enhance healthcare service quality across Somaliland. This strategy is important for strengthening the health system, coordinating efforts for improving health outcomes, and aligning with global health objectives, including Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

The NQPS acknowledges the challenges of delivering quality care in Somaliland, including resource constraints, workforce challenges and a high burden of communicable and non-communicable diseases. It addresses the need to improve service delivery, patient safety, and promote a culture of quality within the health sector.

The NQPS development process involved extensive stakeholder consultation and is structured around eight core elements, including: national health goals and priorities, local definitions of quality, stakeholder engagement, situational analysis, governance, improvement methods, health management information systems, and quality indicators. The development of the NQPS marked the first instance of utilising a People's Voice Survey (PVS) to evaluate demand-side factors within Somaliland's health sector.

The situational analysis highlights gaps in service delivery, infrastructure, workforce capacity, and data management. Key priorities include enhancing governance and leadership, reducing harm to patients and healthcare workers, strengthening workforce capacity, promoting people-centred care, and improving data for quality health services.

The implementation plan details interventions for each objective, the progress of which will be monitored using selected output indicators. The operational plan outlines the levels of implementation and corresponding responsibilities.

Ultimately, the NQPS aims to ensure equitable access to safe, integrated, and patient-centred care, leading to improved health outcomes and greater trust in Somaliland's health system.

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Introduction

1. INTRODUCTION

1.1 Importance of quality and the NQPS

Quality care is the goal in the delivery of health care services. However, delivering quality care alongside political upheavals, recurring natural and man-made disasters, and with a growing burden of communicable disease, non-communicable disease and trauma, make delivering this goal feel unachievable. The recent COVID-19 pandemic added to all these pressures and revealed the huge challenges and risks facing healthcare globally, including in Somaliland, in the context of a pandemic, where the safety of healthcare workers and clients were significantly impacted.

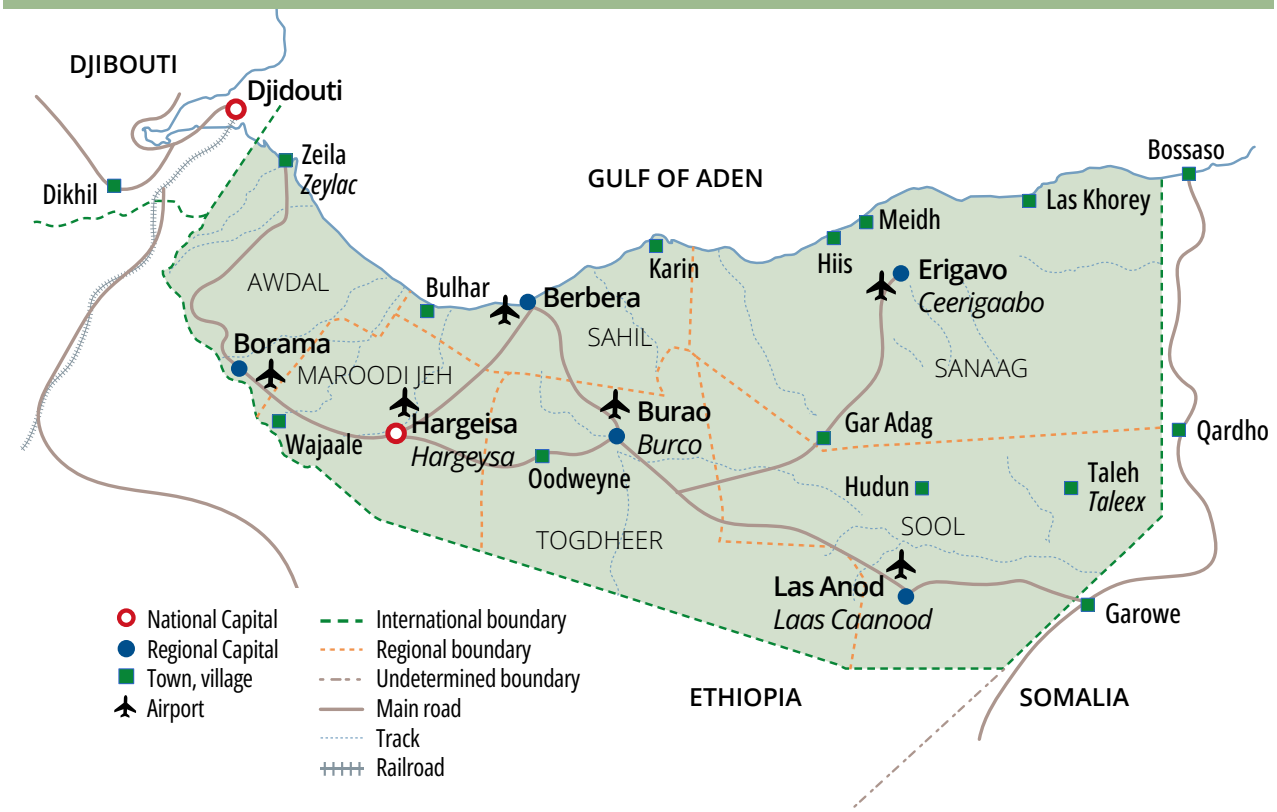
Improvement in the quality of health care is an important entry point for strengthening health systems and ultimately achieving enhanced population health. Indeed, the development, refinement and execution of a National Quality Policy and Strategy (NQPS)[1] is a priority for countries as they strive to improve the performance of their health care systems. The NQPS encourages system wide efforts for improvement and helps to secure political and financial commitment to improve the quality of health care across all six-health system building blocks and ultimately achieve enhanced population health. The NQPS is a global initiative that countries can use to improve the performance of their health system through the development, refinement and implementation of a national policy and a strategy to improve the quality of care. Pragmatic strategies are needed to improve quality of care for fragile, conflict-affected, and vulnerable (FCV) countries, like Somaliland. Consequently, the WHO has developed an approach to support health systems in FCV settings to improve the quality of care.

The ongoing evolution of the health system in Somaliland towards prioritising patient needs and focusing on health outcomes demands a shift not just towards expanding access to healthcare services, but also towards enhancing the quality of these services. The provision of substandard care is a significant obstacle to improving health outcomes in Somaliland, and in certain instances, may result in patient harm. Given this scenario, it is critically important for Somaliland to develop and implement a comprehensive NQPS. The NQPS will strengthen a culture of quality within the healthcare sector, set standards and guidelines for quality care, improve patient safety, increase patient satisfaction, and ultimately, improve the health outcomes for the Somaliland population including maternal, infant and under-5 mortality and mortality from infectious and non-communicable diseases (see Table 1).

Table 1: **Summary of key health indicators**

Indicator	Value
Maternal mortality rate	396 per 100,000[2]
Infant mortality rate	70 per 1,000
Under-5 mortality rate	93 per 1,000
Malaria cases	2.15 per 1,000 persons per year[3]
Tuberculosis (TB)	285 cases per 100,000 population[4]
Non-communicable diseases (NCD)	7% of population[5]

Figure 1: **Map of Somaliland**



Experiences from countries with national quality policies and strategies have highlighted the benefits of one coherent plan that provides guidance and direction on quality at all levels of the system. However, quality-related policies will already exist within the context of wider national governance arrangements. The NQPS can help clarify the linkages with national health – and non-health – policies, plans and priorities, highlight the importance of quality-focused processes in realising overall health priorities, and define lines of accountability to work towards more people-centred health services. This is certainly the case in Somaliland where many national policies already address quality healthcare issues, including the following examples: Somaliland 2030 vision[6], National Development Plan[7], National Health Policy[8], Health Sector Strategic Plan[9], and Roadmap for Universal Health Coverage[10]. By focusing on measurement, accountability, and system-wide action, NQPS can help save millions of lives annually and improve health outcomes, user experience, and trust in health systems.

In 2020, Somaliland, in the Horn of Africa, had a population of 4.2 million, growing at 2.93% annually[11]. The population is predominantly young, with 53% living in urban areas, 11% in rural areas, 34% as nomads, and 2% as internally displaced persons. Life expectancy is 48 years for males and 52 years for females. Administratively, the country has six regions and 19 districts, with Hargeisa as the capital.

While administrative boundaries were revised in the past decade, the MoHD still follows the previous administrative framework. Politically, Somaliland operates under a presidential system with an elected president and vice president who appoint the Cabinet and executive government. The Somaliland NQPS will seek to improve quality of care for all the population across all six regions and 19 districts and for urban, rural, nomadic and displaced communities.

1.2 Defining the concept of quality

There is no single universally accepted definition of "quality". However, the Institute of Medicine (IOM) definition has been widely used:

> *"The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."*[12]

There is a growing acknowledgement that quality health services across the world should be:

- **Effective:** providing evidence-based health care services to those who need them.
- **Safe:** avoiding harm to people for whom the care is intended.
- **People-centred:** providing care that responds to individual preferences, needs, and values.
- **Timely:** reducing waiting times and sometimes harmful delays, for both those who receive and those who give care.
- **Equitable:** providing care that does not vary in quality on account of age, sex, gender, race, ethnicity, geographical location, religion, socioeconomic status, linguistic or political affiliation.
- **Integrated:** providing care that is coordinated across levels and providers and makes available the full range of health services throughout the life course.
- **Efficient:** maximising the benefit of available resources and avoiding waste.

Table 2: **Quality Dimensions**[13]

Effective	Is care appropriate for the health needs of the population and consistent with knowledge and evidence for achieving the best possible health outcomes?
Safe	Does the delivery of health services utilise the safest means possible and reduce avoidable harm?
People-centred	Is the experience of care positive through the eyes of patients and families? Is there a sense of trust among communities in the quality of care available? Do patients, families and communities feel empowered as partners in designing and refining the delivery of health services?
Timely	Are waiting times for treatment acceptable to the population and sufficiently short to avoid unnecessary harm?
Equitable	Are there barriers to, or disparities in, factors related to age, sex, gender, race, ethnicity, geographical location, religion, socioeconomic status, linguistic or political affiliation?
Integrated	Are there gaps in patient care between clinical settings? Do components across the health sector communicate to maintain seamless transition of patient care?
Efficient	Are resources allocated and used in the best possible manner to achieve outcomes?

The recent *Lancet Global Health Commission* report by Margaret E Kruk et al in 2018[14], highlighted that poor quality care is now a greater mortality risk than lack of access in low and middle-income countries (LMICs), and responsible for 60% of deaths from treatable conditions. The report estimated that high-quality health systems could prevent millions of deaths from various conditions, including cardiovascular disease, newborn deaths, tuberculosis, and maternal deaths.

The *Lancet Global Health Commission* defined quality as:

> *"a high-quality health system is one that optimises healthcare within its given context by consistently delivering care that demonstrably improves or maintains health outcomes, by being valued and trusted by all people, and by responding to changing population needs."*

1.3 A culture of quality

There is no single definition of what a culture of quality entails, but it has been described for organisations as:

> *"An organisation which creates a working environment which is open and participative, where ideas and good practices are shared, where education and research are valued and where blame is used exceptionally".*

It is generally understood to mean that, at all levels of a health system, there is an inherent and explicit recognition of the value of efforts to improve the quality of care provided, and such efforts are systematically promoted within an enabling environment that encourages engagement, dialogue, openness and accountability.

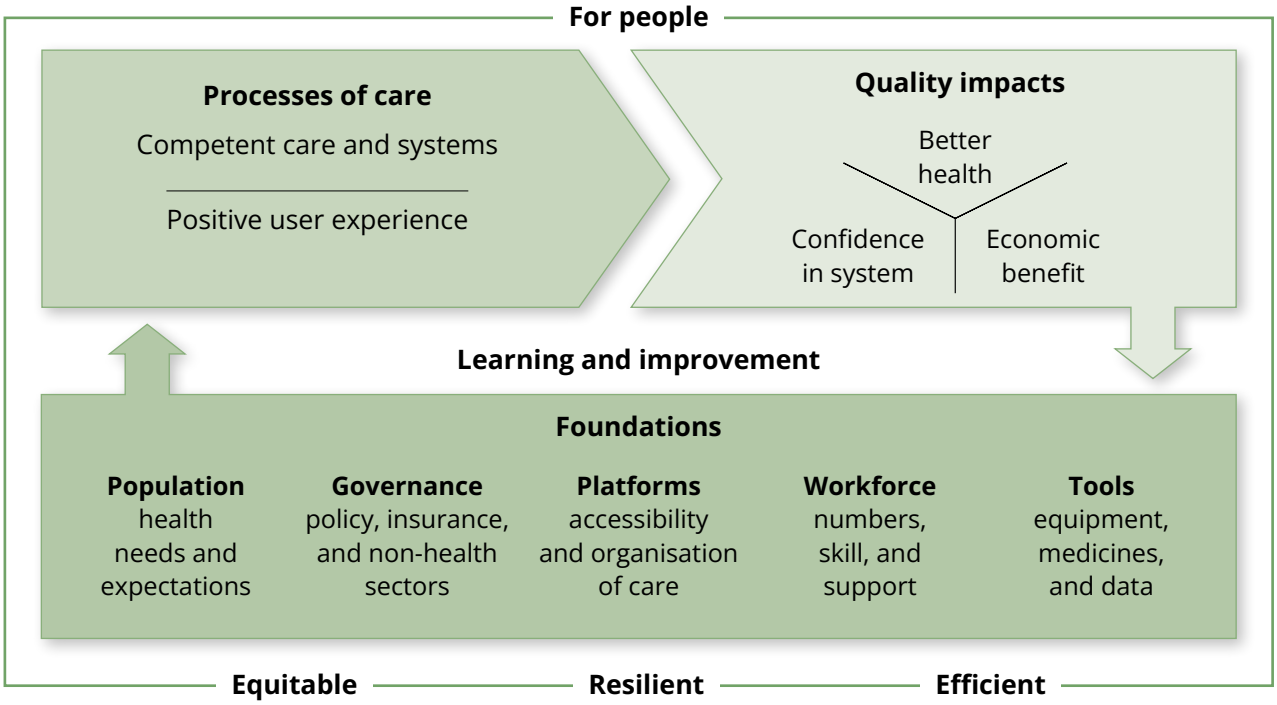
The NQPS of Somaliland will be comprehensive, covering all aspects of healthcare quality and is applicable across various sectors and services within the healthcare system.

- Healthcare Levels: From primary care facilities to tertiary hospitals, ensuring quality across all levels of care.
- Healthcare Sectors: Both public and private sectors are included, aiming for quality standardisation across all healthcare providers.
- Healthcare Services: Covering a wide range of services, including preventive, promotive, curative, rehabilitative, and palliative care, to ensure comprehensive care delivery.
- Health Workforce: Addressing all healthcare workers, emphasising their role in delivering quality care and ensuring patient safety.
- Patient Safety and Rights: Highlighting the importance of safeguarding patient safety and upholding patient rights as central elements of quality care.

1.4 Quality across the health system

While quality of care is predominantly expressed at the level of interaction between the provider and receiver, it takes place within a much broader, complex health system. The recent Lancet Commission produced a quality health system framework (see figure 2), highlighting the values of a high-quality health system as being: for people, equitable, resilient, and efficient. The framework also highlighted that people are concerned with care processes and quality impacts and these demand-side metrics need to be a greater focus of measurement alongside supply-side metrics. This is something that has been captured in the situational analysis for this NQPS. Finally, the framework stressed the importance of learning and improvement across five foundations including: populations, governance, platforms, workforce, and tools. The Commission thus provides a broader perspective for improving the quality of the health system than focusing only on the quality of care at the patient level.

Figure 2: **High-quality health system framework from: High-quality health systems in the SDG era: time for a revolution**



In Somaliland, over the past decade, the MoHD has made significant strides in strengthening primary, secondary, and tertiary healthcare services. As the leading health authority, MoHD oversees governance, policy development and service delivery. Healthcare in Somaliland is delivered through a public-private mix, including traditional practitioners. A 2017 Ministry of Planning report recorded 27 public hospitals, 17 private hospitals, 129 health centres, 159 health posts, and 16 mobile clinics. The healthcare workforce included 868 physicians, 2,042 nurses, and 842 midwives, with doctor and nurse ratios of 2 and 4 per 10,000 people, respectively.

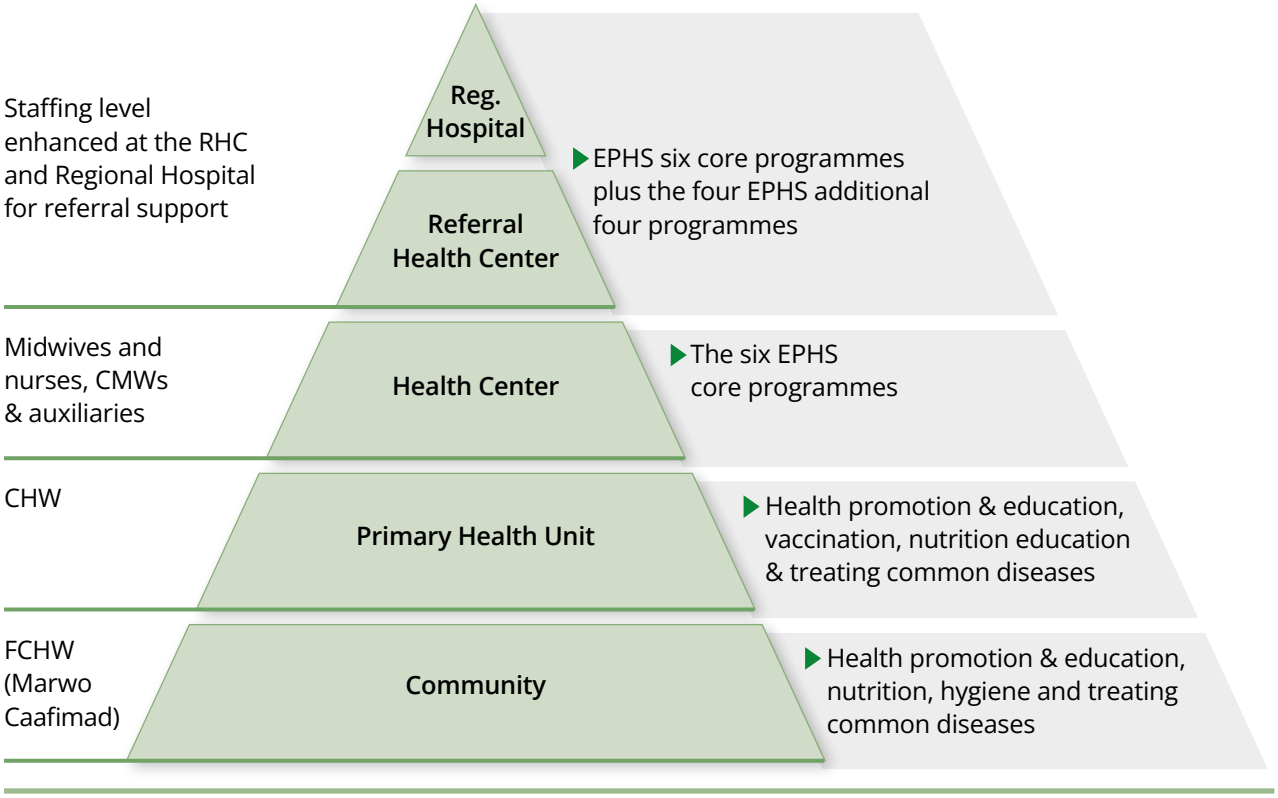
In Somaliland, the Essential Package of Health Services (EPHS) defines the levels of care across the health system and the NQPS should address quality issues at each level.

