Understanding the private health sector
in Somalia

World Health Organization
Eastern Mediterranean Region

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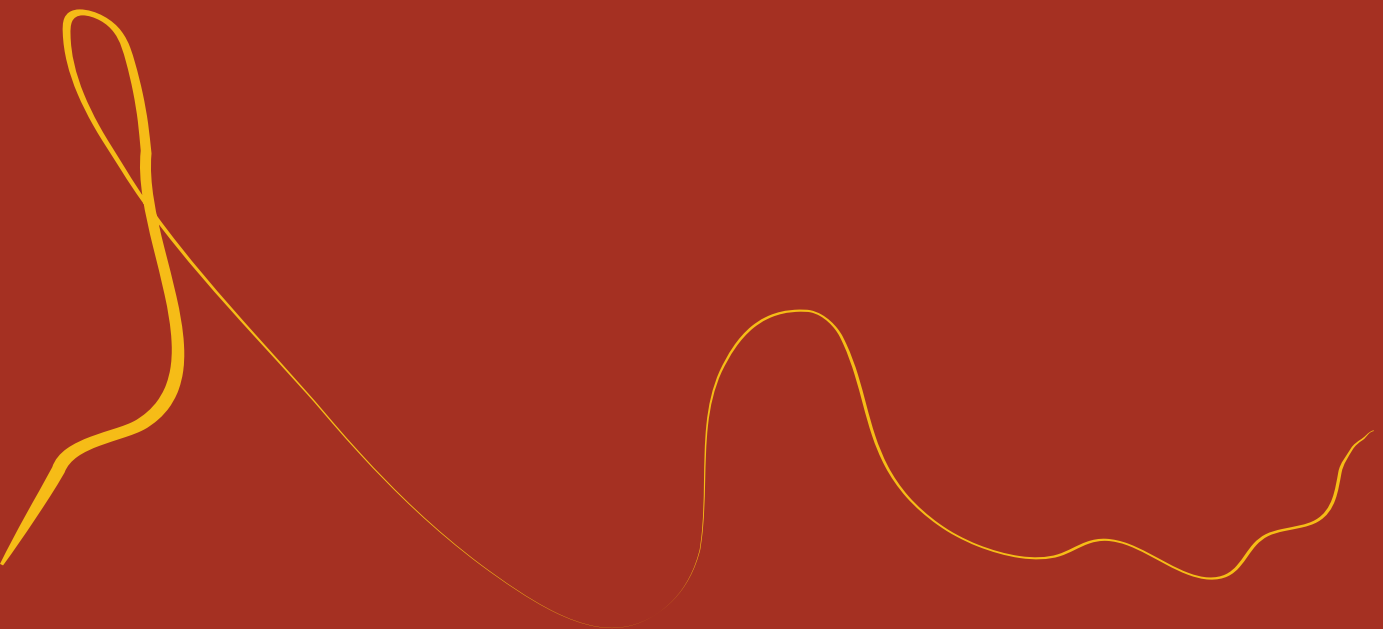
Contents

Acronyms and abbreviations

EPHS	Essential Package of Health Services	NHPC	National Health Professional Council
EPI	Expanded Programme on Immunization	PPP	public–private partnership
FCHW	female community health worker	RDT	rapid diagnostic test
FGS	Federal Government of Somalia	SDG	Sustainable Development Goal
FMS	Federal Member State(s)	SHDS	Somali Health and Demographic Survey
HMIS	health management information system	SHFS	Somalia High Frequency Survey
SSP II	Health Sector Strategic Plan Phase II 2017–2021	SWOT	strengths, weaknesses, opportunities and threats
IDP	internally displaced person	UHC	universal health coverage
MOU	memorandum of understanding	WHO	World Health Organization

Executive summary

The private health sector (both for-profit and not-for-profit) provides about 80% of all curative care services in Somalia. Private sector health care providers act predominantly as referral destinations from facilities run by government and nongovernment organizations. However, accessibility barriers, and an absence of accountability, regulatory environment and coordination are major factors that limit access to the health services offered by private providers.



In 2017,

the health facility density per

10 000

people was

0.76

for public facilities compared to

0.93

for private facilities.

The for-profit private health sector is currently the dominant health care services provider in terms of the number of facilities rather than the proportion of services. Yet, it has remained unregulated. This lack of oversight raises concerns about poor health outcomes created by the suboptimal quality of treatment and poor value for money of out-of-pocket services. Although frameworks, laws and regulations exist that theoretically provide a central regulatory framework for private sector participation in the health sector, they remain in draft form and are largely unenforced. The regulatory environment appears to be better in Somaliland and Puntland than in the other Federal Member States (FMS) of Somalia, where regulatory bodies do not exist.

There is a lack of accreditation and licensing of professional practice. To fill this void, a National Health Professionals Council (NHPC) was created by the Ministry of Health–Federal Government of Somalia in 2019. The Act establishing the legal mandate of the NHPC has been approved but is in the initiation phase, and the implementation of the Health Sector Strategic Plan Phase II (HSSP II) has been limited by a lack of funds and other factors beyond the scope of this assessment.

There is also no regulatory framework for the pricing of services in the private health sector, which makes private health care services expensive for the majority of the population. Patients usually pay cash to access for-profit private health facilities. Regulatory policies for the quality of services provided by the private sector are lacking due to the limited operational capacity of the national authorities. The poor quality of health care services provided by the private sector has also been a longstanding concern that has been aggravated by claims of a large number of unqualified private providers.

Private health sector workforce density is higher than that of the public health sector workforce but remains lower than the World Health Organization (WHO) minimum density threshold of 22.8 doctors, nurses and midwives per 10 000 population. With the exception of Puntland, most of the private health facilities are found in urban areas.

In terms of facilities, the for-profit sector dominates, with only a small percentage identified as not-for-profit facilities. In 2017, the health facility density per 10 000 people was 0.76 for public facilities compared to 0.93 for private facilities. The majority (74%) of private health facilities are owned by individuals, with most such facilities being pharmacies (86% owned by individuals) and hospitals (27% owned by individuals). The hospitals tend to be owned by groups (of individuals), with others owned by cooperatives/communities or international nongovernmental organizations (nongovernmental organizations). Most private health clinics are in buildings designed for residential purposes.

Adherence to health management information system (HMIS) reporting requirements is poor for the private sector, despite some private health care service providers receiving training on HMIS and reporting.

The key priority areas for private sector engagement in health are:

1) governance and leadership;

2) human resources for health;

3) service delivery;

4) health financing;

5) medical products and technologies;

6) service delivery;

7) health preparedness.

The growth of the private sector can be attributed to the absence of a national or state system throughout the civil war and years of protracted conflict, which fragmented and almost destroyed the country's public health system. This limited access to health care and reduced the quality of care, creating a gap that has been filled by the private sector. Relatively high rates of population growth have also driven the rapid expansion of the private health sector due to increasing demand for health care and the limited capacity of the government to meet this demand. Moreover, weak health system governance and a regulatory vacuum have led to the growth of the private health sector in all three administrative zones of Somalia.

In 2020, Somalia with its partners developed a strategic guidance document for engaging the private sector in health services. The initiative aims at mitigating the risks of public-private partnerships (PPP) (*34*). Such risks include project cancellation/modification, lack of accountability among the private sector, imbalance of investment, fraud and other issues regarding PPP contract design and lack of effective regulatory mechanisms.

A number of collaborative efforts between the private sector and the Somali government, and between the private sector and donor/international nongovernmental organization partners, are ongoing or planned. These include credible private sector engagement efforts in pre-service education at mid-level categories, particularly community midwives. Since 2018, there has also been a PPP pilot project within the Malaria Control Programme between the FMS–Banadir Regional Administration and private sector actors in Mogadishu and Bosaso. In addition, there is a tuberculosis pilot programme under way in Mogadishu, and the 2015 Somalia Health and Nutrition Programme (SHINE) led by the Ministry of Health Somaliland in collaboration with United Kingdom's Department for International Development, Population Services International and the Health Consortium for the Somali People programme, among others. Recent engagement activities have included collaboration during the COVID-19 pandemic, in which private entities provided the necessary laboratory/screening services to facilitate service availability and accessibility. Some private entities including doctors also shared their resources with the government to help patients in intensive care units. The key priority areas for private sector engagement in health are: 1) governance and leadership; 2) human resources for health; 3) service delivery; 4) health financing; 5) medical products and technologies; 6) service delivery; and 7) health preparedness.

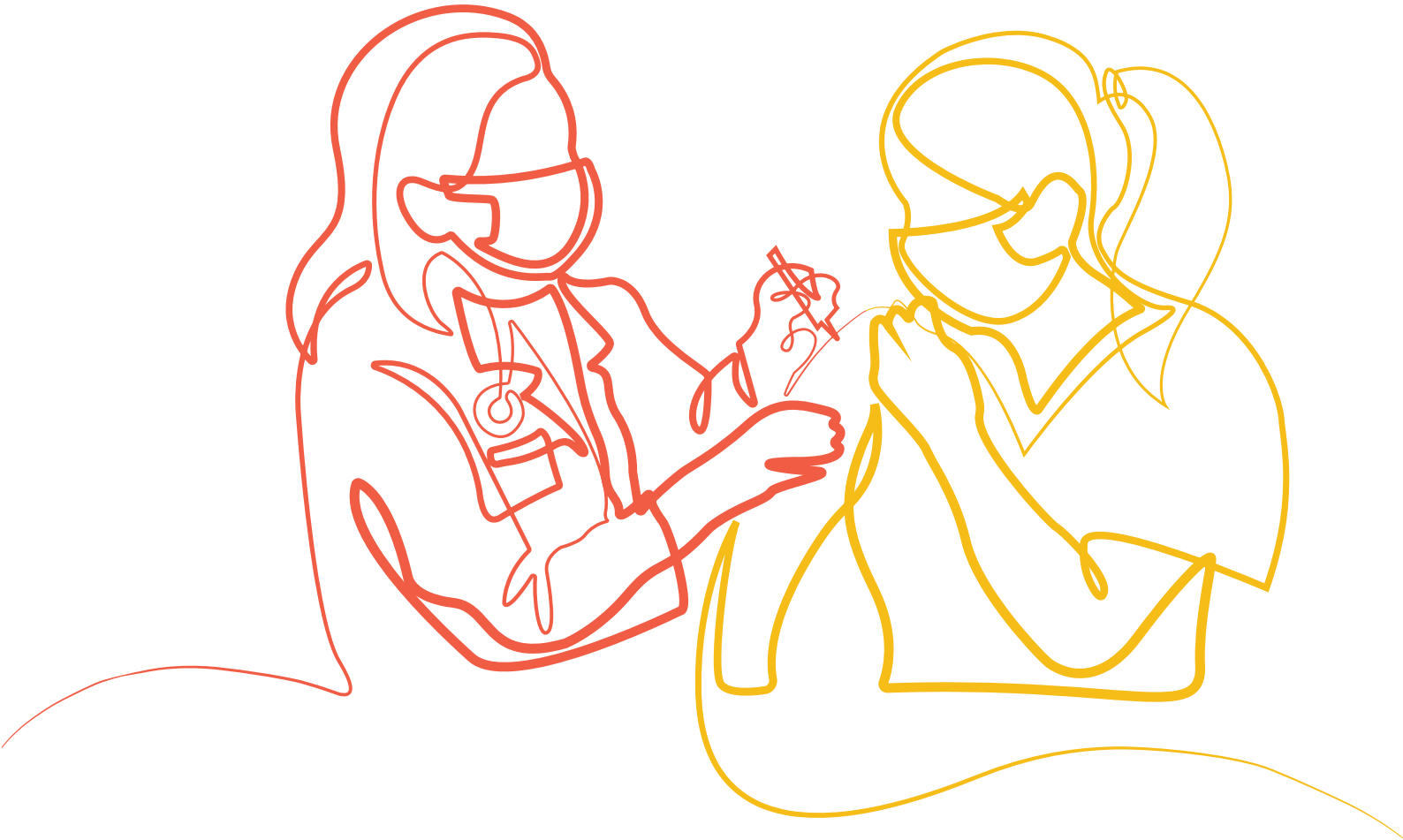
Recommendations moving forward

A. Policy recommendations

1. Develop a PPP policy and a PPP engagement strategy.
2. Develop a clear and sustainable health care financing policy.
3. Develop a resolution or a regulatory framework for pricing in the private health sector.
4. Encourage inclusive engagements between the Ministry of Health–Federal Government of Somalia and Ministries of Health–Federal Member States.
5. Develop a medicines regulatory act and establish a medicines regulatory authority.

