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SOMALI PRIVATE SECTOR PARTNERSHIPS IN HEALTH

MARKET SYSTEMS ASSESSMENT

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SORDI

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Swiss Tropical and Public Health Institute
Schweizerisches Tropen- und Public Health-Institut
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Cover image: A doctor examines a child at the hospital run by the Hawa Abdi Centre in the Afgooye Corridor, Somalia UN Photo/Tobin Jones

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Acronyms and Abbreviations

CDC	Centre for Disease Control
CHF	Swiss Franc
COVID	Coronavirus Disease of 2019
CPR	Contraceptive Prevalence Rate
CSR	Corporate Social Responsibility
CT	Computerised Tomography
DCED	Donor Committee for Enterprise Development
DFID	UK Department for International Development (now FCDO)
DHMIS	District Health Management Information System
EA	East Africa
EPHS	Essential Package of Hospital Services
ESHE	Enabling Sustainable Health Equity (Kenya)
EU	European Union
FCDO	UK Foreign, Commonwealth & Development Office (incorporates former DFID)
FDFA	Federal Department of Foreign Affairs (Swiss Confederation)
FGD	Focus Group Discussion
FGS	Federal Government of Somalia
FMS	Federal Member States
FP	Family Planning
FTS	Financial Tracking Service
GAVI	Global Alliance for Vaccines and Immunizations
GDP	Gross Domestic Product
GPH	Global Programme Health
HC	Health Centre
HEF	Health Equity Funds
HIV	Human Immunodeficiency Virus
IC	International Cooperation
IDP	Internally Displaced Person
IHK	Integrated Health Kiosk
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
KII	Key Informant Interview
MFI	Micro-Finance Institution
MNCH	Maternal, Neonatal, and Child Health
MNO	Mobile Network Operator
MOH	Ministry of Health
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
MSA	Market Systems Assessment
MSD	Market Systems Development (formerly known as M4P)
M4P	Making Markets Work for the Poor (currently known as MSD)
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NHPC	National Health Professionals Council

OCHA	UN Office for the Coordination of Humanitarian Affairs
ODA	Office of Disaster Assistance
ODI	Overseas Development Institute
OECD	Organisation for Economic Cooperation and Development
OOP	Out-Of-Pocket
PEP	Politically Exposed Person
PHU	Primary Health Unit
PPHN	Piloting the Somali Private Healthcare Networks Programme
PPP	Public-Private Partnership
PSI	Population Services International
PSPH	Private Sector Partnerships in Health Programme
PSP4H	Private Sector Innovation Programme for Health (Kenya)
RH	Regional Hospital
RHC	Referral Health Centre
R-I-E-D	Relevance-Impact-Engagement-Do No Harm
SACCO	Savings and Credit Cooperative Association
SDA	Somali Dental Association
SDC	Swiss Agency for Development and Cooperation
SDGs	Sustainable Development Goals
SHDS	Somalia Health and Demographic Survey
SLHDS	Somaliland Health and Demographic Survey
SLMNA	Somaliland Nursing and Midwifery Association
SMA	Somali Medical Association (also Somaliland Medical Association)
SOHWU	Somali Health Workers Union
SOMA	Somali Midwives Association
SOMALI REGION	Federal Government of Somalia, and Somaliland
SORDI	Somali Research and Development Institute
SPA	Somali Pharmacists Association (also Somaliland Pharmacists Association)
STI	Sexually Transmitted Infections
SWISS TPH	Swiss Tropical and Public Health Institute
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's' Fund
USAID	United States Agency for International Development
WASH	Water and Sanitation Hygiene
WATSAN	Water and Sanitation
WB	World Bank
WHO	World Health Organization

Executive Summary

Introduction

The Swiss Agency for Development and Cooperation's (SDC) Somali Private Sector Partnerships in Health (PSPH) programme has been designed to follow a Market Systems Development (MSD) approach and with the general objective of providing Somali citizens, including the most disadvantaged groups, with better access to quality and affordable health services, based on two targeted outcomes:

1. Poor Somalis are able to access better quality and affordable healthcare through the provision of innovative financing mechanisms and safety nets.
   > Lot 1, which is linked to outcome 1, will focus on formal and informal and innovative financing mechanisms that will benefit the poor.
2. Organized private service providers deliver quality and inclusive health services across the country, including areas of difficult access.
   > Lot 2, which is linked to outcome 2, will focus on organising and supporting the private sector through health associations and networks.

The programme falls under the policy umbrella of the United Nations Sustainable Development Goals (SDGs) 3, 8, and 17 and the Swiss Confederation's International Cooperation (IC) Strategy 2021-2024. It supports SDC's Global Programme Health (GPH), the Swiss Cooperation Strategy Horn of Africa 2018–2021, the Federal Government of Somalia (FGS) National Development Plan 2020 to 2024 and the FGS Ministry of Health (MOH)'s 2020 Strategic Guidance for Engaging the Private Sector through Private Partnerships in Health Services.

Cardno Emerging Markets (EA) Ltd. was awarded both lots, which are managed as a unified programme, and has partnered with the Somali Research and Development Institute (SORDI) and the Swiss Tropical and Public Health Institute (Swiss TPH) to implement the programme on behalf of SDC. A four-month planning phase (January – April 2021) includes a detailed MSD analysis on the healthcare financing and service delivery subsystems and will inform some of the interventions which are to be tested and piloted during a subsequent three-year implementation phase 1.

This document is a market systems assessment (MSA) that describes the state of the healthcare market system following the 'donut' structure, analyses drivers and restrainers of change, stakeholders, competitive dynamics, and sustainability, outlines clear constraints and opportunities, and identifies possible areas of intervention, potential partners, and preliminary intervention design. The assessment includes mapping of the target beneficiaries, existing health networks, and existing donor health programmes. The report is based on both primary and secondary research and is structured into six chapters:

1. Introduction and Background
2. Methodology
3. Describing the Market System for the Selected Sub-Sectors
4. Sustainability Analysis
5. Constraints Analysis
6. Identifying Intervention Opportunities

Background

Somalia has some of the world's poorest health indicators. Communicable diseases, reproductive health and under-nutrition conditions constitute the largest contribution to morbidity and mortality. One out of every 12 women dies due to pregnancy related causes, infant mortality rate is 63 per 1,000 live births and under-five mortality rate is 97 per 1,000 live births per year. Pneumonia and diarrhoea are among the major killer diseases in children under-five and routine immunization coverage remains very low. The country has one of the highest total fertility rates in the world at 6.9 children per woman. Non-communicable diseases such as malaria are endemic in some parts of the country and mental disorders are also on the rise. The risk of financial burden on poor populations is especially severe with high out-of-pocket expenditure. Overall, the healthcare system in Somalia remains weak, poorly resourced, and inequitably distributed. Health expenditure remains very low and there is a critical shortage of health workers.

Longstanding conflict and fragility in Somalia have resulted in parallel and fragmented healthcare systems and structures. Somalia's health market is distorted as there is little domestically generated tax base with which to support social health insurance or public health delivery, and the overall Federal budget is highly dependent on funding from external humanitarian donors (49.7 percent in 2020). Private health insurance coverage is low, estimated at only 2 percent. The healthcare market is both underfunded and lacking adequate service delivery mechanisms.

The Somali healthcare sector has primarily been financed through out-of-pocket (OOP) expenditures by the populace, completed by direct funding from external donors over the past few decades. Most public health services provided in country have been "off budget and off treasury" and regarded as humanitarian services provided by donors through implementing NGOs, UN agencies, and the Red Cross/Red Crescent. Estimates are that half of total health expenditure in Somalia comes from donors, with OOP bearing the balance; the public sector contributes only a nominal share. Donors provided over US$92 million in external funding to the Somali health sector in 2020, 96.8 percent of it falling outside government structures. In 2020, NGOs received US$56.4 million or 61.2 percent of donor funding, followed by UN agencies which received US$27.4 or 29.8 percent, and Red Cross/Red Crescent which received US$5.4 million or 5.9 percent. The Federal Ministry of Health's (MOH's) budget is miniscule, totalling only $9.35 million in 2020, this being only 2.0 percent of the total Federal budget. The regulatory framework for healthcare is correspondingly weak.

It is difficult to estimate the total size of the healthcare market as the World Health Organization's (WHO) Global Health Expenditure Database, which holds data on 192 countries, has no data on the Somali health sector. Per capita health expenditure is estimated at only US$5 to US$7 per year, although a decade-old estimate from WHO put it at the range of US$12 to US$20 per year. It can only be inferred from these per capita health expenditure estimates that the size of the total healthcare market is US$100 million to US$400 million. The lower end of the range is likely to be an underestimate as it has already been shown that donors alone contributed US$92 million to the Somali health sector in 2020. The total healthcare market is likely to be in the midrange of the estimates.

Somalia has a vibrant private health sector that continues to grow rapidly; however, there are significant gaps in the areas of quality control, staffing and human capacity, medicines, equipment, and geographical distribution of services. The sector remains largely unregulated causing concerns over the quality of care provided and the impact of OOP payment practices on poor and vulnerable groups. The commercial private health sector is highly fragmented with no single dominant player, although since 2017 the SDC-facilitated Caafinet has organised 200 private hospitals, clinics, and pharmacies into a service provider network.

PSPH is adopting an integrated approach to increase access to healthcare by addressing both the demand side of the market to reduce financial barriers through innovative health financing mechanisms (in Lot 1) and strengthening the supply side to improve the quality and value of private health service delivery (in Lot 2). It is a synergistic approach; healthcare finance cannot function without corresponding service delivery of appropriate quality and value, and service delivery cannot operate without supporting finance.

Methodology

The MSA is based on data from both primary and secondary research. The primary research comprised a total of 50 key informant interviews (KIIs) with representatives from associations/networks, community representatives, insurance companies, mobile telecom operators, MOHs, NGOs and implementers, private providers, and public providers in Mogadishu, Kismayo, Galkayo, and Hargeisa; and 110 client (i.e. patient) exit interviews conducted at hospitals in these same locations. The patient interviews were across 86 private for-profit providers and 24 public health facilities. Interviews were conducted in March and April of 2021.

Secondary research was based on review of key published documents, grey literature, statistical data related to the Somali health market, and internet research. Nearly one hundred secondary sources were consulted.

Essential takeaways and key messages

The Somali health market needs to decrease its reliance and dependency on external donor funding and shift towards sustainability whereby the health system can be sustained with revenues and resources generated in-country. The Private Sector Partnerships for Health (PSPH) programme presents a unique opportunity to strengthen the overall system by exploring health models that address sustainability through

strengthening the private sector, which is the largest health service provider and often the first and only option for Somalis to access healthcare.

Somalia is a low-income country; GDP per capita was estimated at approximately $315 in 2018. In 2020, the international poverty estimate (measured using the $1.90/person/day poverty line) was 70.8 percent. While only 29.2 percent of the Somali population live above the international poverty line, reality is that a greater proportion of Somalis than this operate in the economy due to high level of remittances, family and community contributions and borrowing, the ability to use mobile money transfers from family and community when needed, and other informal means of support which do not register in the formal financial system. As a result, PSPH is focused on health programming that can sustainably deliver quality and affordable health services to the Somali economically active mass market, pushing into the vulnerable population groups that may not normally be considered as part of the healthcare market that can afford services. This mass market may reasonably count up to 50 percent of the population, a substantial number by any means (approximately 10 million out of a population estimated at 20 million).

PSPH's target audience is broadly defined as the poor who have some disposable income (those who are economically active), as the market cannot support sustainable business without a source of income, and the government at present has no substantial indigenous tax base nor the means to create one within the proposed three-year duration of implementation phase 1. The premise for MSD is the ability to mobilize the existing vibrant private sector to address pro-poor healthcare needs in an economically viable manner by supporting the development of the market to grow health businesses while mobilizing revenues to enable them offer affordable healthcare to the Somali mass market (i.e. the poor). MSD considers the poor as active market participants and their voice can help build competition amongst providers, demand better quality, improve provider responsiveness towards clients, negotiate rates/cost containment, and widen access to this mass market.

A limitation to the MSD methodology is that the most marginalized groups who have no disposable income are dependent on free public sector services, which are sustainable only if the government has its own tax base. At present they are served by the humanitarian sector proxying for the government.

Implications of the MSA sustainability analysis are profound and outline what needs to be done in the long run to move from the current state to meet the vision of a sustainable future:

1. The Somali healthcare sector is severely underfunded. To meet the long-term vision of UHC, the healthcare system must be funded from domestic revenue. The government needs to move away from heavy dependency on external donor funding which is dependent on the whim of the international community and outside the direct control of the Somali people.
2. This means the establishment of the basic political consensus and will to establish a sustainable, equitable healthcare system for all Somalis, regardless of income level.
3. Once that is fixed, the tax base and revenue collection capacity of the government must be strengthened to where domestic revenue sources can fund the government's fiscal contributions to the healthcare system, whether they are regulatory, financing, or delivery mechanisms.
4. Simultaneously, healthcare service delivery systems and their supply chains must be strengthened to meet the needs of the population. This shall be done in coordination and cooperation of the public and private sectors, with full engagement and input of the private sector beyond CSR initiatives and government contracting.
5. As public sector funding is currently lacking, the private sector must play a role in delivering services that the public sector cannot pay for or may not place a high priority on.
6. The regulatory environment must be developed with full input of the private sector to assure quality control and value for money.
7. These long run changes will be implemented through a series of small, consistent, coordinated steps and cannot be accomplished all at once through fiat.

The PSPH programme contributes to achieving this future vision by engaging the private sector to use the resources that are available now to better coordinate healthcare financing and help the private sector improve its service delivery systems to bring better value for money, quality, and coverage of healthcare needs to all Somalis, without depending on external donor financing. This not only takes steps towards UHC, but it is also fully sustainable. It is a win-win approach.

Key findings

Primary research – health seeking and health spending

The interviews conducted to gather primary information did not identify any key differences between health seeking and spending behaviours across the various research locations as they all face similar access issues.

All respondents who were surveyed at public facilities did not pay to access health services whereas 87.2 percent of respondents in private facilities paid for the health services they received. The average cost paid was US$55.24 (range US$5-US$200). At private facilities, the average cost for an outpatient visit was US$50.4 (range US$5-US$150) and for inpatient hospitalization was US$167 (range US$100-US$200).

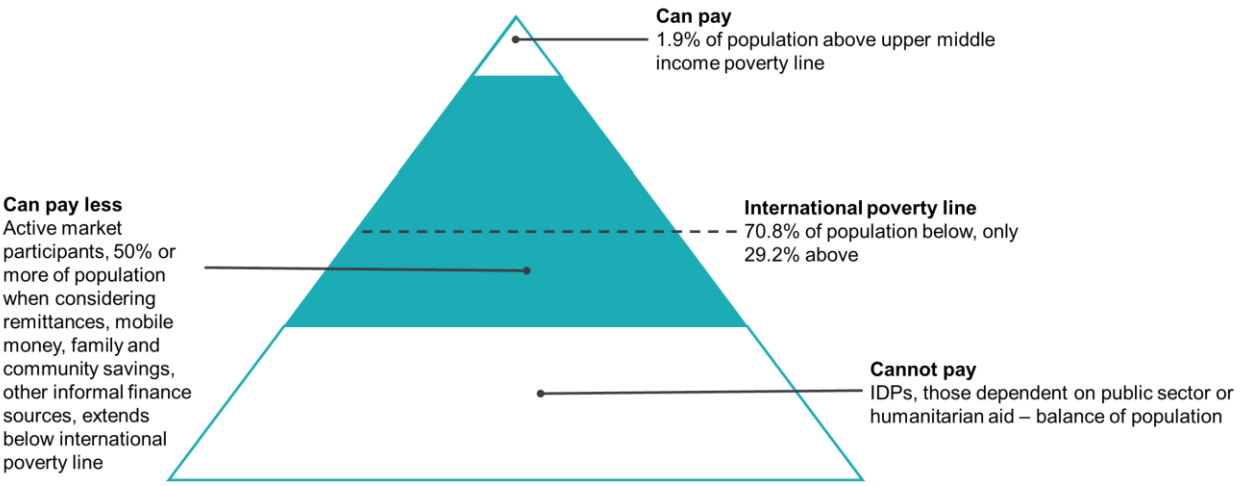
The most common means of payment were through mobile money and physical cash, while only 1.3 percent reported paying with insurance, which tallies with the meagre 2 percent insurance coverage revealed in the secondary research. As there is no social health insurance available and private insurance coverage is low, a vast majority of respondents surveyed at private facilities (98.7 percent) relied on OOP payments to meet the cost of health services. Fifty-nine percent of all respondents reported challenges paying for health services while 53 percent of all respondents stated that they had deferred or delayed treatment because of the inability to pay for health services.

When they are unable to pay, a majority defer treatment or forgo parts of the prescribed treatment while approximately 30 percent go to another lower-cost provider, who may be an informal provider, or go to a free provider. On enquiry where the funds were sourced to pay for the services received, respondents most frequently cited cash at hand, donations and borrowing as the most common source of funds.

Interviewees reported monthly disposable income of approximately US$200 to US$500 of which they estimated 10 percent to 50 percent was used for healthcare spending.

Defining the target market

Looking at the entire Somali health market, while 70.8 percent of the population is living under the $1.90 a day poverty line, the population can further be categorised using alternative measures. There are 29.2 percent with some disposable income who are able to pay for some services; only 1.9 percent of the population is above the upper-middle-income poverty threshold, and this is clearly the ‘can pay’ group for private providers as they currently see the market (e.g. the current coverage of formal health insurance is estimated to be under 2 percent). Within the 70.8 percent, there are IDPs and other indigents with no income whatsoever who cannot pay at all for health services – this group would need humanitarian assistance and cannot be targeted by a market-funded approach; and there are also those who have income when needed from various informal sources (remittances, borrowings, informal saving plans, family and community donations, et al.) and ‘can pay less’. It must also be recognised that healthcare events are considered within the context of the family and family resources are pooled when one family member needs to pay for healthcare, significant when considering that the average household size in Somalia is 6.2 persons. Defining what percentage of the mass market ‘can pay less’ is critical as they form the primary target audience for PSPH. It is reasonable to assume that this group may extend to half or more of the population, as this is the proportion estimated as economically active.



Source: Cardno analysis

The figure above illustrates that the Somali 'can pay less' economically active mass-market group extends well below the international poverty line. This is the target market for PSPH, and it includes millions who have heretofore been categorized as dependent on the public/humanitarian sector.

Stakeholders

Healthcare finance

As only 2 percent of the interviewed households reported that they could draw on a health insurance to pay for health expenses, OOP expenditure is very high, and many Somalis rely on services provided free of charge at public or not-for-profit private health facilities which are externally funded by donors. The leading health donors in 2020 were Thani Bin Abdullah Bin Thani Al-Thani Humanitarian Fund (Qatar), the United States Government (USAID/ODA), the Government of Germany, the European Commission, and the World Bank. The World Bank is planning a major expansion of their contribution in 2021.

In the health insurance sector, there are only two commercial insurers operating: Takaaful Insurance Company and Amaanah Insurance. Both of the companies have presence across the Somali region including Kenya. Takaaful is larger, although precise market share statistics are not available.

Service delivery

Donor money is predominantly spent to finance direct delivery of healthcare services through NGOs, UN agencies, and the Red Cross/Red Crescent, which proxy for the public sector. The Somali Turkish Recep Tayyip Erdogan Training and Research Hospital in Mogadishu is considered as the leading hospital in the country in terms of capacity; it was built and funded by the Turkish government in 2015. The MOH considers it a public hospital and it is co-managed by the Somali and Turkish authorities.