1. **Community Health –** Basic health support at the community level.
2. **Primary Health Unit –** The first point of care, providing essential services.
3. **Health Centre –** A more comprehensive facility offering expanded services.
4. **Referral Health Centre –** Staffed by generalist doctors, serving as the first referral level.
5. **Regional Hospital –** Specialising in advanced medical care with traditional specialties.

1.5 NQPS alignment with global health initiatives

The National Quality Policy and Strategy (NQPS) of Somaliland is a framework designed to improve the healthcare system by aligning with global health initiatives and ensuring that healthcare delivery meets internationally recognised standards and strategies. Here is how the NQPS of Somaliland connects with key global health initiatives:

Figure 3: **Delivery of the Essential Package of Health Services (EPHS)**



1. **Universal Health Coverage (UHC):** Endorsed by the World Health Organization (WHO), Universal Health Coverage aims to ensure that all individuals can access quality health services without financial hardship. Somaliland's NQPS supports this initiative by focusing on enhancing the quality of care, to all segments of the population.

2. **Sustainable Development Goals (SDGs):** The NQPS of Somaliland aligns with the United Nations' Sustainable Development Goals, especially Goal 3, which aims to "Ensure healthy lives and promote well-being for all at all ages." The strategy targets key aspects of this goal, such as reducing the rates of maternal and child mortality, enhancing the management and prevention of chronic diseases, and improving healthcare financing and workforce development, reflecting commitment to national and global health advancement.

3. **WHO's Integrated People-Centred Health Services (IPCHS):** This initiative emphasises care that is coordinated around the full range of needs of individuals and communities, rather than diseases alone. The NQPS of Somaliland embodies these principles by advocating for a people-centred approach that integrates services across different care settings, ensuring seamless and holistic care experiences for patients.

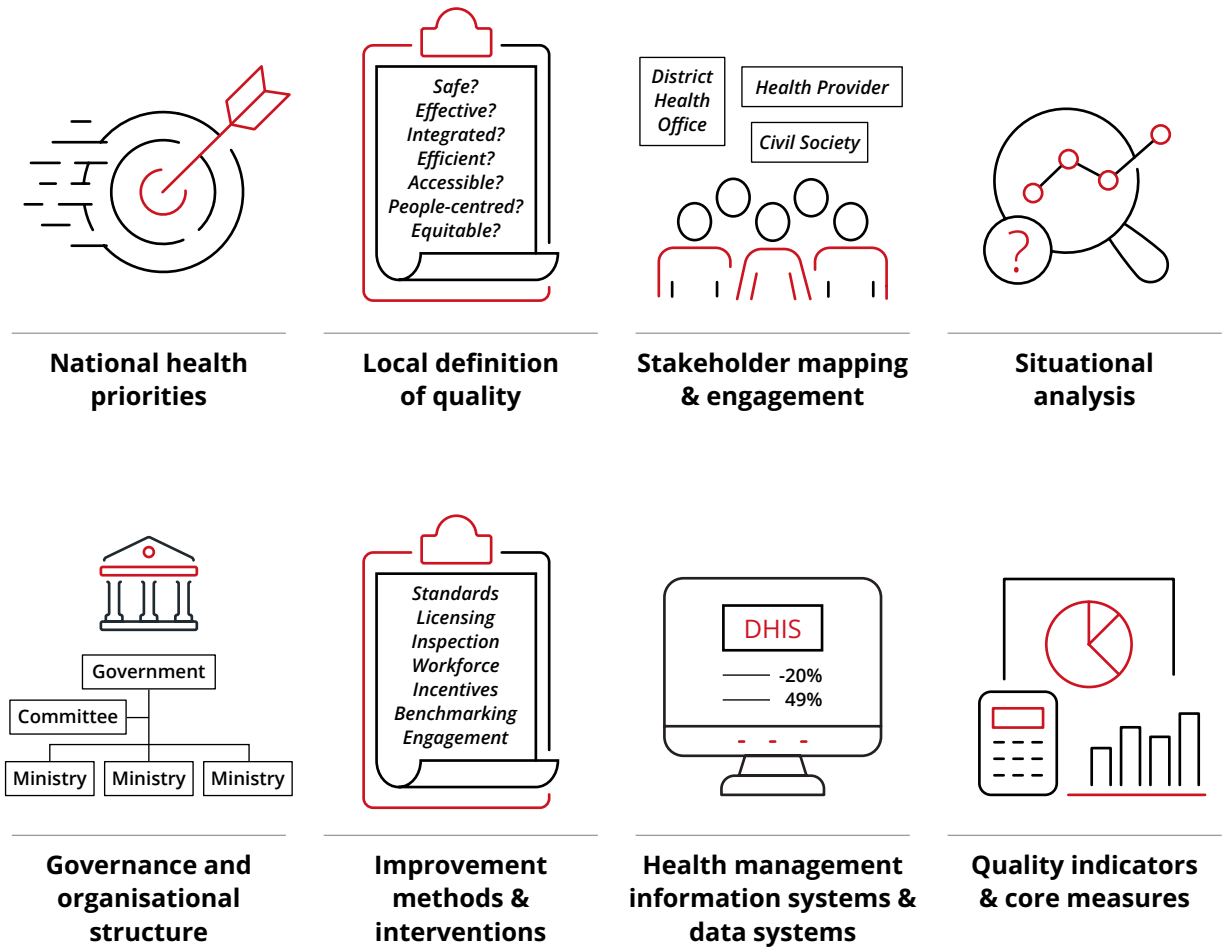
4. **Patient Safety Initiatives:** The NQPS aligns with global efforts, such as the WHO's Global Patient Safety Action Plan 2021-2030[15], to improve healthcare safety. It also aligns with the WHO Regional Office for the Eastern Mediterranean (EMRO) Patient Safety Friendly Hospitals Framework (PSFHF)[16]. It focuses on creating safer healthcare environments in Somaliland through strategies that address common safety concerns, including medication safety, surgical safety, and infection prevention and control, thereby minimising the risk of harm to patients.

1.6 The Somaliland NQPS process

The Ministry of Health Development (MoHD) led in developing the NQPS through a consultative process and engaging multiple stakeholders who have made significant contributions to healthcare in Somaliland. MoHD followed the WHO[17] eight elements for NQPS development (see figure 4):

1. National health goals and priorities
2. Local definition of quality
3. Stakeholder mapping and engagement
4. Situational analysis: state of quality
5. Governance and organisational structure for quality
6. Improvement methods and interventions
7. Health management information systems and data systems
8. Quality indicators and core measures

Figure 4: **WHO Eight Elements for NQPS**



Operational planning	Strategy implementation can be outlined in a detailed operational plan, which defines key tasks, assigns responsibilities, identifies milestones, and considers practical aspects of implementation, such as funding.
Integrating technical programmes	Countries often have existing quality initiatives focused around specific technical areas (such as HIV or water, sanitation and hygiene) or population groups (such as mothers and children). Successfully integrating these efforts with overarching work on national quality necessitates careful planning.

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Policy and strategy development

2. POLICY AND STRATEGY DEVELOPMENT

2.1 National health goals and priorities

The Somaliland 2030[18] vision aspires Somaliland to be a nation whose citizens have equitable access to quality healthcare. In the National Development Plan[19], the MoHD is focused on improving service quality at secondary healthcare level, provided at district or regional hospitals. In the National Health Policy (NHIP III)[20], quality of care is explicitly articulated in this policy statement:

"The National Health Policy urges that quality improvement should remain the cornerstone and foundation for all the healthcare programmes and services implemented in Somaliland. The policy demands that all the documents related to standardisation of services, guidelines, protocols, and legal frameworks that are essential for guiding the quality improvement efforts are to be formulated at national level. The policy, likewise, calls all the stakeholders including the private sector to collaborate better, exchange knowledge and form a coalition body for quality improvement. The policy recommends prioritising regular training in protocols and standards for healthcare staff to adapt their attitudes and practices towards patient safety, performance data and monitoring improvement efforts."

National Health Priorities in NHP III:

1. Expand essential service delivery
2. Improve human resource policy and build capable health workforce
3. Strengthen leadership and governance for health
4. Improve access to quality essential medicine and health technology
5. Strengthen Health Information system
6. Enhance Health financing
7. Strengthen emergency preparedness and response
8. Improve infrastructure for health
9. Scale up tackling of social determinants of health and encourage health in all policies

Finally, many of the objectives in Somaliland's Roadmap for Universal Health Coverage relate to quality issues – see figure 5.

Figure 5: **The new HSSP 2022-2026 Objectives**

SPECIFIC OBJECTIVES

Reorient and strengthen Primary Health Care Services to act as "gatekeepers" for patients' access to health centres and hospitals with focus on people-centred services. Improve quality of care and efficiency measures at all levels of care and strengthen evidence-based decision making.	Accelerate progress towards Sustainable Development Goal 3. Strengthen results based approach for efficient management of human resources and healthcare technology.	Respond to the healthcare needs of the population and ensure a patient-centred approach. Refocus expenditure on health promotion and Primary Health Care Services.

2.2 Local definition of quality

A Somaliland local definition of quality was discussed during the second stakeholders' engagement meeting in December 2023. Stakeholders were placed in groups and gave varied definitions of quality of care. After a plenary discussion, a consensus was reached on the following definition:

"Equitable access to integrated, safe, person/patient centred quality care with continually improving outcomes for urban, rural and nomadic communities that is affordable and trusted by all."

2.3 Stakeholder mapping and engagement

The MoHD led a national stakeholder engagement workshop in Hargeisa in December in 2023 (Appendix 1). This workshop brought together 48 stakeholders from government agencies, healthcare providers, professional associations, regulatory bodies, academia, health facility leaders, UN agencies and health sector partners. Stakeholders developed a definition of quality for the Somaliland health sector and discussed priorities for improving the quality of health services. After the workshop, MoHD launched a National Technical Working Group (TWG) for Quality of Care, responsible for the further development of the NQPS. The membership of this group is in Appendix 2. In April 2025, a second stakeholder workshop was held to engage stakeholders in the finalisation of the NQPS. This included finalising the strategic priorities, objectives, interventions and monitoring framework (Appendix 3).

2.4 Situational analysis: state of quality

The situational analysis to map the state of quality across the health sector was conducted between 2021 and 2024 by the MoHD in collaboration with King's Global Health Partnerships (part of King's College London), the WHO Quality of Care Unit, and the WHO Regional Office for the Eastern Mediterranean (EMRO) and Global Health Partnerships (formerly THET).

The assessment involved:

- Desk review
- Focus group discussions
- Key informant interviews
- Health facility assessments
- National People's Voice Survey (PVS)
- National Assessment of Undergraduate Medical Schools' Capacity
- Mapping of Postgraduate Medical Education courses
- Infection Prevention Control Assessment Framework (IPCAF)

The People's Voice Survey (PVS) was the last element of the situational analysis, and the results were presented at the second stakeholder workshop in April 2025. The methodology for each element of the situational analysis is described below, followed by the results.

Methodology and Findings
Desk Review

Methodology

A consultant conducted a desk review in 2022 to identify past and ongoing quality improvement initiatives in Somaliland. The review examined national strategic health plans to identify commitments to healthcare quality, identified available data on the state of quality, and determined the extent to which quality of care was identified as an existing health sector priority.

Desk Review Findings
Desk reviewed documents include those related to strategic health planning and policy, delivery of quality health care services, and oversight management of quality of care. The documents indicate policymakers' commitment to universal quality health care coverage to all citizens and acknowledge resource constraints to operationalise such commitment, as evidenced by poor health statistics reported in these documents.

a. National Development Plan 2012-2016 (2011): Produced by the Somaliland Ministry of Planning and Development, this document notes that healthcare data was insufficient for monitoring and evaluation. It highlighted poor health service delivery, especially in rural areas, low public health sector uptake, limited resources, and lack of technical expertise. The document places emphasis on strengthening the health management information system for quality care improvement.

b. National Drug Policy (2014): The policy aimed to provide effective, safe, and affordable pharmaceutical services for disease prevention, diagnosis, and treatment. While it addressed drug quality, enforcement by the Ministry of Health Development was unclear.

c. Health Sector Strategic Plan (2013-2016): The plan's vision was for all Somaliland citizens to enjoy the highest possible health status, with a mission to provide essential health services to all, including a commitment to quality care at the policy level.

d. Annual Health Report (Feb 2016): Prepared by the MoHD's Planning, Policy, and Strategic Information Department, this report addressed the lack of access to affordable, quality healthcare services and emphasised improving the Essential Package of Health Services (EPHS).

e. National Health Policy III (2021): The mission focused on ensuring accessible, affordable, and quality health services through a decentralised system. While the policy stressed community participation, the MoHD lacked a strong monitoring and evaluation framework to ensure the policy's goals were met.

f. Somaliland's Road Map for Attaining Universal Health Coverage (Draft, 2022-2030): This draft document outlined the goal of providing affordable, not free, universal health coverage, aligning with sustainable development goals.

g. Borama Regional Hospital Situation Analysis (2021): Based on a workshop held at Borama Hospital, this document identified quality care issues and harmful incidents. The findings aligned with our own situation analysis, although different methods were used.

Focus Group Discussions and Interviews

Methodology
Key informant interviews were held with 19 key health sector stakeholders, including heads of MoHD departments, representatives from professional associations, the National Health Professions Commission (NHPC), UN health partners, private and public hospitals, and academic institutions. Additionally, two focus group discussions were conducted with 10 nurses and 7 family physicians. These discussions aimed to understand perceptions of healthcare quality, evaluate existing standards and procedures, and assess data recording systems related to quality of care. The full list of key informants is provided in **Appendix 3**.

Focus Group Discussions Findings
The focus group sessions and key informant interviews reported varied definitions of quality of care amongst different actors in the health sector, and challenges to the delivery of quality health care services. Participants reported that the current provision of care was often ineffective, inefficient, partially safe, often inaccessible, rarely monitored or evaluated, and had limited regulatory oversight. Discussions identified clear needs and opportunities to improve the quality of care.

Facility Assessments

Facility Assessment Methodology

The **WHO Patient Safety Friendly Hospital Framework** (PSFHF) assesses facilities against five domains: (i) Leadership and Management, (ii) Patient and public involvement, (iii) Safe evidence-based clinical practice, (iv) Safe environment, and (v) Lifelong learning. Each of the five domains includes standards, and each standard is assessed against several identified criteria. Across the five domains there are 134 criteria, including 25 critical criteria, 94 core criteria and 15 developmental criteria. Hospitals are graded to show how far they meet the criteria with four levels of compliance.

Hospitals are defined as Level 1-4 based on the assessment results. Level 1 requires all critical criteria to be met and any of the core and development criteria. Level 4 requires all the critical criteria and at least 90% core criteria and at least 80% developmental criteria see Table 3.

Table 3: **Levels of achievement for the PSFHF**

Level	Critical Criteria	Core Criteria	Development Criteria
1	100%	Any	Any
2	100%	60-89%	Any
3	100%	>90%	Any
4	100%	>90%	>80%

The critical criteria have been prioritised as issues that must be urgently addressed for a hospital to provide safe care. There are 25 critical criteria, and all are based on evidence from the literature of common problems that arise, such as governance, communication, hand hygiene, staff competency and staff training. Addressing all 25 criteria is considered the foundation for a hospital to start their quality journey. The core criteria are an essential set of standards with which a hospital should reach to become safe for patients. The developmental criteria are the requirements a hospital should attempt to comply with, based on its capacity and resources, to enhance safe care.