B. Operational recommendations

1. Federal and Member State ministries of health should invest in technical capacity-building among staff to ensure adherence to laws and regulations and promote stakeholder understanding of the policy and regulatory frameworks geared towards the operationalization of PPP and the mitigating of failure risks.
2. Create a supportive operational environment in which the judiciary is functional and supportive of PPP operationalization in Somalia.
3. Enforce NHPC licensing and registration regulations for health facilities and staff.
4. Provide continuing medical education for health professionals.
5. Consider establishing a relicensing mandate for health professionals once initial licensing mechanisms are established.
6. Adequately enforce the national essential medicines policy.
7. Develop a robust HMIS that is inclusive of the private sector with effective data quality assurance mechanisms and use the evidence generated to inform health policies.

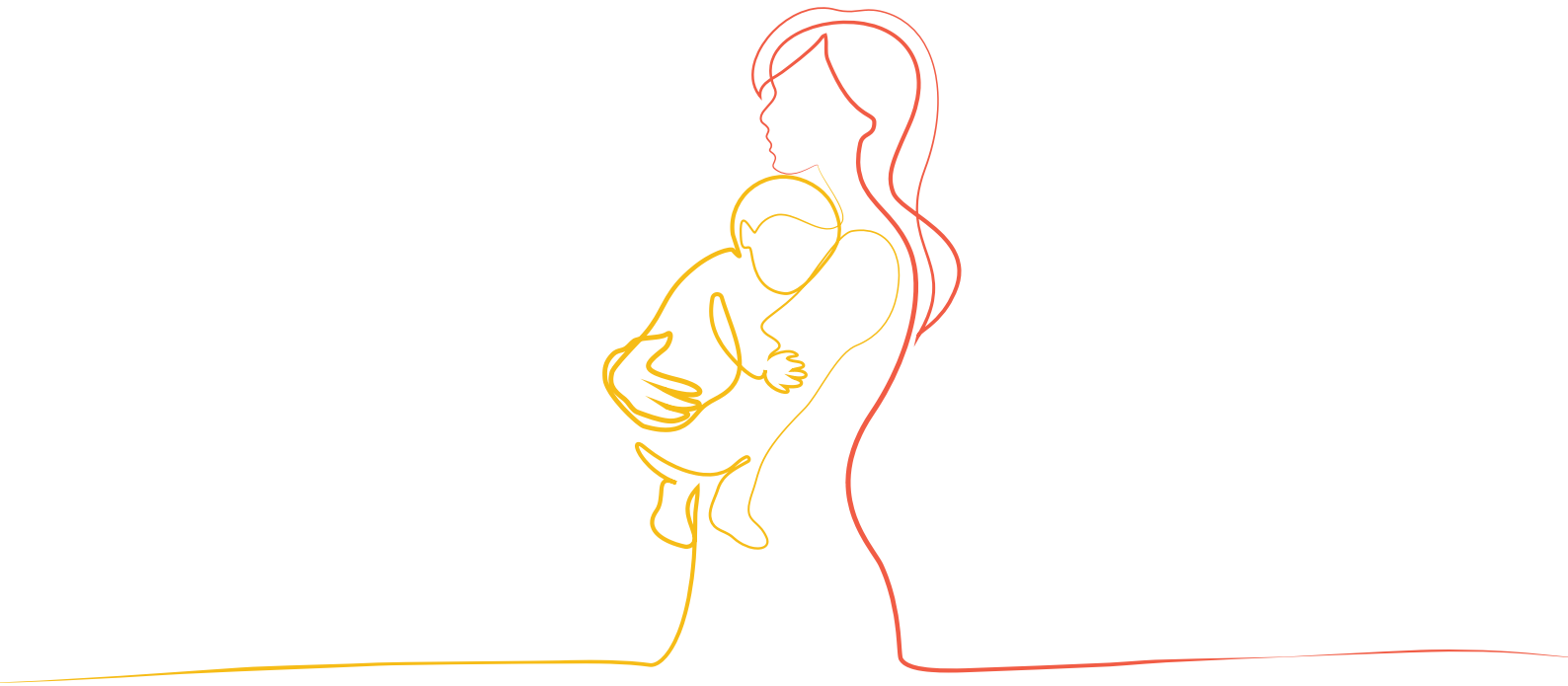


1
Introduction

The private health sector is crucial to advancing the goal of universal health coverage (UHC). However, it has so far not been possible to formulate an evidence-based strategy for harnessing the potential of the private health sector in achieving public health goals in the WHO Eastern Mediterranean Region. The renewed impetus towards UHC in the context of the 2030 Agenda for Sustainable Development, as well as concerns about patient safety and financial protection, underline the need to build the capacity of ministries of health to design, manage, monitor and evaluate PPP. Without the involvement of the private health sector within a mutually-agreed national policy framework, developing effective partnerships for UHC will not be possible in most countries of the Eastern Mediterranean Region. The 65th session of the WHO Regional Committee for the Eastern Mediterranean in October 2018 recognized the critical role of the private health sector in advancing UHC and adopted a framework for action on effective engagement with the private health sector to expand service coverage for UHC (resolution EM/RC65/R.3).

Rationale for the current review and assessment

In light of growing demand for health services and ongoing resource constraints, governments in the Eastern Mediterranean Region are recognizing the need to effectively mobilize the private health sector towards achieving UHC. This recognition stems from the rapid growth of the private health sector across the Region and the fact that the private sector is becoming the dominant service provider in many countries. Following resolution EM/RC65/R.3 on private sector engagement, the WHO Regional Office for the Eastern Mediterranean conducted a review and assessment of the private health sector in Somalia to understand the operational environment of the sector and define the challenges and opportunities for engagement.



2
Study methodology

This report has been prepared based on a review of available country documents/publications on the private health sector in Somalia, supplemented by stakeholder interviews. The approach taken is based on the WHO Private health sector assessment tool (*1*) which is designed to systematically compile information, data and stakeholder views, and to explore policy options for engaging the private health sector in moving towards UHC. The tool is subdivided into descriptive information (Part I); numerical data (Part 2); and views, perspectives and opinions of key stakeholders (Part 3). The current report uses two main data sources:

- **a desk review, in which a large volume of data from research papers, reports, websites and other sources was collected and reviewed; and**
- **a qualitative component, in which key informant interviews were conducted at national and state levels – key informants were chosen using the purposive sampling technique.**

Key informant interviews

The categories and number of key informant interviews conducted in each location are shown in Table 1.

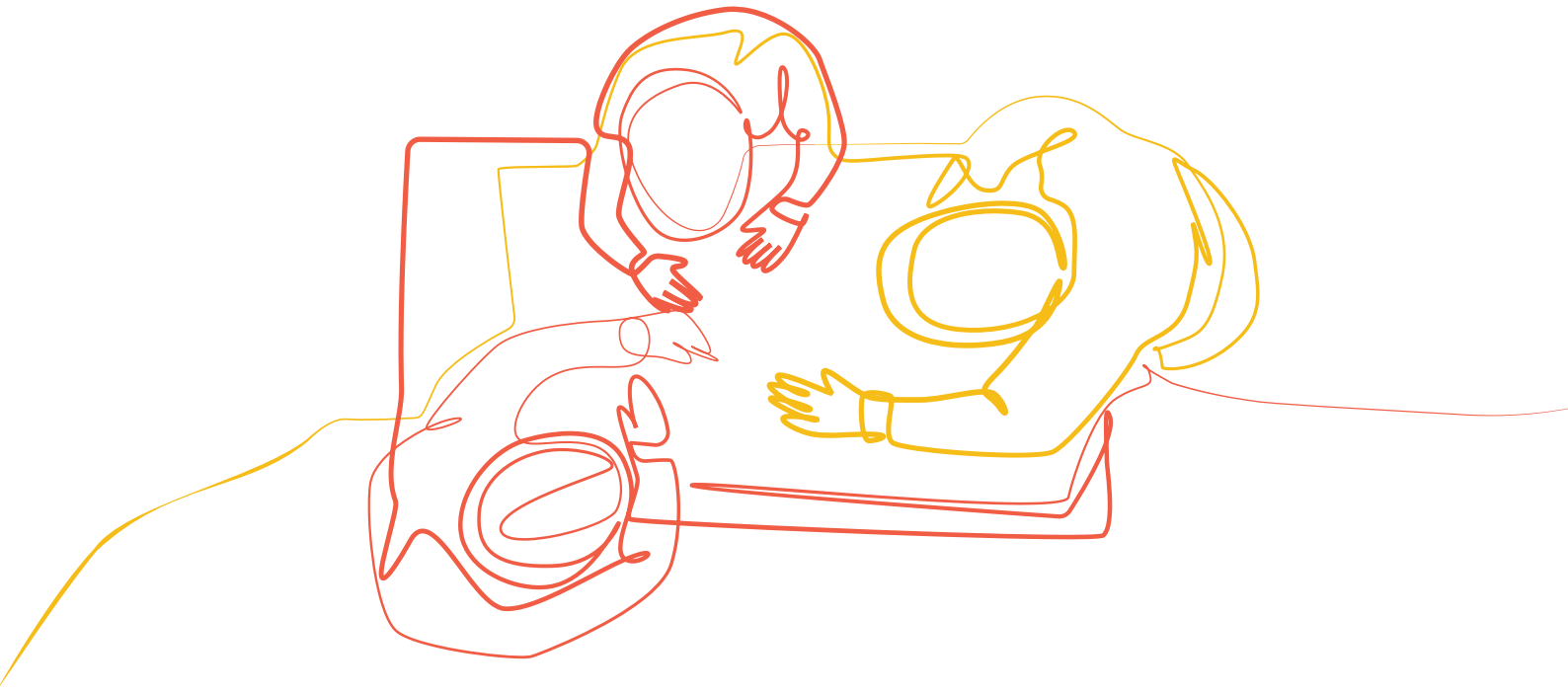
Table 1: Overview of key informant interviews

Category	Number of key informant interviews	Location
Senior policy-makers, national health authorities, health sector experts	7	National and Federal Member States (Galmudug, Hirshabelle, Jubaland, Puntland and South West)
Private sector representatives (hospitals, private health networks)	6	National and Federal Member States (Galmudug, Jubaland and Puntland)
Private pharmaceutical companies	2	National and Federal Member States
Insurance companies	2	National and Federal Member States
Private laboratories	1	National level
Total key informant interviews	**18**	

Interview data analysis

Interviews were recorded and transcribed verbatim after gaining interviewee consent. Thematic analysis of the qualitative interviews was then undertaken using the following step-by-step process:

- **Transcription of interviews from audio to text followed by cleaning and proofreading of the interview content.**
- **Coding – researchers reviewed the transcripts line by line highlighting each code in the text to develop a sequence of codes.**
- **Categorization – codes were grouped together and each set assigned to one main concept or idea to form categories.**
- **Themes were then developed from the key categories and these themes used as the foundation of the study.**



3

Organization and delivery of health services

Somalia – officially the Federal Republic of Somalia – is located in the Horn of Africa. It is the easternmost country of Africa, covering an area of 637 657 km^2 and extending from south of the equator on the Indian Ocean northward past Cape Guardafui to the Gulf of Aden with a coastline stretching over 3333 km. The country has a significant geopolitical position and was historically a major trading hub between sub-Saharan Africa and the Arabian Peninsula as well as south-western Asia (*2*). Somalia borders Djibouti, Ethiopia and Kenya. The climate is largely dry and hot, with four seasons and low annual rainfall.

The country has made significant progress in several areas, including in the building of state and institutions. The state is headed by the president, while the Federal Government of Somalia (FGS) is headed by the prime minister who – with parliamentary approval – is a presidential appointee.

As of 2016, and excluding Somaliland which declared unilateral independence in 1991, Somalia has five Federal Member States (FMS), namely Galmudug, Hirshabelle, Jubaland, Puntland and South West. In addition, the Banadir Regional Administration (where the capital city, Mogadishu, is located) is a standalone regional authority – not an FMS – established and operating as a regional member state administration (under Article 49 of the Provisional Constitution of the Federal Republic of Somalia 2012) (*3*). Although clarity is lacking on the legal and constitutional framework codifying relations between federal and FMS levels, the federal-state structure with Federal Government and Member State formation has been touted as an important element in advancing the country's political stability (*4*).