Private (commercial) healthcare service delivery is fragmented and there are no dominant players. Private hospitals are mainly located in urban areas and have limited reach in rural areas.

Caafinet, which started under an SDC-funded pilot in 2017, is the only functioning commercial private sector service delivery network currently operating in the Somali health sector, with 200 member hospitals, clinics, and pharmacies. Between 2018 and 2020, donors funded the establishment of Tunza, a social franchise network of independent pharmacies that sell subsidized and non-subsidized medicines to low-income communities; funding has now ended. Shifa Pharmacy in Southern Somalia is the only commercial chain of pharmacies with about 15 branches in Mogadishu and the regions.

Informal practitioners (traditional healers and Islamic healers) are widely accepted and are frequently the first stop on the path to treatment.

Constraints

As analysed during the planning phase, the key constraints to proper market function (as well as opportunities therein) have been identified as:

1. Cross-cutting constraints (affecting both healthcare financing and service delivery subsystems)
    a. Consumer behaviour (health seeking, health spending, awareness and knowledge of path to treatment and payment options)
    b. Market distortion (aid dependency drives out private sector)
    c. Human resource capacity
    d. Unmet opportunities for network building and technical skills transfer
2. Constraints pertaining to healthcare finance
    a. Low insurance coverage from both public and private sectors
    b. High mobile penetration underutilised for healthcare
    c. High cost of piloting financing innovations
    d. Inadequate benefit packages
3. Constraints pertaining to service delivery networks
    a. Access
    b. Weak regulation
    c. Business model issues
    d. Supply chain integrity

Recommendations for implementation phase

Following analysis of priority constraints to proper market function, the team identified areas of potential intervention opportunity for the private sector. Interestingly, using the lens of the private sector, the team was able to uncover areas of intervention opportunity that address every one of the priority constraints. Under an MSD approach, it is up to the market to speak, for potential partners to be found that can turn opportunity into sustainable, scalable, systemic actions. Overall, the assessment found vast areas that can be addressed through the private sector using the MSD approach within the programme's scope. This illustrates the wide applicability of the MSD approach to Somali healthcare system strengthening. It is not a marginal approach.

It is apparent from the research that PSPH should continue to build the capacity and reach of the Caafinet network which started under SDC guidance in 2017 and has since established a significant foothold in the Somali healthcare market but is yet immature. It is the only actively functioning service delivery network in the environment that is not dependent on donor support.

The portfolio of implementing partners and interventions will not be fixed during implementation, but rather will evolve to take on new partners as market dynamics change, invest in scaling up successes, and exit failures early to learn from the market's response to innovative models. Initially, it is recommended that the programme will operate in Mogadishu, Kismayo, Galkayo, and Hargeisa, targeting expansion from these main centres through the private sector partners.

1 Introduction and Background

1.A PSPH programme purpose, objectives, target audience, and intended outcomes

1.A.1 Programme introduction

The Swiss Confederation's International Cooperation (IC) Strategy 2021-2024 states that:

"Through its international cooperation, Switzerland contributes to reducing poverty and promoting sustainable development in developing countries.

The action of international cooperation is guided by the United Nations 2030 Agenda for Sustainable Development and its 17 SDGs.

Going forward, the aim will be to fully harness the potential of the private sector…[and] assess the possibility of developing new forms of cooperation involving the private sector. International cooperation will pay particular attention to the principles of subsidiarity and non-distortion of markets."[1]

Under the IC strategy, the Swiss Agency for Development and Cooperation (SDC)'s Global Programme Health (GPH) focuses on the third objective (human development), i.e. providing quality basic services and saving lives. It also contributes to the achievement of the other objectives such as sustainable economic development.[2]

The Swiss Cooperation Strategy Horn of Africa 2018–2021 looks to improve access of the most vulnerable populations to affordable high-quality healthcare, testing partnerships with the private/informal sector to complement public health efforts in service delivery.[3]

The Federal Government of Somalia (FGS) National Development Plan 2020 to 2024 includes a health strategy which, while building towards improved institutional, funding and capacity, will address early challenges such as inadequate access for the poor and under-served, and poor regulation of non-state provision and increased professional standards and provision.[4]

The Ministry of Health (MoH) under the Federal Government of Somalia's July 2020 Strategic Guidance for Engaging the Private Sector through Private Partnerships in Health Services recognizes that there is high out of pocket (OOP) financing for health services, that service delivery is not equally accessible, and that the private health sector is fragmented.[5]

Within this policy framework, in 2020 the Swiss Federal Department of Foreign Affairs (FDFA) under the aegis of SDC entrusted Cardno Emerging Markets (East Africa) Ltd. to execute the planning phase of the Private Sector Partnerships in Health (PSPH) programme.

PSPH follows a Market Systems Development (MSD) approach with the general objective of providing Somali citizens, including the most disadvantaged groups, with better access to quality and affordable health services, based on two targeted outcomes:

> Poor Somalis are able to access better quality and affordable healthcare through the provision of innovative financing mechanisms and safety nets; and
> Organized private service providers deliver quality and inclusive health services across the country, including areas of difficult access.

1 Swiss Confederation (2020), Switzerland's International Cooperation Strategy 2021-2024 (excerpts)
2 Swiss Agency for Development and Cooperation (2020), Global Programme Health Programme Framework 2021–24, p.9
3 Swiss Agency for Development and Cooperation (2018), Swiss Cooperation Strategy Horn of Africa 2018–2021, p.21
4 Federal Government of Somalia (2019), Somalia National Development Plan 2020 to 2024, The Ministry of Planning, Investment and Economic Development, p.258
5 Ministry of Health (MoH) of the Federal Government of Somalia (2020), Strategic Guidance for Engaging the Private Sector through Private Partnerships in Health Services in Somalia, July 7, 2020

Within the global international cooperation framework of the United Nations 2030 Agenda for Sustainable Development and its 17 SDGs, the MSD approach to healthcare is salient in that it supports three SDGs:

> **#3** (ensure healthy lives and promote well-being for all)
> #8 (promote sustained, inclusive and sustainable economic growth)
> #17 (partnerships for sustainable development)

The programme is structured into two thematic lots:

Lot 1, which is linked to outcome 1, will focus on formal and informal and innovative financing mechanisms that will benefit the poor;

Lot 2, which is linked to outcome 2, will focus on organizing and supporting the private sector through health associations and networks.

A six-month planning phase (January - June 2021) included a detailed MSD analysis on the healthcare financing and service delivery subsystems and will inform some of the interventions which are to be tested and piloted during a subsequent three-year implementation phase 1. The overall objective of phase 1 implementation will be to pilot selected and identified intervention models that might improve the conditions of the health market to benefit the poor. These models will be tested, analysed, and documented.

At the end of the phase 1 implementation, evidence and learnings will indicate which models are suitable for further investment and support to scale them up, or to adapt them further, in the second and third phases of PSPH.

1.A.2 Market background

Somalia's health market is distorted as there is little domestically generated tax base with which to support social health insurance or public health delivery, whereas the Federal budget is highly dependent on funding from external humanitarian donors. The Federal budget share funded by donors has actually increased from 33.5 percent in 2018 to 49.7 percent in 2020 as shown in Table 1-1. This under-represents the degree of donor involvement, particularly in the health sector, as these Figures only reflect "on budget" donor financing to the government and do not include the direct project funding by donors through multilaterals and NGOs which pays for a proxy public health system. Donors provided over US$92 million in external funding to the Somali health sector in 2020, 96.8% of it falling outside government structures.[6] The Somali health market needs to decrease its reliance and dependency on external donor funding and shift towards sustainability whereby the health system can be sustained with revenues and resources generated in-country. The Private Sector Partnerships for Health (PSPH) programme presents a unique opportunity to explore health models that address sustainability by strengthening the private sector, which is the largest health service provider and often the first and only option for Somalis to access healthcare.

Table 1-1 Share of Somalia Federal Budget Funded by Donors, 2018-2020

Year	Total Somalia Federal Budget (US$m)	Somalia Federal Budget Funded by Donors (US$m)	Percentage of Total Federal Budget Funded by Donors
2018	276.2	92.8	33.5%
2019	390.1	168.8	43.3%
2020	466.2	231.8	49.7%

Source: Federal Republic of Somalia[7]

Somalia has a vibrant private health sector that continues to grow rapidly; however, there are significant gaps in the areas of quality control, equipment, staffing, human capacity, and geographical distribution of

6 https://fts.unocha.org/countries/206/flows/2020?f%5B0%5D=destinationGlobalClusterIdName%3A7%3AHealth accessed April 17, 2021
7 Federal Republic of Somalia (2020), Appropriation Act for 2020 Budget

services. The sector remains largely unregulated causing concerns over the quality of care provided and the impact of OOP payment practices on poor and vulnerable groups.

Somalia is a low-income country; GDP per capita was estimated at approximately $315 in 2018.[8] In 2020, the international poverty estimate (measured using the $1.90/person/day poverty line) was 70.8 percent; the lower middle income poverty rate (measured using the $3.20/person/day poverty line) was 90.0 percent; and the upper middle income poverty rate (using the $5.50/person/day poverty line) was 98.1 percent.[9] The $1.90 per day poverty rate refers to people living in extreme poverty, defined as "a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information."[10]

While only 29.2 percent of the Somali population live above the international poverty line and have some disposable income, reality is that a greater proportion of Somalis than this operate in the economy due to high level of remittances which may not register in the formal financial system, the ability to use mobile money from family and community when needed, and other informal means of support. As a result, PSPH is focused on health programming that can sustainably deliver quality and affordable health services to the Somali economically active mass market, pushing into the vulnerable population groups that may not normally be considered as part of the healthcare market that can afford services. This mass market may reasonably count up to 50 percent of the population, a substantial number by any means (approximately 10 million out of a population estimated at 20 million).

PSPH's target audience is broadly defined as the poor who have some disposable income (those who are economically active), as the market cannot support sustainable business without a source of income, and the government at present has no substantial indigenous tax base nor the means to create one within the proposed three-year duration of Implementation Phase 1. A limitation to the MSD methodology is that the most marginalized groups who have no disposable income are dependent on free public sector services, which are sustainable only if the government has its own tax base.

PSPH is adopting an integrated approach to increase access to healthcare by addressing both the demand side of the market to reduce financial barriers through innovative health financing mechanisms (in Lot 1) and strengthening the supply side to improve the quality and value of private health service delivery (in Lot 2). It is a synergistic approach; healthcare finance cannot function without corresponding service delivery of appropriate quality and value, and service delivery cannot operate without supporting finance.

1.B Objectives of the market systems assessment report

During a four-month planning phase, Cardno has been tasked with conducting a healthcare market systems assessment with emphasis on the consumer healthcare finance (corresponding to Lot 1) and healthcare services provider networks (corresponding to Lot 2) subsystems, to outline clear constraints and opportunities, possible areas of intervention, potential partners, and preliminary intervention design. The assessment will include mapping of the target beneficiaries, existing health networks and existing donor health programmes. One market systems assessment report shall cover both Lots 1 and 2, with clear justifications on models that will be proposed to be piloted and tested during implementation, with theory of change and results chains for each proposed intervention. Following the MSD approach of analysis leading to action, this report shall inform the Project Documentation that frames subsequent Implementation Phase 1.

This is contemplated as a comprehensive, detailed healthcare market systems assessment to deeply understand both demand and supply sides of the market as it affects Somali healthcare consumers, with an emphasis on access to and payment for health services by those with less spending power, marginalised groups, and women.

8 Directorate of National Statistics, Federal Government of Somalia (2020). The Somalia Health and Demographic Survey (SHDS) 2020, p.3
9 World Bank (2021), Macro Poverty Indicators Somalia, April 2021
10 United Nations (1995), Report of the World Summit for Social Development, 6–12 March 1995

Sub-market systems requiring deep dives are (i) health financing in Somalia, covering public, donor, and private spending, including OOP expenditure; the state and non-state actors involved and processes through which they interface; and the regulatory framework; as well as (ii) existing healthcare provider networks and associations, including their capacities and interfaces with the public sector, and existing donor health programmes. In addition to a comprehensive review of secondary data, the assessment includes primary research including key informant interviews and surveys, to explore these and related questions:

> How do the poor pay for healthcare, either out of pocket or through existing programmes? Are there opportunities for partnership with these programmes? How can this project most equitably facilitate financing without distorting market conditions? How can we best target the poor and can we use existing social safety net targeting mechanisms?
> What are the financial constraints to more equitable and universal healthcare access? What are the decision mechanisms that consumers use to allocate resources for healthcare in an extremely resource-constrained economy? How much disposable income is available per household and how much of this is typically spent on healthcare?
> What are the current institutional arrangements in place for health financing and health insurance? What is the role of Takaful health insurance? How can Caafinet's third party administrator function be leveraged to support purchasing of services?
> What is the federal and regional level capacity to carry out health financing functions? How can we build on existing and potential programmes e.g. the World Bank project?
> What are the sustainable health financing models from other similar environments that provide access to quality health services to the poor that may be adaptable to the Somali context? What is the ability and willingness to pay for health expenses and contribute to different health financing mechanisms?
> How are remittances used to access health services? Are there mobile-based financial services that can be leveraged? Are there partnership opportunities?
> What are the minimum needs for a basic healthcare services package and what is the cost of delivering this basic package? What is the size of the underserved market? Which needs are well-met and which are underserved or unserved? Which services are economically viable for private sector providers?
> In addition to Caafinet, which institutions/networks can be leveraged to contribute to an economically sustainable network of healthcare providers that can offer high quality of care at affordable prices? How can private provider networks reach marginal areas?
> Is there an institution that provides quality assurance to link quality to provider payment? What self-regulatory mechanisms can be explored within the private sector in the absence of strong public sector enforcement?
> What are the core supply/demand functions that affect low income and vulnerable Somalis accessing healthcare, and who are the players? Who does, and who pays? (i.e. who currently provides services, and who currently pays for them? What is the vision of who will do and who will pay in a sustainable future?)
> How can healthcare financing mechanisms and healthcare service provider networks potentially be linked in a sustainable way to benefit more Somali consumers?

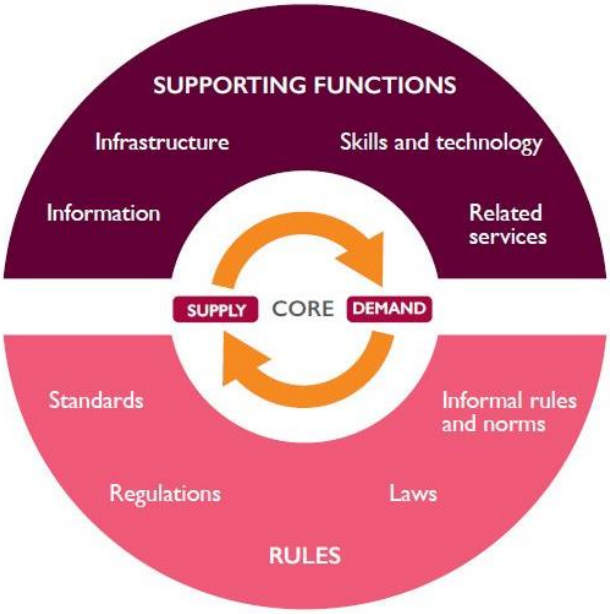
1.C The Market Systems Development approach

Market Systems Development (MSD), formerly known as Making Markets Work for the Poor (M4P), is an approach to developing markets so that they function more effectively, sustainably, and beneficially for poor people. In MSD, poor and disadvantaged groups are considered active market participants as opposed to passive beneficiaries. MSD involves guidance on how to analyse markets as well as how to intervene in them by addressing underlying causes (rather than symptoms) of weak performance. Analysis informs action.

MSD answers some important development questions such as:

> What happens after the donors exit and the donor money dries up?
> How do we ensure that economic growth benefits all, not just those at the top?
> How do we maximise involvement of the private sector in inclusive growth, beyond government contracting and CSR?
> How do we logically connect development programming with lasting systemic change?

Figure 1-1 The market systems 'donut'



Source: The Springfield Centre

A market system may be diagrammed using the 'donut' developed by the Springfield Centre which shows the core supply and demand functions surrounded by supporting functions and rules and regulations in an interdependent ecosystem, shown in Figure 1-1.[11] Chapter IV of this report, Describing the Market System for the Selected Sub-Sectors, follows the donut in structure.

MSD interventions are designed to be:

Pro-Poor: A bottom-up approach driven by the unserved and underserved needs of those on low incomes; interventions are specifically designed to benefit the poor from the outset.

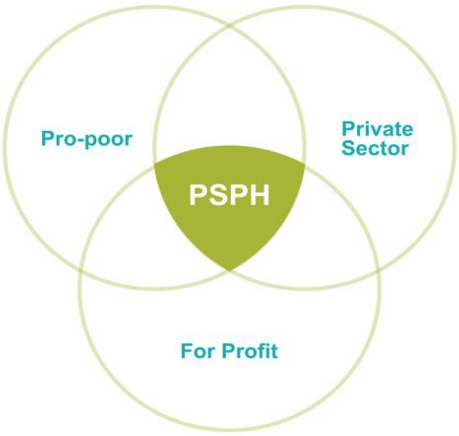
Facilitative: The development partner adopts a facilitative role that stimulates positive change without being a direct market player or part of the market system; change must be implemented and owned by permanent market actors, not by the programme.

Scalable: Striving to reach a large number of target beneficiaries and have significant impact on the underserved portion of the market through aggregation, replication, network synergies, crowding in of other market players, and attraction of private sector investment.

Systemic: Focusing on understanding at root cause level where market systems fail to serve the needs of the poor and acting to correct those failings, considering interdependencies and relationships across the entire market system.

11 The Springfield Centre (2015), The Operational Guide for the Making Markets Work for the Poor (M4P) Approach Second Edition, Swiss Agency for Development and Cooperation (SDC) and the UK Department for International Development (DFID), p.3

Figure 1-2 Constructing sustainable healthcare networks



Source: Cardno

Sustainable: Behaviour change among market participants survives the intervention without further subsidy or dependence on external support; exit is considered upon entry.

PSPH, using an MSD approach, will address both demand and supply-side constraints in parallel. PSPH will apply a mass-market approach serving all Somalis but ensuring that the poor are prioritised through innovative financing mechanisms such as mobile health insurance models or cross subsidization. A mass market approach in Somalia reaches into populations below the easy-to-reach upper income segment and is inherently pro-poor. To successfully deliver quality healthcare to Somalis through inclusive health interventions, the interventions must be pro-poor, private sector driven, and for-profit (Figure 1-2).

Since the Somali healthcare market is largely donor dependent, PSPH will map the donor space to identify existing health projects in a bid to stay away from donor crowded areas and **focus on the underserved areas** that are of interest to the private sector to ensure commercial viability. Instead of having a fixed set of interventions, PSPH will have an **adaptive, diversified portfolio of market interventions** addressing different systemic constraints, some of which will progress and mature, while others will die off. PSPH's portfolio approach will be an iterative learning process where lessons from the successes and failures will be used to inform design, adapt, scale-up and/or shut down market interventions as the markets evolve.

Despite Somalia's high poverty rate, the country has a vibrant private sector and PSPH through its MSD approach will mobilise private sector funds to provide better quality and value for money healthcare for poor Somalis. It is important to establish that PSPH is not a humanitarian aid programme, but a development cooperation programme that seeks to address inefficiencies in the private health market. It must be recognised that there is a fundamental difference between humanitarian assistance and development cooperation.[12] The MSD approach clearly falls under development cooperation where promoting sustainability is paramount.