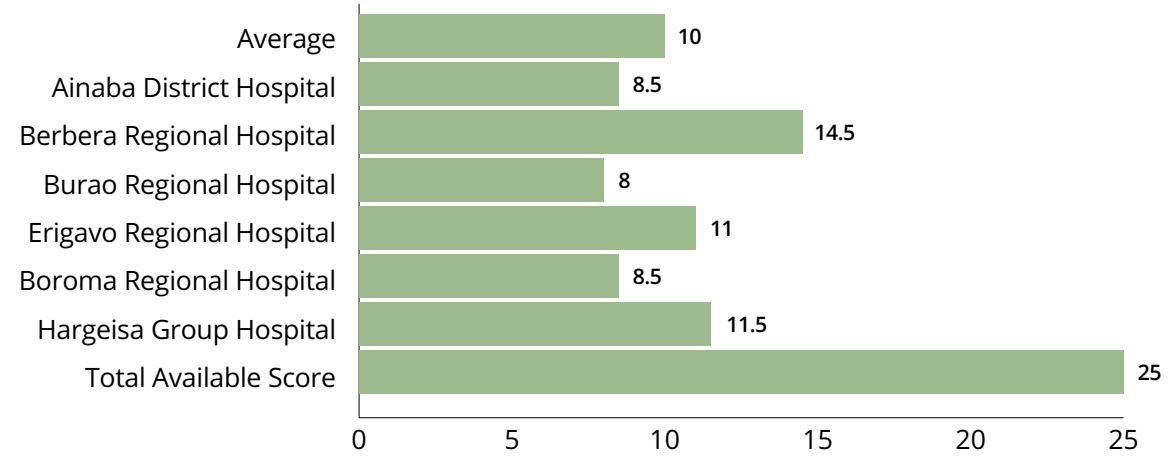
Facility Assessment Findings

Five of Somaliland's six regional hospitals were assessed along with one district hospital. The extent to which hospitals met the critical criteria ranged from 34% – 58%, meaning that none of the hospitals assessed in Somaliland currently meet level 1 in the WHO PSFHF. The extent to which they met the core criteria was 17 – 30% and for developmental criteria was 7 – 14%. Hargeisa Group Hospital was the hospital that met the most criteria, meeting 31% of criteria across critical/core/developmental domains. This was followed by Berbera Regional Hospital and Erigavo Regional Hospital which each met 28% of criteria across all three domains. See Table 4.

Table 4: **Overall results for Somaliland regional hospitals using the PSFH*F***

Facility	Critical Criteria	Core criteria	Developmental Criteria	Total criteria
Hargeisa Group Hospital	46%	30%	14%	31%
Borama Regional Hospital	36%	23%	13%	24%
Berbera Regional Hospital	58%	23%	14%	28%
Burao Regional Hospital	34%	9%	7%	20%
Erigavo Regional Hospital	46%	25.5%	13%	28%
Ainaba District Hospital	34%	17%	10%	20%

Figure 6: **Hospital compliance against PSFHF critical criteria**



Berbera Regional Hospital met the highest number of critical criteria. With a score of 14.5 out of 25 (58%) of the critical criteria. This was followed by Hargeisa Group Hospital and Erigavo Regional Hospital, which scored 11.5 and 11 out of 25, respectively. See Figure 6.

Against the critical criteria, hospitals achieved the highest scores in the domains of leadership and management, patient and public involvement and lifelong learning. For patient and public involvement, all hospitals scored 1 out of a possible score of 2 (50% compliance). For lifelong learning, all hospitals scored 0.5 out of a possible total score of 1 (50% compliance). For leadership and management, the average score was 3.5 out of a possible score of 7 (50% compliance). The scores ranged from 2 out of 7 (29% compliance) at Burao Hospital to 5 out of 7 (71% compliance) at Berbera Hospital. The domains with the lowest scores were safe environment and safe evidence-based clinical practice. In the safe environment domain, three facilities scored 0.5 out of a total possible score of 1 (50% compliance) and three facilities scored 0. For safe evidence-based clinical practice, the average score was 5 out of a total possible score of 15 (33% compliance). The scores ranged from 3.5 out of 14 (25% compliance) at Boroma Regional Hospital to 7.5 out of 14 at Berbera Regional Hospital (54% compliance).

Figure 7: **Hospital compliance across critical criteria domains**

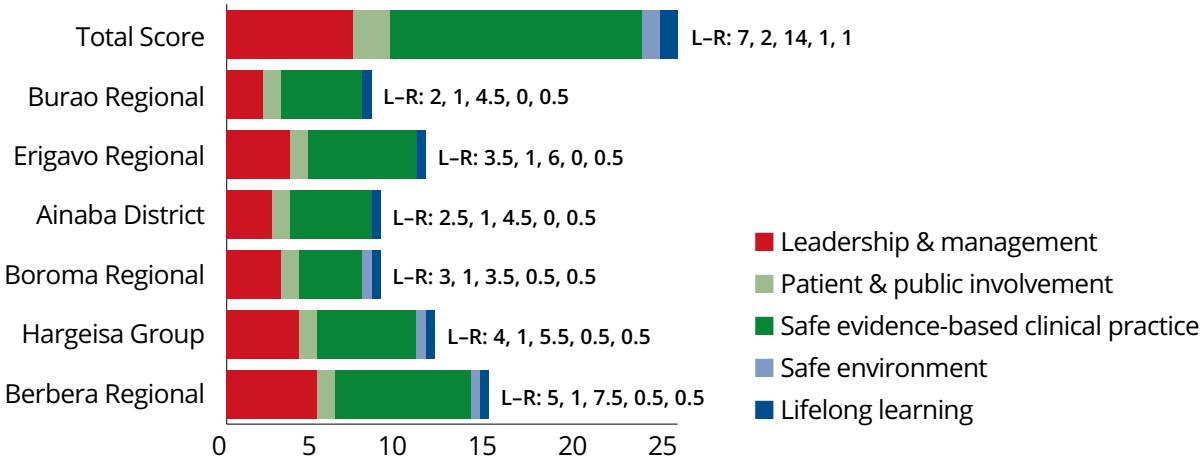
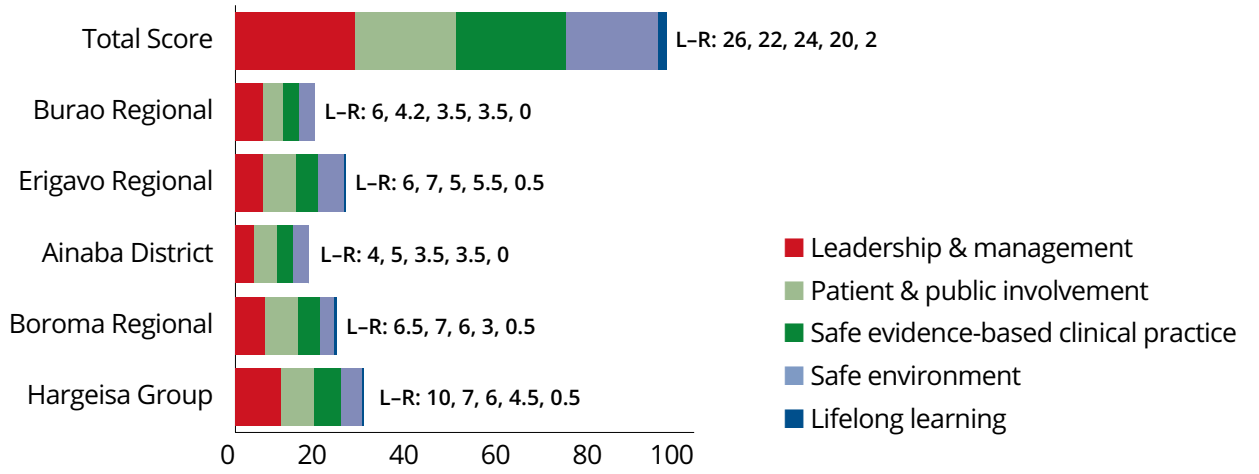


Figure 8: **Hospital compliance across core criteria domains**



Among the hospitals assessed, Hargeisa Group Hospital met the greatest number of core criteria, meeting 28 of the 93 criteria (30%). Hospitals scored highest on patient and public involvement, leadership and management, followed by lifelong learning. On patient and public involvement, the scores ranged from 4.5 of a total possible score of 22 (20% compliance) at Burao Regional Hospital, to 7 of 22 (32% compliance) at Hargeisa Group, Erigavo and Boroma Regional Hospitals. On leadership and management, the scores ranged from 4 out of a possible total score of 26, (15% compliance) at Ainaba District Hospital to 10 out of 26 (38% compliance) at Hargeisa Group Hospital. The lowest scores were recorded on safe evidence-based clinical practice. Burao Regional Hospital scored 3.5 of a possible total 24 (15% compliance) and Hargeisa Group Hospital scored 6 (25% compliance). On safe environment, the scores ranged from 3 of 20 (15% compliance) at Boroma Regional Hospital to 5.5 (27.5% compliance) at Erigavo Regional Hospital.

People's Voice Survey

PVS Methodology

The People's Voice Survey (PVS) is a new instrument developed by the QuEST (Quality Evidence for Health System Transformation) Network https://www.questnetwork.org, a global partnership of researchers, national governments, multilateral organisations, and development partners, who are involved in health system quality research. PVS is designed to integrate people's voices into health system measurement, with a focus on population health needs and expectations as well as people's perspectives on processes of care and confidence in the system. It enables rapid assessment of health system performance from the population perspective to inform health system planning. King's Global Health Partnership (KGHP) commissioned the PVS in Somaliland in 2023 in close partnership with MoHD Somaliland. As part of a National Quality Improvement Programme in Somaliland, the PVS was used to assess people's perspectives on the healthcare system to inform the NQPS. The primary focus of the survey was on the population's health needs, expectations, views on care processes, and confidence in the health system.

The PVS cross-sectional survey was conducted in 2023-24 in Somaliland using a contextualised Somaliland version of the PVS tool with a sample of 2200 telephone and 300 face-to-face interviews. The data collection phase telephone interviews commenced on July 7th, 2024, and closed on July 24th, 2024. The face-to-face data collection started on July 20th, 2024, and closed on July 31st, 2024. The sample was

representative of the population of Somaliland where a random sample of phone numbers was selected in areas with high telephone coverage, boosted with a randomly selected face-to-face sample from low telephone coverage areas. The selected respondents were 18 or above in age. Initial findings were compiled using descriptive analysis on a standard policy brief template by QuEST Network.

PVS Findings

The findings of the PVS are summarised in the PVS: Somaliland Country Brief 2025 in Figure 9. In the PVS sample, 36.02% respondents were from urban areas, 47.08% from rural areas and 16.9% were from nomadic settlements. The median age of the sample was 32 years and 52% of the respondents were female. Only 32.44% of the respondents had any formal education while 45.66% of the respondents had a household income of 100 USD or less. Over 99% of the respondents in Somaliland did not have any health insurance. In our sample, 25.4% of respondents rated their health as poor/fair, of which 55.75% belonged to the lowest income group. Of those rating their health as poor/fair, over 72% were from rural settings with 20.63% from nomadic settlements and 51.49% from villages.

According to the findings on healthcare utilisation patterns, each respondent had an average of 2.98 contacts with the health system in the last 12 months out of which 0.2 average contacts were through telemedicine or virtual consultation. Out of people rating their mental health as poor or fair, only 3% of people received mental health care in the last 12 months. In terms of inpatient admissions, 16.39% of respondents had an overnight hospital stay in the last 12 months. However, 41% of respondents did not seek care in the last 12 months despite needing it, the most common reasons being high costs, distance, and not perceiving the condition serious enough. In Somaliland, 38% of people have a usual source of care – a facility where they regularly go to seek health care, with 26% respondents going to public health facilities and only 12% going to private health facilities for usual care. In the lower income bracket, around 28% of respondents use public facilities as their usual source of care, which is slightly higher than the highest income bracket, where it is 23%. The use of preventative care services in Somaliland is low, and most preventative services are used by less than 50% eligible respondents, with the lowest for cervical cancer screening (7%) and mammograms (8%). These figures are not surprising as Somaliland does not have a national screening programme for cervical and breast cancer.

Around 14% respondents rated the public health system in Somaliland as excellent/very good compared to 27% for the private health sector. Furthermore, quality ratings for most government primary care services are low with around 50% respondents rating most services as poor or fair. The average quality ratings for the last health care visit in the past 12 months were good for overall quality, care competence and user experience. In terms of health security, 53.22% of respondents were very or somewhat confident that they can get and afford good quality care if very sick. And 57.42% respondents were very or somewhat confident that the government considers the public's opinion in health system decisions. However, only 36.33% respondents rated the government's management of COVID-19 pandemic as excellent/very good.

In terms of the trajectory of the healthcare system in the last 2 years, 46% respondents believe that the healthcare system in Somaliland has been getting better, while 38% believe that it has been the same and 18% respondents believe it is getting worse. When asked questions on health system endorsement, 54% respondents agreed that there are some good things in the health system in Somaliland but major changes are needed, while 25% believed that it works very well and only requires minor changes and 21% agreed that so much is wrong and the health system needs to be completely rebuilt.

Figure 9: People's Voice Survey: Somaliland Country Brief 2025

Background

High-quality health systems generate health, trust, and economic benefit while responding to changing population needs. Current measurements of health systems fail to capture people's perspectives at the population level. The People's Voice Survey (PVS) is a new instrument that measures health system performance from the populations' perspective. It assesses use of health care as well as people's experiences, expectations, and confidence in the health system.

Methods

During July 2024, data were collected from a nationally representative sample of 2500 adults in Somaliland via mobile phone and face-to-face surveys. All data are weighted to represent the population.

Key findings

Health care utilisation in the past 12 months

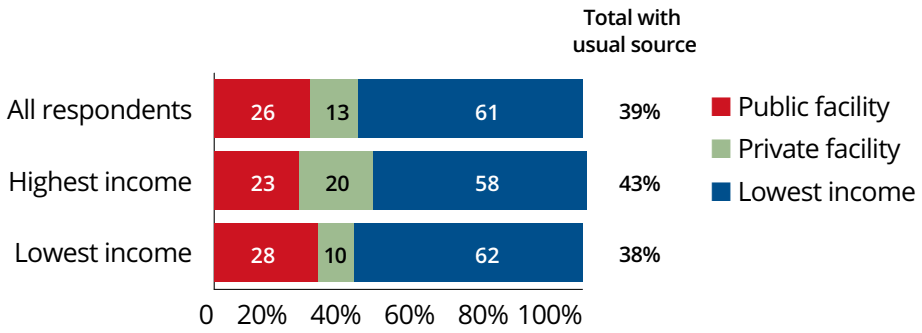
Average number of health care contacts (all types)	2.98
Average number of in-person facility visits	2.49
Average number of virtual or telemedicine contacts	0.19
% of respondents who received mental health care (among those with poor or fair mental health)	3.07
% of all respondents who had an overnight hospital stay	16.39
% of all respondents with no unmet need for health care	56.70

Respondent demographics[1]		Overall (N = 2500)
Age (median) [Min, Max]		32 [18,99]
Female		1300 (52%)
Urban residency		899 (35.98%)
Education (highest level)	Post-secondary	221 (8.98%)
	Secondary	205 (8.32%)
	Primary	385 (15.62%)
Household income (monthly)	Highest (≥ 250 USD)	436 (17.43%)
	Middle (100 to <250 USD)	814 (32.57%)
	Lowest (< 100 USD)	1141 (45.66%)
	Unknown	109 (4.35%)
Health insurance[2]	No insurance	2477 (99.08%)
	Public insurance	0
	Private insurance	23 (0.92%)

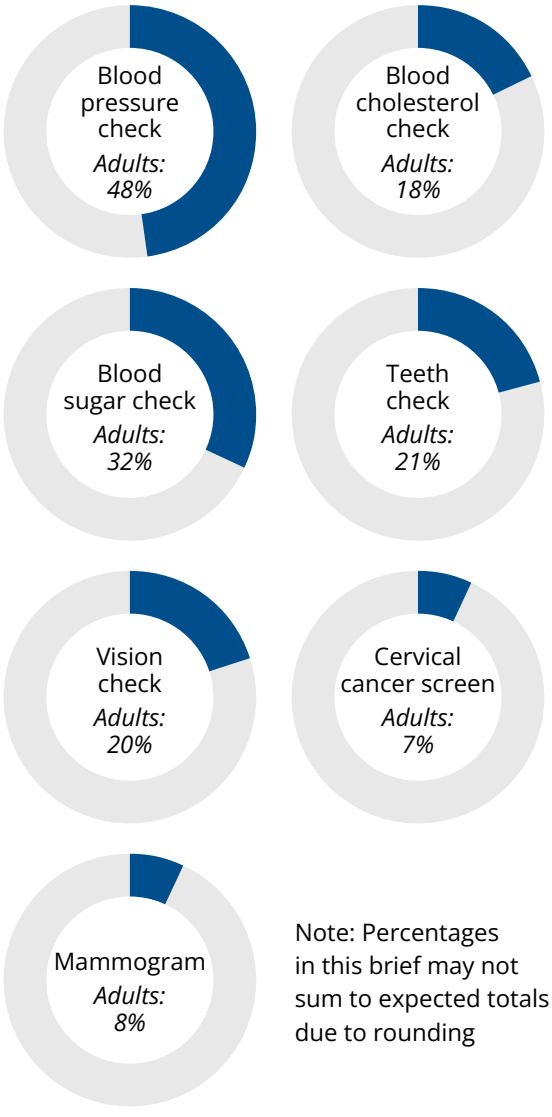
1 Denominators of some items may vary slightly from the full sample size due to missingness
2 Private insurance = employer-provided or other private.