Somalia's population was estimated to be 15.9 million in mid-2020 (*5,6*). In 2014, 51%, 23% and 26% of the population were residing in urban, rural and nomadic areas, respectively (*7,8*). The population is predominantly young, with more than half (55%) below the age of 15 years (*7*). The population growth rate was 3.4% in 2020, the highest in the Horn of Africa, and the fertility rate was 6.4 children per woman, second highest in the world (*9*). Women aged 30–34 years have the highest death rate among women of childbearing age (10.9 deaths per 1000 population). This is also the age of peak childbearing in Somalia, underscoring the toll of maternal mortality, which while declining, remains the sixth highest in the world at 692 per 100 000 live births (*7*).

According to 2019 data from the United Nations Development Programme, life expectancy at birth in Somalia is estimated at 57 years (56 and 59 years for males and females, respectively) (*7*), which is the lowest for all countries in the WHO Eastern Mediterranean Region (*10*). The average household size is 6.2 people (6.6 for urban, 5.7 for rural and 5.3 for nomadic areas). Table 2 summarizes the above demographic and socioeconomic indicators of the country.

Table 2. Demographic and socioeconomic indicators

Indicator	Value
Population (mid-year 2020)	Population size = 15 893 222 50% male – 50% female
Population geographical split (mid-2020)	Urban: 46% Rural: 54%
Population growth rate (2020)	2.9%
Total fertility rate per woman (2020)	6.9
Life expectancy at birth (2019)	57 years
Literacy rate	62% (15–19 years)
Population below the international poverty line (2019)	69%

Somalia is a low-income country according to the World Bank classification. There is deep and widespread poverty, especially in settlements for internally displaced people and in rural households. Findings from the Somalia High Frequency Survey 2017–2018 (SHFS 2017–2018) indicated that 69% of Somalis were living below the international poverty line of US$ 1.90/day (*11*).

With humanitarian crises spanning more than 30 years, Somalia's social development indicators are among the lowest in the world (*4*). In 2020, Sustainable Development Goal (SDG) Index rankings of 52 African countries, based on 97 indicators, placed Somalia at 49th with a score of 42.7% progress towards achieving the SDGs (*12*).

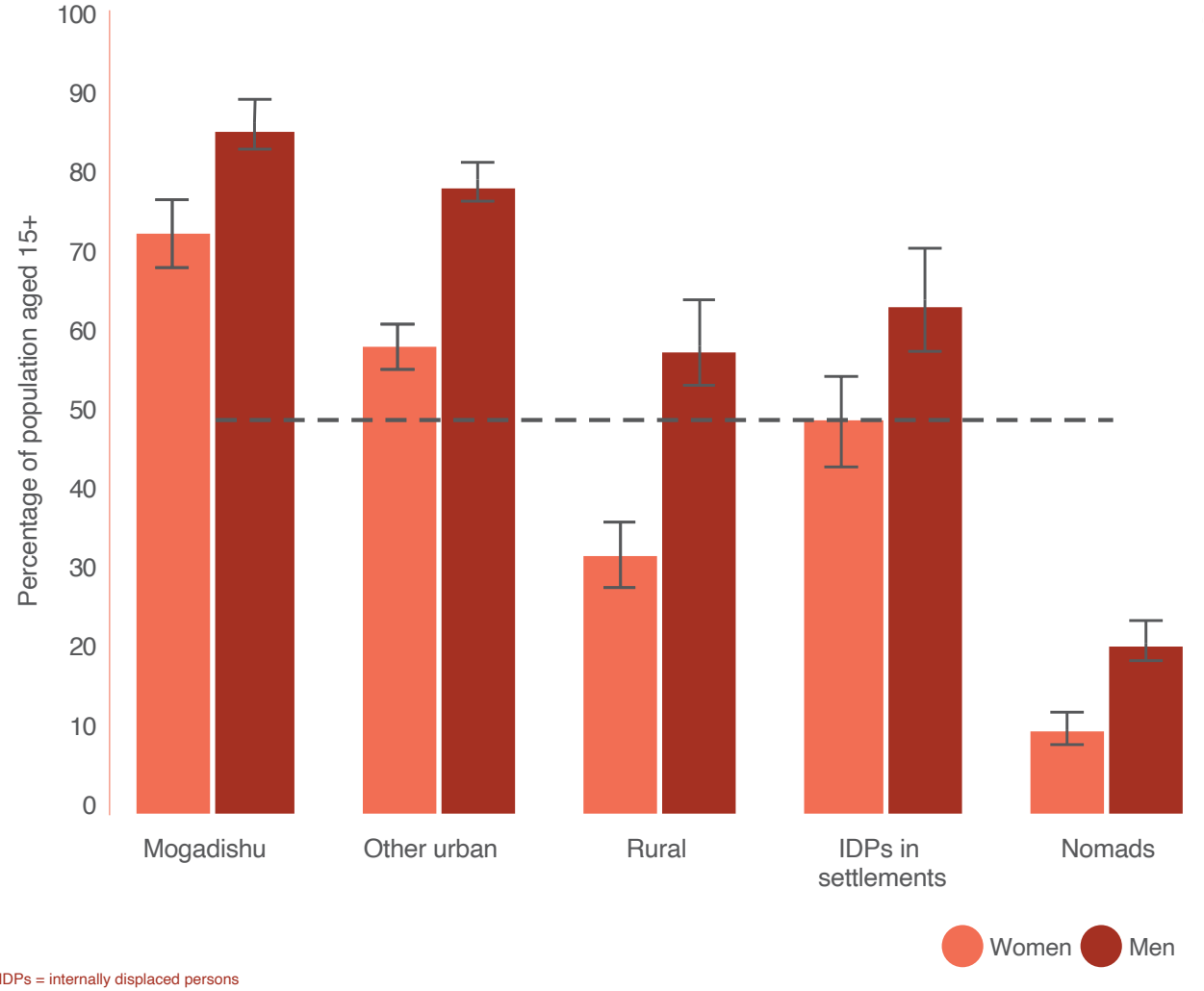
The SHFS 2017–2018 also indicates that the adult literacy rate (aged ≥ 15 years) is 50%. This rate is similar to the unweighted average for low-income countries in sub-Saharan Africa (49%) but compares well in terms of cross-country comparison after taking into account the level of gross domestic product per capita. Literacy rates are higher in urban areas and are estimated at 79% and 68% for Mogadishu and other urban areas, respectively. However, the completion of primary education in urban settings remains low (11%). A recent report also showed that women have lower literacy and educational achievement compared with men in all surveyed population groups (Fig. 1) (*11*).

According to 2019 UHC service coverage data (access to essential health services), Somalia has a score of 27 on the service coverage index – a slight improvement from 25 in 2017 and 21 in 2015 (*13,14,15*). This score is lower than that of neighbouring countries such as Ethiopia (39.4), Djibouti (46.9), Kenya (55.1) and Egypt (67.7). The country's health situation in terms of SDG 3 (Ensuring healthy lives and promoting well-being for all at all ages) is dire, largely due to political, socioeconomic and security challenges. Somalia was among the bottom three of 188 assessed countries on 37 of the 50 SDG health indicators, which implies that the country has a long journey towards realizing SDG 3 (*16*). The paucity of reliable data at national and regional levels also obscures the progress made by the health

sector, making it difficult to discern patterns and trends over time or by region (*17*). More details on selected health indicators in Somalia are provided in Annex 1 of this report.

In 2020, the Federal Government put in place its ninth 5 year national development plan. The Somalia National Development Plan 2020 to 2024 (NDP 9) has the overall objective of reducing poverty by addressing its root causes – political instability, conflict, insecurity, a state of lawlessness and climate change. The plan also aims to address the impact of poverty at both the individual and household levels (*2,4*).

Fig. 1. Literacy rates in men and women aged 15 and over across settings (*11*)

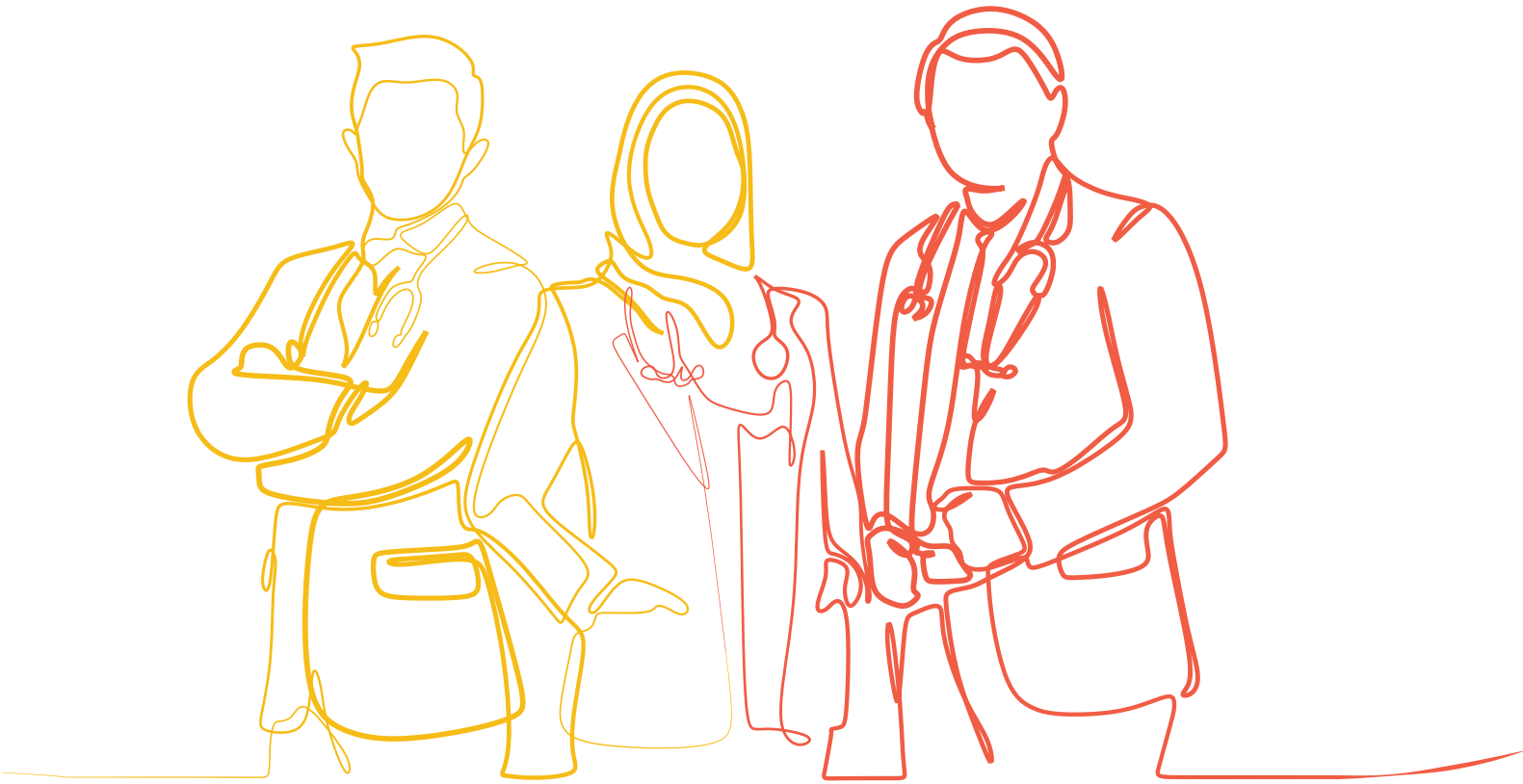


IDPs = internally displaced persons

4

Health sector overview

The Somali health system is a mixture of public and private , with the public sector categorized into three levels with Ministries of Health at the federal level, member state level and region/district level (*16*). Private sector providers include both local and international nongovernmental organizations (which are classified as charitable organizations) and for-profit individual-owned health care service providers (*18,19*). Health-care facilities may also be semi-public for-profit arrangements – for example, the Somali Turkish Recep Tayyip Erdogan Training and Research Hospital, considered the leading hospital in Somalia by capacity and co-managed by Somali and Turkish authorities (*20*). However, the country's health system remains weak, poorly resourced and inequitably distributed. In addition to the often long distances to health facilities, the absence of medicines/ equipment and the paucity of qualified health personnel are also major obstacles to the accessibility of health services (*16*).



5
Organization of the health system

The country has a two-tier system with responsibilities being shared between federal and member state levels.