As mentioned above in the programme introduction, within the global international cooperation framework of the SDGs, the MSD approach to healthcare is salient in that it supports three SDGs:

> **#3** (ensure healthy lives and promote well-being for all)
> **#8** (promote sustained, inclusive, and sustainable economic growth)
> **#17** (partnerships for sustainable development)

Most classical, direct-intervention healthcare development programmes focus entirely on SDG#3, to the detriment of SDG #8 (i.e. they focus on health impact while paying scant attention to adverse effects on sustainability). "Health interventions tend to be judged by how well they achieve their intended [health] goals. Yet even projects that fulfil their stated goals may also cause unanticipated and potentially harmful effects

12 European Centre for Development Policy Management (2019) *Discussion Paper No. 246 Think local. Governance, humanitarian aid, development, and peacebuilding in Somalia*, p.2

during or after their completion. For example, they may create dependency in the recipient population, with the expectation that services would continue to be provided to them as a public good after the project ends…Even with the best of intentions, many interventions that are intended to develop a market for disadvantaged populations often end up distorting it in ways that make it more difficult to deliver or pay for the services once the intervention is over."[13]

The sustainability element of MSD makes it a particularly appropriate approach to support not only the global UN 2030 Agenda but also the Swiss Confederation's International Cooperation Strategy 2021-2024 and SDC's Global Programme Health.

1.D Predecessor programmes

There have been notable MSD in health programmes in both Somalia and neighbouring Kenya that preceded PSPH and provide valuable lessons. Three such programmes are described herein.

1.D.1 Piloting Private Healthcare Networks

Caafinet is a network of qualified private healthcare service providers primarily in Mogadishu that was conceptualised, started up, and piloted under the SDC-funded Piloting Private Healthcare Networks (PPHN) programme that ran from 2017 – 2018, also implemented by Cardno. In many ways, PPHN was the direct antecedent to PSPH, as it pioneered the MSD approach to healthcare in Somalia. At time of writing in 2021, Caafinet not only survives but thrives, demonstrating that the MSD approach to healthcare is valid in the Somali context and that the commercial private sector can contribute beneficially to health systems strengthening. The Caafinet network is the first of its kind in Somalia — an organised platform made up of and led by private sector medical doctors and other healthcare providers. It provides clear benefits to its members who in turn are better positioned to provide affordable, modern, and quality healthcare services to low-income households.

Snapshot of Caafinet

- Caafinet was established using a purely MSD approach as only technical assistance was used to develop the network.
- Caafinet gret from 0 to 135 members during its one-year pilot
- Between 2018 to date (post-pilot), Caafinet's membership has grown from 135 to 200 showing it is a sustainable model
- Caafinet network has a collective of 40 hospitals, 60 clinics, and 35 pharmacies
- Caafinet facilities serve between 200,000 to 250,000 clients monthly, providing both inpatient and outpatient services
- Caafinet facilities are located in major cities – Mogadishu, Kismaayo, Baidao, and Galkayo.

Caafinet has three objectives namely,

> Strengthening the Caafinet network to become commercially viable that can sustain itself based on membership fees received and other sources of revenue generated from the provision of core services.
> Improving the quality of services being provided by members to improve health outcomes.
> Partnering with Government to complement and support public health provision.

Caafinet's intervention logic says that by networking together trained health professionals and service providers, a uniform brand can be created which healthcare consumers can recognise and under which quality can be controlled through a rigorous eligibility criteria and regular audits to ensure compliance with the Caafinet quality standards manual. The assumption is that consumers (i.e. patients) will be more likely to access a recognised brand that represents quality and better value for money, thereby increasing positive health outcomes.

Caafinet facilities provide different services, including inpatient and outpatient consultations for different specialties such as Internal Medicine, Paediatrics, Obstetrics & Gynaecology, Ophthalmology, Neurology, Ear Nose Throat specialist, Dental, and so on, the hospitals of the network provide surgical services such as general surgery and orthopaedics. Caafinet has a good relationship with the Federal Government of Somalia

13 Peters, David H, Ligia Paina and Sara Bennett (2012). "Expecting the Unexpected: Applying the Develop-Distort Dilemma to Maximize Positive Market Impacts in Health" in *Health Policy and Planning* 27:iv44–iv53. Oxford: Oxford University Press.

and assists the MOH on the improvement and standardization of the services of private healthcare facilities and the development of private healthcare regulations.

Some important lessons learned from Caafinet, including challenges are:

> Use existing aggregations and service providers already in the market who understand the market challenge; avoid creating new entities based on external assessment only.
> Governance is key to success and must be emphasised; a sustainable network cannot be built without an indigenous governance structure. Leadership is the key to governance.
> Technical assistance is progressive – what is needed in forming the network is different from what is needed as the network matures.
> Significant opportunities exist to expand network membership, network territorial coverage, and to add services (in healthcare finance, clinical service delivery, and support).
> Challenges were faced in collecting membership fees in particular.
> Avoiding grants, commodity/asset support, and paying for operational costs fostered market sustainability.
> It would be a mistake to halt technical assistance before the network matures.

1.D.2 Private Sector Innovation Programme for Health (PSP4H)

PSP4H was an action research[14] programme that ran from 2013 to 2018 in neighbouring Kenya which was designed to explore a new area for DFID Kenya, namely the markets in which poor people pay for-profit providers and shopkeepers for healthcare. The overall objective of the programme was to learn lessons of how a market systems approach might benefit pro-poor health interventions, to advise future programme design. The programme targeted the 'working poor' who have nominal disposable income and spend OOP for healthcare, to see if it was possible to engage the commercial private sector to deliver better quality and value for money.

BEAM Exchange, a platform for knowledge exchange for MSD approaches, credits PSP4H as "pioneering MSD healthcare services for the poor." DFID rated the programme A+ in its annual reviews four successive years because of its impact of its market-based interventions on the pro-poor health market in underserved areas. The October 2014 DFID Annual Review stated, "The first-year experience of PSP4H is that M4P in Health is a valid approach for technical assistance to the for-profit private healthcare sector. The fundamental M4P market systems framework of a pro-poor, facilitative, systemic, sustainable, scalable approach does not need to be radically altered to operate in the healthcare sector."[15] Two years later, the December 2016 DFID Annual Review stated, "There is good evidence from this programme to demonstrate that a Market Systems Development approach can work in the health sector."[16]

The first phase of PSP4H involved market research to define the working poor target market and to understand their health seeking behaviour and patterns. The second phase involved the scale up and replication of viable interventions, drawing from lessons learnt from the first phase. Ten top key lessons that emerged from PSP4H's pro-poor programming include:

> The Market Systems approach is valid approach for technical assistance to the for-profit private healthcare sector.
> Before designing interventions, the health sector needs to be well mapped to identify donor crowded areas and underserved areas.
> Partner engagement is fundamental to programmatic success. Choosing the most appropriate partners proves at least as important, or possibly more important, than completing a comprehensive analysis.
> Interventions need to be designed narrowly, with clear logic, in order to ensure that they are easy to measure and also easy to attribute.

14 In this instance 'action research' is defined as research which is a reflective process of progressive problem solving led by individuals working with others in teams or as part of a "community of practice" to improve the way they address issues and solve problems.
15 DFID (2014). October 2014 Annual Review Summary Sheet, Private Sector Innovation Programme for Health, FCDO Development Tracker https://iati.fcdo.gov.uk/iati_documents/4764549.odt accessed April 13, 2021
16 DFID (2016). December 2016 Annual Review Summary Sheet, Private Sector Innovation Programme for Health, FCDO Development Tracker https://iati.fcdo.gov.uk/iati_documents/5651651.odt accessed April 13, 2021

> A bottom-up approach brings the programme closer to the beneficiaries, so programming can better understand the behaviours of the target group.
> Using a portfolio approach allows a flexible mix of interventions and helps minimise risks when facilitating change in health markets.
> Market interventions with potential scale may require more time and several attempts.
> The success of a healthcare private enterprise is dependent on its business model.
> Redefine the term 'working poor' as the 'mass market'.
> The mass market in Kenyan healthcare is largely underserved.

The programme piloted interventions (in the form of technical support) with 19 existing private sector providers across different health market areas that were not donor-crowded such as private healthcare financing, low-cost service delivery, non-communicable diseases, supply chain, and public-private partnerships. Showing that a properly designed and executed market systems approach could support sustainability after programme funding ended, some notable interventions that are still thriving three years after PSP4H closed include:

Afya Poa: Mobile-enabled health insurance and health savings plan for informal workers. Afya Poa is an affordable and appropriate health insurance product for the informally employed, who constitute over 80 percent of Kenya's workforce. The product combines three benefits, namely health insurance, health savings, and health loans on a mobile-enabled platform. PSP4H focused during its first phase on supporting Afya Poa to develop a viable product for the targeted market. During the roll out and activation phase, the partner realised that the product was not competitive compared to other health saving plans available for the same audience. Afya Poa did a business re-modelling, considering the feedback received from the market. PSP4H supported the development of this innovative mobile health financing product with marketing strategy, branding, and capacity building. Since programme support ended, Afya Poa has received private equity investment and focused more on partnerships with organizations to extend their reach instead of only targeting individual informal workers. Some of their current partnerships include digital taxi service companies which have brought in 216 members; logistics operators that use motorbike riders to deliver products have brought 283 members; jewellery exporting company who work with local artisans now have 132 artists insured and three small SACCOs (Savings and Credit Cooperative Organization) with an average of 130 members each. While Afya Poa still has individual members, the partnership model has greatly expanded private health insurance and savings for Kenya's informal workers using a commercial yet affordable model.

Ukunga Bora: Private midwives network engaged in a PPP with Kilifi County Health team. This is a network of private midwives in Kilifi County, which was established in 2015 with PSP4H technical support from loose groups of retired midwives in Kilifi and Malindi counties which had been working together informally since 2010. The project brokered a public-private partnership between the private midwives and Kilifi County to address gaps in the public healthcare delivery system. The project provided the midwives with training in business skills, basic emergency obstetric care, kangaroo mother care (KMC), network management, and helped design the "Ukunga Bora" brand to identify facilities in the network. Facilities join the network following a due diligence visit and are expected to conform to a set of standard operating procedures and quality standards. Network facilities are able to access training, commodities and supportive supervision provided by the county government. After programme assistance ended, the network has now grown to 52 private facilities from 29. The County government reported that Ukunga Bora has contributed to improvements in skilled birth attendance (from 42 percent to 62 percent) as well as family planning (CPR from 32 percent to 54 percent) in the County.[17] Four years after PSP4H, Ukunga Bora continues to enjoy an excellent relationship with the County government who invite them to all the important health trainings, including those conducted for COVID-19. An Ukunga Bora members facility was selected by the County as a COVID-19 vaccination site and they commenced this service roll-out in March 2021. Baby deliveries at Ukunga Bora facilities have doubled since the beginning of the COVID-19 pandemic since residents feared going to hospitals for fear of contracting COVID and the County government has encouraged residents go to

17 From interviews with the county health team lead in Kilifi during the PCR field visit in May 2018

midwives instead of home deliveries. Some Ukunga Bora members have done up to 8 deliveries a day during this period. Undoubtedly, COVID-19 has resulted in a lot of referrals to Ukunga Bora member facilities, and the network foresees an increase in membership after the pandemic when they will be able to run recruitment drives.

City Eye Hospital (CEH): Affordable eye-care and treatment. CEH is a successful initiative by Upper Hill Eye and Laser Centre (UHEAL), a high-end private ophthalmology clinic in Nairobi, to establish a hospital in Nairobi providing quality eye care services for the working poor. CEH replicates a model of low-cost, high-quality eye care services developed in India by Aravind Eye Hospitals, the world's largest and most productive eye-care service group. PSP4H supported CEH by providing the initial market research giving them the confidence to invest in the business. PSP4H helped design and implement a marketing strategy in line with the research findings, including outreach visits to poor sections of the city to raise awareness about the hospital and its services. CEH conducts outreach activities within and outside Nairobi and before COVID-19, the hospital would see 130-150 patients a day, most from the outreach camps. To ensure that all these patients were served on the same day CEH added the following specialists as full-time staff; a Retina specialist making a total of two Retina Specialists, one Glaucoma Specialist, one Ophthalmic Clinical Office and one Optometrist. However, due to the COVID– 19 outbreak, the medical camps/outreaches have been suspended, which has led to a decline in the number of patients seen to between 100 – 120 a day. Consultations are just US$4, a fraction of the US$40 charged by other high-quality service providers in Nairobi. CEH now generates more gross income than UHEAL even though margins are much thinner, making it profitable.

Tanaka Nursing Home (TNH): Increasing access to affordable healthcare for low-income earners. TNH, located in Busia, one of the poorer counties in Kenya, was trying to attract cash paying patients as most of their clientele were only those covered by the National Health Insurance Fund (NHIF) insurance which was slow in paying claims and thus negatively affected cash flow. TNH was barely breaking even and their cash flow was problematic. PSP4H supported marketing activities through community outreach which had a significant impact on attracting new clientele in poor areas of Busia and raising awareness of the affordable quality services that Tanaka offers. Tanaka experienced a 132 percent increase in revenue in 2017 compared to the base period in 2015. Profits increased from a loss in 2015 to 11.2 million Kenyan Shillings in 2017. As a result of the positive growth, a number of benefits have been extended to the patients, such as fee waiver to low socio-economic segment patients. Post-PSP4H programme support, Tanaka has expanded both its physical structure and services delivered to accommodate the fast-rising demand of its services. The business model shows that understanding mass market health spending behaviour and perceptions and communicating pricing and service availability appropriately can break longstanding myths about the private sector being unaffordable, expanding access to quality private sector services to previously unreachable demographics.

Looking at these four PSP4H interventions, which all achieved sustainability, PSP4H's definition of sustainability as "behaviour change among market participants that survives the intervention without further subsidy or dependence on external support, incorporating a customer-driven business model that replenishes capital and attracts new investment"[18] is reinforced.

1.D.3 Enabling Sustainable Health Equity (ESHE)

Enabling Sustainable Health Equity (ESHE) was a five-and-one-half-year DFID-funded family planning programme in Kenya (2012–2018). The intended impact of the ESHE project was increased use of modern contraceptive methods as measured by increase in Contraceptive Prevalence Rate (CPR), with an expected outcome of greater access to family planning (FP) for the poorest Kenyans and adolescent girls. ESHE was a $30 million programme delivering a host of supply and demand interventions across 40 counties and strengthening the private sector's involvement in Kenya with the objective of reducing unmet need at

18 Ashkin, Ronald (2014), What Does "Sustainability" Mean in the Context of M4P in Health? PSP4H Policy Brief No. 6. The Private Sector Innovation Programme for Health, Nairobi, Kenya.

34 percent and increasing the uptake of modern family planning. The programme had an emphasis on poor rural women and adolescent girls aged 15-19.

ESHE (then titled Delivering Increased Family Planning Across Rural Kenya – DIFPARK) did not perform up to DFID's expectations in its 2013 and 2014 Annual Reviews,[19] particularly with regard to its planned employment of an M4P (MSD) approach. DFID requested that Cardno become involved and Cardno performed a comprehensive Diagnostic Assessment of Kenya's Family Planning Market during the first half of 2015.

Along the programme, ESHE established 60 integrated health kiosks (IHKs) in selected rural sites across 19 Kenyan counties. The objective of the IHKs was to sustainably increase the access to, availability and choice of FP methods among women and adolescent girls of reproductive age, including Kenyans in rural areas, ultimately to contribute to increased CPR in Kenya. In one of ESHE's DFID Annual Reviews, the economic viability of ESHE's highly subsidised approach to establishing the IHKs was questioned; hence in response an evaluation of the sustainability of the IHK business model had to be carried out to inform future programme actions. A further IHK sustainability study conducted by Cardno was based on the MSD approach and the sustainability definition adopted was the same as PSP4H.

From the findings, 19 percent of sampled IHKs were lossmaking, 13 percent were breaking even, and 69 percent were profitable: 31 percent marginally profitable, 19 percent moderately profitable, and only 19 percent substantially profitable. To be sustainable beyond the end of the ESHE programme, most IHKs needed to earn higher profits than they were in order to cover the incremental costs of advertising, mobilising clients, refresher training, equipment replacement, and facility maintenance. The IHKs breaking even or minimally profitable needed to take actions that would increase income and minimize costs in order to become more sustainable (44 percent of the total). The 19 percent of IHKs that were lossmaking may need to be culled from the programme. The study team analysed the reasons why some of the IHKs were more successful than others, with success defined in terms of profitability. The survey showed that on average only 35 percent of transactions and 15 percent of IHK revenues come from FP; it was apparent that virtually all of the IHKs provided services beyond FP and to reach sustainability the fundamental IHK mandate must be expanded beyond FP. ESHE's programme intervention logic was adapted for the balance of the programme to focus primarily on business sustainability, with FP as a mandatory component.

Some key lessons learned from ESHE are:

> It is essential to conduct a thorough market systems assessment at the beginning of the programme, before interventions are designed and implemented, so interventions can be based on evidence rather than *a priori* assumptions of what might work.
> Interventions must be designed with sound logic connecting programme inputs to expected outcomes and impact; it is difficult to re-install logic once an intervention is underway.
> Sound financial models looking at revenues and expenditures are fundamental to market-based interventions.
> Direct support of assets and commodities makes replication difficult.
> To foster sustainability, put a governance structure run by market players in place.

1.E Overview of the Somali health sector

1.E.1 The Somali healthcare market

Longstanding conflict and fragility in Somalia have resulted in parallel and fragmented healthcare systems and structures.[20] By the end of the 20-year military dictatorship, an estimated 80 percent of Somalis were estimated to have no access to basic healthcare, particularly in rural areas.[21]

19 DFID (2014). December 2014 Annual Review, Delivering Increased Family Planning Across Rural Kenya (DIFPARK), FCDO Development Tracker https://iati.fcdo.gov.uk/iati_documents/4837817.odt accessed April 14, 2021
20 Buckley, Joanna, Liz O'Neill and Ahmed Mohamed Aden (2015). Assessment of the Private Health Sector in Somaliland, Puntland and South Central Final Report: March 2015, Health & Education Advice & Resource Team (HEART), UK Department for International Development
21 Joint Needs Assessment Somalia (2006). Cluster: Social Services and Protection of Vulnerable Groups. Sub-Cluster: Health. Draft April 21, 2006

It is difficult to estimate the total size of the healthcare market as the World Health Organization's (WHO's) Global Health Expenditure Database, which holds data on 192 countries, has no data on the Somali health sector. Per capita health expenditure is estimated at only US$5 to US$7 per year, as shown in Table 1-2,[22] although a decade-old estimate from WHO put it at the range of US$12 to US$20 per year.[23] It can only be inferred from these per capita health expenditure estimates that the size of the total healthcare market is US$100 million to US$400 million. The lower end of the range is likely to be an underestimate as it has already been shown that donors alone contributed US$92 million to the Somali health sector in 2020.