Figure 9: People's Voice Survey: Somaliland Country Brief 2025

Usual source of care:
Percent with usual health care facility or provider's group

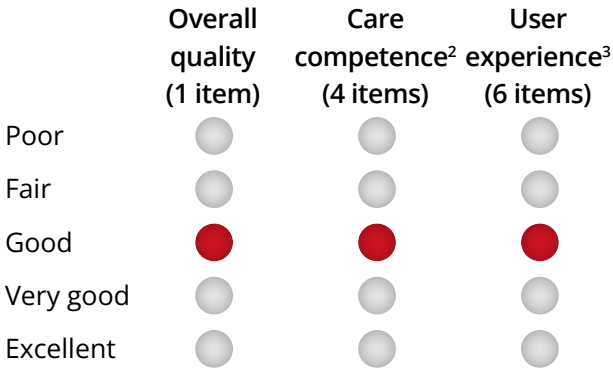


Health system competence
Preventative care services: Percent of eligible population who received service in the past 12 months



Note: Percentages in this brief may not sum to expected totals due to rounding

Care competence and user experience
Average[1] quality ratings for last health care visit in past 12 months



1 Rounded to the closest Likert category
2 Provider skills, knowledge of past visits, explanations, equipment/supplies
3 Respect, courtesy, joint decisions, visit time, wait time, scheduling time

Health system quality
Quality ratings of national public and private health systems (% of all respondents)

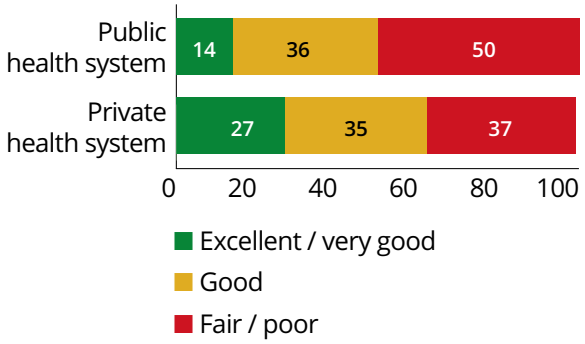
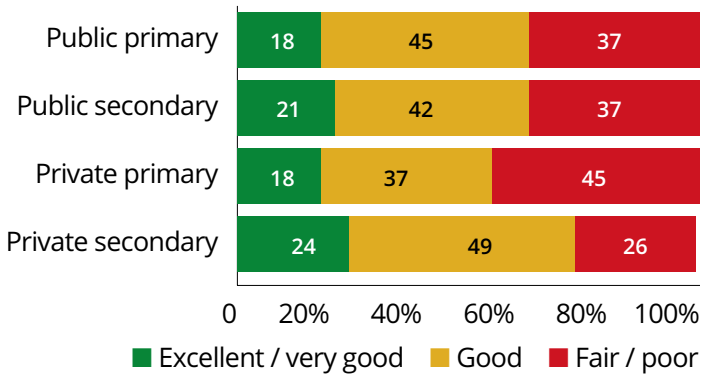


Figure 9: People's Voice Survey: Somaliland Country Brief 2025

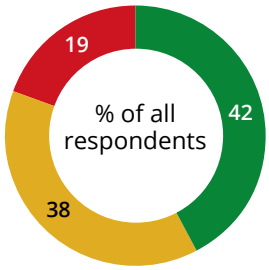
Confidence in and endorsement of the health system

Confidence in health system as a whole (% of all respondents): Including public, private, NGO health care facilities/providers		
Health security: % very or somewhat confident	Can get good quality care if very sick	72.78
	Can afford good quality care if very sick	61.53
	Can get and afford good quality care if very sick	53.22
Government considers the public's opinion in health system decisions (% of all respondents): % very or somewhat confident		57.42
Government's management of the COVID-19 pandemic (% of all respondents): % excellent or very good		36.33

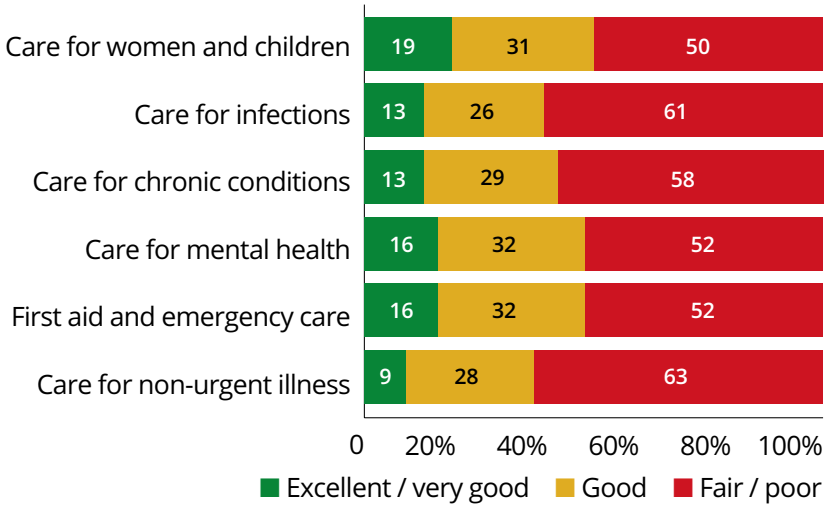
Quality ratings for last health care visit (1% of users of facility type in past 12 months)



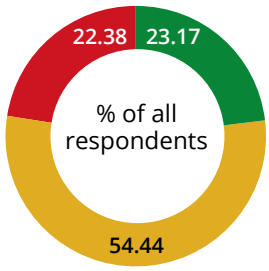
Endorsement: Health system trajectory over past 2 years



Quality ratings of key primary care services provided by government (1% of all respondents)



Endorsement: Current health system



National Assessment of Undergraduate Medical Schools' Capacity

Methodology

The ability of a health system to provide quality care is in part dependent on the capacity of its health workers to provide quality care. As part of the situation analysis, Global Health Partnerships (GHP), (formerly THET) supported the MoHD to assess the capacity of Medical Schools to implement the Harmonised National Medical Curriculum. This curriculum was introduced by the Ministry of Education and MoHD in 2021 as one of several measures to improve the quality of teaching on Somaliland's medical education courses, and ultimately to strengthen the health workforce.

The capacity assessment aimed at evaluating the extent to which institutions were ready to implement the national harmonised curriculum. It used a mixed-method approach combining in-person and remote methods. Key informant interviews (5–7 per institution) were conducted with curriculum committee members and medical leadership. The assessment tool was informed by literature reviews, UK experts, and local input. Key areas explored included leadership and vision, policies and practices, equity, strategy and planning, teaching and learning, engagement and communication, and data and technology. The assessment was conducted at 8 public and private higher education institutions with undergraduate medical schools: Gollis University, University of Hargeisa, Edna Adan University, Frantz Fanon University, Buro University, Buro Gollis University, Amoud University, and Adel University.

National Assessment of Undergraduate Medical Schools' Capacity Findings

The capacity assessment found that three (38%) of the 8 undergraduate medical schools assessed have partially or fully implemented the National Medical Curriculum. These include Amoud University and Buro University, which are both public institutions, and Gollis University Buro Campus, which is private. Amongst the 5 institutions which are not yet implementing the curriculum, the most cited barriers for implementation were the absence of a functional curriculum committee to lead the transition to the new curriculum and insufficient specialised staff. The new curriculum includes content on basic and behavioural sciences, which several universities do not have. Medical schools also noted financial constraints and a lack of decision-making autonomy of the content of curricula, showing that broad engagement within the university is needed to secure financial and non-financial support for the new curriculum.

Mapping of Postgraduate Medical Education Courses

Methodology

The availability of postgraduate medical education (PGME) courses in Somaliland and therefore the presence of well-trained medical specialists is essential for quality healthcare. Recognising this, the MoHD, with support from GHP, conducted a comprehensive survey to map the availability and distribution of specialist doctors and existing PGME programmes. The objectives included identifying the current number and distribution of medical specialists, assessing the scope of PGME offerings across institutions, analysing gaps in specialist numbers and types, and recommending pathways to strengthen PGME provision. Methodologically, the study utilised two tailored questionnaires targeting medical specialists and training institutions, with data collected by trained enumerators using KoboToolbox between December 2023 and January 2024. The study aimed to inform a strategic roadmap that aligns PGME expansion with the healthcare system's demand for high-quality, specialised care across Somaliland.

Mapping of Postgraduate Medical Education Courses Findings

The mapping of existing postgraduate medical education courses revealed that most specialist doctors in Somaliland are concentrated in Hargeisa, with smaller numbers in Boroma and Burao. The majority were male, relatively young, and had been in their roles for less than two years, highlighting workforce instability and gender imbalance. While Somalilanders made up the bulk of specialists, there were also professionals from Syria, Ethiopia, and Egypt.

The most frequently reported specialisations were surgery, paediatrics, obstetrics and gynaecology, and family medicine, indicating alignment with Somaliland's broad healthcare needs. Most of the specialists held postgraduate specialty degrees, with a significant portion having obtained their qualifications in Ethiopia and Somaliland. This highlights the importance of regional educational pathways in shaping the country's specialist workforce.

In terms of PGME provision, three institutions — Amoud University, the University of Hargeisa, and Frantz Fanon University — currently offer postgraduate programmes. These institutions represent the core of Somaliland's PGME infrastructure but also highlight major gaps in coverage and capacity across the country. Amoud University offers four master's programmes: paediatrics, family medicine, surgery, and internal medicine. University of Hargeisa offers four master's programmes: surgery, emergency medicine, ophthalmology, and orthopaedics. It is also the only institution offering a diploma course, in ophthalmology. Frantz Fanon University offers two master's programmes: paediatrics and obstetrics and gynaecology. All master's programmes are 3 to 4 years in length, depending on the specialisation.

Despite these offerings, the PGME landscape faces significant challenges. Many medical schools lack compliance with national training standards and are under-resourced. The rise of unregulated and unaccredited private institutions, many of which are not formally recognised by the government but still produce graduates accredited by the National Health Professions Commission (NHPC), contributes to inconsistencies in quality of physicians entering PGME. A lack of coordination between institutions and regulatory bodies, insufficient faculty training programmes, and limited funding and educational resources further constrain the effectiveness of PGME delivery.

Finally, the mapping revealed that no needs-based health workforce planning for PGME currently exists. This gap makes it difficult to align the types and numbers of trained specialists with the healthcare demands of the population, limiting the potential for PGME programmes to directly contribute to improved quality of care in Somaliland.

Infection Prevention Control Assessment

Methodology

An assessment was conducted by an independent consultant in November 2023 using the WHO Infection Prevention and Control Assessment Framework (IPCAF) (accessible here: WHO-HIS-SDS-2018.9-eng.pdf). A total of 116 health facilities across all regions of Somaliland were selected through a multistage cluster random sampling technique (see Table 5). Trained and qualified data collectors and supervisors were equipped with the IPCAF tool, digitised in Open Data Kit (ODK), to ensure reliable and accurate data collection. The IPCAF tool evaluates infection prevention and control (IPC) performance across eight core components using 81 measurable indicators. These components are:

1. IPC programme
2. IPC guidelines
3. IPC education and training
4. healthcare-associated infection (HAI) surveillance
5. multimodal strategies for implementation of IPC interventions
6. monitoring/audit of IPC practices and feedback
7. workload, staffing and bed occupancy
8. built environment, materials and equipment for IPC at the facility level.

Each core component in the tool has a maximum score of 100. The maximum cumulative score of all eight components is 800. This cumulative score is categorised into 4 levels of IPC services. A score of 0-200 is Inadequate: where IPC core components implementation is deficient and significant improvement is required. 201-400 is Basic: where some aspects of the IPC core components are in place, but not sufficiently implemented and further improvement is required. 401-600 is Intermediate: where most aspects of the IPC core components are appropriately implemented. 601-800 is Advanced: where the IPC core components are fully implemented according to the WHO recommendations and appropriate to the needs of the facility.

When we look at the scores for each of the core components, 7 and 8 – which look at workload, staffing and bed occupancy and the built environment, materials and equipment for IPC at facility level – received the highest mean scores, with scores of 36 and 44 out of 100 respectively. Core component 5 on multimodal strategies obtained the lowest score with a mean score of only 3.5 out of 100.

Table 5: **Distribution of health facilities across regions and settings**

Region	Total	Public	Private	Hospital	Non-Hospital	Urban	Rural
Awdel	20	19	1	6	14	10	10
Marodijeh	30	18	12	20	10	24	6
Saxil	22	21	1	4	18	8	14
Togdheer	21	17	4	7	14	12	9
Sanaag	14	12	2	5	9	7	7
Sool	9	9	0	2	7	4	5
Total	**116**	**96**	**20**	**44**	**72**	**65**	**51**

Table 6: **IPC Assessment Framework with Results from Somaliland Facilities**

IPCAF Scoring System

Level	Points
Inadequate	0 – 200
Basic	201 – 400
Intermediate	401 – 600
Advanced	601 – 800

Somaliland Results

Level	Facilities N (%)
Inadequate	81 (70%)
Basic	31 (27%)
Intermediate	4 (3%)
Advanced	0

Table 7: **Mean IPCAF scores for IPC components across facilities**

Component	Mean IPCAF score	Total possible score
1. IPC programme	12.93	100
2. IPC guidelines	16.40	100
3. IPC education and training	13.97	100
4. HAI surveillance	15.17	100
5. Multimodal strategies	3.58	100
6. Monitoring/audits of IPC practices and feedback	16.53	100
7. Workload, staffing and bed occupancy	36.03	100
8. Built environment, materials and equipment for IPC at the facility level	44.26	100
Total	**158.88**	**800**

In terms of the **IPC Programme component**, nationally 74% (n = 119) of health facilities assessed did not have an IPC programme in place. This indicates a lack of structured and systematic approaches to the prevention and control of infection across healthcare facilities. The existence of an IPC Programme was higher in hospitals, with 43% of hospitals having one, compared to 15% of non-hospital facilities, indicating a need to support smaller facilities to take a structured approach to IPC. Only 7% of facilities have a dedicated IPC team comprised of IPC professionals. The majority (89%) of government (public) healthcare facilities do not have IPC teams or focal persons supporting the implementation of IPC programmes. 80% of hospitals and 96% of non-hospitals did not have active IPC committees suggesting a lack of organisational support and engagement in prioritising infection prevention and control efforts.

On **IPC Guidelines**, most healthcare facilities in Somaliland (87%) do not have the necessary expertise in IPC and/or infectious diseases for developing or adapting guidelines. 25% of hospitals in Somaliland have adapted IPC guidelines. Non-hospitals have an even lower adaptation rate, with only 6% using adapted IPC guidelines. This shows a limited implementation of standardised IPC protocols within these healthcare settings. Among non-governmental (private) health facilities, 65% did not adapt IPC guidelines, highlighting a significant gap in IPC guideline implementation within non-governmental healthcare facilities. The 35% of non-governmental health facilities that were using IPC guidelines were predominantly those managed by local or international non-governmental organisations (NGOs). This suggests that NGOs play a crucial role in promoting and implementing IPC guidelines in non-governmental healthcare settings compared to those facilities that didn't have NGO support.

On **IPC Education and Training**, 85% of health facilities assessed lack personnel with IPC expertise to lead IPC training. This deficiency is particularly pronounced in governmental (public) non-hospital facilities, with more than 90% of those trained personnel. This indicates a significant gap in the availability of qualified individuals who can effectively lead and deliver IPC training programmes. More than 80% of healthcare workers in Somaliland have never received IPC training, this can lead to potential risks for both patients and healthcare providers.

In terms of **healthcare associated infections (HAI)** surveillance, 84% of health facilities in

Somaliland did not have HAI surveillance as a defined component in their IPC programmes, suggesting a lack of systematic monitoring and tracking of HAIs. Just over a quarter of hospitals (27%) and 8% of non-hospitals have some level of HAI surveillance for certain indicators. 77% of governmental (public) health facilities in Somaliland did not have dedicated personnel for HAIs, which can impact the implementation of effective surveillance, prevention, and control measures. More than 90% of health facilities in Somaliland did not have a surveillance system for the different HAI indicators.

In terms of use of **multimodal strategy** to implement IPC interventions in healthcare facilities, the data indicates that only 9% of hospitals assessed utilise a multimodal strategy approach. This suggests most hospitals do not effectively adopt the comprehensive multisectoral IPC interventions, such as regular hand hygiene compliance, effective and regular environmental cleaning, effective use of personal protective equipment (PPE) and IPC education and training programmes to reduce the impact of healthcare infections.

In terms of **staffing, workload and bed occupancy**, approximately 85% of government (public) health facilities in Somaliland do not assess staffing levels according to patient workload using national or international standards. Among hospitals, 50% have adequate bed spacing of >1 meter between patients. This represents a better compliance rate compared to non-hospitals with only 13% having adequate bed spacing. Despite this there is still the need to ensure adequate spacing in healthcare facilities of Somaliland to minimise the risk of cross-infection.

Finally, on the **built environment, materials and equipment** for IPC, 51% of health facilities always had water services available and of sufficient quantity for all uses. 15% of governmental health facilities had reliable and functioning hand hygiene stations with soap and water or alcohol-based hand rub available at point of care. Approximately 70% of health facilities had sufficient energy/power supplies available for some or all departments while one third (30%) didn't have sufficient power. More than half (57%) of non-hospitals didn't always have sufficient personal protective equipment (PPEs) available for all health care workers. 65% of all health facilities assessed didn't have dedicated decontamination area (either present on or off site) for the decontamination and sterilisation of medical devices and other items/ equipment. More than 70% of these facilities were governmental non-hospitals.

Strengths and Limitations

This situational analysis builds on evidence on quality within the Somaliland health sector that has been captured in past documents and reports. It has been conducted over a three-year period. A strength of this situational analysis is that comprehensive data has been collected that assesses both supply and demand side issues. A significant emphasis has been placed on assessment of service delivery and workforce, and less focus has been placed on other building blocks. There has been a greater focus on secondary and tertiary care facilities than primary care. The use of validated methods such as the WHO Patient Safety Friendly Hospital Framework (PSFHF), the Infection Prevention Control Assessment Framework, and the People's Voice Survey, means that repeat assessments can be conducted and future results compared with rich baseline analysis. Ongoing assessments of quality will be important and captured during implementation of this NQPS.

SWOT Analysis for Quality across the Somaliland Health System

A SWOT Analysis on the state of quality and the trajectory for strengthening quality within the Somaliland health sector has been undertaken. This analysis reflects on the findings of the situational analysis, and on the NQPS development process and NQPS implementation plans.