At the federal level, the Ministry of Health–FGS is responsible for overall strategic leadership and comprises the following departments:

- **Department of Human Resources**
- **Department of Policy and Planning**
- **Department of Family Health**
- **Department of Medical Services**
- **Administration and Finance Department**
- **Department of Public Health.**

The federal Ministry of Health has specifically led the development of the Health Sector Strategic Plan Phase II 2017–2021 (HSSP II) as well as other policy initiatives such as the National Decentralization Policy, National Development Plan and Human Resources for Health Development Policy (*16*). However, the federal Ministry of Health has not sufficiently established its mandate over the whole country, due partly to the complexity and inadequate capacity of the federal structure. In Somaliland and Puntland the Ministry of Health has established service delivery capacities based on decentralized structures for health governance, which has been delegated to the regions and districts. The relatively improved capacity in these states has reportedly improved their primary health care status.

The state ministries of health lead the Federal Member State-level chapters of HSSP II, including setting priorities and coordinating and supervising the provision of public health care throughout the respective state. Remarkable progress has been made in the recently formed states in what was formerly known as the South Central Somalia zone – though human resource and financial challenges persist (*21*). The role of the Somaliland government is considered to be a special case, involving complex dynamics resulting from its self-declared independence since 1991. Although foreign governments do not recognize Somaliland's sovereignty, many effectively acknowledge that it is a separate region from the current federal system (*22*). Despite these and other issues, the overall in-country coordination of health actors has improved over time, with the active involvement of both the federal and state ministries of health (*17*).

The ministries of health at regional/district level oversee and coordinate all regional/district health programmes. They also set health priorities, prepare regional/district health plans, and manage financial inputs, commodities, health infrastructure, and human resources and health information.

The federal and state ministries of finance are responsible for earmarking the budgetary outlays necessary for policy implementation (*23*).

5.1 Public health sector

The public health system comprises the following geographically-defined levels (*24*):

- **Primary health units in rural areas;**
- **Health centres at the sub-district level;**
- **Referral health centres in districts;**
- **Regional hospitals located in the regional capitals.**

The public system also includes specialized centres, including tuberculosis centres, computed tomography/antiretroviral therapy facilities and mental health centres.

Health professionals working in public health facilities are assigned by the health authorities to manage service delivery across the sub-district rural, district and regional levels (*25*). Although the public health system has seen marginal improvements since 2014, considerable challenges remain in ensuring access to and provision of health services (*26*). Public health services are non-existent in many places, especially the southern and central regions more affected by conflict, leaving the private sector to fill the gaps in health service provision. Health care is often unaffordable, unavailable or not trusted (*27*).

According to the 2016 Somali service availability and readiness assessment (SARA), on average, Somalia is 28.3% of the way towards achieving health infrastructure targets (facility density, inpatient bed density and maternity bed density) and 18.6% of the way towards achieving the health workforce density target (23 per 10 000 population). The assessment further indicates that service utilization target achievement was much lower, with Somalia being only 6.3% of the way towards achieving this goal of 5 outpatient visits per person per year and 10 hospital discharges per 100 people per year (*24,28*). Although the country developed an Essential Package of Health Services (EPHS) in 2009, the poor showing on these health indicators highlight that its implementation has not been successful. A revised EPHS framework was developed in 2020 and its implementation scheduled for 2022. It is expected that implementation of the revised framework will build upon the experience and lessons learnt from the earlier version.

5.2 Private health sector

In Somalia, private health care service providers dominate in terms of capacity, service delivery, diagnostic equipment and experienced staff (*20*).

5.2.1 The private for-profit sector

Formal private sector health facilities are often established by diaspora returnees holding health qualifications (*29*). The private sector includes small-scale clinics, diagnostic facilities, pharmacies and hospitals. Facilities owned by individuals tend to function as profit-seeking businesses (*18*). For-profit facilities owned by organizations may also function as not-for-profit entities by providing pro bono health care to vulnerable populations without being officially labelled as not-for-profit. These include several private provider facilities that are financed by members of the diaspora community or by Islamic donors with a social objective in mind. The contribution made by Islamic charity work has been very significant in this regard (*19*).

Informal private providers include traditional and complementary medicine practitioners. Around 60% of the population, especially the rural population, seek herbal or traditional treatment from such practitioners at the primary health facility level (*29*).

About 60–80% of the country's medicines are imported and distributed by the private sector through pharmacies and retail outlets (*21*).

5.2.2 The private not-for-profit sector

The not-for-profit health care sector is dominant in Somalia. Most of this sector is run by United Nations agencies or by nongovernmental organizations via the contracting out of services. For example, UNICEF contracted out a private health care firm to support the strengthening of HMIS in all three former administrative zones (*30*).

More than half of the estimated 1200 functional health care facilities are run by nongovernmental organizations (*20*), with some having institutional arrangements with the FGS (*19*). For example, in the case of the multi-donor funded Joint Health and Nutrition Programme, the government took on the role of contracting out health services to the implementing partners (NGOs) under the technical guidance of United Nations agencies (*30*) – an approach that has been cited as a way of mitigating fiduciary risk. The government thus supports overall leadership, supervision and quality control (*20*). As the main implementers of health services across Somalia, nongovernmental organizations share their human resources for health planning, in-service training programmes and supervision accountability with the Federal Government and Member States (*25*). However, some of the agencies and/or international nongovernmental organizations also work with implementing partners.

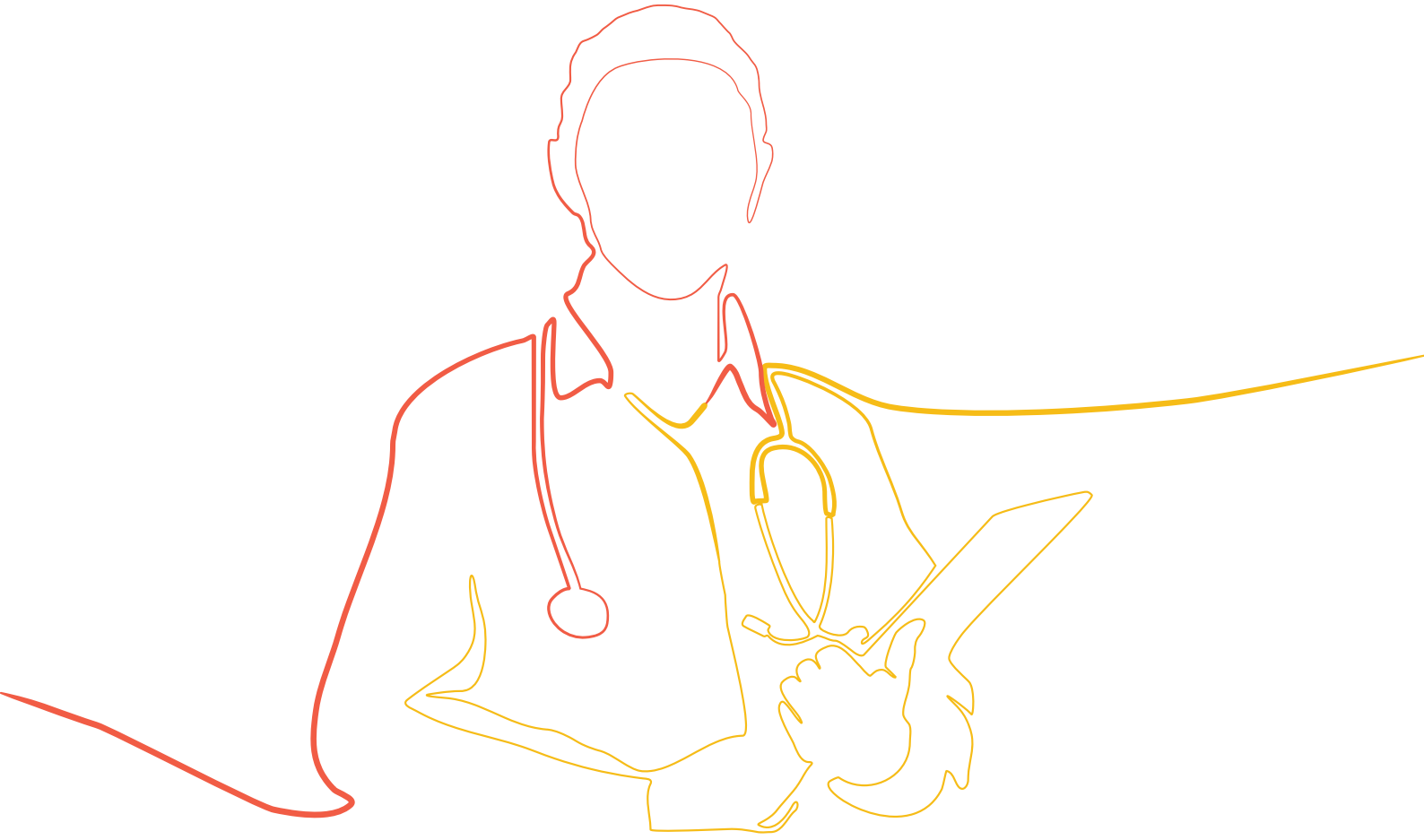
According to one survey, purely not-for-profit facilities make up around 9% of all private health facilities. This survey reported that the highest concentration of such not-for-profit facilities was found in Puntland (19%) followed by Somaliland (10%) – but just 6% in other in FGS-controlled states (*31*).* However, there could be many more not-for-profit private sector facilities providing free health care without officially being viewed as not-for-profit entities.

6
Health system governance

Somalia's public health laws and regulations have not been updated since 1991. Moreover, existing laws and regulations remain in draft form (*21,32*). The capacity to implement policies is also inadequate (*20*). Such limited capacity is found across nearly all governance technical areas. However, capacity-building activities are ongoing within the federal Ministry of Health.

Regarding the implementation of the Somali Human Resources for Health Development Policy 2016–2021 (*25*), the education ministries liaise with both the public and private health sector to regulate pre-service technical and undergraduate/graduate health professional training programmes, while also carrying out periodic accreditation and quality improvements as identified in the policy. The ministries for higher education are responsible for determining the policy directions of the higher education system in Somalia.

A national strategic plan is also being developed to restructure and strengthen the health system, and to develop procurement and service-contracting capacity strategies among stakeholders (*33*). Recognizing the need to leverage the country's health resources, the strategic plan includes the development of guidance on engaging the private sector through partnerships in health services (*34*).



7 Health sector resources

7.1 Human resources

Human resources for health are the weakest factor of the Somali health system. There is a severe shortage of qualified health professionals, particularly in rural, nomadic and hard-to-reach geographical areas.

In 2014, a WHO and Joint Health and Nutrition Programme study estimated that the total number of health care professionals in Somalia was 9566 (Table 3). This equates to a ratio of 0.34 essential health workers (physicians, nurses and midwives) per 1000 population – severely below the minimum WHO requirement of 4.5 per 1000 population. There were just 4 nurses and 1 midwife per 20 000 people (equivalent to 2 nurses and 0.5 midwives per 10 000 population) compared to the threshold of 22.8 nurses and midwives per 10 000 population set by WHO (*35*). In 2016, the country had 1 doctor per 20 000 people. Meanwhile, women are well-represented in the sector, making up almost 42% of all qualified doctors, nurses, midwives and skilled technicians (*25*). It has been estimated that Somalia would need to employ 97 700 physicians, nurses and midwives (24 350 doctors and 73 350 nurses and midwives) by 2030 to achieve UHC (*24*). Yet, the number of health staff needed could even be higher given increasing population growth.

Federal Ministry of Health data show an apparently even distribution of the health care workforce across the country, with 38.6% of the workforce in South Central, 25.5% in Puntland and 35.7% in Somaliland (calculated from the totals shown in Table 3). However, when population distribution is taken into account, it becomes clear that the distribution of health workers is not even. According to the 2014 Population estimation survey (*8*), health care workforce density is 5.6 per 10 000 in Puntland (population = 4 334 633) and almost twice that at 9.7 per 10 000 in Somaliland (population = 3 508 180). Given the overall figure for Somalia of 3.4 per 10 000, these states are clearly in better shape than the others.

This uneven pattern has been attributed to the migration of the skilled Somali workforce to urban areas, as well as the inherent tendency of graduates to seek employment in the urban areas, the private sector and overseas (*25*). In 2019 (without data for Banadir and Hirshabelle), the total public health sector workforce was 4280 in Puntland, 1266 in Jubaland, 1010 in Galmudug and 262 in South West.