Table 1-2 Estimates of health spending in Somalia based on data from the Institute for Health Metrics and Evaluation

Indicator	Year	Somalia
Health spending per capita, 2019 US$	2017	$6 (range 5–7)
Health spending per capita, 2019 purchasing-power parity-adjusted $	2017	$14 (range 12–16)
Total health spending per GDP, percent	2017	4.7% (range 3.9–5.6)
Total government health spending and prepaid private spending per total health spending, percent	2017	19.3% (range 14.7–24.9)

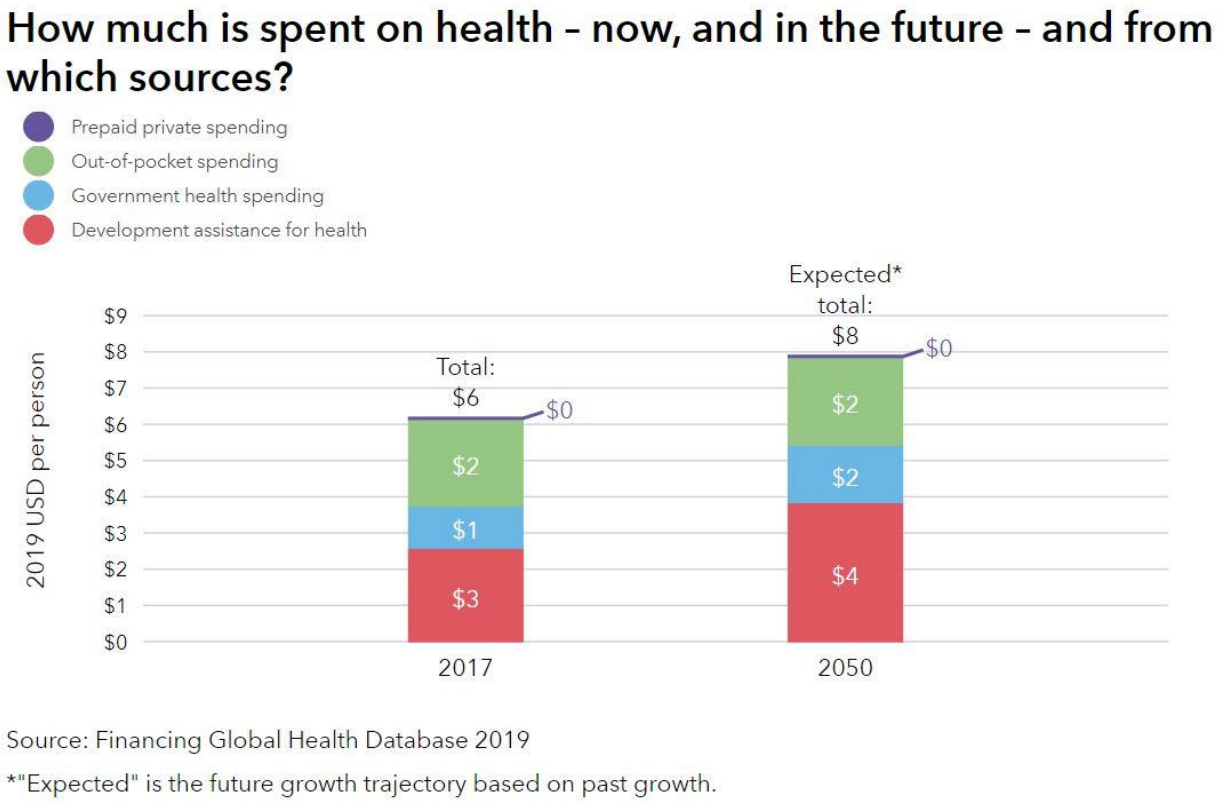
Source: The Lancet[24]

Somalia has some of the world's poorest health indicators. Communicable diseases, reproductive health and under-nutrition conditions constitute the largest contribution to morbidity and mortality.[25] One out of every 12 women dies due to pregnancy related causes, infant mortality rate is 63 per 1,000 live births and under-five mortality rate is 97 per 1,000 live births per year which is higher than average according to UNICEF (2017). Pneumonia and diarrhoea are among the major killer diseases in children under-five and routine immunization coverage remains very low. The country has one of the highest total fertility rates in the world at 6.9 children per woman,[26] with an unmet need for birth spacing at 26 percent.[27] Non-communicable diseases such as malaria are endemic in some parts of the country and mental disorders are also on the rise. The risk of financial burden on poor populations is especially severe with high out-of-pocket expenditure. Overall, the Somali healthcare system in remains weak, poorly resourced, and inequitably distributed. Health expenditure remains very low and there is a critical shortage of health workers.[28]

The Somali health sector has primarily been financed through OOP expenditures by the populace, completed by funding from donors and development partners over the past few decades. Most health services provided in country have been "off budget and off treasury" and regarded as humanitarian services provided by donors.[29] Figure 1-3 below estimates that half of total health expenditure in Somalia comes from donors, with OOP bearing a significant burden. If this is indeed the case, then the total healthcare market can be estimated at US$184 million based on donor contributions in 2020, which is in the midrange of the earlier estimates. The Somali diaspora contribute significantly to the health sector, but again information on actual healthcare remittance volume is not well documented.

22 This is an estimate from the Institute for Health Metrics and Evaluation. The WHO's Global Health Expenditure Database has no current data for Somalia; see https://apps.who.int/nha/database/Select/Indicators/en accessed April 10, 2021
23 WHO (2011). Country Cooperation Strategy for WHO and Somalia 2010–2014, p.44 https://www.who.int/country-cooperation/what-who-does/strategies-and-briefs/en/ accessed April 28, 2021. The WHO's more recent 2017 Country Cooperation Strategy at a Glance, available at the same website, has null entries for health expenditure.
24 Global Burden of Disease Health Financing Collaborator Network (2020), Health sector spending and spending on HIV/AIDS, tuberculosis, and malaria, and development assistance for health: progress towards Sustainable Development Goal 3, The Lancet Volume 396 Issue 10252 p.693-724, September 5, 2020
25 Somalia National Development Plan 2017-2019, op. cit.
26 SHDS (2020), op. cit. p. 75
27 Somalia National Development Plan 2017-2019, op. cit.
28 World Health Organization (2015), Humanitarian Response Plans in 2015
29 Ibid

Figure 1-3 Sources of health spending in Somalia



Source: Institute for Health Metrics and Evaluation[30]

1.E.2 Public health sector

Both past and present realities have affected the expectations of Somalis regarding health services and their health consumption. Before the collapse of the government in 1991, healthcare in Somalia was overseen by the Ministry of Health. Post-civil war, the government was able to re-establish a partially functioning health system covering primary and secondary healthcare services albeit with limited funding.

Regulatory supervision of health service provision remains a major issue. Regulation of health professionals/facilities and enforcement of health regulations are very weak, although some efforts have been made in Puntland and Somaliland. Somaliland has reported the existence of an independent regulatory body, although it has not been effective. Public health laws have not been updated for more than 25 years[31] until the passage of the National Health Professional Council (NHPC) Act in 2020. Also, the Federal Government does not have complete oversight of all the donor health programmes across Somalia, the areas they cover, and the funding received for each programme.

The Federal Ministry of Health's budget is miniscule, totalling only $9.35 million in 2020 this being only 2.0 percent of the total Federal budget, shown in Table 1-3 below. This is allocated into compensation of employees $2.81 million, use of goods and services $4.04 million, and consumption of fixed capital $2.50 million. There is no budget for a social insurance fund nor for nationwide service delivery.

30 http://www.healthdata.org/somalia accessed April 10, 2021
31 WHO (2015). Strategic Review of the Somali Health Sector: Challenges and Prioritized Actions (2015), Report of WHO Mission.

Table 1-3 Somalia's Health Budget as a Share of Total Government Budget, 2018 - 2020

Year	Somalia Federal Ministry of Health Budget (USD)	Total Somalia Federal Budget (USD)	Percentage of Ministry of Health in Total Federal Budget
2018	1,168,173	276,247,979	0.4%
2019	6,260,440	390,158,833	1.6%
2020	9,350,466	466,150,903	2.0%

Source: Federal Republic of Somalia[32]

1.E.3 Private health sector

Post 1991, private providers, both formal and informal, have filled the vacuum and replaced the former government monopoly in healthcare with homegrown drug shops, pharmacies, health centres and clinics. The private sector is the main provider of essential healthcare services for Somalis seeking health advice and healthcare products. The services of traditional and religious healers are also commonly sought. According to the Danish Immigration Service's 2020 Somalia Health System report, "The private healthcare sector is the dominating provider of health services in Somalia: up to 90 percent of the population is estimated to use private healthcare facilities; between 60 and 80 percent of all curative services are estimated to be covered by private health facilities.

Counting pharmacies (58 percent), health clinics (32 percent), hospitals (6 percent) and diagnostics centres (4 percent), the total number of private facilities reach 3,289 in total across the country. The vast majority of private health facilities (79 percent) are located in urban areas and only a small minority in the rural areas. Private healthcare may be provided as for-profit services (e.g. Ladnan Hospital), by semi-public arrangements (as the Somali Turkish Recep Tayyip Erdogan Training and Research Hospital), as private pharmacies, or as UN-run or NGO-run facilities. There is a very large presence of development partners on the ground, in particularly NGOs such as International Red Cross, USAID funded NGOs as well as agencies such as UNICEF, IOM, American Refugee Committee, World Vision International (WVI) and WHO."[33]

1.E.3.a NGOs and donor agencies

NGOs and donor agencies (non-commercial non-state actors) proxy for the public sector and deliver free and subsidised healthcare services at clinics and hospitals across the various regions. According to the Overseas Development Institute (ODI), "Most funding for the health sector comes from international donors and is 'off-budget'. This means it is channelled directly to healthcare providers through a patchwork of projects and instruments, rather than through government systems and budgets. **Although bypassing Somali systems is unsustainable and diminishes government accountability**[34] over the longer-term, this has been a pragmatic response to poor levels of donor confidence in weak government financial systems."[35] Health sector coordination is undertaken by various stakeholders including the government (ministries of health), donors, United Nations (UN) agencies, and nongovernmental organizations. Membership of the various coordination bodies is largely constituency-based. Key challenges to coordination include the lack of high-level institutional backing for the Health Advisory Board to enforce decisions; limited capacity of the Health Sector Committee to deal with a huge volume of information beyond information sharing; and no structures being in place to bring clusters and development partners to work together.

1.E.3.b Commercial private sector

The private sector continues to grow rapidly and be the major provider of essential healthcare services for consumers and patients seeking health advice and healthcare products in Somalia. Because the health

32 Federal Republic of Somalia (2020), Appropriation Act for 2020 Budget, op. cit.
33 Danish Immigration Service (2020), Country Report: Somalia Health System, November 2020, p.26
34 Emphasis added by Cardno
35 Sorcha O'Callaghan, Director of the Humanitarian Policy Group, ODI (2020). *Beyond the pandemic: strengthening Somalia's health system*, 07 October 2020, https://odi.org/en/insights/beyond-the-pandemic-strengthening-somalias-health-system/ accessed April 11, 2021

sector remains largely unregulated, there are concerns over the quality of care provided and the impact of OOP payment practices on poor and vulnerable groups. Studies on the private healthcare system in Mogadishu have revealed it is unregulated and expensive, finding evidence of inappropriate treatment, tendency to conduct unnecessary laboratory tests, excessive use of higher diagnostic technologies and overcharging, poor patient–provider relationships, and distrust of the private healthcare system.[36] There is a clear indication of the importance of the government's role in regulation and oversight, whilst also suggesting that there could be an opportunity for provider-led quality control to help people better differentiate better quality providers.

Despite the fact that many patients turn to the private sector to meet their healthcare needs, healthcare provided by the private health facilities is often not affordable for many Somalis.[37] Salaries, remittances, and support from family are the most frequently mentioned sources of finance used to cover healthcare expenses in Somalia.[38] Considering the high cost of private healthcare which is often paid OOP, identifying ways to make healthcare more affordable and accessible for more Somalis is imperative.

1.F Healthcare sub-sectors selected for intervention, and rationale for intervening in the selected sub-sectors

1.F.1 Healthcare financing for the poor

SDC noted in the PSPH tender documents that in order for the private sector to effectively engage the public sector, one of the bottlenecks that needs to be addressed is the lack of risk pooling mechanisms as there is no equitable source of health financing.

PSPH conducted a landscaping of the literature to identify pro-poor health financing interventions that may be relevant to the Somali context. Virtually all the examples identified for the poor, rely on external aid channelled as subsidies through various demand and supply side approaches. In all contexts, the long-term sustainability of these externally funded subsidies remains a challenge. An MSD approach merits consideration in contrast to past development approaches.

As public health structures are weak and there is a strong dependence on the private sector to cater to healthcare needs, there is merit in this approach to organise and utilise private healthcare facilities through networks like Caafinet. While this can address some key supply side questions, from a health financing perspective there is a parallel need to organise the demand side and give clients a voice to balance out market forces, especially when the healthcare sector is heavily dependent on private interests. As state actors are weak, options for such a role for the private sector need to be explored further. While the private sector is key in the PSPH intervention, the public sector also needs to be engaged, especially in the long-term.

Revenue Raising for healthcare is a challenging aspect for a context like Somalia due to the high donor dependency to fund health programming. Better coordination among donors is one logical conclusion from the literature reviewed, but it does not answer the question of long-term sustainability. Experience shows that targeted humanitarian aid (subsidised vouchers, cash, or mobile money transfers, etc.) will not be effective when it comes to developing the healthcare market system. While the State has been weak, unlike during the pre-civil war period, private investments in commercial activities driven by the Somali diaspora have gradually risen. Dependence on domestically raised revenues for health seems challenging, though one aspect to further explore is innovative ways in which the current private sector can be leveraged to generate revenues that can be earmarked for healthcare. Areas like telecommunication and remittances have steadily grown in Somalia, even in times of uncertainty, with the latter in 2019 accounting for 20 percent of the nation's Gross Domestic Product and providing livelihood for 40 percent of the Somali population.[39] These

36 Gele, et al. (2017). Beneficiaries of Conflict: A Qualitative Study of People's Trust in the Private Health Care System in Mogadishu, Somalia
37 Buckley, O'Neill, and Aden (2015), op. cit.
38 Ibid
39 Central Bank of Somalia, Economics Research & Statistics Department (2018). *Annual Report 2018*.

sectors in particular could be explored to find innovative ways to generate additional revenues to pay healthcare costs for the poor.

Contributory mechanisms especially user fees at point of care are found to be hurdles in increasing access to care for poor Somalis living at the $1.90/person/day poverty line with no disposable income at all. This section of the population will rely more on health services delivered by the public sector and I/NGOs which are free. An MSD development approach is primed to serve the poor who have some level of disposable income. However, at present the private sector can likely play a significant and largely unexplored role in raising and pooling funds for healthcare on the demand side (especially from those working in the informal sector) as well as providing better value for money from the (primarily private) supply side. This would serve to expand the reach of the private healthcare sector deeper into lower-income population groups.

The premise for MSD is the ability to mobilize the existing vibrant private sector to address pro-poor healthcare needs in an economically viable manner by supporting the development of the market to grow health businesses while mobilizing revenues to enable them offer affordable healthcare to the Somali mass market (i.e. the poor).

MSD considers the poor as active market participants and their voice can help build competition amongst providers, demand better quality, improve provider responsiveness towards clients, negotiate rates/cost containment, and widen access to this mass market.

In the absence of publicly funded social health insurance, the contribution of the population ideally should be in some prepaid form (health savings or insurance) and not at the point of care when need arises (OOP expenditure). Targeting in such a context becomes important and here the definition of the target group for PSPH is important, differentiating those who can pay from those who can pay less and those who cannot pay at all. To our knowledge no such targeting mechanism exists at present in Somalia. There is also the possibility of exploring cross-subsidy payment models within the private sector businesses themselves.

While raising additional money to pay for healthcare for more of the vulnerable population is crucial, it is of course important to ensure good value for money. A mechanism needs to be developed to ensure that the limited resources to pay for the poor are optimally used and ensure that poor do not end up paying the *Poverty Penalty*, and also get better value from the money that is spent seeking health services. This translates into the pooling and purchasing functions in a health financing intervention.

Pooling revenues can lead to better redistributive effects especially when prepaid. Efforts should be made to identify how PSPH interventions can increase the pooling aspect which will also help reduce the fragmentation and duplication of effort that often occurs in such contexts, with multiple development partners and international non-governmental organizations (INGOs) supporting various population subsets. This can be in form of a coordination function established under a purchasing entity as mentioned above, an aggregator of the population (e.g. types of social structures already trusted by the community), or in form of an insurer undertaking such a role. A voucher or insurance entity or a Health Equity Fund (HEF) operator in this regard including in the private sector could be a possibility but should ideally be able to undertake a coordinating role incorporating other efforts currently underway.

Purchasing of services as observed in literature, seems to have some efficiency gains when contracting out to private providers and as well looking at the Somali context this seems quite clear. While the service provider aggregators like Caafinet are useful in this regard, a definition of a standard benefit package (established list of basic or specific targeted healthcare services) across the facilities provided at acceptable quality and negotiated rates would be important in a PSPH intervention. An active purchasing entity to undertake such contracting will go a long way and improve efficiency as well as ensure intended effects are observed from the provider side. Healthcare has a cost which cannot be removed completely (e.g. waiving user fees without off setting loss in revenue) but a balance must be met where health facilities are appropriately remunerated and able to cover their costs, while at the same time private healthcare providers are not able to unreasonably drive-up costs, which ultimately constitute barriers to access for the poor.

1.F.2 Delivery of healthcare services by private sector networks

The PSPH tender document states that strengthening health service delivery through engagement with the private sector has substantial potential to improve access and quality of health services for Somalis. To complement health financing for the poor which focuses on the demand side, PSPH will explore the nascent private provider networks as entry points for engagement of the private sector on the supply side by:

> Identifying private sector networks/organizations that can be harnessed to complement private sector engagement strategy under development.
> Building capacity of and further development of private sector networks/organizations.
> Building and institutionalizing public-private dialogue process and platform.

From previous MSD programming in health in Kenya, PSP4H found that the success or failure of an intervention is largely based on the business model adopted and how the business operates in the local environment. The business model is simply the means and methods a firm employs to generate revenues and sustainably deliver health services and products to the mass market (i.e. the low-income, economically active population which constitutes the majority of Somalis). Starting at scale by engaging with existing aggregations has been one of the most fruitful and innovative approaches explored by PSP4H. Scale-up occurs much easier when support extends to a group of partners with similar interests as opposed to working with individual enterprises and their associated value chains. Networks are a route to scale that have proven to be an effective value for money alternative to the classical 'pilot and scale up' model that is commonplace but seldom actually achieves the desired scale. Leveraging the scale within and then between health networks (e.g. between a provider network and an insurance network) presents opportunities that can be used to provide broad access to better quality and competitively priced health services.

In Somalia where policy, legal and regulatory frameworks overseeing the private sector are incipient and oversight capacity is weak, exploring private health provider networks such as Caafinet can provide a measure of oversight and enforce quality assurance in service provision through self-regulation and audit mechanisms. *Quality Audits* can be "any summary of clinical performance of healthcare over a specified period of time aimed at providing information to health professionals to allow them to assess and adjust their performance".[40] Private provider networks can develop criteria checklists for quality audits and the process coordinated by the administrative centre of the network. Checklists can be aligned with regulatory guidelines issued by government regulatory bodies such as MOH. The benefits of private sector-driven regulatory enforcement include closing the oversight gap in the private health sector which the MOHs currently have low capacity to meet, leveraging weak government enforcement capacity; and enhancing quality assurance among private providers within the network, enabling them to provide better clinical quality to their customers.

Networks could provide other membership services that provide value-added incentives to keep members in the network and attract new members whilst providing quality health services for low-income Somalis who have some disposable income.

Pooled Procurement of Essential Medicines is a membership service that could be a great attraction to providers in the network since quality assurance of pharmaceuticals products remains a challenge in Somalia. Networks would purchase in bulk from verified quality-assured suppliers and then maintain supply chain integrity. Having an arrangement where group discounts or delivery of quality assured medicines and supplies can be negotiated based on the purchase volumes providing additional value to member health providers which would positively affect their bottom line, assure genuine medicines to their patients, and allow them to pass along affordable prices.