Strengths (S):

- Policy Commitment: There's a clear commitment from policymakers to improve healthcare quality in various national health plans and policies.
- Alignment with Global Initiatives: The NQPS aligns with global health initiatives like Universal Health Coverage (UHC), Sustainable Development Goals (SDGs), and WHO's patient safety initiatives.
- Comprehensive Approach: The NQPS aims to cover all aspects of healthcare quality across various levels, sectors, services, and the health workforce.
- Stakeholder Engagement: There's a consultative process involving multiple stakeholders in the development of the NQPS.
- Data Availability: There's an effort to collect and analyse data to assess the current situation and track improvements.

Weaknesses (W):

- Resource Constraints: Limited resources hinder the implementation of quality healthcare interventions.
- Infrastructure Gaps: Inadequate infrastructure, including water, hygiene, and equipment, affects the delivery of quality care.
- Workforce Challenges: Insufficient numbers, uneven distribution, lack of training, and inadequate supervision of healthcare workers.
- Data and Monitoring Deficiencies: Weak health management information systems, insufficient data for monitoring and evaluation, and limited regulatory oversight.
- IPC Deficiencies: Lack of infection prevention and control programmes, guidelines, training, and surveillance in many facilities.
- Patient Safety Concerns: Issues with patient safety, including medication safety, surgical safety, and risk of harm.
- Access Barriers: Challenges in access to affordable and quality healthcare services, especially in rural areas.

Opportunities (O):

- NQPS Implementation: The development and implementation of a National Quality Policy and Strategy provide a framework for systematic quality improvement.
- Established Structures: The Ministry of Health Development (MoHD) has established a Quality Care Unit and there is a move towards developing a National Quality Policy and Strategy (NQPS).
- Global Support: Alignment with global health initiatives and support from organisations like KGHP and WHO can provide resources and expertise.
- Technology Adoption: Improving health management information systems and using data for quality improvement can enhance efficiency and effectiveness.
- Workforce Development: Investing in training, education, and professional development of the healthcare workforce can improve their capacity to deliver quality care.
- Patient Empowerment: Engaging and empowering patients and communities in the design and delivery of healthcare services can improve patient-centredness.
- Private Sector Collaboration: Collaborating with the private sector can leverage additional resources and expertise for quality improvement.
- Learning from Best Practices: Learning from experiences of other countries with national quality policies and strategies can provide valuable insights.

Threats (S):

- Global and Regional Political Instability: Political upheavals and instability can disrupt healthcare services and hinder quality improvement efforts.
- Climate Change Impact: Drought can have an impact on infrastructure and strain resources.
- Disease Burden: The growing burden of communicable and non-communicable diseases can overwhelm the health system.

- Financial Constraints & Sustainability: Limited financial resources may impede the implementation of the NQPS and quality improvement initiatives.
- Resistance to Change: Resistance from stakeholders to adopt new quality improvement practices can slow progress.
- Lack of Accountability: Weak accountability mechanisms can undermine efforts to improve quality.
- External Shocks: Events like pandemics (e.g., COVID-19) can put immense pressure on the health system and expose vulnerabilities.

Situational Analysis Conclusion

The situational analysis reveals significant systemic challenges in the quality of healthcare delivery in Somaliland. Despite policy-level commitments to universal, affordable, and quality healthcare, there is a stark gap in implementation due to limited resources, weak regulatory oversight, and inadequate health infrastructure. Hospital assessments show that none of the facilities meet the minimum patient safety standards set by the WHO, with critical deficiencies in safe clinical practices, infection prevention, and safe environments. Community feedback reflects mixed experiences, with concerns about access, affordability, and the quality of services – particularly in rural areas – and low uptake of preventive care. Infection prevention practices are particularly poor, with 70% of facilities deemed inadequate and major gaps in IPC programmes, training, and surveillance. Key initiatives to improve the quality of health services – such as the introduction of a national harmonised medical education curriculum – have seen low uptake. Overall, while there is recognition of the issues and some areas of progress, significant investment and structural reform are needed to bridge the gap between policy ambition and healthcare quality in practice.

2.5 Governance and organisational structure for quality

The Ministry of Health Development is the leading governmental institution for the health of the people of Somaliland. Its mandate falls within the areas of leadership and governance, institutional development, policy setting and strategic direction, service delivery and promoting Universal Health Coverage (UHC) through increasing access to essential health services for all. The health system is regulated by a structured governance system guided by Somaliland constitution, health law, health professionals' commission law and relevant national policies and plans. The **MoHD vision** is: All people in Somaliland enjoy the highest possible health status. The **MoHD mission** is: The Mission is to ensure the provision of socially acceptable, affordable, accessible, equitably distributed essential package of **quality health and nutrition care** that responds to the needs of the community, with special attention to those with the greatest need, delivered in a sustainable way through a decentralised health system and through focusing on health-related SDG goals. Community participation in all phases of planning, implementation and monitoring will be central to the mission of the MoHD.

The MoHD core principles and values are Equity, Gender-sensitivity, Universality, **Quality,** Integrity, Solidarity, Ethics, Accountability, Respect, and Right to health.

The MoHD carries out its operational and strategic duties through seven departments, managed by a Director General and Departmental Leads, under the leadership of the Deputy Minister and the Minister of Health (see Appendix 6). The recently established quality care unit sits in the Department of Health Services and Hospitals, overseeing the quality of health care services. The Department of Community Health Services oversees MCH clinics.

The **NQPS Steering Committee** is a high-level body responsible for the overall strategic direction, approval, and oversight of the NQPS. This committee will include representatives from: Ministry of Health Development; relevant associations, institutions and stakeholders; and community advocacy. The roles and responsibilities are:

- Define the overall vision and goals for the NQPS.
- Mobilise resources for the implementation of the NQPS.
- Approve the policy, strategy, and annual action plans.
- Oversee the progress and impact of the NQPS.

The **NQPS Technical Working Group** (TWG) comprises experts in healthcare quality, patient safety, and health informatics. The roles and responsibilities are:

- Conduct situational analysis.
- Draft the NQPS policy and strategy based on input from stakeholders and research.
- Guide the development of regional annual plans.
- Design training modules and capacity-building programmes.
- Monitor and evaluate the implementation of the NQPS.

Regional Implementation Teams based in different provinces or regions of Somaliland will ensure that the NQPS is effectively implemented according to local needs and conditions.

- Customise the NQPS to local contexts and develop annual action plans.
- Facilitate training and capacity-building initiatives at the regional level.
- Monitor and report on regional NQPS implementation progress.
- Engage local stakeholders and communities in NQPS activities.

Transparency and accountability mechanisms for these groups include:

- Annual public reports on the progress and challenges of the NQPS.
- Encouraging public and stakeholder feedback on the NQPS implementation.

2.6 Improvement methods and interventions for National Health Quality Priorities

Stakeholders identified national health quality priorities during the first and second NQPS engagement workshops, informed by a review of Somaliland's national health priorities. The TWG convened on December 6th, 2023 after the first workshop, met between workshops, and contributed to the third workshop to formulate the necessary interventions for an implementation plan to address these priorities.

The national health quality priorities and objectives are:

Priority 1: Effective governance and leadership for quality across all levels

Objectives:

O1.1 To strengthen collaboration and coordination between NHPC and the MoHD on quality and safety
O1.2 To develop leadership structure, plans, policies and SOPs for quality and patient safety
O1.3 To create a culture of quality across all levels
O1.4 To strengthen coordination mechanism between MoHD and stakeholders for planning and resource mobilisation of quality improvement interventions
O1.5 To enhance clinical effectiveness

Priority 2: Reduction of avoidable harm to patients and healthcare workers

Objectives:

O2.1 To develop and implement WHO IPC framework across all levels
O2.2 To implement and monitor compliance with patient safety at all levels using verified/ evidence-based tools
O2.3 To enhance medication safety at all levels
O2.4 To enhance environmental safety in healthcare facilities
O2.5 To address avoidable sources of harm for obstetric and surgery patients

Priority 3: Enhancing the capacity of health workers in quality and safety

Objectives:

O3.1 To support the workforce by promoting health and safety of healthcare workers
O3.2 To develop and ensure implementation of CPD programmes for healthcare professionals in quality and safety
O3.3 To integrate quality improvement and patient safety in education and training (undergraduate, and postgraduate)

Priority 4: Enhancement of integrated people-centred health services

Objectives:

O4.1 To improve patient experience
O4.2 To strengthen people's involvement in service planning and monitoring
O4.3 To promote continuity of care

Priority 5: Strengthening data for quality health services

Objectives:

O5.1 To enhance the Health Management Information System to include supply and demand side quality & patient safety measures from all levels
O5.2 To strengthen capacity for quality and safety data management
O5.3 To strengthen data dissemination, benchmarking and data driven decision-making

Quality Interventions have been developed for each objective and are shown in Table 8.

Table 8: **National Quality Priorities, Objectives and Interventions**

Priority 1: Effective governance and leadership for quality across all levels

O1.1	***To strengthen collaboration and coordination between NHPC and the MoHD on quality and safety***	1.1.1 Hold regular meetings between NHPC and MoHD on quality and safety 1.1.2 Conduct joint regular reviews of facility records of individual licenses
O1.2	**To develop leadership structure, plans, policies and SOPs for quality and patient safety**	1.2.1 Develop hospital strategic plans with a focus on quality and safety 1.2.2 Conduct review to identify any missing policies and SOPs 1.2.3 Develop policies & procedures related to quality assurance at all levels of healthcare system 1.2.4 Regular review of policies and SOPs 1.2.5 Establish/revitalise accountable team/units overseeing the quality improvement at the central Ministry and lower levels with clear roles and responsibilities for accountability 1.2.6 Establish/ strengthen multi-disciplinary quality committees at all levels with clear roles and responsibilities for accountability
O1.3	**To create a culture of quality across all levels**	1.3.1 Conduct baseline assessment for quality culture 1.3.2 Regular assess/ re-assess culture of quality 1.3.3 Regularly monitoring for adherence and compliance of policies, SOPs and processes to create a culture of quality 1.3.4 Communication and advocacy for quality and safety 1.3.5 Implement quality improvement programme (based on gaps identified from monitoring and assessing) 1.3.6 Establish and implement incidence reporting system
O1.4	**To strengthen coordination mechanism between MoHD and stakeholders for planning and resource mobilisation of quality improvement interventions**	1.4.1 Assessment of current supply chain management 1.4.2 Strengthen utilisation of ELMIS database for medical and non-medical supplies reporting 1.4.3 Development and implementation of guidelines and SOPs for supply chain management 1.4.4 Encourage Government/Ministry to allocate specific budget lines for quality improvement activities 1.4.5 Sensitise the hospital management teams to set aside resources for quality improvement activities within the hospital budget envelope. 1.4.6 Ensure leveraging resources of other Ministry programmes for the inclusion and implementation of quality improvement activities

O1.5	To enhance clinical effectiveness	1.5.1 Conduct regular clinical audits at facility level 1.5.2 Support health facilities to adopt the national clinical guidelines 1.5.3 Adopt/adapt evidence based clinical practice guidelines for high volume, high risk & high-cost diseases 1.5.4 Develop hospital strategic plans with prioritising clinical governance as strategic priority 1.5.5 Develop a comprehensive framework for clinical supervision that includes guidelines for mentorship, peer review, and performance evaluation 1.5.6 Implementation of clinical supervision framework

Priority 2: Reduction of avoidable harm to patients and healthcare workers

O2.1	To develop and implement WHO IPC framework across all levels	2.1.1 Appoint national IPC Coordinator within MoHD 2.1.2 Train health facilities on IPC framework using multimodal approach 2.1.3 Disseminate national IPC guidelines and SOPs to hospitals and primary care levels 2.1.4 Provide resources to meet requirements in IPC framework 2.1.5 Regularly assess facility compliance with IPC framework
O2.2	To implement and monitor compliance with patient safety at all levels using verified/ evidence-based tools.	2.2.1 Extend WHO PSFHF and PSFPC programme for all hospitals and PHCs 2.2.2 Train healthcare workers on PSFHF and PSFPC and provide guidelines and protocol 2.2.3 Regular assessment of health facilities against PSFHF and PSFHPC
O2.3	To enhance medication safety at all levels	2.3.1 Establish a national pharmacovigilance system for monitoring and reporting drug reactions ADRs 2.3.2 Establish and conduct regular engagement and collaboration with Quality Control Commission on drug quality control 2.3.3 Develop and implement policies and procedures for safe medications 2.3.4 Train all healthcare workers on medication safety
O2.4	To enhance environmental safety in healthcare facilities	2.4.1 Establish protocols for radiology safety, fire safety, infrastructure and equipment safety, emergency hazard preparedness 2.4.2 Implement environmental cleaning SOPs
O2.5	To address avoidable sources of harm for obstetric and surgery patients	2.5.1 Implement WHO Safe Surgery Checklist for surgical complication reduction 2.5.2 Implement WHO Safe Childbirth Checklist to decrease maternal and neonatal mortality

Priority 3: Enhancing the capacity of health workers in quality and safety

03.1	**To support the workforce by promoting health and safety of healthcare workers**	3.1.1 Review and strengthen existing safety policies and procedures and guidelines 3.1.2 Train health workers in safety policies and procedures and guidelines 3.1.3 Establish occupational health in all facilities responsible for health and wellbeing of health workers 3.1.4 Monitor implementation of safety policies and procedures and guidelines 3.1.5 Regularly identify and evaluate potential hazards in the workplace
03.2	**To develop and ensure implementation of CPD programmes for healthcare professionals in quality and safety**	3.2.1 Ensure quality and safety in CPD programmes 3.2.2 Deliver mentorship programme for health facility leadership and management on quality and safety
03.3	**To integrate quality improvement and patient safety in education and training (undergraduate and postgraduate)**	3.3.1 Meet with curricula leads/committees across all undergraduate and postgraduate health professions training courses to review quality and safety in curricula 3.3.2 Develop action plan to strengthen content on quality and safety

Priority 4: Enhancement of integrated people-centred health services

O4.1	**To improve patient experience**	4.1.1. Establish/ renew patient feedback mechanism in each health facility at all levels 4.1.2. Implement patient feedback response mechanism to ensure accountability 4.1.3. Conduct patient experience surveys in each facility 4.1.4. Implement Patient & Families rights and consent procedures
O4.2	**To strengthen people's involvement in service planning and monitoring**	4.2.1 Engage/revitalise Hospital Community Boards on quality interventions 4.2.2 Include patients in their decision-making processes for their treatment 4.2.3 Community participation at planning for resource allocation 4.2.4 Develop participatory monitoring framework at all levels

O4.3	**To promote continuity of care**	4.3.1 Review existing referral system in place 4.3.2 Ensure referral guidelines, SOPs and forms are available and communicated to all relevant staff 4.3.3 INGO/LNGOs to comply with the national referral system 4.3.4 Establish a good mechanism for referral data collection and utilisation to improve referral process

Priority 5: Strengthening data for quality health services

05.1	**To enhance the Health Management Information System to include supply and demand side quality and patient safety measures from all levels**	5.1.1 Review and identify missing HMIS indicators for quality and patient safety 5.1.2 Upgrade HMIS to cover newly defined quality and patient safety indicators 5.1.3 Digitalise Monitoring and Evaluation (M&E) tools for quality 5.1.4 Establishment of maternal and perinatal death surveillance and response system in major hospitals 5.1.5 Undertake demand side data collection (including People's Voice Survey)
05.2	**To strengthen capacity for quality and safety data management**	5.2.1 Develop standardised protocols for quality indicators 5.2.2 Provide training for DHIS core team, HMIS regional and district teams on quality and patient safety indicators 5.2.3 Provide specific training on advanced data analysis of quality and safety indicators 5.2.4 Create dashboards that provide up-to-date visual summaries of key comparative health indicators 5.2.5 Integrate DHS2 data at all levels 5.2.6 Implementation of high-level senior monitoring and reporting by regional health data officers 5.2.7 Conduct training programmes for doctors, nurses and administrative staff on documentation standards
05.3	**To strengthen data dissemination, benchmarking and data driven decision-making**	5.3.1 Regular data review meetings within MoHD 5.3.2 Regular data review meetings amongst hospital leadership and with community health boards

2.7 Health management information systems and data systems

A comprehensive integrated system that provides information on health and healthcare is known as Health Management Information System (HMIS), which aims to support evidence based decision-making process. Information could be described as "the guidance of health systems", when it is good quality information. HMIS can lead to improved governance and stewardship; provision of quality health care services; and more efficient management of resources.

The National Health Sector Strategic Plan (HSSP) 2023–2027 aims to *"generate sound and reliable* ***information at all levels of the health system*** *in a holistic approach for better decision-making".* This has been driven by increasing concerns shown by various health sector stakeholders and development partners to strengthen and reform health information systems. The need to guide such efforts using research evidence was crucial and was motivated by large data gaps in availability, access and utilisation of reliable health information, because of fragmented, under-developed and poor performing HMIS. More specifically, the strategic plan aimed to describe the contextual framework in which HMIS operates, identify major gaps and their reasons not determinists, and to propose evidence-based recommendations for action.

Significant progress has been made in expanding facility-based data collection. Nevertheless, gaps exist in capacities to analyse and interpret data at all levels. Different data collection systems proliferated by vertical programmes and supporting agencies still require a clear policy to consolidate the HMIS system throughout the country. Available facility-based data needs to be harnessed with other sources of information such as the periodic health and demographic surveys, regular health and nutrition, and research data.

The current practice of HMIS data flow is based on the mechanism where facilities generate the data and report either to district or regional level using hard copy of summary reports or directly to the DHIS2 where facilities have capacity. Practically, the regional level is a key junction where data is verified before it goes to the national level; and the data entry occurs in some of the districts where there is manpower, capacity and equipment. All public health facilities report to HMIS apart from Primary Health Units (PHUs) of which only about 20% report to HMIS currently.