Table 3. Somali health care workforce in 2014 (*25*)

Category	Other FMS Absolute number (%)	Puntland Absolute number (%)	Somaliland Absolute number (%)	Total Absolute number (%)
Physicians	339 (9.2)	120 (4.9)	179 (5.2)	638 (6.7)
Dentists	0 (0)	2 (0.08)	0 (0)	2 (0.02)
Pharmacists	20 (0.54)	6 (0.2)	4 (0.1)	30 (0.31)
Registered nurses	817 (22.1)	664 (27.2)	1256 (36.8)	2737 (28.6)
Registered and community midwives	82 (2.2)	321 (13.2)	344 (10.1)	747 (7.8)
Health and allied professionals	508 (13.8)	512 (21.0)	388 (11.4)	1408 (14.7)
Auxiliary nurses and midwives	1838 (49.8)	706 (28.9)	1016 (29.8)	3560 (37.2)
Female community health workers	75 (2.0)	65 (2.7)	39 (1.1)	179 (1.9)
Hospital administrators	34 (0.9)	44 (1.8)	187 (5.5)	265 (2.7)
Total	**3694 (100)**	**2440 (100)**	**3413 (100)**	**9566 (100)**

The collapse of the Somali state led to a rapid increase in private health training institutions formed to respond to market demands (*36*). In all there are about 20 Somali health education institutions, public and private, offering approximately 63 programmes and courses. With the exception of several well-established institutions in Mogadishu and Puntland, and the newly established National Institute for Health under the Ministry of Health, the majority of health education institutions were not properly planned. Unfortunately, such institutions lack the essential infrastructure and/or administrative and academic staff needed to ensure effective learning/training (*24*).

WHO recognizes six major health system building blocks as critical components for maturing health systems to reach their full potential: human resources for health, service delivery, research/information, medical products and technologies, financing, and leadership/governance (*37,38*). Human resources for health is the most important of these blocks because it is cross-cutting (*39*). An IFTIN Foundation survey (*40*) found that the number of graduating students from 54 Somali universities increased from 14 971 in 2018 to 15 927 in 2019. The estimates from the survey indicate that 36.6% of the total 2019 graduates are from health and allied programmes. The review also found that Somali universities mostly teach nursing and midwifery (29% of health and allied graduates) and public health programmes (25%). There were fewer 2019 graduates in nutrition and clinical medicine, and just 13 in pharmacology and 12 in dentistry. In addition, there were more female graduates than male (Table 4). These estimates are lower than figures for sub-Saharan Africa in general, where 40% of health graduates in 2018 were in nursing and midwifery, and 14% were physicians.

Table 4. Somali health and allied graduates (2019) (*40*)

Programme/faculty	Total graduates (%)	Male graduates (%)	Female graduates (%)
Nursing & midwifery	1691 (29.0)	15.3	84.7
Public health	1477 (25.4)	43.3	56.7
Medicine & surgery	1104 (19.0)	57.3	42.7
Laboratory	1078 (18.5)	53.0	47.0
Nutrition	359 (6.2)	35.9	64.1
Clinical medicine	88 (1.5)	84.1	15.9
Pharmacology	13 (0.2)	0.0	100.0
Dentistry	12 (0.2)	75.0	25.0
Total	**5822 (100)**	**39.7**	**60.3**

7.2 Health facilities

In the 2016 Somali Service Availability and Readiness Assessment, the Ministry of Health and WHO mapped the Somali public sector health facilities and reported a total of 1074 such facilities (*17,28*). Of these, only 74.4% (799) were functioning and accessible, indicating a severe shortage. In 2017, general hospital bed density was estimated to be 8.7 per 10 000 population. This represents a significant increase compared to 2015 when the estimated average hospital bed density was 1.1 per 10 000 population (*21*).

Heritage Institute for Policy Studies and City University of Mogadishu found 661 active public health facilities, distributed as follows (*24*):

- **Puntland: 305 (46%)**
- **Jubaland: 93 (14%)**
- **Galmudug: 92 (14%)**
- **Hirshabelle: 81 (13%)**
- **Banadir: 61 (9%)**
- **South West: 29 (4%).**

8

Health sector finance and expenditures

8.1 Health financing, expenditures and financial accessibility

As noted above in section 5, the federal and state ministries of finance are responsible for earmarking the budgetary outlays necessary for policy implementation (*23*). The Somali government's health financing comes mainly from international development partners in the form of aid to the government structures (*41*). Other sources of funds include domestic tax revenue, non-tax revenue (for example, visa fees, departure fees for passengers on international flights, licence fees and stamp duty) and multilateral and bilateral donor grants (*23*). Direct foreign investments by members of the diaspora, donations and household out-of-pocket expenditures also fund the health sector and social enterprise.

Donated public health sector aid is mostly managed and dispensed according to the priority areas of the donors, and may not necessarily meet the needs of the Somali health authorities (*17*). Data from the Federal Ministry of Planning and International Development and the World Bank show that between 2015 and 2019, external aid to the health sector amounted to US$ 589.1 million (Table 5). As of 2020, the main donors were Thani Bin Abdullah Bin Thani Al-Thani Humanitarian Fund (Qatar), the United States (via the United States Agency for International Development/Official Development Assistance), Germany, the European Commission and the World Bank.

Table 5. External health sector aid to Somalia, 2015–2019

Year	Health sector external aid (US$ million)
2015	105.3
2016	128.9
2017	109.3
2018	108.6
2019	137.0
Total	**589.1**

Source: Ministry of Planning and International Development and the World Bank (2019). Aid flows in Somalia, March 2018, in: Heritage Institute for Policy Studies, City University of Mogadishu (*24*).

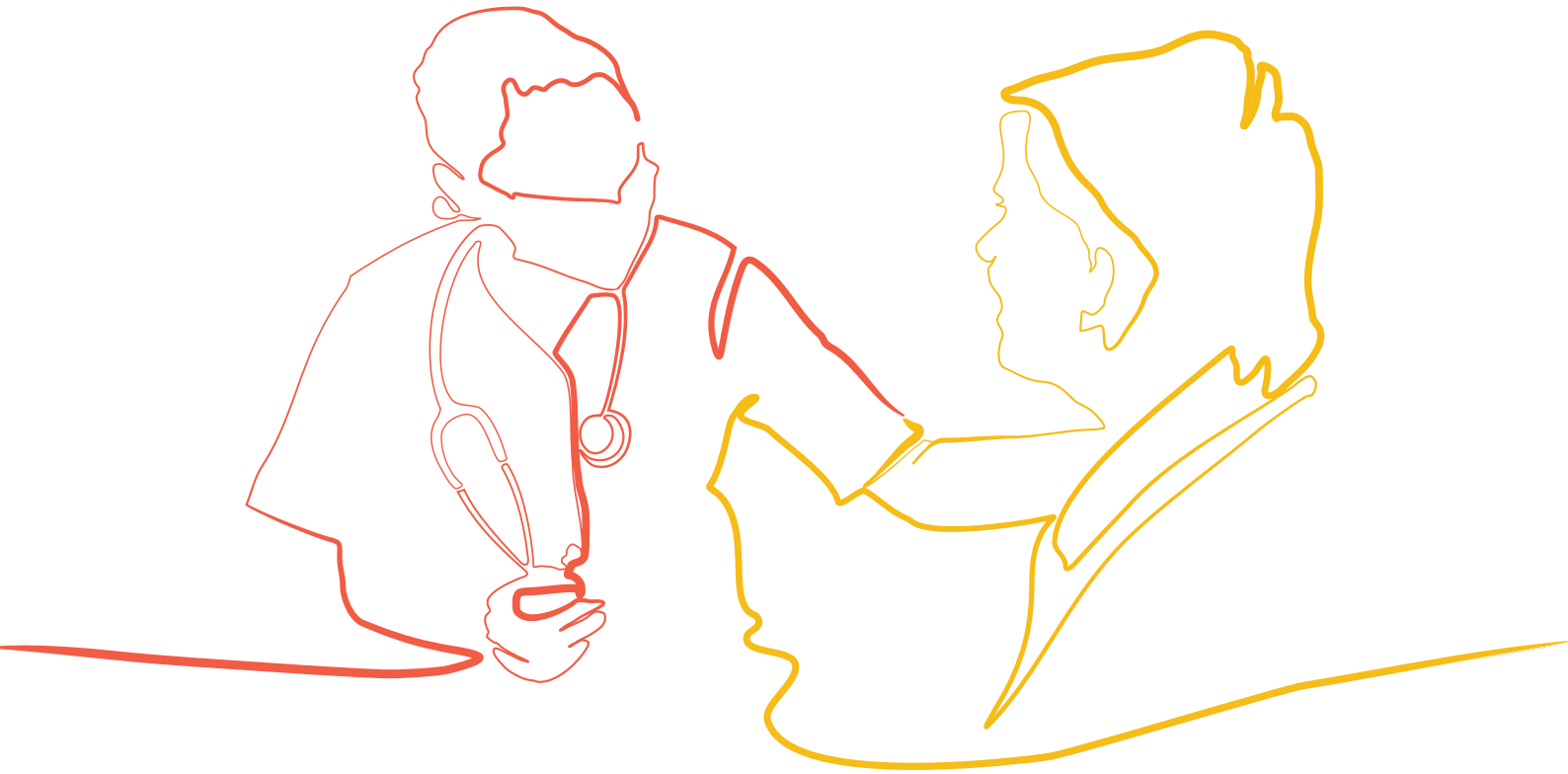
Health expenditure by the Somali government in 2017 (including official development assistance) was US$ 9.8–12.0 per capita. This was lower than the US$ 41 average per capita health expenditure for low-income countries in the same year. (Average per capita health spending was US$ 2937 in high-income countries) (*42*). Conversely, the total health care budget in Somaliland in 2015 was estimated to be US$ 150 million for a population of around 3.5 million people (an average of US$ 42.8 per capita), of which human resources expenditure accounted for more than 60% (*43*). The stark difference in the per capita expenditure in Somaliland compared to other regions is due to most of its funding for health services coming from nongovernmental organizations and international donors, along with direct diaspora assistance to the health sector and private remittances.

In 2017, the Somali government's contribution to health expenditure was less than 1% of total health expenditures. Federal Ministry of Finance data for 2018 showed that health sector financing represented 4% of the national budget (*34*) with trends indicating decreasing allocations for significant areas of public health, such as health care administration and interventions for malaria, tuberculosis and HIV (*23*).

There is no national health insurance scheme in Somalia. Most Somalis are reliant on free services at public or not-for-profit private health facilities, especially those funded by United Nations agencies and/or nongovernmental organizations. In the Somali health and demographic survey 2020, 48% of households indicated that they paid for their health expenses using personal income. In addition, 25% of surveyed households indicated that their health expenses were paid by their family or friends, 14% used borrowed money, while 11% sold assets to cover health expenses. Only 2% of households stated that they used private health insurance (*7,20*). The limited coverage of private insurance is mainly due to limited financial capacity, the unaffordability of insurance schemes, limited awareness of the usefulness of such insurance, and the belief by some that it would be against their religion.

Both insurance companies in Somalia (Takaful Insurance and Amanah Insurance) apply the Islamic insurance system. Unlike the conventional insurance model in which premiums are not refunded to the beneficiary even when the insurance is not used, the Islamic insurance model deducts the operational costs in such a case and then refunds the remaining amount to the beneficiary. The companies insure all medical-related conditions, including HIV, cancer and chronic diseases for inpatients or outpatients.

Government employees are generally not insured except those supported by international agencies where insurance is one of the requirements. For example, Amanah Insurance provides a service to staff members of the Ministry of Aviation and the Central Bank with the help of the World Bank. Takaful Insurance also provides services to Bosaso Airport administration staff.



9

Private health sector analysis and stakeholder perspectives

9.1 Private health sector resources

9.1.1 Human resources

In the post-conflict era, the skilled workforce migrated to urban areas from rural areas and overseas and similarly, from the public health sector to the private health sector (*25*). The migration of the health workforce was motivated by professional development and the better financial opportunities available in the private health sector.

In 2018, there were 10 753 qualified health care workers in the private sector. These included doctors, clinical officers, nurses/midwives and pharmacists (Table 6). This equates to an estimated density of 7.2 per 10 000 population – or 4.89 per 10 000 population, excluding pharmacists (*31*).

Although the number of health professionals working in the private sector is significant, the qualitative interviews confirmed that the capacity of staff remains an issue. Although the private sector provides most of the health services in the country, these do not benefit from the capacity-development programmes of the government and international partners.

Table 6 summarizes the composition of the private health sector workforce working in both for-profit and not-for-profit facilities.