Business Skills Training on subjects proven to be essential to the success of low-cost healthcare provision like inventory management, cash flow management, and customer care (which are common issues among private health providers) could be arranged and coordinated by the network administrator. Each of the healthcare providers within a network are private enterprises; to keep their facility doors open to Somalia's mass market, managing the business profitably while offering quality yet affordable care will need to be

40 Flottoorp, Signe, Gro Jamtvedt, et al. (2010). *Using Audit and Feedback to Health Professionals to Improve the Quality and Safety of Health Care.*

achieved. Somali healthcare professionals receive clinical training during their education but no associated training on the business of running a clinic or facility.

As the private health market continues to develop, a differentiator will begin to emerge for health providers within networks as they ensure a good level of quality assurance in their service delivery, provide quality assured medicines, and have good customer care at their clinics and hospitals amongst other benefits.

1.G Drivers and restrainers of change

Drivers and restrainers of change in the Somali private healthcare sector are analysed in Table 1-4 below, categorised by political, economic, and social forces. A broad range of influences and circumstances determine the dynamic of the overall healthcare ecosystem. Driving forces are positive forces that facilitate change. Restraining forces are negative forces that block or hinder progress.

Table 1-4 Drivers and Restrainers of Change in the Somali Private Healthcare Sector

Intensity Scale: 1 (lowest impact) to 5 (highest impact)

Drivers	Intensity	Restrainers	Intensity
Political			
Under-regulated business environment opens opportunities for rapid private sector expansion	5	Regulatory environment is underdeveloped; licensing and enforcement are virtually non-existent	5
The government needs all the help it can get from an organised private sector if UHC is to succeed	5	Overall political system is highly fragmented and in flux at time of this writing	5
An organised private sector can influence a rational regulatory regime that fully recognises the private sector's role in the ecosystem	4	Security situation is difficult; large areas of territory are insecure and unreachable	5
Donors desire to get leverage out of their development investment and want to build economically sustainable models if they only knew how	2	The public sector is addicted to donor funding and has no tax base of its own from which to build a social safety net without continued external support	5
Total Political Drivers	16	Total Political Restrainers	20
Economic			
Cash velocity is much higher than would be expected from a country with a 70.8 percent absolute poverty rate	5	Donors continue to put large sums into direct-delivery healthcare models that distort markets and drive out private sector investment	5
Private sector dominates healthcare delivery now	5	Financial markets are underdeveloped; health insurance covers less than 2 percent of the population and there is no social health insurance	5
Private sector enterprises have an imperative to grow or die	5	Healthcare finance field has high barriers to entry; high investment required and large volumes necessary to distribute risk	4
Private sector is perpetually seeking new products, markets, customers	5	Donors only want to work with the private sector as government contractors and project implementers	4
Driving up the value proposition delivered by private healthcare providers (lower costs – higher quality) is a no-lose proposition	5	Disposable income is low	3
The Caafinet network has already proven an incipient success with very little donor support, showing that it can be done in Somalia	5	Country is un-investable from the point of view of the conventional finance and banking sector	3
There are successful low-cost delivery business models that can be adapted to the Somali business environment	3	Few existing sustainable pro-poor healthcare financing models that can be ported over to Somali context; virtually all evidence is from initiatives where the donors pay the bills	3

Drivers	Intensity	Restrainers	Intensity
Successful market-based approaches to healthcare have been pioneered in neighbouring markets such as Kenya, which has a large Somali population	3	Some powerful private sector players are happy to take donor money and have no incentive to follow commercial models	2
Frontier investors can and have been successful in the Somali market	3		
Total Economic Drivers	36	Total Economic Restrainers	29
Social			
Somalis are highly entrepreneurial, resilient, and adapt to new models quickly	5	Traditional health seeking and health spending practices are deeply acculturated and difficult to change	5
Poor people with some disposable income – the mass market – are active market participants and continuously seek better value for their healthcare money; businesses that understand how to tap that will thrive	5	Donors and the public sector do not well understand private sector behaviour and incentives	3
The commercial private sector can be successful serving the mass market if they follow business models that (i) match consumer behaviour, and (ii) are affordable to lower income groups	5	Informal sector is well accepted by the population and has no incentive to formalise	3
Heavy mobile phone coverage and mobile use; virtually every family has access to at least one mobile phone	4	Misperceptions and mistrust between the public and private sectors abound	3
		Risks of moral hazard as private sector might exploit lack of regulatory enforcement	2
Total Social Drivers	19	Total Social Restrainers	16
Total Drivers of Change	71	Total Restrainers of Change	65

Source: Cardno analysis

The overall analysis indicates that forces for drivers of change exceed restrainers of change in the economic and social spheres, and restrainers of change exceed drivers of change in the political sphere. Total drivers of change exceed restrainers of change for the Somali private healthcare sector overall, indicating that positive change is indeed possible for the PSPH programme.

1.H Stakeholder analysis

Stakeholders have been analysed by group in Table 1-5 below in order to assess their power, interest, level of support for the project, and engagement strategy. Definitions follow the table.

Table 1-5 Stakeholder Analysis Table – PSPH

Stakeholder Group	Power	Interest	Level of Support for the Project	Engagement Strategy	Notes
SDC	HIGH	HIGH	5. Leading	Active engagement	Power: SDC is the sole funding agency for PSPH and holds ultimate influence on its future. Interest: A successful programme following on the unexpected success of the Caafinet pilot will support overall health systems strengthening.
Other donors	LOW	MED	Ranges from 1. Unaware to 2. Resistant to 3. Neutral	Keep informed	Power: Other donors have low power to stop or change the programme as they do not contribute financially to PSPH, and it is not a component of a larger donor programme. Interest: Overall health sector donor coordination is weak. Some donors are unaware of the

Stakeholder Group	Power	Interest	Level of Support for the Project	Engagement Strategy	Notes
					programme; those that are aware are primarily neutral. However, the World Bank is introducing a large health sector programme later in 2021 and they have been resistant to open coordination with SDC's Horn of Africa office. The World Bank has convened several coordination meetings with the MoH and other donors concerning their forthcoming programme.
Government / MOHs	HIGH	MED	Ranges from 2. Resisitant to 4. Supportive	Keep satisfied	Power: The Ministries of Health have the power to obstruct the programme if they are not satisfied. Interest: The Ministries of Health in general are supportive of health systems strengthening and increased private sector involvement. They have expressed support during the planning phase. With proper communication the government entities can understand and fully support programme contributions. There is the potential for government entities to be resistant to the programme as PSPH does not offer direct government assistance and does not offer cash or financial support as do other donor programmes.
Implementers (multilaterals and NGOs)	LOW	MED	Ranges from 1. Unaware to 2. Resistant to 3. Neutral	Keep informed	Power: Implementers have low power to stop or change the programme as they do not contribute financially to PSPH, and it is not a component of a larger donor programme. Interest: Coordination among health sector implementers is weak, primarily opportunistic coordination between individual implementers. Some implementers are unaware of the programme; those that are aware are primarily neutral. The possibility exists that some may resist the raised profile of the commercial private sector.
Commercial private sector	HIGH	HIGH	Ranges from 1. Unaware to 5. Leading	Active engagement	Power: The commercial private sector can make or break the programme. Deep participation will lead to successful outcomes whereas lack of interest will lead to failure, as the programme's MSD approach is dependent on market uptake. Interest: Many private sector players and associations are as of yet unaware of the programme beyond consultations during planning phase research. Caafinet is heavily involved in health sector development, is committed to work with PSPH to further develop and expand and is a leading supporter.
Traditional healers and informal providers	LOW	MED	Ranges from 1. Unaware to 2. Resistant to 3. Neutral	Monitor	Power: Traditional healers and informal providers have little power to stop or change to programme. Interest: This group is primarily unaware of the programme. Some may resist the formalization of networks; however, most would be expected to see it as ancillary to their interests and remain neutral.
Community groups	LOW	MED	1. Unaware	Monitor	Power: Community groups have little power to stop or change to programme. Interest: Community groups are primarily unaware of the programme beyond those interviewed during planning phase research. Their support would be expected once they become aware.
Individuals	LOW	HIGH	1. Unaware	Keep informed	Power: Individuals have little power to stop or change to programme.

Stakeholder Group	Power	Interest	Level of Support for the Project	Engagement Strategy	Notes
					Interest: Individuals are primarily unaware of the programme beyond those interviewed during planning phase research. Their interest would be expected to be high once they become aware.

Source: Cardno analysis

Definitions used in this stakeholder analysis table:[41]

Power: Their power to stop or change the project

Interest: The size and location of the overlap between their interests and the project's goals

Engagement Strategy: The type and frequency of communication

Interests include factors such as: Financial interests, business interests, political interests, moral and ethical values, religious beliefs, demographics, et al.

Level of support:

1. Unaware
2. Resistant
3. Neutral
4. Supportive
5. Leading

Unaware – They are not aware of the project and its potential impacts on them

Resistant – they are aware of the project but not in support of it

Neutral – they are aware of the project but have no opinion regarding their support for it

Supportive – they are supportive of the project and wish it to succeed

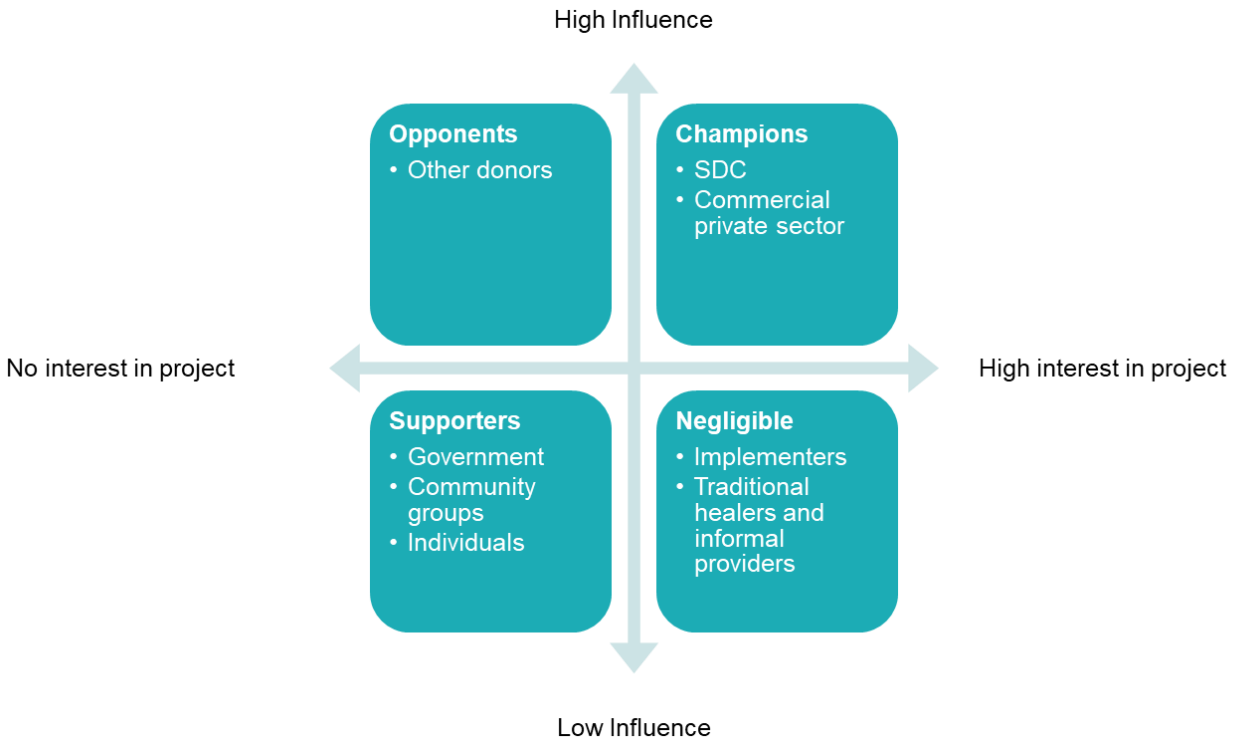
Leading – They are actively engaged in project success and willing to lend assistance to help it succeed.

Assessing the engagement approach for PSPH, both SDC and the commercial private sector require active engagement, government stakeholders must be kept satisfied, donors, implementers, and individuals must all be kept informed, and community groups must be monitored.

Stakeholders may be mapped graphically into an Interest-Influence Matrix (Figure 1-4):

41 https://www.projectengineer.net/ accessed April 20, 2021

Figure 1-4 Stakeholder interest-influence matrix



Source: Cardno analysis

Key individual stakeholders with their relationships and interests are enumerated in detail in the stakeholder Tables under Chapter 3, Describing the Market System.

1.I Gender considerations

Human Rights are guaranteed in the Federal Constitution and with federalism steps have been made since 2020 by the establishment of a committee on women, human rights, and humanitarian issues in South West State[42] and other states are considering similar moves.

Overall, the women of Somalia (approximately 50 percent of the population)[43] are far from equal to men and are placed 4th highest on the gender inequality index (Index: 0.776 where 1 denotes complete inequality).[44] Women bear an unequal brunt of the hardships occasioned by poverty, conflict, and clan–based culture which promotes strict hierarchy and authority. This is further exacerbated by religious and cultural limitations on the role and status of women in Somali society. As a result, deeply rooted gender inequality prevails. Adult literacy in 2006 was 26 percent for women compared to men at 36 percent.[45] Women are lacking access to fundamental tools such as healthcare, education, and financial credit.

With the on-going presence of Al Shaabab, gender-based violence which is heightened in areas of conflict remains high especially vulnerable being displaced women and girls.

Women's access to justice is restricted both within the formal and clan based judicial systems where corruption often prevails. Traditional or customary law is applied more instead of state judiciary. Sexual and gender-based violence often goes unpunished particularly as traditional Somali society does not mention such issues. The practice of female gender mutilation is legal where 98 percent of Somali girls have undergone this before they turn 13 years.[46]

42 UN Security Council (2020). August 2020 Situation in Somalia https://www.undocs.org/en/S/2020/798
43 https://borgenproject.org/womens-rights-in-somalia/
44 UNDP Somalia: Gender in Somalia
45 United Nations Development Programme (2012). Somalia Human Development Report 2012: Empowering Youth for Peace and Development, p. 54.
46 https://data.unicef.org/resources/fgm-statistical-overview-and-dynamics-of-change/

Women's access to health services are limited. Maternal mortality rates are high; in 2017 Somalia had the fifth highest maternal mortality rate globally of 829 deaths per 100,000 live births (compared to its neighbour Kenya of 342 deaths per 100,000).[47] The maternal mortality rate is currently 692 per 100,000 as per the SDHS 2020.[48] Demand for MNCH services is high with a total fertility rate of 6.9; however due to access issues although at least 12 – 13 antenatal visits are recommended, only 24.4 percent of women who sought antenatal care made 4+ visits, while 55.8 percent made 2 – 3 visits and 18.9 percent made only one visit (there are no statistics on the proportion of women who make no antenatal visits whatsoever).[49]

Child marriage is common with 45 percent of women aged 20 to 24 years are married before the age of 18 years.[50] With young marriages frequent, obstetric fistula remains a relatively common occurrence in Somalia.[51] However, it is estimated that only one woman in 50 has access to fistula treatment.[52]

There is a notable absence of women in the higher levels of government such as director general and head of department levels. The limited participation and role of women in politics and decision-making spheres compounds their narrow gender-based roles and further deepens inequalities. Women comprise more than 75 percent of the health workforce yet occupy approximately less than 10 percent of leadership positions at local, state, and national levels as well as in INGOs and government bodies.[53]

In terms of women's economic empowerment, women in Somalia generally have a weak position in the labour market and represent a large proportion of people in vulnerable employment. With an overwhelming pastoralist economy, livestock represents the family's wealth and has traditionally been the property of men – however women often manage the sale and exchange of livestock products such as milk and spend their earnings on household needs.[54] Economically, women have made some gains, expanding into employment and livelihood sectors traditionally held by men; women's participation in wage employment in the non-agricultural sector is highest in Puntland (40 percent) followed by Somaliland at 36 percent and 33 percent in South Central State.[55]

PSPH will be mindful of the above-described gender-based barriers and how these may limit women's access to the proposed interventions. The programme will aim to establish linkages between women service providers with private sector networks to improve access to skills and financial services. In relation to the MSD approach, PSPH will engage with the misconception that women's (economic) empowerment is 'socially' driven and has nothing to do with markets. This has already started in the planning phase by looking into women's constraints in the market diagnosis and intervention design step and making sure to involve women and men providers of health services, and also taking the health financing needs of women and men into account.

For instance, when arranging a training or a marketing event, the programme will recognize how women's lack of mobility and care duties may prevent them from participating and then select a venue and timing that accommodates accordingly. Mainstreaming in this sense does not necessarily address the root causes of gender inequality nor targets women's constraints, but at least allows PSPH to be responsive, and to facilitate broader, more inclusive reach so that both men and women will benefit from interventions. Mainstreaming tactics are essentially about 'opening and leaving the door open', so they help when women are 'invisible' players, or we need – as in this case – to challenge gender stereotypes that market engagement may not target women by believing they do not have economic power.

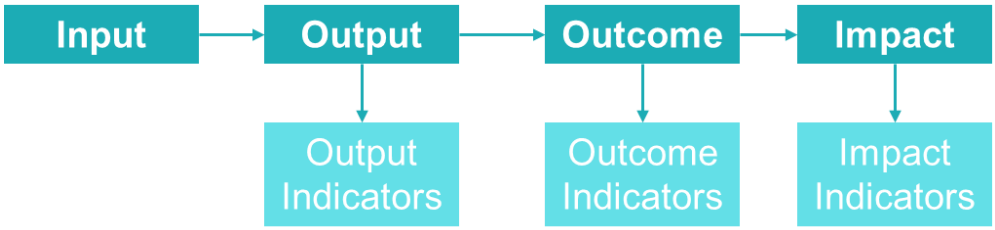
The PSPH methodology for engagement of intervention partners includes a screening mechanism that will ensure pre-screening for gender inclusion as well as considering adverse unintended consequences to vulnerable groups. To track our progress in involving women in PSPH interventions, the logframe will make use of indicators that are disaggregated by gender.

47 https://photius.com/rankings/2020/population/maternal_mortality_rate_2020_0.html
48 SDHS (2020) op. cit. p. 274
49 Ibid, pp.108-109
50 United Nations Development Programme (2012), op. cit. p.xviii.
51 United Nations Somalia (2020), UN Somalia Country Results Report 2019, p.38
52 https://www.figo.org/news/eradicating-obstetric-fistula-somalia accessed April 24, 2021
53 https://www.womeningh.org/wgh-somalia accessed April 23, 2021
54 United Nations Entity for Gender Equality and the Empowerment of Women (2012). Somalia Humanitarian Strategy 2012-2015 (draft)
55 http://www.so.undp.org/index.php/Millennium-Development-Goals.html

1.J Intervention logic/theory of change

Results chains (Figure 1-5) demonstrate the intervention logic and define the cause-effect hypotheses between the inputs of an intervention and the different results. Results chains may be represented in various ways, for example through a logframe or a theory of change.[56]

Figure 1-5 Results chain



Source: SDC Swiss Agency for Development and Cooperation (2020). SDC Quality Assurance, SDC Guidance on Results Indicators, p.4

1.J.1 Intervention Logic / Theory of Change for PSPH

By helping private sector healthcare finance and service delivery providers better understand the extent, capacity, and behaviour of Somali healthcare consumers, and how they can serve needs of the unserved and underserved in a systemic, scalable, economically viable manner, private sector providers will expand and introduce innovative healthcare finance and service delivery business models to the market that will enable Somali citizens, including the most disadvantaged groups, with better access to quality and affordable healthcare.