However, the available additional resources to support the other key essential HMIS activities are weak at the moment and there are other critical activities which have so many opposite challenges including limited or no financial support. Currently the funds available for the HMIS tools are irregular. Most HMIS core documents such as SOPs, HMIS Policy, strategic plan, indicator reference manual, Data Quality Assurance (DQA) guidelines, data dissemination guidelines, and standard case definitions either do not exist or are in draft form.

Incomplete indicator reference manual is not capturing all the indicators in the National Development Plan (NDP) and HSSP also has some challenges in terms of indicators, and health service quality indicators are not captured.

In the National Health Policy III, key policy objectives for health management information system are delineated as follows:

- Redefine information needs and objectives such as core indicators, HMIS plans and strategies;
- Ensure timely, complete, and accurate data collection to monitor notifiable diseases;
- Ensure timely, complete, and accurate data collection from service record data, from infrastructure, equipment, and facilities, and from human resources;
- Strengthen data management [coordinating and integrating from programmes];

- Enhance data quality assurance;
- Improve data analysis and synthesising to produce useful information;
- And disseminate health system information to policy makers, managers, providers, and relevant partners

Building upon the strategic direction for a robust HMIS, efforts are underway to leverage existing and proposed systems for national quality efforts. Currently, facility-based data collection through HMIS and DHIS2 is a primary source of health information. To further support quality, the Health Network Quality Improvement System (HNQIS) 2.0 is proposed and is being operationalised. This system, utilising digital checklists and feedback mechanisms, aims to enhance the quality of care. The integration of quality efforts with health management and information systems is evident in the migration of HNQIS 2.0 checklists into the national DHIS2 platform. This allows for a more unified approach to data collection, analysis, and action planning for both routine health service monitoring and targeted quality improvement initiatives, as demonstrated by the baseline supportive supervision assessment in the Marodijeh region. The current HMIS still needs efforts to include indicators focused more on quality and safety of healthcare.

2.8 Quality indicators and core measures

The MoHD existing monitored indicators are collected, extracted, and subsequently mapped in accordance with the WHO health system building blocks. The development plan for the Somaliland national healthcare information system incorporates quality indicators with the objective of:

- Align with the National Health Priorities in Somaliland
- Focus on the selected national quality priorities i.e., effective governance and leadership, improving service delivery, reducing avoidable harm to patients and healthcare workers and strengthening people-centred approach.
- Support the aims of Universal Health Coverage and Sustainable Developmental Goals
- Consider the quality dimensions & health system building blocks.

The selection of the quality and safety indicators will follow these criteria:

1. **Importance:** Does it address a public health/ quality priority?
2. **Validity:** Does it really measure what it was intended to measure?
3. **Scope:** What is the scope of impact in measuring this indicator (e.g., population-size clinical outcomes)? Does the indicator speak to a larger issue?
4. **Feasibility:** Is it easy to collect? Does it involve additional cost/resources for its collection?
5. **Actionality:** Is the indicator amenable to intervention: for example, is it possible to make improvements through changes in policy, service configuration, and behaviour change or resource allocation?
6. **Credibility:** Does this indicator provide fair and credible information to providers and managers?

An emphasis will be placed on using currently existent sources such as the current Health Information System, key performance indicators for facility level, district level, regional level and national level.

The MoHD will be principally responsible for the collection and analysis of the data through its HMIS unit. Therefore, the collected data can be aggregated at various levels (facility, district, regional and central levels) and the HMIS unit should ensure timely analysis and dissemination of quality indicator data to facilitate timely decision-making.

Quality Indicators for all 5 Quality Priorities have been defined and are shown in Table 9.

Table 9: **Somaliland National Quality Health Indicators**

Indicator	Indicator Definition, Unit of Measure	Data Source, Disaggregation	Frequency	Responsibility	Rationale
1. Effective governance and leadership for quality across all levels					
Endorsed sector health strategic plan in place	Existence of an updated, comprehensive, and government-endorsed sectorial health strategy.	Department of Planning, Policy and Strategic Information	Once	Department of Planning, Policy and Strategic Information / Senior Management	To include as evidence that there are strategic guidance documents at policy level
National Health Policy endorsed	Existence of an updated, comprehensive, and government-endorsed sectorial health policy.	Department of Planning, Policy and Strategic Information	Once	Department of Planning, Policy and Strategic Information / Senior Management	To include as evidence of the national health policy
Health sector coordination mechanism in place	No. of regular health sector coordination meetings held at national and sub-national levels.	Department of Planning, Policy and Strategic Information	Quarterly/ Yearly	Department of Planning, Policy and Strategic Information / Senior Management	To include as evidence of regular coordination at different levels
Percentage facilities with no monthly stockouts	Percentage of health facilities with no stock-outs of essential medicines or vaccines in a month	ELMIS	monthly	Supply Chain Management, Health Services and Hospitals department	Evidence of appropriate supply chain management
2. Reduction of avoidable harm to patients and healthcare workers					
Percentage enrolment in PSFHF for public health facilities	Percentage of public health facilities enrolled in PSFHF program out of total public facilities	MoHD annually	MoHD, Hospitals	Evidence of facilities taking steps to ensuring patient safety	
Percentage of public facilities with IPC program	Percentage of public facilities with IPC program in place out of total public health facilities	MoHD	Annually	MoHD, Hospitals	Evidence of facilities ensuring patient safety
A national pharmacovigilance program developed	A national pharmacovigilance program developed enrolling all public health facilities	MoHD	Annually	MoHD, Hospitals	Evidence of facilities ensuring patient safety

Table 9: **Somaliland National Quality Health Indicators**

Indicator	Indicator Definition, Unit of Measure	Data Source, Disaggregation	Frequency	Responsibility	Rationale
Percentage of public facilities using safe surgery checklist	Percentage of eligible hospitals using safe surgery checklist out of all eligible public hospitals	MoHD	Annually	MoHD, Hospitals	Evidence of facilities ensuring patient safety
Percentage of public facilities using safe childbirth checklist	Percentage of eligible public facilities using safe childbirth checklist out of all eligible public hospitals	MoHD	Annually	MoHD, Hospitals	Evidence of facilities ensuring patient safety
3. Enhancing the capacity of health workers in quality and safety					
Percentage of frontline health workers trained in IPC	Percentage of frontline health workers trained in IPC out of eligible frontline health workers	MoHD	Annually	MoHD	Evidence of improving staff capacity for quality and safety
Number of health workers completing CPD on safety and quality	Number of health workers completed safety and quality CPD	MoHD	Annually	MoHD	Evidence of improving staff capacity for quality and safety
4. Enhancement of integrated people-centred health services					
Patient feedback mechanisms availability	Percentage of public health facilities with patient feedback mechanisms in place	MoHD	Annually	MoHD, Hospital Directors	Evidence of considering patient experience in planning
Percentage of facilities conducting community board meetings regularly	Percentage of public health facilities that conducted community board meetings on Quality improvement	MoHD	Annually	MoHD, Hospital Directors	Evidence of considering patient experience in planning
5. Strengthening data for quality health services					
HMIS reporting	Proportion of Public Health Facilities reporting data monthly to the HMIS as percentage of Total Public Health Facilities	HMIS	Quarterly	DoP-HMIS	Evidence of facilities reporting data to HMIS
Number of published health sector reports	Annual reports produced and disseminated using HMIS data	HMIS	Annually	DoP-HMIS	Evidence of using data reported by facilities to HMIS

03

Operational plan for implementation

3. OPERATIONAL PLAN FOR IMPLEMENTATION

An implementation plan was drafted on the third day of the stakeholder workshop in April 2025. It contains Key Performance Indicators for each quality intervention and describes the level of implementation and responsibility for data collection across 2026-2030. These intervention indicators are at a far more granular level than the high-level quality indicators.

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP1: Effective governance and leadership for quality across all levels

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Imple-mentation	Responsibility
O1.1: To strengthen collaboration and coordination between NHPC and the MoHD on quality and safety	1.1.1 Regular meetings between NHPC and MoHD on quality and safety	# of meetings in a year						National	MoHD (Health Services Director)
	1.1.2 Joint regular reviews of facility compliance on individual licenses.	# of joint reviews % of compliance of facility on individual licenses/compliance rate per facility						National Regional	MoHD (Health Services Director) Regional Directors
O1.2: To develop leadership structure, plans, policies and SOPs for quality and patient safety	1.2.1 Develop hospital strategic plans with a focus on quality and safety	# of hospitals with a strategic plan with a focus on quality and safety						Facility	Hospital Director
	1.2.2 Conduct review to identify any missing policies and SOPs/ regular review of policies and SOPs	# of joint review meetings with relevant stakeholders to identify missing policies and SOPs in relation to quality and safety						Facility	Facility Director
	1.2.3 Develop policies & procedures related to quality assurance in all levels of healthcare system	# of developed policies and procedures per level						Facility	Facility Director
	1.2.4 Regular review of policies and SOPs							Facility	Facility Director

Table 10: Key Performance Indicators, Data Collection, Level of Implementation and Responsibility

NQP1: Effective governance and leadership for quality across all levels

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Imple-mentation	Responsibility
	1.2.5 Establish/revitalise accountable team/units overseeing the quality improvement at the central Ministry and lower levels with clear roles and responsibilities for accountability	# of facilities with functional quality team /units (with clear ToR) # of RMOs with functional quality team /units (with clear ToR)						Regional Facility	Regional Directors Facility Director
	1.2.6 Establish/ strengthen multi-disciplinary quality committees at all levels with clear roles and responsibilities for accountability	# of facilities with functional quality committees						Facility	Facility Director
O1.3: To create a culture of quality across all levels	1.3.1 Conduct baseline assessment for quality culture	# of baseline assessments conducted for culture of safety						Facility	Facility Director
	1.3.2 Regularly assess/ reassess culture of quality	# of reassessments every 3 years						Facility	Facility Director
	1.3.3 Regularly monitoring for adherence and compliance of policies, SOPs and processes to create a culture of quality	# of culture of safety assessments per facility						Regional Facility	Regional Directors Facility Director
	1.3.4 Communication and advocacy for quality and safety	# of meetings focussed on quality and safety in a year # of advocacy groups established # of IEC materials developed on quality and safety						National Regional Facility	(Health Services Director) Regional Director Facility Director
	1.3.5 Implement quality improvement programme (based on gaps identified from monitoring and assessing)	# of programmes being implemented						Facility	Facility Director

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP1: Effective governance and leadership for quality across all levels

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
	1.3.6 Establish and implement incidence reporting system	# of facilities with active incidence reporting systems							Facility Director
O1.4: To strengthen coordination mechanism between MoHD and stakeholders for planning and resource mobilisation of quality improvement interventions	1.4.1 Assessment of current supply chain management	# of facilities with a functional supply chain management system						Regional	Regional Directors
	1.4.2 Strengthen utilisation of ELMIS database for medical and non-medical supplies reporting	# of facilities actively reporting on the ELMIS						Facility	Facility Director
	1.4.3 Development and implementation of guidelines and SOP for supply chain management	# of guidelines and SOPs for supply chain management developed # of guidelines and SOPs implemented						National	MoHD (Supply Chain Dept)
	1.4.4 Encourage Government/Ministry to allocate specific budget lines for quality improvement activities	% of MoHD budget allocated for quality improvement						National	MoHD (Admin & Finance Dept)
	1.4.5 Sensitise the hospital management teams to set aside resources for quality improvement activities within the hospital budget envelope.	% of hospital budget allocated for quality improvement						Facility	Hospital Director
	1.4.6 Ensure leveraging resources of other Ministry programmes for the inclusion and implementations of quality improvement activities							National Regional	MoHD Regional Directors

Table 10: Key Performance Indicators, Data Collection, Level of Implementation and Responsibility

NQP1: Effective governance and leadership for quality across all levels

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O1.5: To enhance clinical effectiveness	1.5.1 Conduct regular clinical audits at facility level	# of clinical audits annually						Facility	Facility Director
	1.5.2 Support health facilities to adopt the national clinical guidelines	# of guidelines adopted/adapted per facility # of training activities conducted # of cadres trained						National Regional	MoHD (Health Services Dept) Regional Directors
	1.5.3 Adopt/adapt evidence based clinical practice guidelines for high volume, high risk & high-cost diseases							Facility	Facility Director
	1.5.4 Develop hospital strategic plans with prioritising clinical governance as strategic priority.	# of hospitals with a strategic plan with a focus on clinical governance						Facility	Facility Director
	1.5.5 Develop a comprehensive framework for clinical supervision that includes guidelines for mentorship, peer review, and performance evaluation.	# of clinical supervision frameworks developed						Facility	Facility Director
	1.5.6 Implementation of clinical supervision framework	# of clinical supervisions frameworks implemented						Facility	Facility Director

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP2: Reduction of avoidable harm to patients and healthcare workers

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O2.1: To develop and implement WHO IPC framework across all levels	2.1.1 Appoint national IPC Coordinator within MoHD							National	MoHD (Health Services Dept)
	2.1.2 Train health facilities on IPC framework using multimodal approach	# health workers trained for IPC framework using multimodal approach per health facility						Regional Facility	Regional Director Facility Director
	2.1.3 Disseminate national IPC guidelines and SOPs to hospitals and primary care levels	# of hospitals received national IPC package						National	MoHD (Quality)
	2.1.4 Provide resources to meet requirements in IPC framework	# facilities received IPC resources						National	MoHD (Supply Chain)
	2.1.5 Regularly assess facility compliance with IPC framework	# facility assessed for compliance IPC framework annually						National Regional Facility	MoHD (Quality) Regional Directors Facility Directors
O2.2: To implement and monitor compliance to patient safety at all levels using verified/ evidence-based tools.	2.2.1 Extend WHO PSFHF and PSFPC programme for all hospitals and PHCs	# facilities enrolled WHO PSFHF and PSFPC programme						National Facility	MoHD (Quality) Facility Director
	2.2.2 Train healthcare workers on PSFHF and PSFPC and provide guidelines and protocols	# healthcare workers trained on PSFHF and PSFPC, # health facilities adopted PSFHF and PSFPC guidelines and protocols						National Facility	MoHD (Quality) Facility Director
	2.2.3 Regular assessment of health facilities against PSFHF and PSFPC	# facilities assessed for using PSFHF and PSFPC framework and achieved level (1)						National	MoHD (Quality)

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP2: Reduction of avoidable harm to patients and healthcare workers

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O2.3: To enhance medication safety at all levels	2.3.1 Establish a national pharmacovigilance system for monitoring and reporting drug reactions ADRs	# adopting national pharmacovigilance system with clear SOPs						National	MoHD
	2.3.2 Establish and conduct regular engagement and collaboration with Quality Control Commission on drug quality control	# joint meetings with quality control commission and MoHD on drug quality control						National	MoHD
	2.3.3 Develop and implement policies and procedures for safe medications	# of policies and procedures for safe medications drafted, approved and implemented						Facility	Facility Director
	2.3.4 Train all healthcare workers on medication safety	# healthcare workers trained on medication safety per health facility						Facility	Facility Director
	2.3.5 Strengthen medical reconciliations by using internal monitoring	# of internal monitoring audits conducted for medical reconciliations per facility						Facility	Facility Director

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP2: Reduction of avoidable harm to patients and healthcare workers

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O2.4: To enhance environmental safety in healthcare facilities	2.4.1 Establish protocols for radiology safety, fire safety, infrastructure and equipment safety, emergency hazard preparedness	# of safety protocols established per health facility						Facility	Facility Director
	2.4.2 Implement environmental cleaning SOP	# facilities implemented environmental cleaning SOP # of healthcare workers trained environmental cleaning SOP per facility						Regional Facility	Regional Directors Facility Director
O2.5: Address avoidable sources of harm for obstetric and surgery patients	2.5.1 Implement WHO Safe Surgery Checklist for surgical complication reduction	# facilities adopted/ adopt WHO Safe Surgery Checklist						Facility	Facility Director
	2.5.2 Implement WHO Safe Childbirth Checklist to decrease maternal and neonatal mortality	# facilities adopted/ adopt WHO Safe Childbirth						Facility	Facility Director

NQP3: Enhance the capacity of health workers in quality and safety

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O3.1: To support the workforce by promoting health and safety of healthcare workers	3.1.1 Review and strengthen existing safety policies and procedures and guidelines	# of developed/ updated safety policies and procedures and guidelines						Facility	Facility Director

Table 10: Key Performance Indicators, Data Collection, Level of Implementation and Responsibility

NQP3: Enhance the capacity of health workers in quality and safety

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Imple-mentation	Responsibility
	3.1.2 Train health workers in safety policies and procedures and guidelines	# of health workers trained in safety policies and procedures and guidelines						National Regional Facility	MoHD Regional Directors Facility Director
	3.1.3 Establish occupational health in all facilities responsible for health and wellbeing of health workers	# of facilities with active occupational health program.						Facility	Facility Director
	3.1.3 Monitor implementation of safety policies and procedures and guidelines	# of safety policies and procedures implemented and monitored per facility						Facility	Facility Director
	3.1.4 Regularly identify and evaluate potential hazards in the workplace	# of "potential safety hazards in the workplace" identified per facility						Facility	Facility Director
O3.2: To develop and ensure implementation of CPD program for healthcare professionals in quality and safety	3.2.1 Ensure quality and safety in CPD programmes	% of quality and safety content in CPD programmes.						Facility	Facility Director
	3.2.2 Deliver mentorship programme for health facility leadership and management on quality and safety	# of facility leaders who successfully received training on quality and safety						National Regional	MoHD (Health Services) Regional Directors
O3.3: To integrate quality improvement and patient service in education training (undergraduate, and postgraduate).	3.3.1 Meet with curricula leads/committees across all undergraduate and postgraduate health professions training courses to review quality and safety in curricula.							National	MoHD
	3.3.2 Develop action plan to strengthen content on quality and safety	# of curricula with strengthened content on quality and safety						National	MoHD