Table 6. The private health sector workforce in 2018 (*31*)

Qualified workforce	Estimated total	Health workforce per 10 000 population
Doctors	1949	1.31
Clinical officers	1648	1.10
Nurses/midwives	3702	2.48
Pharmacists	3454	2.31
Total	**10 753**	**7.20**
Excluding pharmacists	**7299**	**4.89**

9.1.2 Health facilities

Reliable data on the size of Somalia's private health sector are scarce (*21,24*). However, a 2018 Oxford Policy Management study (*31*) identified a total of 3289 private health facilities across Somalia (see Table 7) – with 1279 such facilities in FGS-controlled states, 228 in Puntland and 746 in Somaliland. Most (79%) of these private health facilities were found in urban areas, with the exception of Puntland which has a higher proportion of facilities in rural areas than Somaliland and other FMS (*29*). The private health facilities identified were mostly for profit (81%). Most of the private health clinics were based in residential areas, with the buildings they were housed in not intended for health care service provision. Some were very small, with only limited rented space. Conversely, some of the independently organized or community-sponsored private professionals provided mobile health services in remote areas.

The joint WHO-USAID Service Availability and Readiness Assessment tool/core instrument is a questionnaire that is "designed to assess and monitor the service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system." The SARA tool covers assessments related to staffing, inpatient and observation beds, infrastructure, available services, diagnostics, medicines and commodities, and interviewer observations (*31*). One UNICEF study piloted the use of the SARA tool in 30 private health care facilities in Somalia (12 hospitals, 12 clinics, four health centres and two other facilities). In 2017, the average number of inpatient beds in private facilities (excluding any delivery beds) was 17.3, close to the national average number of 16.7 beds (excluding any delivery beds) estimated during the mapping of national facilities (confidence interval = 12.5–21.0). In 2017, health facility density was estimated to be 0.76 per 10 000 population in public facilities compared to 0.93 per 10 000 population in private facilities.

In 2018, 74% of private health facilities were owned by individuals – accounting for 86% of pharmacies and 27% of hospitals. Hospitals in the country are generally owned by groups of individuals, or by cooperative/ community or nongovernmental organizations. Details on ownership trends by state are presented in Table 8.

Table 7. Distribution of private health facilities by state and by type in 2018

Distribution by state				Distribution by facility type (%)			
	PL	SL	SC	Hospital	Clinic	Diagnostic centre	Pharmacy
	228	746	1279	6	32	4	58
Total		**3289***				**100%**	

PL = Puntland; SL = Somaliland; and SC = South Central (FGS-controlled states).
*Corresponding to a density of 0.93 private health facilities per 10 000 population.

Table 8. Ownership structure of private health facilities by state in 2018 (*31*)

	Overall	By State							
		BA	JU	SW	HS	GA	FGS states	PL	SL
Individual	74%	72%	79%	87%	76%	65%	76%	55%	75%
Group	12%	22%	10%	5%	7%	14%	11%	18%	10%
Cooperative/ Community	5%	1%	8%	2%	7%	12%	5%	6%	3%
Local NGO	2%	1%	1%	2%	4%	2%	2%	2%	1%
International NGO	7%	4%	1%	5%	6%	7%	4%	17%	8%
Other	1%	0%	2%	0%	1%	0%	1%	1%	2%

BA = Banadir; GA = Galmudug; HS = Hirshabelle; JU = Jubaland; PL = Puntland; SL = Somaliland; and SW = South West.

Health management information system (HMIS) activities

There is little private sector involvement in HMIS reporting. Despite the provision of training in HMIS reporting to some private health care service providers, the data provided are very limited. For example, only a small number of facilities report immunization data and information-sharing generally is very weak.

9.2 Legal regulatory frameworks and governance in the private health sector

Although the for-profit private health sector is currently the dominant health care services provider, it remains unregulated. This lack of oversight is reflected in observed poor health outcomes resulting from the suboptimal quality of treatment and the poor value for money of out-of-pocket services (*19*). These findings have been confirmed during qualitative interviews. In addition, pharmaceutical importers do not follow the standard drug list guidelines provided by the government and import drugs of suboptimal standard. The issue of regulation therefore remains a concern.

There are frameworks, laws and regulations that theoretically provide a central regulatory framework for private sector participation in the health sector (*19*). Some of these frameworks are FMS-led but are mostly focused on quality and professional conduct/practice regulations within the public sector. None of the plans or laws appears to be used for regulating private sector entry into the health sector. The recently revised EPHS 2020 framework scheduled for implementation in 2022 (see section 5.1 above) outlines the standard treatment guidelines for health care service providers (*17*). Other regulations in place include the National Medicines Policy which was endorsed in 2016 by the Federal Government. Most of these policies are set out in the *Strategic guidance for engaging the private sector through private partnerships in health services in Somalia* (*34*) and are summarized in Table 9. Due to the absence of quality standards for medicines, drug importers rely on the quality regulations issued by other bodies, including those applied in neighbouring countries.

Adherence to the current regulations is also very limited. In 2015, the United Kingdom's Foreign, Commonwealth & Development Office assessed the private health sector in Somalia and found that it remains unregulated – though the capacity of the FGS in this respect is increasing (*17*). The continuing lack of regulation is mainly due to poor dissemination and limited understanding of the interpretations of relevant policies. Additionally, government regulatory agencies do not have adequate staff and resources to implement their mandates. The regulatory environment appears to be better in Somaliland and Puntland than in South Central, where no centralized regulatory body exists.

Recognizing the weaknesses in the regulation of its health sector, Somalia developed the HSSP II to provide an administrative framework and strategic direction for implementing health sector activities – including a regulatory framework for the private health sector. The HSSP II aimed to direct all health stakeholders to align their efforts

towards the realization of national health priorities, which include UHC and SDG 3 (*44*). Although progress has been made in certain areas, the targets set for HSSP II had not been attained by the end of 2021. The HSSP III is therefore now being developed to serve as an overarching strategic framework to guide each FMS in the development and implementation of state-specific operational plans (*45*). To date, a number of regulations have been prepared and the relevant bills presented to the parliamentary legislative committees for signing (*20*). The National Development Plan 2020–2024 also covers health sector policy and plans (*17*). Moreover, the ministries of health of Puntland and Somaliland have developed plans that aim to provide guidance to both the public and private health sectors (*24*). Somalia has also been part of the Primary Health Care Measurement and Improvement initiative led and coordinated by WHO (*46*).

Table 9 summarizes both existing and non-existing policies and regulatory mechanisms for private sector operations, along with those in place but not enforced and/or endorsed.

Table 9. Private sector policy and regulatory mechanisms

Policy, legislation and regulatory frameworks	Federal Ministry of Health	FMS[a]	Puntland	Somaliland
What exists				
National Health Professional Council (*19*)	√√	Part of Federal Ministry of Health	√√	√√
National Development Plan 2020–2024 (*2,34*)	√√	Part of Federal National Development Plan	√√	√√
Health Sector Strategic Plan II (2017–2021) (*34*)	√√	Part of Federal Ministry of Health HSSP II	√√	√√
Somali Human Resources for Health Development Policy as part of HSSP II (2017–2021) (*34*)	√√	Part of Federal Ministry HSSP II	√√	√√
Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy 2020–2024 (*34,47*)	√√	Part of Federal Ministry of Health HSSP II	√√	√√
Expanded Programme on Immunization, National Immunization Policy, Somalia, May 2014[b] (*34*)	√√	Part of Federal Ministry HSSP II	√√	√√
National Long-Lasting Insecticidal Nets Strategy, Somalia, 2016–2020 (*34*)	√√	Part of Federal Ministry HSSP II	√√	√√

a FMS comprise all non-contested states and Banadir Regional Administration.
b A new national EPI policy was developed in the second half of 2019 and was approved in April 2020.

Policy, legislation and regulatory frameworks	Federal Ministry of Health	FMS[a]	Puntland	Somaliland
Somali Community Health Strategy 2015 (*34*)	√√	√√	√√	√√
Somali Guidelines on Integrated Management of Newborn and Childhood Illness 2019 (*34*)	√√	√√	√√	√√
Somali National Malaria Strategic Plan 2017–2020 (*34*)	√√	√√	√√	√√
Somali National Strategic Plan for Tuberculosis Control 2015–2019 (*34*)	√√	√√	√√	√√
Somali Every Newborn Action Plan 2019–2023 (*34*)	√√	√√	√√	√√
National Strategic Plan and M&E Framework for Somali HIV & AIDS Response 2018–2020 (*34*)	√√	√√	√√	√√
What does not exist				
PPP policy (*34*)	XX	XX	XX	XX
PPP engagement strategy health bill (*34*)	XX	XX	XX	XX
What exists but is not enforced and/or endorsed				
National Health Professional Council Regulations (*34*)	√X	√X	√X	√X
The Community Health Strategy (*34*)	√X	√X	√X	√X

b A new national EPI policy was developed in the second half of 2019 and was approved in April 2020.

9.2.1 Registration, contracting and licensing

Private health facilities

The federal Ministry of Health has the authority to grant licences to private health facilities, but the requirement is not enforced. The Ministry has not yet begun to issue licences to pharmacies and importers of medicines because of limited technical capacities and an inadequate legal framework (*20*). In addition, hospitals – public and private – receive medical supplies from different sources, including development partners such as UNICEF and WHO, or directly import from abroad. The existing framework for registration and licensing (see Annex 2) also only covers registration/company incorporation and licensing of private health ventures and imports, and does not cover areas such as infrastructure specifications. As a result, although the Ministry does grant licences to treatment facilities, its capacity to operationalize and regulate in this area remains weak.

Key informants have stated that several private health clinics have been established in residential areas, suggesting that housing infrastructure requirements also need to be implicitly specified. However, any undocumented specifications are not usually followed or met by private health facility owners. No documented registration requirements in relation to infrastructure, staffing, devices and so on appear to exist other than those described in Annex 2.

Health professionals

There is currently a lack of accreditation and licensing mandates in relation to health professionals. However, the FGS developed the first Somali Human Resources for Health Development Policy as part of HSSP II. In 2019, the National Health Professional Council (NHPC) was created by the the federal Ministry of Health with the responsibility of regulating private health care service providers in FGS-controlled areas (*24,31*). Although the Act establishing the legal mandate of the NHPC has been approved, work is still at an early stage and the implementation of HSSP II has been limited by a lack of funds and other factors beyond the scope of the current assessment. Nevertheless, there is growing capacity in the newly formed states, with Puntland having a better health system compared with other states. This state has now established its own NHPC to register health professionals, validate their qualifications and oversee the quality of services provided. Registration is currently voluntary for all health professionals but it is intended that this will become compulsory in the future.

The NHPC has an equivalent body in Somaliland known as the National Health Professions Commission (NHPC) – also referred to as the National Health Professional Council. NHPC-Somaliland was established in 2013 to regulate health providers across both the public and private sectors. The commission is guided by the Health Professional Committee Act/Law 19. As of 2015, the NHPC-Somaliland had 600 registered local professionals and 70 international professionals (*19*), with 4500 professionals waiting to be verified and registered. Studies have reported that the work of NHPC-Somaliland has been limited due to inadequate capacity (*31,43*). Similarly, some state health authorities believe that the process that established the NHPC was not sufficiently inclusive (*24*), with some states not being involved in its creation, and this too is constraining or limiting the health sector policy and planning work of the NHPC.

To help fill the regulatory gap, the Somali Medical Association was founded in Mogadishu in 1999 as a civil society organization aiming to hold the Ministry of Health and health sector professionals accountable. The association focuses primarily on awarding certificates of good standing to medical doctors who wish to practise abroad and/or undertake postgraduate studies. The Somaliland Medical Association is a similar organization founded in 2004 (*47*) to certify the qualifications of all medical practitioners intending to work in Somaliland, and to regulate

the formal health sector in coordination with the Ministry of Health-Somaliland and the NHPC-Somaliland. However, this regulatory gap has not yet been filled by these organizations. Qualitative interviews indicate that the private sector is not regulated at either state or national level. Table 10 shows the list of states and their status in terms of private health sector regulation.

Table 10. Private health sector regulation

State	Private sector regulation
Banadir	In Banadir, the Federal Ministry of Health issues licences to treatment facilities but its capacity to operationalize and regulate is still weak.
Galmudug	The state-level Ministry of Health does not engage with the private sector; such facilities are not registered by the ministry.
Hirshabelle	There is no regulation of the private sector.
Jubaland	No regulation except for an initial mapping stage during which private hospitals and clinics were listed to improve communication. The lack of a legal framework is the main issue preventing regulation.
Puntland	The Health Professional Council was established in 2020 but the registration of professionals is voluntary. Registration is envisaged to become mandatory in the future.
Somaliland	Somaliland has a functioning National Health Professions Commission that regulates health professionals.
South West	The state-level Ministry of Health is functioning and expanding its mandate but does not at present regulate the private sector.