1.J.2 Inputs / Activities

> Capacity building and training (e.g. business skills and governance)
> Introduction of innovations and pilots to Somali environment
> Market research and testing
> Economic research and business modelling
> Partnerships and linkages
> Public-private dialogue
> Recruitment of market-based intervention partners with appropriate incentive and capacity into the programme

These inputs pertain to both output areas.

1.J.3 Outputs

> Innovative formal and informal healthcare financing mechanisms that benefit the poor are operating in the market and demonstrate commercial viability, effectiveness, and scalability.
> Organised private sector healthcare service provider associations and networks are operating in the market and demonstrate commercial viability, effectiveness, and scalability.

1.J.4 Outcomes

> Poor Somalis are able to access better quality and affordable healthcare through the provision of innovative financing mechanisms and safety nets.
> Organised private service providers deliver quality and inclusive health services across the country, including areas of difficult access.

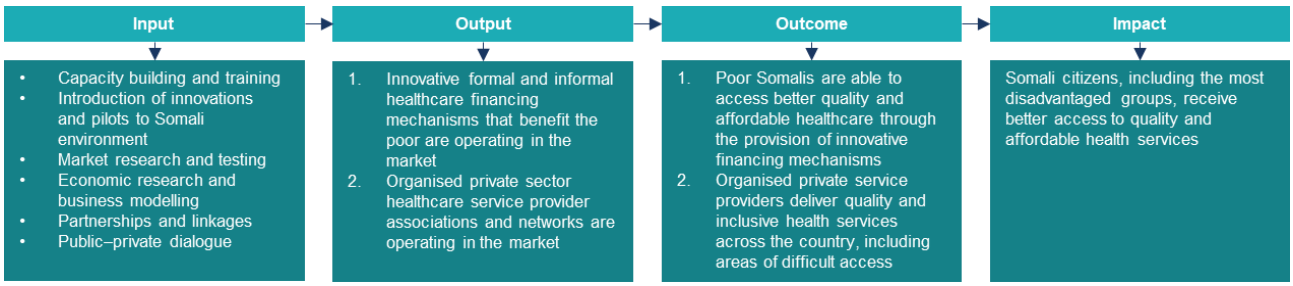
56 Swiss Agency for Development and Cooperation (2020). SDC Quality Assurance, SDC Guidance on Results Indicators, p.4

1.J.5 Impact (overall objective of the programme)

Somali citizens, including the most disadvantaged groups, receive better access to quality and affordable health services.

The consolidated results chain showing the overall intervention logic for PSPH is depicted in Figure 1-6 below:

Figure 1-6 Overall results chain for PSPH

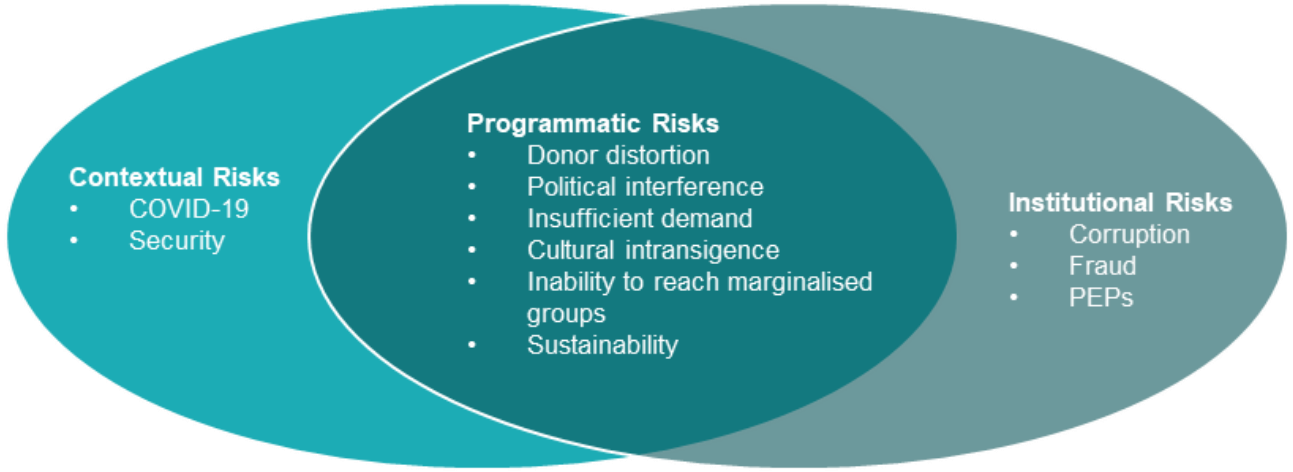


While the intervention logic shown in the consolidated results chain above is for the entire PSPH programme, each individual intervention within the programme will have its own results chain demonstrating its intervention logic and defining the cause-and-effect between inputs and results. From the individual results chains, a measurement plan following the DCED standard will be derived for each intervention. The cumulative results gathered from the individual interventions feed into the overall programme objective of improved access to quality and affordable health services for all Somalis.

1.K Key risks

Key risks identified for the PSPH programme have been categorised per the OECD “Copenhagen Circles” model (Figure 1-7) as either contextual, institutional, or programmatic, and then prioritised by intensity (probability x impact) within each category.

Figure 1-7 ‘Copenhagen Circles’ risk categorisation for PSPH



Source: Cardno analysis

A summary of these key risks is shown in Table 1-6 below.

Table 1-6 Summary of key risks for PSPH

Risk	Probability	Impact
Contextual Risks		
COVID-19	High	High
Security	High	High
Institutional Risks		
Corruption	High	Medium
Fraud	Low	High
PEPs	Low	High
Programmatic Risks		
Donor Distortion	High	High
Political Interference	Medium	High
Insufficient Demand for Programme Services	Low	High
Cultural Intransigence	Medium	Medium
Inability to Reach Marginalized Areas and Disadvantaged Groups	Medium	Medium
Sustainability	Low	Medium

Source: Cardno analysis

Implications of the risk analysis are that the contextual risks of working in Somalia are of high intensity due to ongoing security issues (e.g. political instability, large areas of the country out of central government control) and the uncertain future of the COVID-19 pandemic (at time of writing) where there is an under-resourced health system. These risks are not unique to the PSPH programme, nor are they within the direct control of the programme. The institutional risks of corruption are high while fraud and exposure to PEPs are medium, again not unique to PSPH, but these can be mitigated with appropriate programme design and financial control measures.

The risk of the programme supporting Politically Exposed Persons (PEPs) (i.e. an individual either currently or formerly in high public office, or closely associated with such office for family or personal reasons or as a result of business relations) is medium (low probability x high impact) as the programme will have an active screen in place to reject dealing with PEPs prior to investing resources in an intervention.

Most of the identified risks fall into the programmatic category and are of varying intensity. The highest programmatic risk comes from donor distortion, with external donor funds working counter to sustainability and disincentivising private sector investment as well as diminishing public sector accountability. The risk of political interference is also of high intensity. Medium intensity programmatic risks are insufficient demand for programme services, cultural intransigence, and the inability to reach disadvantaged groups and marginalised areas; and there is low risk of not being sustainable post-programme exit. Programmatic risks can be managed with appropriate programme design, careful monitoring, and adaptive management.

Please see the detailed risk matrix in Appendix A that addresses both the main risks for the project and mitigation measures.

2 Methodology

The MSA is based on data from both primary and secondary research.

2.A Primary research

Due to the combination of risks posed by the COVID pandemic and the fluctuating security environment during the timeframe allocated for the assessment, it was decided to limit the primary research to key informant interviews (KIIs) and patient exit interviews, to avoid gatherings such as would be necessary to run

focus groups. The primary research thus comprised a total of 50 KIIs supported by approved interview guides with representatives from associations/networks, community representatives, insurance companies, mobile telecom operators, MOHs, NGOs and implementers, private providers, and public providers in Mogadishu, Kismayo, Galkayo, and Hargeisa; and 110 clients (i.e. patient) exit interviews conducted at hospitals in these same locations. The patient interviews were across 86 private for-profit providers and 24 public health facilities. Interviews were conducted in March and April of 2021.

2.A.1 Key informant interviews

Table 2-1 summarises the KIIs by category and location and Table 2-2summarises the client interviews by location and ownership.

Table 2-1 Key informant interviews by category and location

Location Category	Mogadishu	Kismayo	Galkayo	Hargeisa	Total Per Category
Associations/networks	2	0	0	4	6
Banks	1	0	0	0	1
Community representatives	7	6	5	6	24
Insurance companies	2	0	0	2	4
Mobile operators	1	0	0	2	3
MOH officials	2	0	0	1	3
NGOs/implementers	2	0	0	1	3
Private providers	2	0	0	3	5
Public provider	1	0	0	0	1
Total Per Location	**20**	**6**	**5**	**19**	**50**

PSPH conducted interviews with two key consumer groups – clients/patients of health services, and community representatives as a proxy for individuals who may not be accessing private health services. The purpose of these interviews was to describe and better understand the health seeking behaviours of the target population. Two different strategies were used to target these individuals:

> Client exit interviews targeted individuals who are already accessing services at private and public providers;
> Community interviews targeted community representatives representing prospective clients of private facilities who may not be accessing private health services.

2.A.2 Client exit interviews

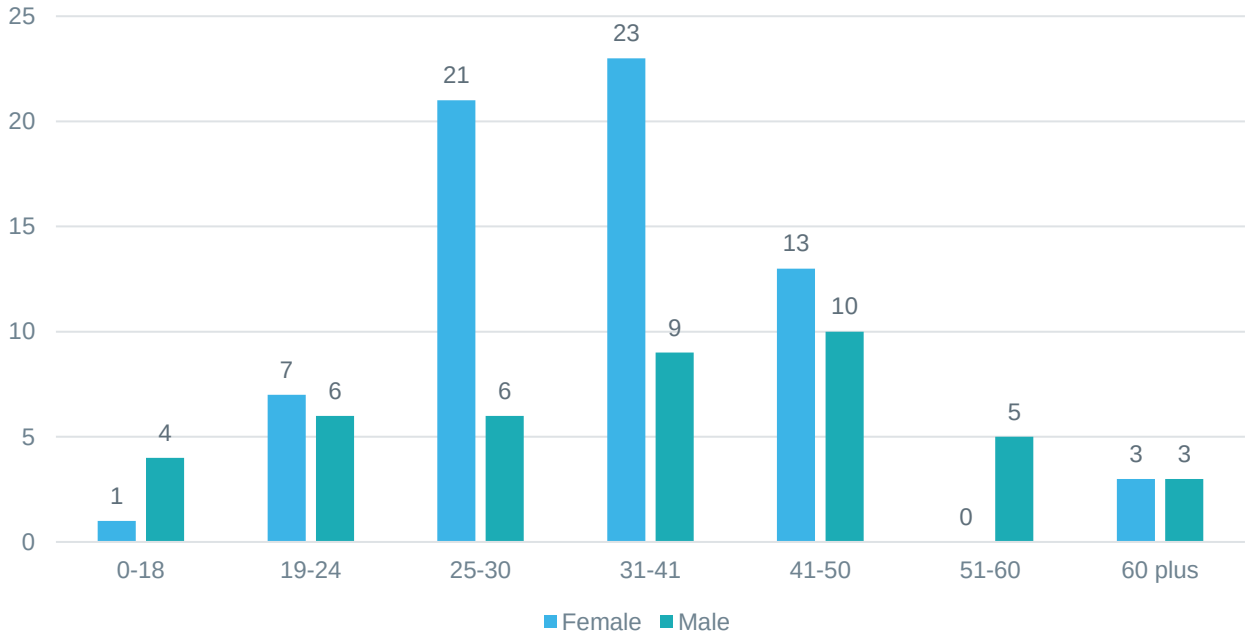
Interviews (110) were conducted in public and private health facilities located in the urban areas of Mogadishu, Kismayo, Galkayo and Hargeisa.

Table 2-2 Breakdown of client interviews by area and ownership

Region	Private	Public	Total
Galkayo	16	4	20
Kismayo	16	4	20
Mogadishu	24	8	32
Hargeisa	30	8	38
Total	**86**	**24**	**110**

The majority of respondents were female between 25-40 years. Figure 2-1 provides details of the age and gender profile of interviewees.

Figure 2-1 Gender and age profile of interviewees



2.A.3 Community representatives

Interviews (n = 24) were conducted in urban areas of Mogadishu, Galkayo and Hargeisa. These were community representatives from youth, people living with disabilities, women, and informal sector groups.

As noted in both the client exit interviews and community representative interviews, there are perspectives of the target audience that we can infer from comments made by the respondents in both groups.

> They indicated the unpredictability of health emergencies and accidents and that they are often not prepared to meet the costs of these emergencies when they occur. Either they do not have enough savings, or these emergencies can be significantly large requiring more funds than they can organise.
> Affordability of services was a challenge; respondents perceived healthcare services as expensive and would prefer to have less costly services.
> Donor dependence came out strongly, with requests for continued humanitarian agencies to support their access to free healthcare services.
> The role of the public sector cannot be overlooked; respondents noted the need to increase public health services to provide more coverage.
> Despite the relatively high approval ratings on the perceived quality of health services, respondents stated there was a need to increase the quality of health services provided at both public and private health centres.

2.B Secondary research

Secondary research was based on literature review of key documents published, grey literature, statistical data related to the Somali health market, and internet research. Some key documents used as reference include:

> Somali Health and Demographic Survey (SHDS) and Somaliland Health and Demographic Survey (SLHDS), United Nations Population Fund (UNFPA) for the respective governments, 2020.
> Strategic Guidance for Engaging the Private Sector Through Private Partnerships in Health Services in Somalia, Philanthropy Advisors for the Federal Government of Somalia, July 2020;
> Final Analysis on the Market, Systems, Gender and Consumers in Somalia and Somaliland (technical backstopping to SDC's tendering process related to the Private Sector Partnerships for Health), Halcyon Consulting for SDC, November 2019;
> Assessment of the Private Health Sector in Somaliland, Puntland and South Central, Oxford Policy Management for DFID (now FCDO), March 2015;

See Appendix B for a full bibliography.

2.C Limitations of the methodology

Several limitations were faced during data collection, as outlined below:

> **Inability to use certain research methods like focus group discussions (FGDs):** Due to COVID protocols and security guidelines, the field team was unable to gather groups of people for FGDs as a tool for information gathering and data collection.
> **Inaccessibility of health providers because of the heavy COVID case load:** The study was conducted in a period when there was a surge of COVID-19 cases and health service providers were overwhelmed. It was difficult to physically conduct all the key informant interviews, with frequent rescheduling and cancellation of appointments. Some interviews were conducted over the phone while other respondents chose to send written responses via email. This may have affected the depth of the collected information.
> **Inaccessibility of government officials:** In addition to the COVID-19 pandemic, the study was conducted during a period of heightened election-related insecurity and political tension in Somalia and as a result, government officials were busy, some did not answer calls, while others were working from home. It was difficult to physically conduct all the planned government KIIs. As a result, some targeted government officials were not interviewed and when they were, tight timelines had to be further extended. Where possible, implementing NGOs that work closely with the government helped to reflect policy considerations, backed by secondary data.
> **Short study timeline:** Owing to the short study timeline and limitations on movement at the time of study, the client exit interviews were only done in urban settings (Hargeisa, Mogadishu, Kismayo, Galkayo), thereby missing out on the experience of rural areas. The primary findings are not representative of the rural populace.
> **Security restrictions in some marginalised areas:** Some marginalised areas would not be reachable due to security considerations regardless of the timeline.
> **Some information lost in translation:** Interviews were conducted in the local Somali language with transcription/translation done by the Somali field team. The understanding and application of meaning of various words or terminologies may affect the quality of translation to convey the precise responses of the interviewees.

3 Describing the Market System for the Selected Sub-Sectors

3.A The core

3.A.1 Demand side (healthcare consumers)

The Federal areas of Somalia have a population of 16.2 million people at an annual population growth rate of 2.9 percent.[57] 46.8 percent of the population is urban. The Somali population is youthful with a median age of 16.7 years. The largest age group is the under 14 years bracket (46.1 percent) followed by those between 25 and 54 years (26 percent); Only 6.6 percent of the population is over 55 years (see Figure 3-1). The ratio of female to male is almost equal at 50.81 percent (female) to 49.9 percent (male).[58] The average household size in Somalia is 6.2 persons.[59]

Somaliland's population is projected at 4.2 million in 2020 and the bulk of the population living in urban centres. Somaliland has a young population with 37.8 percent of the population being less than 15 years old, and roughly 72 percent of the population under 30 years. The population growth rate is high at 3.1 percent.[60] [61]

57 Worldometer https://www.worldometers.info/world-population/somalia-population/ accessed April 11, 2021
58 Ibid
59 SHDS (2020), op. cit.
60 Population Data Net https://en.populationdata.net/countries/somaliland/ accessed April 11,2021
61 SHDS (2020), op. cit.

Figure 3-1 Somalia 2020 population by age groups

Source: Worldometer- Somalia Population[62]

Almost half of the population live in urban areas while approximately 26 percent live in rural areas. The nomadic population constitute a quarter of the population while 9 percent are internally displaced persons (IDPs).[63] Factors like the high percentage of youth and urban dwellers, a significant percentage of pastoralists and IDPs are important considerations when looking at the demand for health services in Somalia.