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP4: Enhancement of integrated people-centred health services

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Imple-mentation	Responsibility
O4.1: Improve patient experience	4.1.1 Establish/ renew patient feedback mechanism in each health facility at all levels	# of Health facilities implemented patient feedback mechanism						Facility	Facility Director
	4.1.2 Implement patient feedback response mechanism to ensure accountability	% of resolved patient complaints						Facility	Facility Director
	4.1.3 Conduct patient experience surveys in each facility	# of patient experience surveys conducted annually						Facility	Facility Director
	4.1.4 Implement Patient & Families rights and consent procedures	# of facilities implementing patient & families rights and consent procedures						Facility	Facility Director
O4.2: To strengthen people involvement in service planning and monitoring	4.2.1 Engage/revitalise Hospital Community Boards on quality interventions	# of hospitals conducted community board meetings on quality improvement						Facility Community	Facility Director Hospital Community Board Chairperson
	4.2.2 Include patients in their decision-making processes for their treatment							Facility Individual	Clinicians Patients
	4.2.3 Community participation at planning for resource allocation	# of meetings community representatives participated on resource planning						National Community	MoHD Community Represen-tatives
	4.2.4 Develop participatory monitoring framework at all levels	# of facilities using monitoring dashboard for KPIs						National Regional Facility	MoHD (HMIS) Regional Director Facility Leaders

Table 10: Key Performance Indicators, Data Collection, Level of Implementation and Responsibility

NQP4: Enhancement of integrated people-centred health services

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O4.3: To promote continuity of care	4.3.1 Review existing referral system in place							National	MoHD (Health Services)
	4.3.2 Ensure referral guidelines, SOPs and forms are available and communicated to all relevant staff	# of health facilities implementing referral guidelines, SOPs and forms						Regional Facility	Regional Director Facility Director
	4.3.4 INGO/LNGOs to comply with the national referral system	# of INGO/LNGOs implementing national referral system						Regional Facility	Regional Director NGO Facility Director
	4.3.5 Establish a good mechanism for referral data collection and utilisation to improve referral process							National	MoHD

NQP5: Strengthening data for quality health services

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
O5.1: To enhance the Health Management Information System to include supply and demand side Quality & Patient Safety Measures from all levels	5.1.1 Review and identify missing HMIS indicators for quality and patient safety	# of meetings to review and identify missing HMIS indicators for quality and patient safety						National	MoHD (Quality & HMIS)
	5.1.2 Upgrade HMIS to cover newly defined quality and patient safety indicators	# of added quality and patient safety indicators to the HMIS core measures						National	MoHD (HMIS)
	5.1.3 Digitalise M&E tools for quality	# of facilities using digitalised M&E tools						Facility	Facility Director

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP5: Strengthening data for quality health services

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Implementation	Responsibility
	5.1.4 Establishment of maternal and perinatal death surveillance and response system in major hospitals	# of hospitals with active maternal and perinatal death surveillance and response system						Facility	Hospital Director
	5.1.5 Undertake demand side data collection (including People's Voice Survey)	# of surveys addressing demand-side data collection (including People's Voice Survey)						National Community	MoHD (Planning) Community Representatives
O5.2: To strengthen capacity for quality and safety data management	5.2.1 Develop standardised protocols for quality indicators	# of standardised protocols for quality indicators						National	MoHD (Quality & HMIS)
	5.2.2 Provide training for DHIS core team, HMIS regional and district teams on quality and patient safety indicators	# of trainings conducted for DHIS core team, HMIS regional and district teams on quality and patient safety indicators						National Regional Facility	MoHD (Quality & HMIS) Regional Directors Facility Directors
	5.2.3 Provide specific training on advanced data analysis of quality and safety indicators	# of trained staff on advanced data analysis of quality and safety indicators						Facility	Facility Director
	5.2.4 Create dashboards that provide up-to-date visual summaries of key comparative health indicators	# of regional directors using up-to-date dashboards with visual summaries of key comparative health indicators for facilities. # of facilities using up-to-date dashboards with visual summaries of key comparative health indicators						National Regional Facility	MoHD (Health Services & HMIS) Regional Directors Facility Directors

Table 10: **Key Performance Indicators, Data Collection, Level of Implementation and Responsibility**

NQP5: Strengthening data for quality health services

Objective	Intervention	KPIs	2026	2027	2028	2029	2030	Level of Imple-mentation	Responsibility
	5.2.5 Integrate DHS2 data at all levels	# of facilities using DHS2						National Regional Facility	MoHD (Health Services & HMIS) Regional Data Officers Facility Directors
	5.2.6 Implementation of high-level senior monitoring and reporting by regional health data officers	# of reports by regional health data officers to senior levels						National Regional	MoHD (Health Services & HMIS) Regional Data Officers
	5.2.7 Conduct training programmes for doctors, nurses and administrative staff on documentation standards	# of trained doctors, nurses and administrative staff on documentation standards						Facility	Facility Director
O5.3: To strengthen data dissemination, benchmarking and data driven decision-making	5.3.1 Regular data review meetings within MoHD	review and discuss KPI results						National Regional	MoHD Regional Directors
	5.3.2 Regular data review meetings amongst hospital leadership and with community health boards	# of meetings conducted review discuss KPIs amongst hospital leadership and with community health boards						Facility Community	Facility Director Hospital Community Board Chairperson

04

Appendices

4: APPENDICES

Appendix 1 – Attendees at Stakeholder Engagement Workshop (December 2023)

Dr Mohamed Abdi Hergeye
Director General, MoHD

Mohamed A. Hussein
Director of Policy, Planning and Strategic Information, MoHD

Abdirahman Ibrahim Hassan
Director of Hospitals and Health services, MoHD

Rahma Yusuf
Director of Community Health Services, MoHD

Mustafe Mohamed Ahmed
Director of Mental Health, MoHD

Nimco Mohamed Hassan
Human Resource director, MoHD

Dr Islam Abouyoussef
NQPS consultant, WHO

Professor Andrew Leather
Director, KGHP

Piera Freccero
Head of Programmes, KGHP

Hamda Ali Abdillahi
In-country Coordinator, KGHP

Abdifatah Abdi Jimale
Finance and logistics officer, KGHP

Nura Aided Ibrahim
Country Director, Global Health Partnerships (formerly THET)

Dr Bashir Dirie
NQIP Technical Lead, MoHD

Hodan Adam
NQIP focal person, MoHD

Khalid Abdi
NQIP M&E, MoHD

Dr Fadumo Jama
SBCC & Community Health Manager, PSI

Abdikarin Mohamed
Save the children

Nasir Mohamed
HMIS Manager, MoHD

Dr Mohamed Yusuf
Pharo-foundation

Dr Layla Hashi
RH specialist, UNFPA

Dr Abdirisaq Yousuf
Manhal Hospital

Dr Ayanle Saleban
Dean of Health Science, University of Hargeisa

Dr Abdiasis Omar
RMO in Marodijeh region

Dr Mustafe Hussein
RMO in Awdal region

Mohamed Abdi
RMO in Togdheer region

Dr Mubarik Yasin
RMO in Sahil region

Dr Jama Ali
RMO in Sanaag region

Ali Nour
RMO in Saraar region

Sainab Ali Warsame
QI Manager, Hargeisa Group Hospital

Dr Abdirahim Hiis
Burao Hospital director

Dr Adam Ibrahim
Borama Hospital director

Dr Mohamed Hussein
Erigavo Hospital director

Dr Mustafa Hussein
Berbera Hospital director

Dr Mustafa Mohamoud
Ainaba Hospital director

Mustafe Mohamed Abdi
Drug Authority

Huda Elmi
Program Manager, Somaliland nursing and midwifery association

Filsan Hussein
Somaliland nursing and midwifery association

Dr Soheir Hassan
Health Poverty Action

Anisa Abdi Ahmed
Nagaad Network

Asma Hassan Sulub
Hayat Women Trust

Maryam Jama Du'aale
WHO

Abdi Dahir Elmi
WHO

Mohamed Geedi Qayad
Consultant, MoHD

Abdi Hassan Du'ale
Consultant, MoHD

Dr Abdirahman Omar
MoHD

Hussein Mohamed
Consultant, MoHD

Mohamud Abdi Muhumed
Ministry of planning and National Development

Mohamed Aydiid
Public health, MoHD

Appendix 2 – Attendees at Stakeholder Engagement Workshop (April 2025)

Ying Shi Shu
Head of Taiwan Medical Mission

Dr Islam Abouyoussef
NQPS Consultant, WHO

Hannah Burrows
Programme Manager, KGHP

Dr Khalid Ali Ahmed
Director of planning, policy and strategic development, MoHD

Hodan Adam
NQIP focal person, MoHD

Dr Zeinab Warsame
Quality Lead, Hargeisa Group Hospital

Naima Mohamed Ismail
Deputy Director Planning and Policy, Somaliland Quality Control Commission

Dr Hasan Mohammad Abdullah
Sahil Regional Medical Officer, MoHD

Dr Ahmed Muse Ibrahim
Director, Berbera Hospital, MoHD

Hashir Mohamed Rableh
Communications Director, MoHD

Dr Abokor Mohamad Hassan
Director, Burao General Hospital, MoHD

Kelly Fletcher
International Relations, Edna Adan University

Nawal Warsame
Dean of Nursing, Edna Adan University

Abdirahman Jamal Ahmed
M and E section, MoHD

Maxel Abokor
Sool Regional Medical Officer, MoHD

Dr Abdillahi Hassan
Director, Ainaba General Hospital, MoHD

Dr Ibrahim Yasin Suleiman
Director of Khalifa Hospital, MoHD

Dr Ahmednoursh Abdirahman Elmi
Director, Borama Regional Hospital, MoHD

Hario Lin
Public Health, ICFTTM

Mohamed Saed Ahmed
SCI

Nour Mohamoud Hersi
Regional Medical Officer, MoHD

Dr Abdisamed Rooble
Togdheer Regional Medical Officer, MoHD

Dr Abdirizak Yussef
Clinical coordinator, Manhal Private Hospital

Nasra Mohamed Ibrahim
P.D. Manager, ACRIF

Dr Abdiaziz Omar Ader
NQIP M and E focal, MoHD

Abdirahman Moumin
DDOPHD, MoHD

Roda Ali Ahmed
BOD Chair, SLNMA

Rahma Ahmed Mohmed
Emergency section, MoHD

Mubarik Yasin Warsame
Awal RMO, MoHD

Elmi Hussein Essa
Supply Chain Department, MoHD

Abdulkarem Dahir
QI Manager, PSI

Ahmed Mohammed Jama
Health Specialist, UNICEF

Dr Omar Mohamed
Regional Coordinator, MoHD

Professor Andrew Leather
Director, KGHP

Samia Khatun
Head of Programmes, KGHP

Dr Layla Mohamed Hashi
Team Leader, Alight

Dr Fatima Ismail
WHO

Dr Bashir Dirie Jame
NQIP Technical Lead, MoHD

Ahmed-Yasin Abdi
Hargeisa Group Hospital

Jaweria Abdirashid Farah
Director of health services and hospitals, MoHD

Mohamed Aden Muhumed
National malaria program control

Abdirahman Farah Afi
NHMIS

Ahmed Wais
Alight

Nasir Mohamed Ahmed
Head of HMIS, MoHD

Abdiladif Mohamed Hussain
Nutrition programme M and E focal, MoHD

Horseed Hassan Elmi
Deputy director Human Resources Department, MoHD

Ahmed Faarah Kamir
MoHD

Nura Aydid
THET

Hamda Ali Abdilahi
Somaliland Country Coordinator, KGHP

Appendix 3 – Key Informant Interview List

#	Name	Institution	Department
1	Dr Ahmed Raman Elmi	Borama Regional Hospital	In-charge of Surgical Ward
2	Dr Fathia Nur	Borama Regional Hospital	In-charge of Maternity Ward
3	Dr Sabah Mohamed	Borama Regional Hospital	In-charge of Medical Ward
4	Dr Hodan Jama	Borama Regional Hospital	In-charge of NICU
5	Dr Hawa Dahir	Borama Regional Hospital	Maternity Ward Doctor
6	Dr Abdulqadir Jibril	Borama Regional Hospital	Out-patient Department
7	Dr Jama Muhumed	Borama Regional Hospital	Severe Malnutrition Ward
8	Hodan Elmi	Borama Regional Hospital	Emergency Department
9	Ugbaad Abillahi	Borama Regional Hospital	In-charge of Female Medical Ward
10	Filsan Mohamed	Borama Regional Hospital	In-charge of Maternity Ward
11	Fathia Yusuf	Borama Regional Hospital	In-charge of Medical Ward
12	Aswan Sharmarke	Borama Regional Hospital	New Payment Ward
13	Hamda Mohamed	Borama Regional Hospital	In-charge of Male Surgical
14	Ismahan Mohamed	Borama Regional Hospital	In-charge of Neonatal Ward
15	Sahra Abdulgadir	Borama Regional Hospital	Payment Ward
16	Omer Ahmed	Borama Regional Hospital	Pharmacy Department
17	Safiya Awale Good	Borama Regional Hospital	Paediatric Ward
18	Dr Adan	Hargeisa Group Hospital	Deputy Director
19	Dr Ayanle S Ahmed	Hargeisa University	Dean of Medical School
20	Dr Mukhtar A Yusuf	Edna Adan University	Dean of Medical School
21	Dr Shukri M Dahir	Edna Adan Hospital	Hospital Physician
22	Ms. Fozia M Ismail	Somaliland Nursing and Midwifery Association	CEO
23	Fardowa O Ayaan	Borama Central MCH	MCH Director
24	Asmahan A Hussein	Xawaadle MCH Center	MCH Director
25	Nasir M Ahmed	National HMIS	Head HMIS
26	Dr Luul Jireh	National Health Professional Commission	Director
27	Dr Suheir Ahmed	National Health Professional Commission	NHPC Member
28	Dr Yassin Arab	National Health Professional Commission	NHPC Member
29	Dr Yusuf Dirir	National Health Professional Commission	NHPC Member
30	Abdirahman A Hussein	MoHD	Quality Care Unit Head
31	Dr Hamdi Issa	MoHD	Head of Community Health
32	Dr Fadumo M Ismail	WHO	Health Emergency Officer
33	Dr Yakub Aden	MoHD	Director of Mental Health
34	Dr Fadumo Hashi	MoHD	Director of Obstetrics & Gynaecology
35	Mr. Abdirakim Yusuf	Kaah Hospital-Private	Director of Kaah Hospital
36	UNICEF Officer X2	UNICEF	UNICEF Officer
38	Ms Faiza Ibrahim	UNFPA	Head of UNFPA Sub-office Hargeisa

Appendix 4 – Summary of Facility Assessments Conducted

Facility	Assessment Date
Primary Level	
Central MCH	1 December 2021
Shifo MCH	2 December 2021
Sheed Dheer MCH	2 December 2021
Sheikh Osman MCH	2 December 2021
Hadi MCH	4 December 2021
Qor Gaab MCH	4 December 2021
Ali Jawhar MCH	4 December 2021
District Level	
Ainaba District Hospital	14 – 15 October 2023
Regional Level	
Hargeisa Group Hospital	21 – 24 September 2023
Boroma Regional Hospital	28 – 30 September 2023
Berbera Regional Hospital	2 – 3 October 2023
Erigavo Regional Hospital	17 – 18 October 2023
Burao Regional Hospital	21 – 23 October 2023

Appendix 5 – Patient Friendly Safety Hospital Framework Domains and Criteria

A: LEADERSHIP & MANAGEMENT		
	A.1.	**The leadership and governance are committed to patient safety**
CRITICAL	A.1.1.1	The hospital has a strategic plan with patient safety as a priority
	A.1.1.2	There is a recognised corporate and clinical governance/leadership system within the hospital
	A.1.1.3	The leadership promotes a culture of patient safety by conducting different activities, including monthly patient safety walk-rounds to identify and take action on safety issues
CORE	A.1.2.1	The leadership provides resources, including an annual budget for patient safety activities based on a detailed action plan
	A.1.2.2	The leadership provides a framework for ethical management that supports decision-making in clinical care and the management of research
	A.1.2.3	The leadership assesses patient safety culture on an annual basis with resulting action plans reviewed every three months
	A.1.2.4	Every year the leadership acknowledges and celebrates WHO Hand Hygiene Day (5 May) and World Patient Safety Day (17 September)
DEVELOPMENTAL	A.1.3.1	The hospital's strategic plans have mission, vision and values statements that demonstrate a culture of patient safety
	A.2.	**The hospital has a patient safety programme**
CRITICAL	A.2.1.1	The leadership ensures there is a designated qualified senior staff member with responsibility, accountability and authority for patient safety
CORE	A.2.2.1	The hospital has a multidisciplinary patient safety internal body/ committee to guide all safety and risk within the hospital
	A.2.2.2	The patient safety pro-gramme has a schedule of quarterly audits and uses the results to improve patient services
	A.2.2.3	The patient safety manager develops reports on different safe-ty/risk activities and disseminates them to all staff every quarter
	A.2.2.4	Patient safety-related risk is managed proactively
	A.2.2.5	A risk management framework, including a plan, policy and register, is used to identify and reduce adverse events and other safety risks to patients, visitors and staff.
	A.2.2.6	The hospital conducts bi-monthly morbidity and mortality (M&M) meetings
	A.2.2.7	The patient safety manager develops and implements a process to improve the effectiveness of communication among all staff
DEVELOPMENTAL	A.2.3.1	The patient safety manager develops reports on different safety/risk activities and disseminates them externally.