9.2.2 Pricing regulation

No regulatory framework for pricing in the private health sector is apparent, potentially explaining the high cost of private health care services for a majority of the population in some areas, including Mogadishu (*42*). Patients usually pay cash to access for-profit private health facilities. The average cost of an outpatient visit is estimated at US$ 50.4 (ranging from US$ 5 to 150) and inpatient hospitalization at US$ 167 (range US$ 100 to 200) (*46*) – both of which are considered to be well beyond affordable for a population whose average annual per capita income was US$ 535 in 2017 (*11*).

According to the HSSP II (*32*), a strategic goal of the FGS/FMS is to contract the private sector to provide public health services at affordable prices.

9.2.3 Quality of services in the private health sector

There is a lack of regulatory policies on the quality of services provided by the private sector due to the absence of an operational regulatory authority. Poor-quality health care services provided by the private sector are a longstanding concern, aggravated by the large number of unqualified private providers. For example, multiple cases of the misdiagnosis and treatment of malaria by the private sector have been reported, and these have been attributed to the significant number of unqualified laboratory technicians working in the sector (*19*).

Despite the development of the National Medicines Policy endorsed in 2016 by the FGS and the existence of well-organized procurement and supply chains operating in the private sector, a quality assurance mechanism is lacking. Quality concerns are also exacerbated by the lack of refrigeration facilities and disruption in the supply chain due to insecurity. For example, during the process of developing a private sector engagement strategy (*48*), the Malaria Control Programme and other malaria stakeholders noted the private sale of large volumes of malaria drugs that were no longer considered to be effective for treatment (*29*).

9.3 Role in service delivery

The Somali private health sector (for-profit and not-for-profit) provides about 80% of all curative care services (*13,24*). The sector also plays a role in the provision of preventive services in the Somali health sector. In general, people in Somalia do not distinguish between different types of service providers and often seek health care services from a combination of providers. According to a 2020 study (*17*), private sector health care service providers act predominantly as referral facilities for facilities run by the government and nongovernmental organizations. However, accessibility barriers, and an absence of accountability, regulatory environment and coordination, are major factors that limit access to health services offered by private health care service providers.

Caafinet is the only network of private sector providers in Somalia and was established as part of a pilot project funded by the Swiss Agency for Development and Cooperation in 2017. It is the only functioning commercial private sector service delivery network in the country, with 200 member hospitals, clinics and pharmacies. Shifa Pharmacy in South Central Somalia is the only commercial chain of pharmacies, with about 15 branches in Mogadishu and the regions (*46*).

9.4 Private sector growth and its determinants

The lack of a government or state system all through the civil war, followed by years of protracted conflict, fragmented and degraded the public health system of Somalia to nearly zero (*26*). This led to the unregulated proliferation of a private health sector of varying quality throughout the country. As nongovernmental organizations took over the

public health infrastructure that did still exist (*17,24)*, the for-profit private sector thrived by filling the void.

- **Health system organization drivers: fragmented public health system**

  As a result of its conflictual past, Somalia's health system became fragmented with a lack of clear-cut distribution of roles, responsibilities and sovereignties between the state-level and the federal ministries of health (*20*). This deterioration of the public health system was a significant factor in the growth of the private health sector in the country.

- **Health financing drivers: low governmental expenditure on health**

  Due to poor public health sector financing, the private sector began to invest in the health sector to fill the gaps in the public health system.

- **Quality of care drivers: reduced quality of services in the public health sector**

  The deterioration of the public health sector led to limited access to health care and a severe reduction in the quality of health care services available. This situation was exploited by the private sector to its advantage.

- **High rate of population growth in Somalia**

  The relatively high level of population growth resulted in the rapid expansion of the private health sector due to increasing demand for health care and the limited capacity of the government to meet such demand.

- **Weak regulatory framework and limited enforcement capacity**

  Weak health system governance led to the unregulated growth of the private health sector across Somalia (*21,36*) as it took advantage of the regulatory vacuum in the country. The continuing absence of effective policies and regulatory frameworks has resulted in further proliferation of the private health sector.

9.5 Private sector engagement

9.5.1 Legal and institutional environment for PPP/private sector engagement

Engaging the private sector entails collaboration between the private and public sectors in different ways, including policy dialogue, information sharing and PPP. The World Bank defines PPP as "a long-term contract between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility" (*49*).

There are ongoing and/or planned ad hoc collaborative efforts between the private sector and Somali government, and between the private sector and donor/international NGO partners. Memoranda of understanding (MOUs) and legal contracts within the framework of donor organization policies, and the existing laws in Somalia, have been developed. However, there is neither a PPP policy nor strategy to date.

Following an assessment and consultative exercise to identify opportunities for collaboration and partnership with the private sector in the delivery of health services, Somalia with its partners developed the *Strategic guidance for engaging the private sector through private partnerships in health services in Somalia* document to mitigate the risks of PPP. The guidance identifies multiple challenges, such as project cancellation/modification, lack of accountability in the private sector, imbalance of investment, fraud and other issues affecting PPP contract design, and lack of effective regulatory mechanisms (*34*).

9.5.2 Current engagement activities

There are several private sector engagement modalities currently in use for the medical education of certain health professionals, particularly community midwives. These efforts aim to increase access to essential health services (*21*). Other examples of service delivery engagements include:

- In 2019, the Centre for Peace and Democracy[1] set up a subsidiary medical supply organization – Medify Solutions – the first and only specialized medical supply chain organization in Somalia. Medify Solutions signed a partnership agreement with Mission for Essential Drugs and Supplies (MEDS)[2] making Medify Solutions a MEDS-authorized agent in Somalia supplying medicinal products and technologies (*29*).

- A PPP/private sector engagement pilot project has been under way since 2018 within the Malaria Control Programme between the FMS-Banadir Regional Administration and different private sector actors (*34*). This project aims to increase the capacity of health professionals with regard to malaria treatment guidelines and the use of related tests in Mogadishu and Bosaso. The agreement was formalized through an MOU, with around 12 private facilities in Mogadishu and Bosaso voluntarily joining the programme. Facility laboratory and clinical staff were trained in the use of rapid diagnostic tests (RDTs) and the application of standard treatment guidelines. The facilities were also supplied by the Ministry of Health and its partners, with RDTs, malaria drugs (including artemisinin-based combination therapy) and tools for regularly submitting data to the Ministry's HMIS platform (*34*). The initiative provides a good example of the potential effectiveness of

1 The Centre for Peace and Democracy (CPD) is a national non-profit and non-political organization in Somalia founded in 2003. CPD's scope includes humanitarian assistance, poverty reduction through socioeconomic development and support for the country's stabilization initiatives. For further information, please see: https://cpd-africa.org/about-us/.

2 Mission for Essential Drugs and Supplies (MEDS) is a Kenyan-based medical supply organization and humanitarian procurement centre with accreditation from USAID and WHO. For further information, please see: https://meds.or.ke/.

private sector engagement since it could also provide a platform for addressing the challenge of counterfeit drugs, while also promoting private health sector trust in working with the Ministry of Health in other programmes.

- A tuberculosis pilot programme in Mogadishu also involves private sector engagement. The programme is led by the Global Fund as part of its support to the National Tuberculosis Programme. Through this programme, 15 private health facilities were able to offer testing and treatment services either free or for a consultation fee. Although one such facility treated 740 patients in 2019, this engagement was not well structured due to a lack of contractual arrangements (*34*).

- The 2015 Somalia Health and Nutrition Programme (SHINE) provides another example of an ongoing PPP/private sector engagement activity. Led by the Ministry of Health Somaliland in collaboration with the United Kingdom's Department for International Development, Population Services International and the Health Consortium for the Somali People programme, SHINE aims to reduce deaths among mothers and children in Somalia/Somaliland by improving the supply of and demand for health and nutrition services. Population Services International is supporting the Ministry of Health-Somaliland in the development of an associated national PPP framework (*34*). For SHINE, a nine-month pilot social franchise network of 17 private sector clinics was established to implement and deliver a standardized package of quality health services.

- A contractual agreement was reached in 2015 between the Ministry of Health-Puntland and a private sector firm for the establishment and management of a health care service provider database, and the printing of certificates for the accredited health workers (*19*).

Informal partnerships with the private sector also exist in a number of facilities. For example, in Adado Hospital, tertiary services are charged for while primary health care is free. This informal agreement with the Ministry of Health enables the hospital to be sustainable. Informal engagements have also been reported in Puntland, where the government has informally agreed that certain private facilities can treat military personnel or other government staff and the government will pay the treatment expenses. Similar arrangements also apply in other FMS such as Galmudug.

In summary however, the current assessment indicates the absence of effective PPP activities, with most interviewed private sector representatives and state-level authorities unable to identify specific PPP activities except for some ad hoc or informal engagements. Efforts are being made by donor and development partners to provide support in this regard, with the Swiss government leading a pilot project which aims to raise the capacity of the private sector, establish networks and strengthen business management. The same project is also providing support to networks such as Caafinet (*29,46,50*). Furthermore, private sector engagement is among the World Bank's priority areas in Somalia and work is under way to establish a platform to enable and facilitate dialogue between the private and public sectors (*29*).

9.5.3 Scope and priority areas for PPP/private sector engagement in the future

The current analysis has identified the key priority areas of various stakeholders. The components ranked the highest are: 1) governance and leadership; 2) human resources for health; 3) service delivery; 4) health financing; 5) medical products and technologies; and 6) health preparedness (*44*). For service delivery, a particular priority area is sexual and reproductive health (*51*).

9.5.4 Strengths, weaknesses, opportunities and threats (SWOT) analysis for private sector engagement

The current status of private sector engagement in Somalia can be summarized using the SWOT analysis matrix shown in Fig. 2.

Fig. 2. Private sector engagement SWOT analysis matrix

STRENGTHS

- The private sector is a dominant player in the provision of services. It is also more resourced than the public sector.
- Successful pilots of PPP exist (e.g. EPI Project).
- The private sector can function as for-profit and not-for-profit.
- Well-organized procurement and supply chains already operate in the private sector.

WEAKNESSES

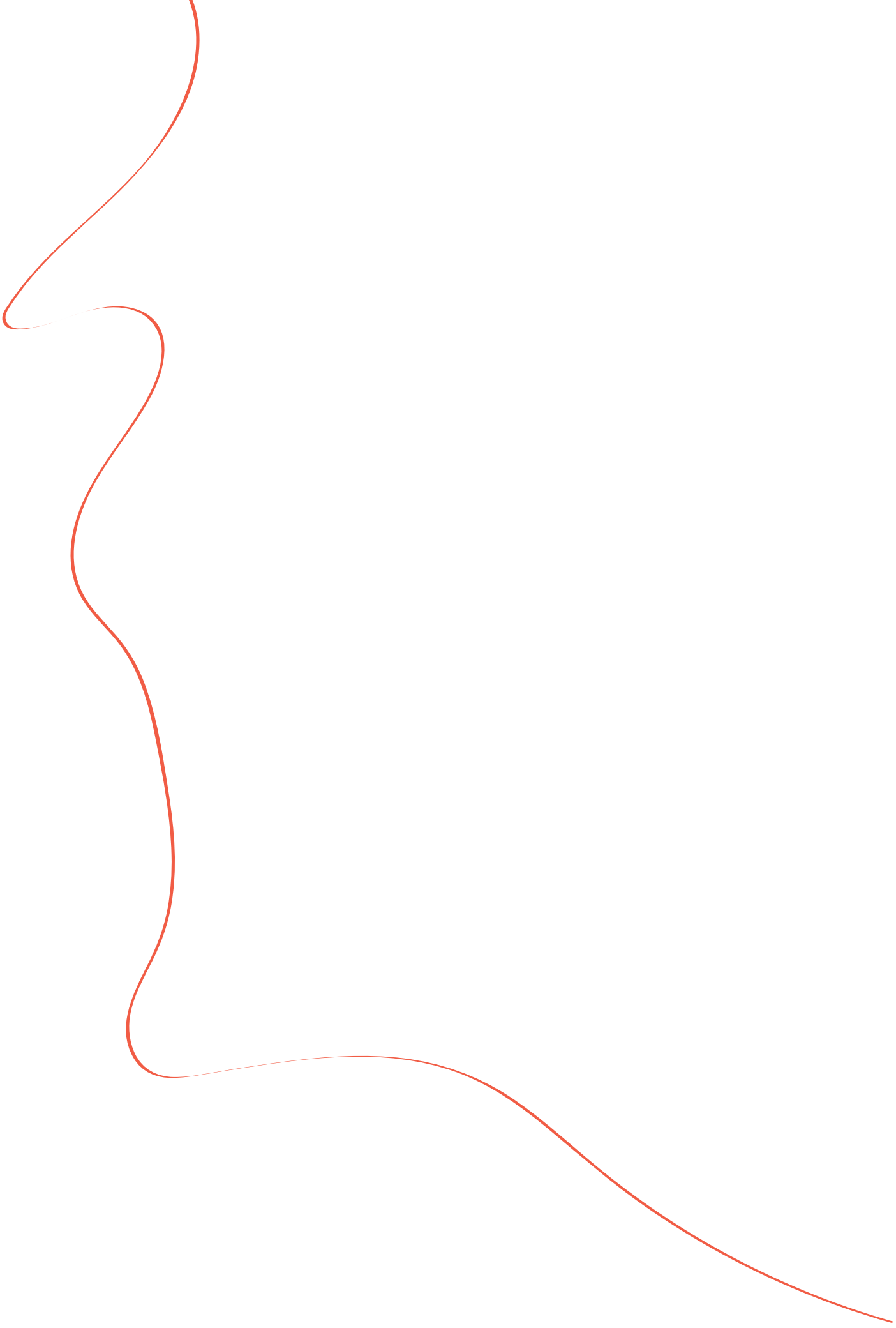
- Weak legal and institutional framework and no judiciary support system.
- Nonexistent PPP policy or PPP strategy.
- Large number of unqualified staff and hence compromised quality of care.
- No resolution or regulatory framework for pricing in the private health sector.
- Lack of quality oversight.
- Lack of capacity-building activiites.
- Limited data sharing and absence of information.
- Urban bias.