3.A.1.a Definition of the target audience

3.A.1.a.i Demographic profile as seen by economists

Somalia is one of the poorest countries in the world. Just over half of people are economically active and the predominant sectors of economic engagement are livestock and agriculture. The overall economy remains severely under-developed and under diversified.[64] The rate of poverty, defined as expenditure for consumption lower than the international poverty line of US$1.90 a day, is 70.8 percent.[65] Despite the decades of conflict in the past, Somalia's GDP has been on a growth trajectory, averaging 3.5 percent (real GDP growth) between 2012 and 2017, growing 2.8 percent in 2018 and 2.9 percent in 2019 before the COVID-19 pandemic impacted growth in 2020 (-1.5 percent).[66] The economy is projected to recover in 2021 at a rate of 2.9 percent, according to the most recent World Bank Figures.[67] The inflation rate was moderate during the same period. The country's GDP is dominated by imports and private consumption of which household consumption is largely financed by remittances.[68] Remittances make important contributions to welfare, with one in five Somali households receiving them.[69] Somalis in the diaspora remit over US$1 billion annually, making up between 20 percent and 40 percent of Somalia's GDP.[70] While the impacts of the COVID-19 pandemic on Somalia's financial sector are ongoing, the country has seen a drop in remittances from a pre-COVID estimate of 32.4 percent of GDP to a post-COVID estimate 31.4 percent of GDP for 2020.[71] Recipients depend heavily on these transfers and their reduction or absence is a major risk for falling into poverty.[72]

The revenue-to-GDP ratio is one of the lowest in the world at 3 percent.[73] Domestic resource mobilization is very weak in Somalia and in order to raise domestic revenues to fund public health and education, substantial efforts are required to increase tax collection. Effective policy reforms will need to be

62 Worldometer https://www.worldometers.info/world-population/somalia-population/ op.cit.
63 UNFPA (2014). Population Estimation Survey 2014.
64 Mazzilli, Caitlin and Austen Davis. UNICEF (2009). *Healthcare Seeking Behaviour in Somalia* (Report 10) - A Literature Review.
65 World Bank (2021), op. cit.
66 Ibid
67 Ibid
68 Somalia National Development Plan 2017-2019, op. cit.
69 World Bank (2017). Somali Poverty Profile: Findings from Wave 1 of the Somali High Frequency Survey.
70 US Department of State (2020). Investment Climate Statements: Somalia. https://www.state.gov/reports/2020-investment-climate-statements/somalia/ accessed April 8, 2021
71 Federal Government of Somalia (2021). Somalia Socio-Economic Impact Assessment (SEIA) of COVID-19, March 15, 2021
72 World Bank (2017), op. cit.
73 Ibid

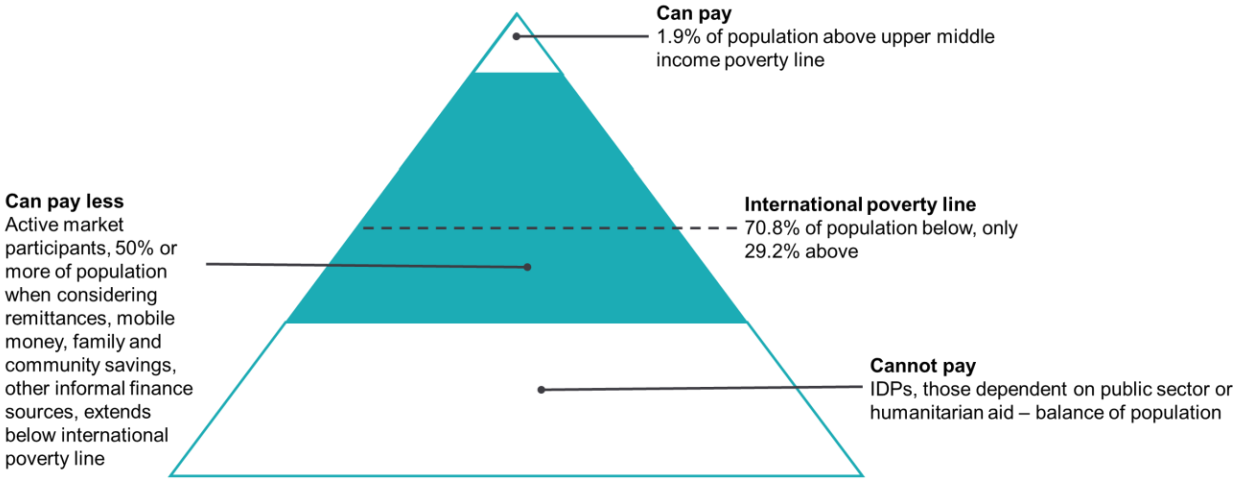
implemented and enforcement mechanisms put in place, which are not easy, short-term changes. Robust revenue growth will give development partners confidence to continue providing more assistance to the government to finance operating budget; however, while donor assistance can temporarily bridge the fiscal gap it is not a sustainable solution and in fact disincentives efforts at domestic revenue generation.

These economic facts only buttress the reality that the public sector is not currently financially resourced to run health facilities relative to the private sector in Somalia. While the public sector will be able to run some facilities, it will likely not be able to run enough facilities for the entire country. With heavy fiscal constraints and in order to effectively use meagre revenues, regulatory oversight is a key area the Ministry of Health can focus on, to ensure that the private sector is properly regulated to complement the government's sparse health delivery and support public health objectives.

3.A.1.a.ii Demographic profile as seen by the private sector (i.e. can pay, can pay less, cannot pay)

Looking at the entire Somali health market, while 70.8 percent of the population is living under the $1.90 a day poverty line, the population can further be categorised using alternative measures. There are 29.2 percent with some disposable income who are able to pay for some services; only 1.9 percent of the population is above the upper-middle-income poverty threshold, and this is clearly the 'can pay' group for private providers as they currently see the market (e.g. the current coverage of formal health insurance is estimated to be under 2 percent). Within the 70.8 percent, there are IDPs and other indigents with no income whatsoever who cannot pay at all for health services – this group would need humanitarian assistance and cannot be targeted by a market-funded approach; and there are also those who have income when needed from various informal sources (remittances, borrowings, informal saving plans, family and community donations et al.) and 'can pay less'. It must also be recognised that healthcare events are considered within the context of the family and family resources are pooled when one family member needs to pay for healthcare, significant when considering that the average household size in Somalia is 6.2 persons. Defining what percentage of the mass market 'can pay less' is critical as they form the primary target audience for PSPH. It is reasonable to assume that this group may extend to half or more of the population, as this is the proportion estimated as economically active.

Figure 3-2 The Somali Healthcare Market as Seen by the Private Sector



Source: Cardno analysis

Figure 3-2 illustrates that the Somali 'can pay less' economically active mass-market group extends well below the international poverty line.

In comments from respondents in both the community representative and client interview groups cited above, affordability of health services was a challenge to many. Respondents perceived private healthcare services as expensive and would prefer to have lower cost services. Donor dependence (and consequent market distortion) came out strongly with requests for continued humanitarian support for access to free

healthcare, which is unsustainable and can only serve as a short-term measure. This is rationale for PSPH to intervene in healthcare delivery areas not heavily donor-dependent, so the private sector has incentive to invest, to foster low-cost, high quality business models, and to help the private sector understand and target the behaviour, scale, and capabilities of the underserved population. Respondents also indicated the unpredictability of health emergencies and accidents, stating that they were often not prepared to meet the costs of these emergencies when they occur. This is the rationale for PSPH to help the private sector organise health financing models, both formal and informal, that pool risk and organise purchasing while matching consumer behaviour and revenue-raising capacities.

3.A.1.b Health seeking behaviour

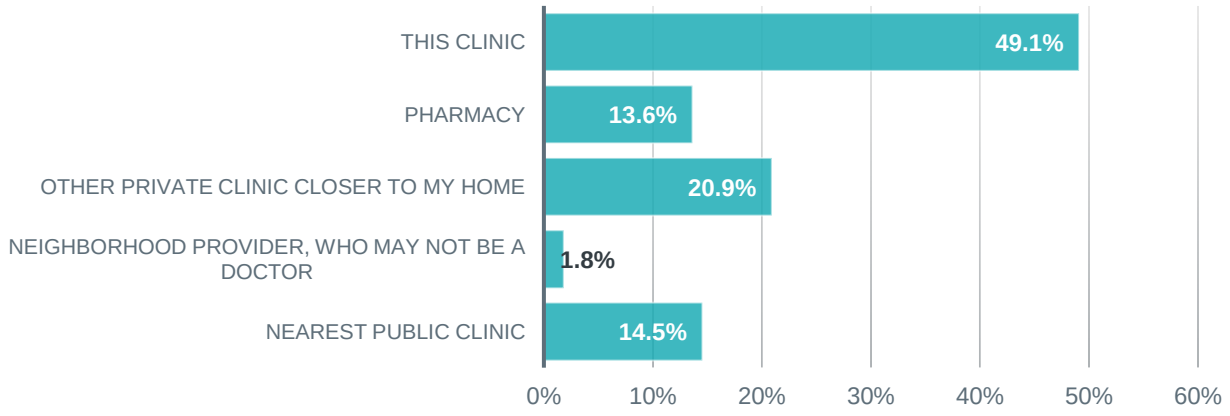
3.A.1.b.i How and where the target group seeks services

People often do not seek one source of care and how they seek healthcare is determined by who is affected and what diseases are experienced. Health seeking behaviour is also affected by beliefs of causation behind certain diseases, such as evil eye, infection, or accident. The decision to seek care is influenced by opportunities to seek care, especially time and cost. These decisions are not isolated to individuals but are embedded in a broader household and social and societal organizational structures.

Client Interviews

Point of access for healthcare services: Forty-nine percent of respondents in the client exit interviews reported that the point of interview was their usual first point of access to healthcare services (Figure 3-3). The majority (84.6 percent) go to a formal healthcare provider either a public or private health facility. 13.6 percent indicated pharmacies as their first point of contact while 1.8 percent have their first contact of care as informal care givers who may not be doctors. The main reasons given for their facility selection were proximity to their home, cost and quality in that order.

Figure 3-3 First point of contact for treatment



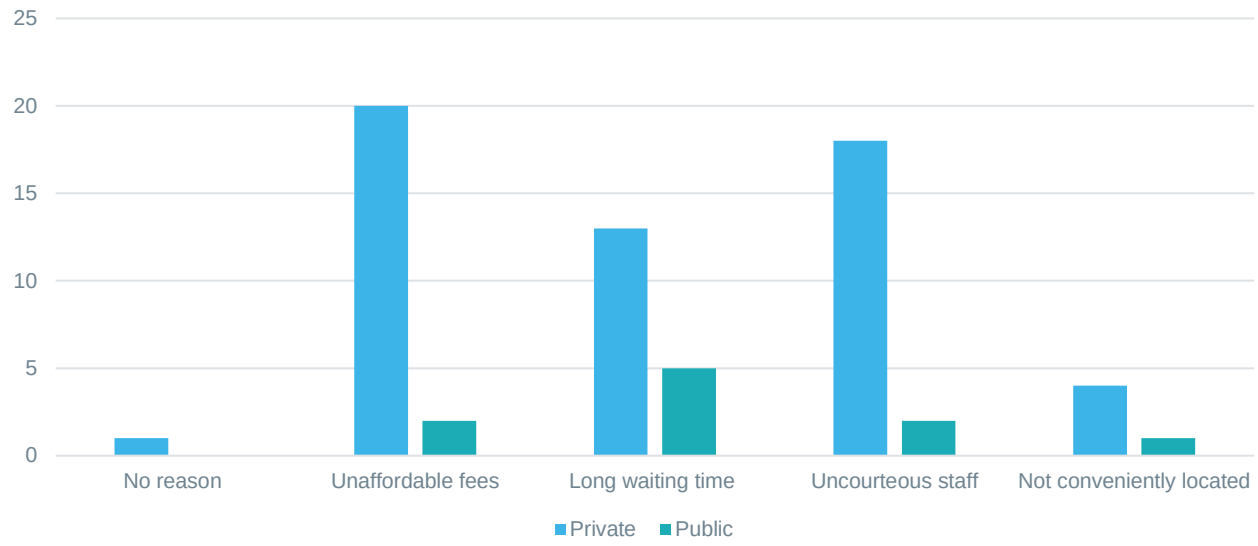
Physical access to the surveyed facility: Fifty-eight percent of respondents reported it took them 30 minutes or less to reach the facility they were being interviewed at. However, 17.3 percent of them took more than one hour to reach the health facility. A quarter of respondents in Hargeisa and Kismayo reported taking more than one hour to reach the health facility, 12.5 percent of respondents in Mogadishu, while none of the respondents in Galkayo reported taking more than an hour to reach the health facility. This may indicate challenges in geographical access to healthcare in Hargeisa and Kismayo.

Reasons for bypassing their nearest facility: Forty-three percent of respondents visited facilities closest to where they live while 57 percent bypassed their nearest facility. For those who bypassed their nearest

facility, 32 percent reported the nearest facility they had bypassed was private for profit, while only 10 percent reported the nearest facility they had bypassed as public.

Respondents were also asked the reasons for bypassing their nearest facilities (Figure 3-4) and PSPH analysed these responses by facility type – either private or public. The top three most frequently cited reasons by respondents from private facilities for bypassing health facilities closest to their home were that these particular facilities had unaffordable fees, uncourteous staff and long waiting times. For respondents from public facilities, the most frequently cited reasons were long waiting times, uncourteous staff and unaffordable fees, in order of incidence.

Figure 3-4 Reasons for bypassing their nearest facility



Services accessed at the surveyed facility: In terms of services accessed, most respondents (97 percent) had received an outpatient service and 3 percent an inpatient service with an average length of stay of 4.3 days. All respondents from public facilities accessed an outpatient service. The majority of respondents indicated that the medical personnel prescribed two or more services at the health facility where they were surveyed (Figure 3-5). Whereas most patients were able to access the medicines and laboratory tests they required, access to imaging, theatre, and specialist consultation were not available at most health

facilities surveyed (Figure 3-6). This caused patients requiring these services to travel elsewhere resulting in more time spent accessing care and using additional funds.

Figure 3-5 Services prescribed / needed at the surveyed facility

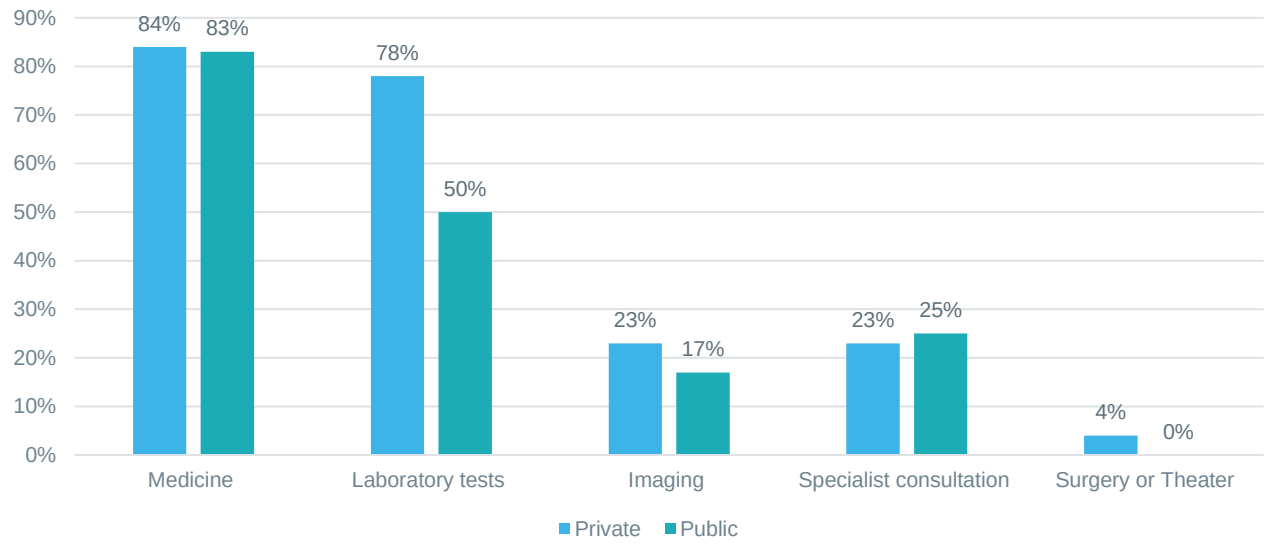
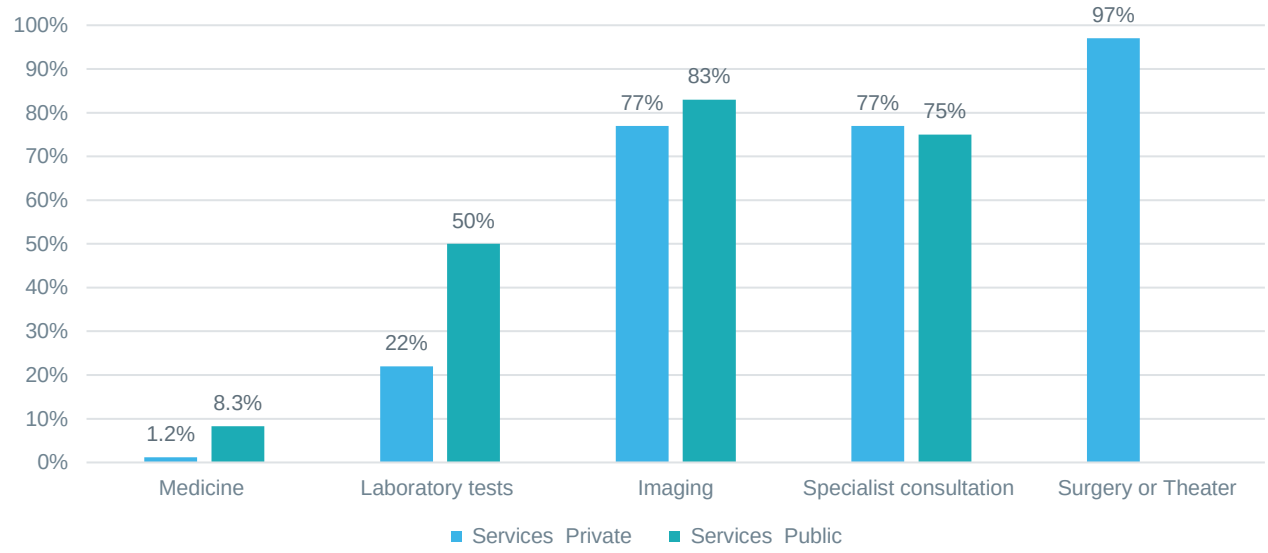


Figure 3-6 Prescribed services that were not available



Community representatives' interviews: Most of this information from the client exit interviews was corroborated by the community interviews. In general, there was a preference to access private facilities in Galkayo and Hargeisa, but Mogadishu interviewees stated a preference for public facilities. Perhaps this is an indication that public services are much better and easily accessible in the capital city – Mogadishu. In addition, pharmacies were commonly mentioned as a point of access to healthcare services.

From secondary research, the Food Security Assessment Unit (FSAU) managed by the UN Food and Agriculture Organisation (FAO) collects, analyses, and disseminates information on the overall food and nutrition security situation in Somalia. The summary table below insights on different health seeking

behaviour trends of pastoralists, agro-pastoralists, riverine and IDP communities, as well as comparisons between zones.[74]

Table 3-1 Summary table of trends: averages from FSAU nutritional survey findings 2006–2008

Healthcare seeking for recent child illnesses, 2006-2008 averages (% of caregivers)					
Cross-sections of Somalia	**Private**	**Public**	**Own medicine**	**Traditional**	**Not sought**
South Central Zone	25.8	24.7	11.6	8.3	27.3
North West Zone	33.1	14.7	5.5	12.9	18.2
North East Zone	36.1	29.6	6.1	4.4	33.4
Pastoral – all zones	32.0	19.5	9.6	8.5	30.1
Agro-pastoral – all zones	22.4	25.1	12.0	9.0	31.3
Riverine – SCZ	29.1	32.0	10.2	5.4	23.5
IDP - all zones	27.4	41.7	7.7	1.95	24.9

Note: Not all populations are represented in these averages. This table serves only to register trends and comparisons. Figures cannot be used to describe any actual population group.

Source: FAO

Though Table 3-1 is not representative of the entire Somali population and relates to child illnesses, it is clear that the private sector is a major source of health services in Somalia and is likely to be surpassing public service figures at most locations. Private health facilities are particularly used in urban centres by populations with the financial means to use them and private pharmacies are particularly used in major urban areas.[75]

3.A.1.b.ii Drivers of healthcare decision-making

Client Interview Findings

Reasons for selecting the facility they visited: Respondents had almost similar preferences regardless of facility type. For those who were interviewed at a private facility, the four most commonly cited factors for selection were: availability of drugs; affordable services; courteous staff; short waiting time. While for public facilities the respondents cited availability of drugs; affordable services; short waiting time, and courteous staff.