A: LEADERSHIP & MANAGEMENT		
	A.3.	**The hospital uses data to improve safety performance**
CORE	A.3.2.1	The patient safety manager acts on measures and results through an action plan and patient safety improvement projects
	A.3.2.2	The patient safety manager has a set of process and output measures that assesses performance with a special focus on patient safety
DEVELOPMENTAL	A.3.3.1	The hospital compares its patient safety indicator data over time, and/or with other patient safety friendly hospitals, and/or international best practices
	A.4.	**The hospital has essential functioning equipment and supplies to deliver its services**
CRITICAL	A.4.1.1	The leadership ensures the availability of essential functioning equipment and supplies
CORE	A.4.2.1	There is a preventive maintenance programme to inspect, test and calibrate all equipment
	A.4.2.2	There is a system in place to repair or replace broken (malfunctioning) equipment, including recalls or hazard notices
	A.4.2.3	The hospital ensures that staff receive appropriate training for all essential equipment, including medical devices, and only trained and competent people handle specialised equipment
	A.5.	**The leadership ensures the provision of competent staff, including independent practitioners and volunteers, to deliver safe care at all times**
CRITICAL	A.5.1.1	The leadership ensures the provision of sufficient numbers of competent staff to deliver safe patient care at all times
	A.5.1.2	There is a defined process to ensure all clinical staff are registered to practise with an appropriate body
CORE	A.5.2.1	There is a system in place to monitor the ongoing competency levels for all health care staff, including independent practitioners and volunteers
	A.5.2.2	The hospital has a workplace violence prevention programme
	A.5.2.3	Staff are allowed sufficient rest breaks to practise safely and adhere to national labour laws
	A.5.2.4	Students and trainees work within their competencies and under appropriate supervision
	A.5.2.5	An occupational health programme is implemented for all staff
	A.5.2.6	The hospital has systems in place to ensure safe injection practice
	A.6.	**The hospital has an information management system to support safe practices for all departments**
CORE	A.6.2.1	There is a process to develop and control all documents, policies and procedures for all departments in a consistent controlled manner
	A.6.2.2	The hospital maintains a standardised medical record with a unique identifier for every patient.
	A.6.2.3	The hospital uses standardised codes for diseases diagnosis and procedures
	A.6.2.4	The hospital ensures that medical records are secure and easily accessed by care providers whenever needed

B: PATIENT & PUBLIC INVOLVEMENT		
	B.1.	**The hospital builds health awareness for its patients and carers to empower them to share in making the right decisions regarding their care**
CORE	**B.1.2.1**	The hospital has a patient rights statement that is accessible to all patient, families and visitors
	B.1.2.2	Patient safety is included in the patient rights statement
	B.1.2.3	There is a documented process to deal with situation if patients refuse treatment
	B.1.2.4	The hospital informs patients about their responsibilities while receiving care
	B.2.	**The hospital builds health awareness for its patients and carers to empower them to share in making the right decisions regarding their care**
CRITICAL	**B.2.1.1**	Informed consent is obtained, before a procedure requiring informed consent, by trained staff in a manner and language the patient or authorised person can understand.
CORE	**B.2.2.1**	The hospital provides education that supports patient and family participation in care decisions and for general patient safety issues
	B.2.2.2	All patients obtain from their treating physicians complete updated information on their diagnosis and treatment
	B.2.2.3	The hospital trains patients' and their carers in post-discharge care
	B.2.2.4	On admission, a full medical history, treatment plan and needs requirements are assessed and recorded in the patients' medical record
	B.2.2.5	On discharge, a detailed discharge/ referral summary is shared with the patient and patient's primary physician
	B.2.2.6	Education methods consider the patient's and family's cultures, values and preferences
	B.2.2.7	Patients are made aware and encouraged to use their voice in relation to the three WHO Global Patient Safety Challenges (Safe Surgery Saves Lives, Clean Care is Safer Care, and Medication Without Harm)
DEVELOPMENTAL	**B.2.3.1**	The hospital encourages patients to participate in planning and making decisions regarding their health care, including discharge or referral.
	B.2.3.2	The hospital provides patient safety advice through multiple mediums, including printed material, social media and on a publicly accessible website.
	B.3.	**The hospital ensures proper patient identification and verification at all stages of care**
CRITICAL	**B.3.1.1**	The identification process used throughout the hospital requires at least two ways in which to identify a patient
CORE	**B.3.2.1**	A system is in place to identify and document allergies
	B.3.2.2	The patient's right to privacy and confidentiality of care and information are respected
DEVELOPMENTAL	**B.3.3.1**	The hospital uses barcoding for patient identification.

B: PATIENT & PUBLIC INVOLVEMENT		
	B.4.	**The hospital involves the community in different patient safety activities**
CRITICAL	B.4.2.1	The hospital conducts patient safety campaigns that share solutions and raise awareness of patient safety in the community
	B.4.2.2	The hospital uses media and/or marketing to promote patient safety
DEVELOPMENTAL	B.4.3.1	The hospital involves the community in designing and implementing patient safety programmes and improvement projects
	B.4.3.2	Patients have access to their medical records with the opportunity to seek clarification from the relevant medical practitioner
	B.5.	**The hospital communicates patient safety incidents to patients and their carers**
CORE	B.5.2.1	The hospital has a policy on disclosure of incidents to staff, patients and their carers
	B.5.2.2	The hospital has a patient advocacy service to explain information received from the clinical team or incidents to patients and their careers
	B.6	**The hospital encourages feedback from patients and acts upon the patients' concerns and compliments**
CORE	B.6.2.1	The hospital obtains patients' and their carers' feedback through both reactive and proactive processes
	B.6.2.2	There is a process for feedback (compliment or complaint or improvement) that includes how to receive, investigate and resolve in a defined time and the process is made available to patients, their family and the public
DEVELOPMENTAL	B.6.3.1	The hospital involves patients and their carers in governance structures, developing policies and in implementing quality improvement and patient safety projects
	B.6.3.2	The hospital provides information and educates patients on patient safety, health literacy and patient well-being
	B.7.	**The hospital has a patient safety friendly environment**
CORE	B.7.2.1	The hospital provides patients with a private, confidential and gender friendly environment.
	B.7.2.2	The hospital provides space for social interaction, including entertainment for patients.
	B.7.2.3	The hospital has a place for prayers and meets patients' spiritual and religious needs.

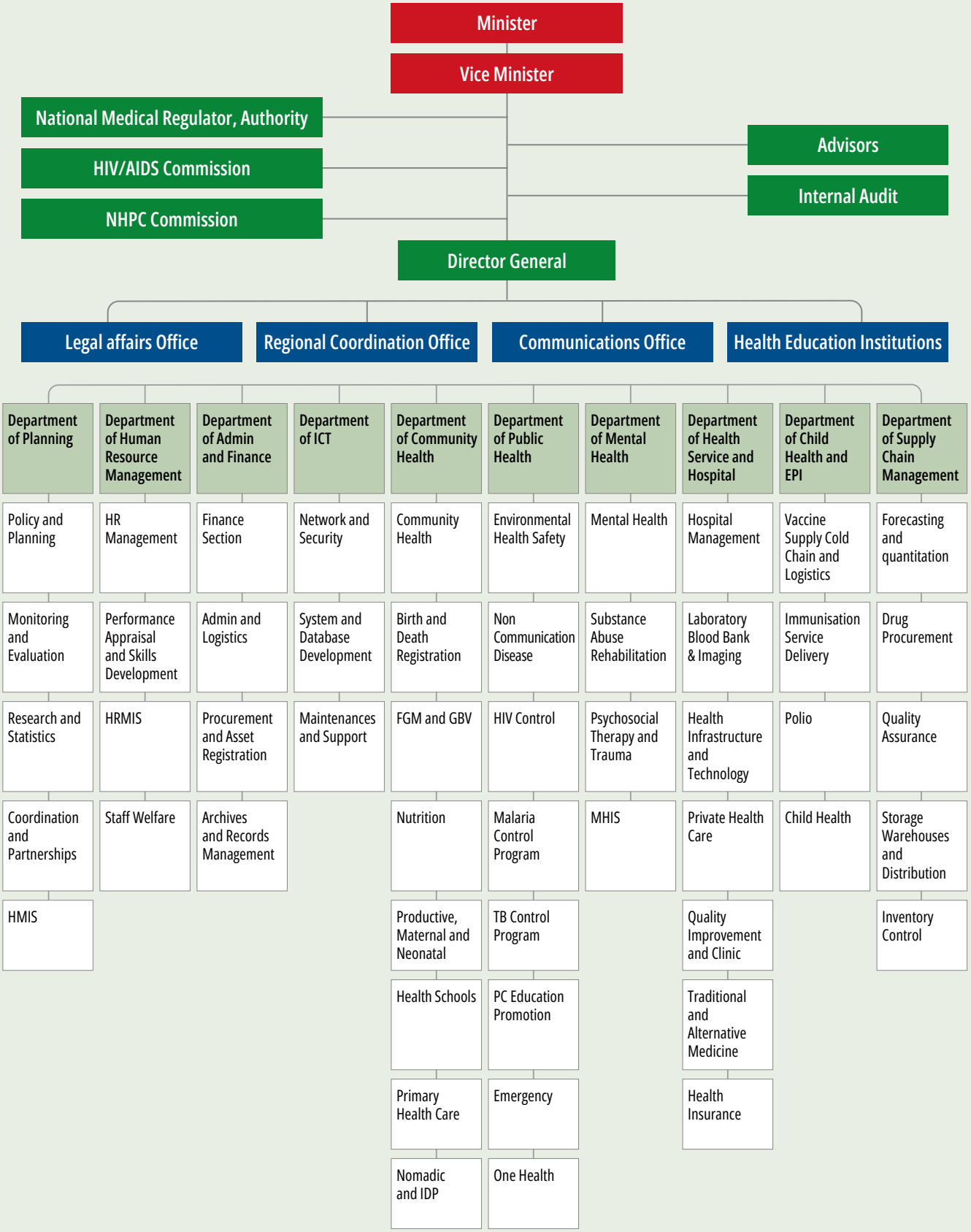
C: SAFE EVIDENCE-BASED CLINICAL PRACTICE		
	C.1.	**The hospital has effective clinical governance that ensures inclusion of patient safety**
CRITICAL	C.1.1.1	The hospital leadership maintains effective channels of communication throughout the hospital, including for urgent critical results, with a designated channel for safety issues
	C.1.1.2	The hospital implements the use of a surgical safety checklist and conforms to guidelines, including WHO guidelines on safe surgery
	C.1.1.3	The hospital has systems in place to ensure hospital-wide recognition of and response to clinical deterioration.
	C.1.1.4	The hospital minimises use of verbal and telephone orders and transmission of results, and "read back" is practised where verbal communication is essential
	C.1.1.5	The hospital has systems in place for safe and thorough handover of patients between clinical teams and between shifts, with safe intra-hospital patient transfer
	C.1.1.6	The hospital implements safe childbirth guidelines and pathways of care
	C.1.2.1	The hospital has a process to develop clinical guidelines and a local clinical guideline committee that meets regularly to select, and ensure implementation of guidelines, protocols and checklists relevant to safety.
CORE	C.1.2.2	The hospital has systems in place to ensure safe communication of pending test results to patients and care providers after discharge.
	C.1.2.3	The hospital ensures invasive diagnostic procedures are carried out safely, and according to standard guidelines.
	C.1.2.4	The hospital implements guidelines, to reduce venous thromboembolism (deep venous thrombosis and pulmonary embolism).
	C.1.2.5	The hospital screens patients to identify those vulnerable to harm and acts to reduce risk.
	C.1.2.6	The hospital maintains a list of approved abbreviations symbols and dose designations for use in hospitals
	C.1.2.7	There is a process to integrate and coordinate the care provided to each patient within and between departments and with relevant external services.
	C.1.2.8	The hospital screens patients to identify those vulnerable to falls and acts to reduce risk.
	C.2.	**The hospital has a system to reduce risk of hospital-acquired infections (HAIs)**
CRITICAL	C.2.1.1	The hospital has a coordinated programme for all infection prevention and control (IPC) activities that involves all disciplines
	C.2.1.2	The hospital ensures proper cleaning, disinfection and sterilisation of all equipment
	C.2.1.3	There is a qualified, designated person responsible for all infection prevention and control (IPC) activities
CORE	C.2.2.1	The hospital conforms to evidence-based guidelines for infection prevention and control (IPC), including WHO multimodal improvement strategy for effective IPC programmes.
	C.2.2.2	The hospital ensures continuous availability of essential, functioning infection prevention and control (IPC) equipment and supplies.

C: SAFE EVIDENCE-BASED CLINICAL PRACTICE		
CORE continued	C.2.2.3	The hospital has functioning isolation protocols, definitions and precautions.
	C.2.2.4	The hospital implements policies and procedures for rational use of antibiotics to reduce resistance and has an active antimicrobial stewardship programme.
	C.2.2.5	The hospital implements recognised guidelines for hand hygiene, including WHO guidelines
	C.2.2.6	Staff are screened before employment and as best practice indicates, and afterwards for colonisation and transmissible infections.
	C.2.2.7	The hospital acts to protect staff and volunteers from health care-associated infections, including provision of hepatitis B vaccination
	C.2.2.8	The hospital conforms to bundle management wherever appropriate
DEVELOPMENTAL	C.2.3.1	The hospital has a surveillance system for hospital acquired infections (HAIs).
	C.3.	**The hospital ensures safety of blood and blood products**
CRITICAL	C.3.1.1	The hospital implements guidelines, including WHO guidelines, on safe quality blood and blood products
	C.3.1.2	The hospital ensures that patient blood samples for cross-matching are securely identified with two unique identifiers
CORE	C.3.2.1	The hospital complies with guidelines on safe and appropriate prescribing of blood and blood products, including the use of alternative fluids.
	C.3.2.2	The hospital has policies and procedures for post-blood transfusion incident management
	C.4.	**The hospital has a safe medication system**
CRITICAL	C.4.1.1	A licenced pharmacist provides a medication management system that addresses patient needs, meets applicable regulations and adheres to WHO guidelines
	C.4.1.2	The hospital keeps high concentrations of electrolytes in a safe place
	C.4.1.3	The hospital ensures availability of life-saving medications in proper quantities at all times
CRITICAL	C.4.1.1	A licenced pharmacist provides a medication management system that addresses patient needs, meets applicable regulations and adheres to WHO guidelines
	C.4.1.2	The hospital keeps high concentrations of electrolytes in a safe place
	C.4.1.3	The hospital ensures availability of life-saving medications in proper quantities at all times
CORE	C.4.2.1	The hospital ensures legible handwriting when prescribing or writing physicians' orders
	C.4.2.2	The hospital ensures medication reconciliation at admission, transfer and discharge
	C.4.2.3	The hospital ensures patient (or carer) education about medication at discharge
	C.4.2.4	The hospital standardises and limits the number of medication concentrations
	C.4.2.5	The hospital has a pain management system and controls, access to and storage of narcotic products according to legislation
	C.4.2.6	The hospital has an implemented policy and procedures to manage medication errors
DEVELOPMENTAL	C.4.3.1	The hospital has clinical pharmacists who participate in medication orders and a system to identify drug–drug and drug–food interactions.

D: SAFE ENVIRONMENT		
	D.1.	**The hospital has a safe and secure physical environment for patients, staff, volunteers and visitors**
CORE	D.1.2.1	The hospital has a designated person in charge of environmental safety with the support of a multidisciplinary committee
	D.1.2.2	The hospital design is maximised to provide a safe environment, including for infection control and the segregation of clean and dirty spaces.
	D.1.2.3	The hospital has a preventive maintenance programme for its medical equipment and the physical environment
	D.1.2.4	The hospital implements a security programme and uses secure areas whenever appropriate
	D.1.2.5	The hospital ensures that staff display personal identification
	D.1.2.6	The hospital develops and tests plans for internal and external emergencies
	D.1.2.7	The hospital provides a monitoring system that alerts when critical services are at risk, such as electricity, water and medical gases
	D.1.2.8	The hospital implements a fire safety programme with an evacuation plan
	D.1.2.9	The hospital has an effective utility system plan, including water, medical gases and fuel
	D.1.2.10	The hospital has a radiation safety programme, including a designated responsible person
	D.1.2.11	The hospital displays warning signs marking unsafe areas
	D.1.2.12	The hospital supplies appropriate and safe food and drinks for patients, staff and visitors
	D.1.2.13	The hospital maintains a clean environment
	D.1.2.14	The hospital has an implemented smoke-free policy
	D.1.2.15	The hospital provides mechanisms to ensure a backup supply of essential services, including medical gases, water and electricity
DEVELOPMENTAL	D.1.3.1	The hospital has an automated information management and electronic medical records system with an appropriate backup system
	D.2.	**The hospital has a safe waste management system**
CRITICAL	D.2.1.2	The hospital conforms to guidelines on management of all types of hazardous waste, including sharps waste
CORE	D.2.2.1	The hospital conforms to guidelines on safe waste management, including safe storage and disposal of waste
	D.2.2.2	The hospital conforms to guidelines on management of biological waste
	D.2.2.3	The hospital conforms to guidelines on management of chemical waste
	D.2.2.4	The hospital conforms to guidelines on management of radiological waste
	D.2.2.5	The hospital segregates waste according to hazard level and colour codes it

E: LIFELONG LEARNING		
	E.1.	**The hospital has a staff professional development programme with patient safety as a cross-cutting theme**
CRITICAL	E.1.1.1	All hospital staff are provided with a patient safety orientation programme
CORE	E.1.2.1	The hospital provides ongoing training and education for all staff to ensure safe patient care and staff respect patient rights
	E.2.	**The hospital conducts research and quality improvement projects in patient safety on an ongoing basis**
CORE	E.2.2.1	All research is approved and monitored by the patient safety internal body or other committee according to the needs of the hospital
DEVELOPMENTAL	E.2.3.1	The hospital conducts prospective, retrospective, and/or cross-sectional studies to assess the magnitude and nature of adverse events to improve the safety of care, on an annual basis
	E.2.3.2	The hospital conducts quality improvement projects to promote patient safety activities

Appendix 6 – Organogram of MoHD



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