OPPORTUNITIES

- Somali diaspora investment support.
- High-level commitment to UHC implementation.
- Increasing demand for health care coupled with high population growth.
- Privilige of neutrality since private health facilities can operate in remote and insecure locations.
- Donor support for the the private sector engagement agenda.
- FGS/FMS willingness to engage private sector already expressed and documents drafted on engaging the private sector.

THREATS

- Unregulated competition in the private sector.
- Lack of judiciary support.
- Nonexistent sustainable health care financing policy.
- Political instability.



10

Recommendations on private sector engagement for UHC

A. Policy recommendations

1. Develop a PPP policy and a PPP engagement strategy.
2. Develop a clear and sustainable health care financing policy.
3. Develop a resolution or a regulatory framework for pricing in the private health sector.
4. Encourage inclusive engagements between the Ministry of Health–Federal Government of Somalia and Ministries of Health–Federal Member States.
5. Develop a medicines regulatory act and establish a medicines regulatory authority.

B. Operational recommendations

1. Federal and Member State ministries of health should invest in technical capacity building among staff to ensure adherence to laws and regulations, and promote stakeholder understanding of the policy and regulatory frameworks geared towards the operationalization of PPP and the mitigating of failure risks.
2. Create a supportive operational environment in which the judiciary system is functional and supportive of PPP operationalization in Somalia.
3. Enforce NHPC licensing and registration regulations for health facilities and staff.
4. Provide continuing medical education activities for health professionals.
5. Consider establishing a relicensing mandate once initial licensing mechanisms are established.
6. Adequately enforce the national essential medicines policy.
7. Develop a robust HMIS that is inclusive of the private sector with effective data quality assurance mechanisms and use the evidence generated to inform health policies.

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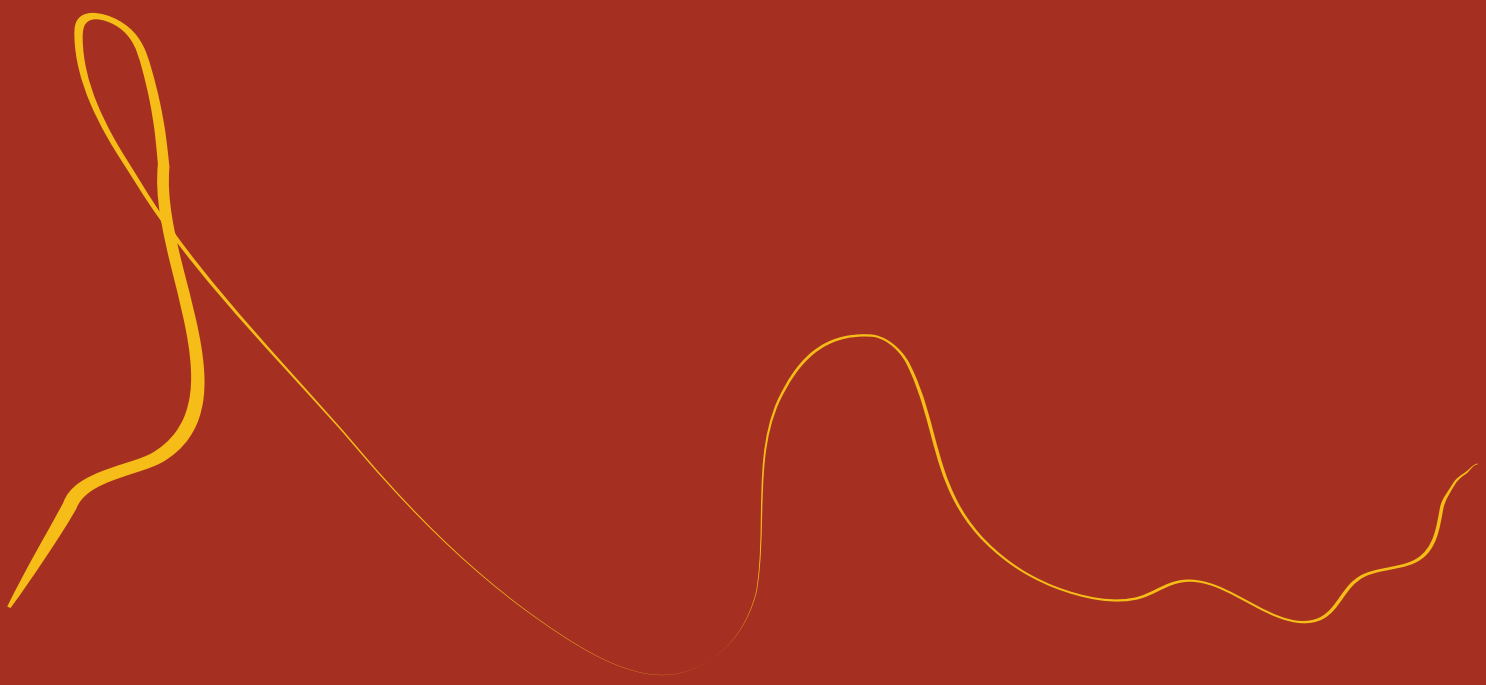

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Annexes

Annex 1. Selected health indicators

Indicator	Value
The proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods (%)[1]	2.1
Adolescent birth rate (aged 15–19 years) per 1000 women in that age group[2]	140
The proportion of births attended by skilled health personnel (%)[3]	31.9
The proportion of the target population covered by all vaccines included in their national programme (%)[4]	10.7
Neonatal mortality rate[5] (2019)[6]	36.8
Under-5 mortality rate per 1000 live births (2015)[7]	137
Maternal mortality ratio per 100 000 live births (2020)[8]	692
Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene per 100 000 population (2016)[9]	86.6

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Indicator		Value
Mortality rate attributed to NCDs (%)[1]		31.9
Mortality rate attributed to communicable diseases (%, 2017)[2]		56.2
Mortality rate attributed to injuries (per 100 000)		33
Morbidity	Adults aged 15–49 years HIV prevalence rate (2019)[3]	0.1
	Malaria, incidence per 1000 (2020)	1.8
	Diabetes prevalence (%) (2020)[4]	20.4
	Tuberculosis incidence per 100 000 (2016)	274
	Cancer prevalence (%) (2020)[5]	0.5
	Hypertension (%) (2020)[6]	33.3

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6. Ibid.

Annex 2. Formal steps of registration and licensing in Somalia[1]

State	Registration and licensing
SL	**Registration** ▪ Establish company or partnership memorandum of understanding (MOU) in Somali and English languages; ▪ Notarize at a public notary; ▪ Register membership at the Somaliland Chamber of Commerce; ▪ Submit an application to the Ministry of Trade and Investment (including the MOU and Chamber of Commerce membership registration). The Ministry of Trade and Investment will review the application and refer you on to the Attorney General's Office; ▪ The Attorney General's Office issues a certificate of company incorporation to secure the name, logo and shares, and refers you back to the Ministry of Trade and Investment.
	Licensing ▪ The Ministry of Trade and Investment issues a document that enables you to pay the licence fee to the Ministry of Finance; ▪ The receipt of payment to the Ministry of Finance, together with a tax clearance certificate from the Ministry of Finance Inland Revenue, is returned to the Department of Commerce within the Ministry of Trade and Investment; ▪ The Department of Commerce issues a licence; ▪ A licence is requested at the municipality and issued at the respective district administration.
PL	▪ Register at Puntland Chamber of Commerce and Industry; ▪ Request a letter of support and approval from the Puntland Ministry of Health; ▪ Take the approved letter to the Puntland Ministry of Commerce (trade department); ▪ Get a separate licence from the municipality at the respective local administration.
SC	▪ Obtain support or approval letters for trade from the Federal Ministry of Health (only for importers). This only gained prominence in 2014, with enforcement being very weak; ▪ Apply for the licence at the Ministry of Trade and Industry (for importers only) and get a separate licence from the municipality at the respective local administration. ▪ There are four documents that customs check on arrival at a port/border: 1) Commercial invoice; 2) Certificate of origin; 3) Transport document (e.g. bill of landing, including the names of the shipper); and 4) Certificate of product analysis.

SL = Somaliland; PL = Puntland; and SC = South Central (FGS-controlled states).

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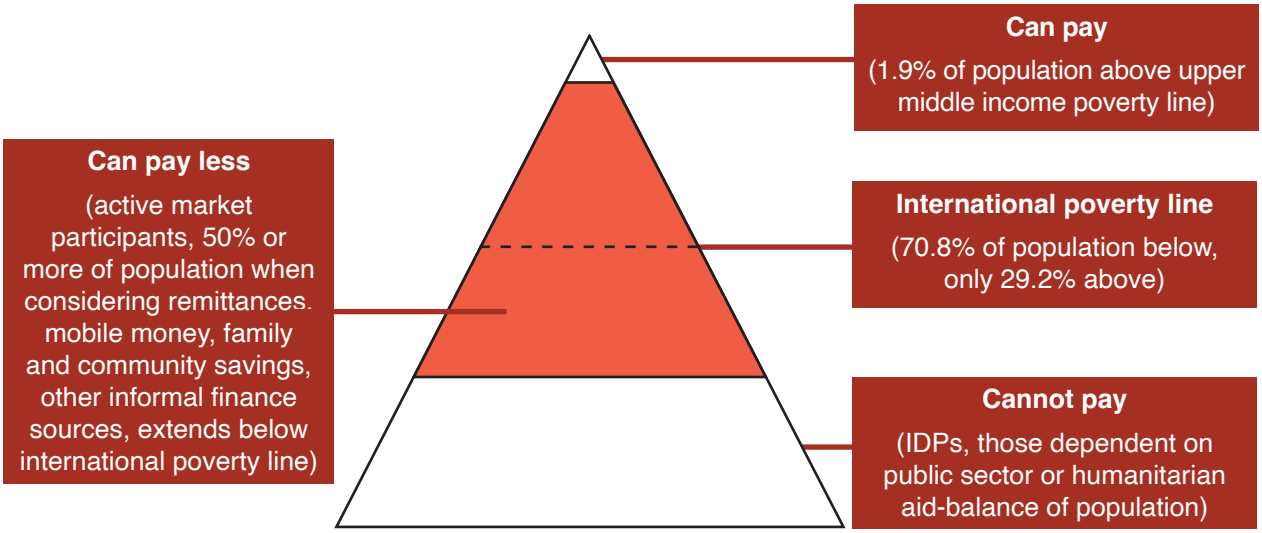
Annex 3: Somali health care market as seen by the private sector[1]



Source: Cardno analysis

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