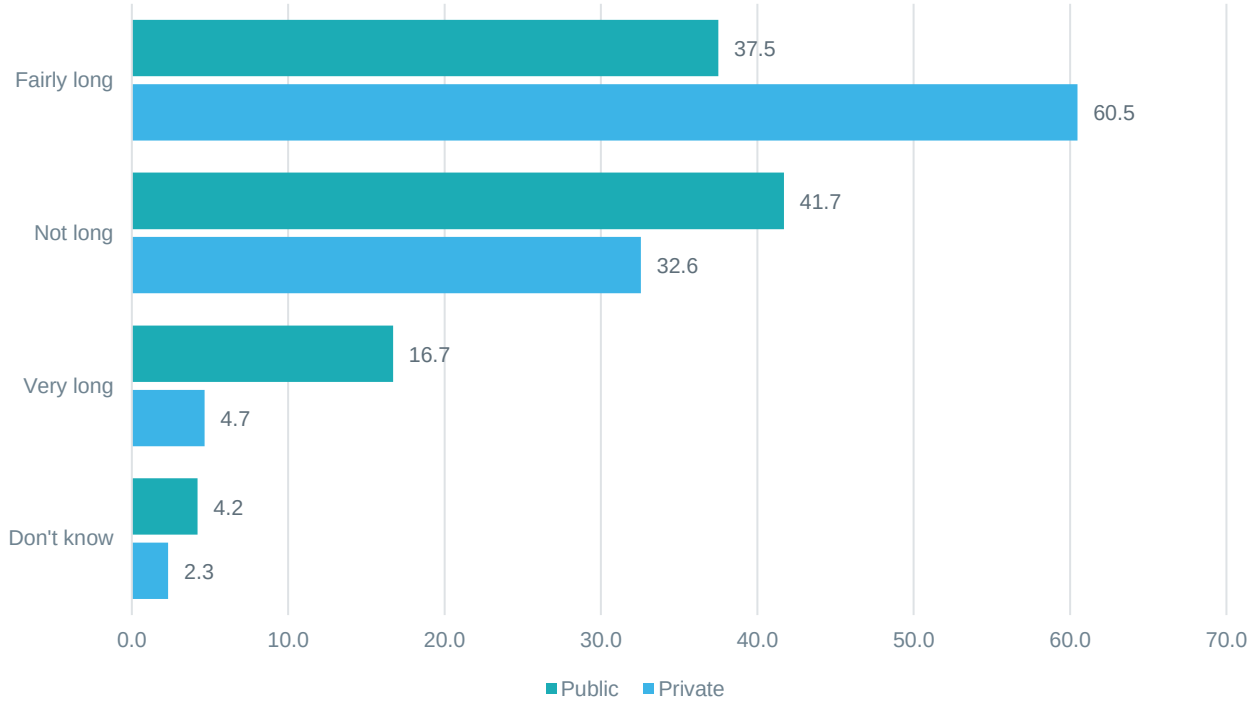
Satisfaction with the care received: The majority of respondents indicated they were very satisfied (21.8 percent) or satisfied (75.5 percent) with the care they received at the surveyed facility. More respondents at private facilities reported higher satisfaction levels - 18.6 percent very satisfied and 79 percent satisfied - as compared to the public facilities – 33.3 percent very satisfied and 61 percent satisfied.

Waiting time while accessing care: Of the respondents, 41.7 percent in public facilities and 32.6 percent in private facilities indicated they did not wait long before being seen by the clinician (Figure 3-7). However,

74 Mazzilli and Davis (2009), op. cit.
75 UNICEF, Somalia (2009). Somaliland Private Pharmacy Situation Analysis. May 2009.

16.7 percent of respondents indicated having had to wait “very long” at public facilities as compared to private facilities.

Figure 3-7 Waiting time to be seen by a clinician by facility type

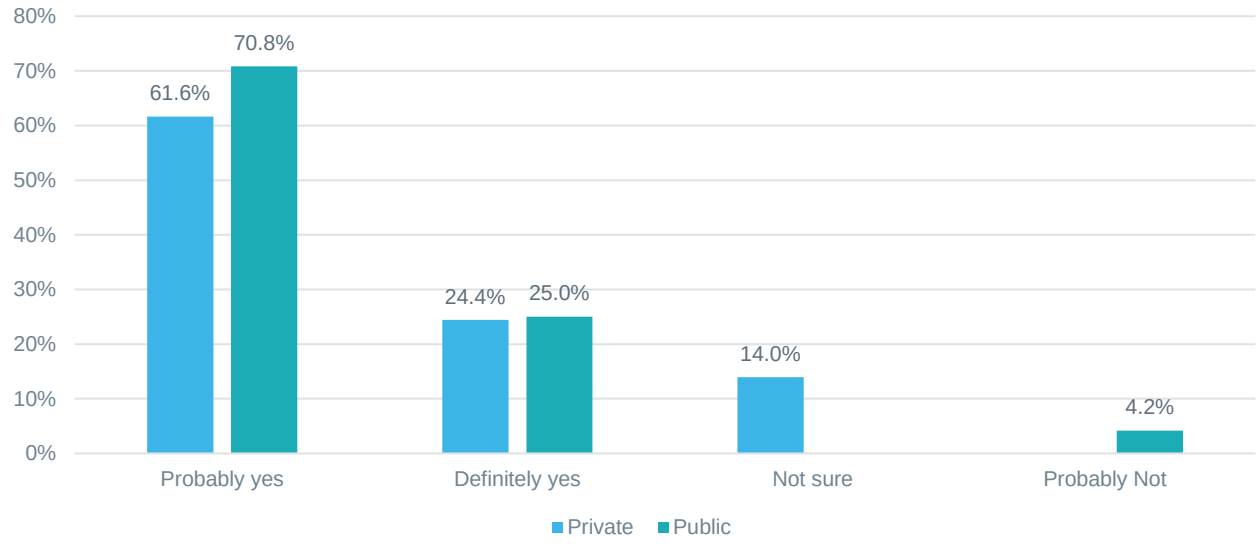


Perceived quality of care received by the clinician

PSPH sought to understand the respondents’ perspective to the perceived quality of care at the facility they had most recently visited. All respondents either strongly agreed or agreed that the clinician listened attentively to their complaints and explained to them the treatment in a way they understood. Of the respondents, 99 percent either strongly agreed or agreed the clinician was thorough in their assessment and was respectful and courteous, while 98 percent either strongly agreed or agreed that they spent adequate time with the clinician. There were no perceptible differences between public and private facilities.

Most respondents reported they were treated respectfully and courteously by office staff while only 2.3 percent of respondents disagreed with this view. The majority of respondents were likely to refer the facility to a family member and the majority were likely to return to the health facility where they were surveyed (Figure 3-8). This correlates with the high levels of satisfaction with the perceived quality of services received.

Figure 3-8 Likelihood of returning to the health facility surveyed



Community Representatives' Interviews

Cost and quality of service were the most cited factors for selecting their preferred health facilities in Hargeisa and Mogadishu, but proximity was the most frequently cited reason by Galkayo interviewees.

The most commonly cited challenges to accessing healthcare services were inadequate funds, waiting times, quality of care, and particularly availability of medicines, and travel needed to access care. Mogadishu interviewees had additional concerns of access barriers due to road closures and language/communication barriers with foreign doctors speaking a different language. To address these challenges, interviewees either forgo care, look for alternative care from free facilities or borrow money from a friend to access services.

> "When I have a money, I just go a private hospital and when I don't have, I just go the public hospitals to get free services and medicines."
> Youth group, Male, 36, Secondary (education), Garsoor/Urban: Galkayo

Interviewees had suggestions to overcome these access challenges including building public health infrastructure (health workers, medicines, equipment etc.), health insurance, standardizing private facilities and drug regulations.

Secondary research reinforced primary research findings that the drivers influencing consumer choice were cost, proximity/distance, the nature of the illness, perceived quality and the disease burden are the key determinants of consumer and/or patient choice. Price was a determinant, particularly for lower socioeconomic income groups who are more likely to try to access lower cost care in the first instance. Treatment within the home is common and preferred especially in rural areas and treatment from a formal healthcare provider is often seen as a last step.[76] Decisions surrounding where health treatment is sought are taken by the family, elders and traditional practitioners as well as the individual. For-profit private providers are able to offer differing prices to patients according to perceived need. In some cases, free treatment was said by participants to be perceived as lower quality.[77]

Mazzilli and Davis (2009) found that the major obstacles to seeking care are distance, cost and trust in the service/staff, quality, and availability of medicines for treatment.[78]

76 Buckley, O'Neill, and Aden (2015), op. cit.
77 Ibid
78 Mazzilli and Davis (2009), op. cit.

3.A.1.b.iii Differences between urban and rural behaviour

The secondary research showed that there was not a significant difference between urban households who sought medical treatment in comparison to rural households. The SHDS 2020 survey showed that 71 percent of urban households sought treatment while rural households were not too far behind at 64 percent. Similarly, the amount of money spent on health expenses did not greatly vary between the urban and rural areas especially for the lesser amounts under US$100, though the number of urban households (n=1,215) surveyed was much larger than the sample size for rural households (n= 390). Forty-three percent of the health expenditure in urban households and 45 percent in rural households fall under the less than US$50 expenditure range. A bigger difference is seen when the health expenditure rose to between US$100- US$300 plus; For health expenditure that was between the US$100 - US$199 range, 19 percent of urban households fell into this category while it was 14 percent for rural households (Table 3-2).[79] There is a much larger disparity between health expenditure for nomadic households in comparison to both rural and urban households.

Table 3-2 Amount incurred in health expenses, SHDS 2020

Amount of money that households incurred for health services in the last month by background characteristics, SHDS 2020

	Amount in health expenses (US $)						Number of households
	1-49	50-99	100 -199	200- 299	300+	Total	
Type of residence							
Urban	42.7	23.1	18.8	2.8	12.6	100.0	1,215
Rural	45.0	24.0	13.5	4.0	13.5	100.0	390
Nomadic	22.4	30.6	19.4	10.4	17.1	100.0	55
Total	**42.6**	**23.6**	**17.6**	**3.3**	**12.9**	**100.0**	**1,660**

Source: SDHS 2020

Regarding financial sources for health expenditure, the difference between urban and rural households was also marginal although the number of urban households (n=1,318) surveyed in the SHDS was much higher than rural households (n= 462). Almost half of the respondents in both urban (48.5 percent) and rural (48.7 percent) households sourced their health expenditure from their incomes. Two percent of both urban and rural households covered their health expenses using insurance and twenty-six percent of urban households covered their health expenses from the contributions of family and friends compared to twenty-three in rural households. The main difference between urban and rural households was where savings was used as a source of health expenditure; Five percent of urban households used their savings to cover health expenses in comparison to 1 percent in rural households. This could be indicative that urban households typically have more savings than those in rural areas (Table 3-3).[80]

Table 3-3 Financial Sources Used to Pay for Health Services

Percentage distribution of financial sources used for health services by households in the last month by background characteristics, SHDS 2020

Background characteristics	Financial sources for health services							Number of households
	Income	Insurance	Savings	Borrowing	Relatives/ Friends	Sold Assets	Other	
Type of residence								
Urban	48.5	2.0	4.9	14.4	25.9	10.8	3.7	1,318
Rural	48.7	2.2	1.3	12.4	23.0	9.2	0.7	462
Nomadic	25.6	0.0	3.8	14.0	31.4	21.2	8.6	59

Source: SHDS 2020

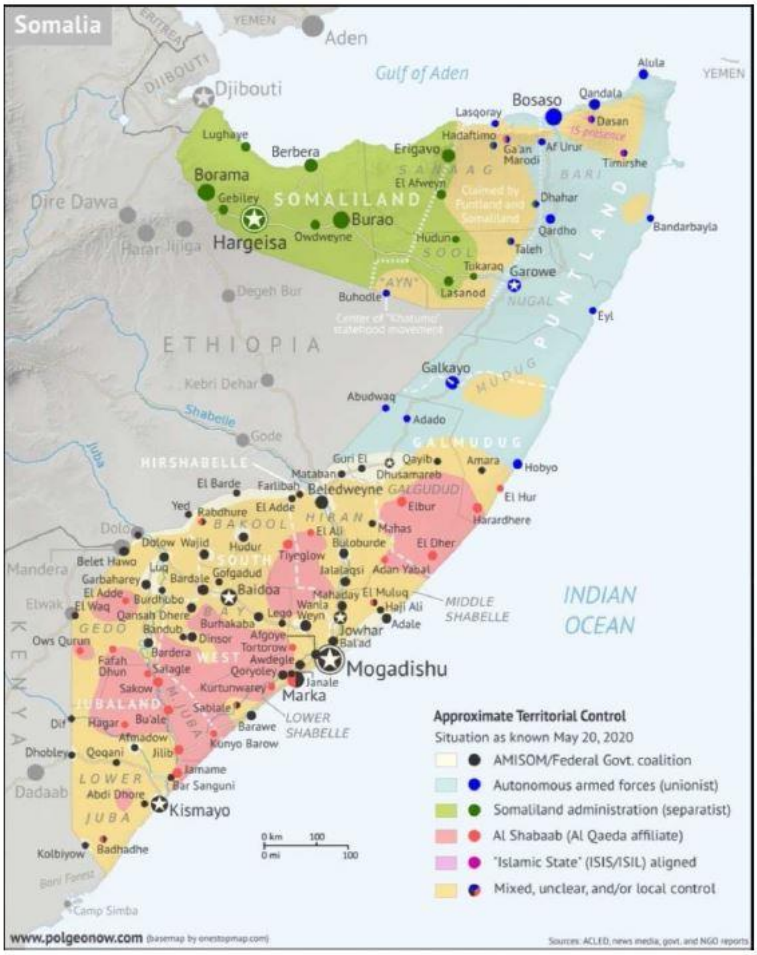
79 SHDS (2020), op cit. p.269
80 SHDS (2020), op cit. p.269

3.A.1.b.iv Differences between regions

The interviews conducted to gather primary information did not identify any key differences between health seeking and spending behaviours across the various locations as they all face similar access issues to health services such as high costs, distance, long wait times, nature of the illness, perceived quality, and uncourteous staff. However, the security issues across the country based on the political divide is a factor affecting access to health in different regions.

There are areas which are inaccessible because of al-Shabaab activities. Al-Shabaab does not have problems with people accessing healthcare, but they will not allow federal government officials or NGOs in areas they control. In these places people may not access some healthcare services such as routine immunization for children or mass immunization campaigns for measles or polio in these areas because of insecurity.[81] [82] Similarly, private health providers also face security issues in these areas.

Figure 3-9 Somalia Control Map, 2020



Source: Political Geography Now 2020

3.A.1.b.v Differences between economic segments

Approximately 2 percent of the population who live above the upper middle income poverty line fall into the category of Somalis who 'can pay' for health services. This population segment either have insurance or/and can afford to pay OOP locally or even afford to travel for treatment to Kenya, Dubai, Turkey, or Europe. Based on the pyramid of the Somali healthcare market in Figure 3-2 on page 31, about half of the population being active market participants 'can pay less', meaning they have some disposable income considering the

81 Danish Immigration Services (2020), op cit. pg. 80
82 South and Central Somalia. Brief Report, July 2020, p. 9

different sources they currently access to cover health expenses such as remittances, family and community savings and other informal finance means. Those who 'can pay less' are likely already paying for health services at local private facilities; however, they may not be receiving good value for money based on the quality of services delivered depending on where they go. The bottom of the pyramid is the segment of the population (estimated at under 50 percent) who have no disposable income and are dependent on free services which are donor-funded through humanitarian assistance (not development programmes), 'off-budget' projects, public health facilities, multilaterals, and NGOs.

3.A.1.b.vi Gender differences

WHO (2011) highlights that gender segregation is deeply entrenched in Somali social and cultural structures and remains a formidable barrier to women's participation in decision-making processes and access to health services.[83] Women may experience multiple barriers in their access to health services because of their position in the family, their marital status or their age. These barriers include limited decision-making power in relation to major interventions and in their access to health services performed by male health workers. However, the representatives of the Federal Ministry of Health and WHO found that women enjoy the liberty to exercise their right to health services.[84] Women are confronted with barriers in access to health services due to their status in the family when they are in need of major surgical interventions, including emergency obstetric care and other sexual and reproductive health needs. Male consent as a barrier for women's free access to health services is being recognised and addressed by advocacy activities but so far no bill or law, act or decree has been put in place.[85]

Reproductive Health Seeking Behaviour

Reproductive health services which include services such as modern family planning services, ante and post-natal care, skilled deliveries, STI and HIV testing, are weak in Somalia, inhibited by both supply and demand.[86] Even though costs for reproductive health are high and availability and quality of these services are low; Somalis do not commonly seek reproductive health services as local communities generally believe the challenges in accessing them outweigh the potential benefits.[87]

Most providers of reproductive health services report major obstacles and barriers in provision of these services due to customs and beliefs. Often Somali women will refuse to use available services and some of their reasons include fear of assisted and caesarean deliveries, stigma and social acceptability, lack of information and low availability of the services. Beliefs and social construct are a big factor to consider when looking at uptake of reproductive health services in Somalia. According to UNFPA, married women need the consent of a male relative (or in some cases the mother-in-law)[88] before a doctor will perform a lifesaving intervention at any public or private hospital such as a caesarean section. This is not only a matter of securing the financial means to pay for the procedures and the required medical supplies, but according to UNFPA a matter of ensuring that the family agrees with the intervention and possible negative outcomes. If the doctor does not ensure male consent, he might run the risk of repercussions after the intervention.

Family Planning: Unmarried, young women may not access family planning or sexual health services of any kind unless accompanied by their mother or father.[89] Unmet need for FP in Somalia has been calculated at 26.6 percent of currently married women of reproductive age, of whom only 1.2 percent currently use a modern method of FP.[90] Natural FP methods are by far the most used amongst women desiring birth spacing. Determinants related to low use of modern FP in Somalia have not been well explored in the literature but are assumed to be largely influenced by Islam and socio-cultural norms combined with low awareness of potential benefits.

83 WHO (2011), op. cit.
84 WHO (2016).Somali Service Availability and Readiness Assessment (SARA): 2016 Report, p. 23 op.cit.
85 Danish Immigration Services (2020), op. cit. p.33
86 Sorbye, I. WHO/UNFPA Somalia (2009). Addressing Maternal and Neonatal Survival in Somalia: a Situation Analysis of Reproductive Health in Somalia. Nairobi, February 2009
87 Mazzilli, C. & Davis, A. (2009) op. cit.
88 Danish Immigration Services (2020). op.cit. p.32
89 Ibid, p.33
90 UNICEF (2006). Multiple Cluster Surveys (MICS) and Millennium Development Goals (MDG) Indicators, Somalia, 2006. UNICEF Somalia.

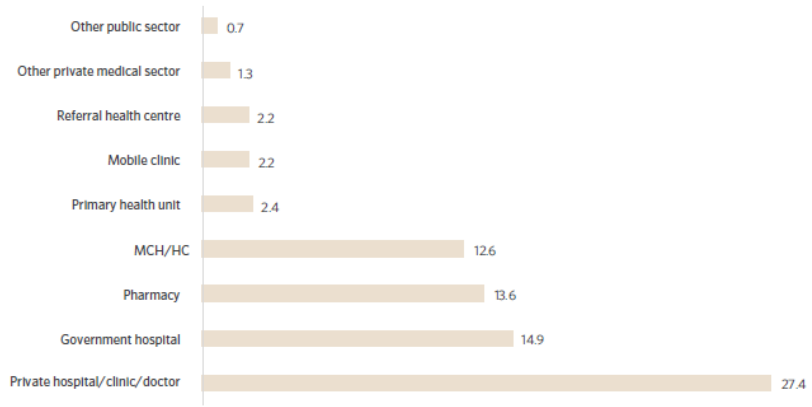
3.A.1.c Health spending behaviour

3.A.1.c.i Household income and household spending patterns/priorities

The average Somali household size in Somalia is 6.2 persons and household income is generally pooled. Most households have not had any form of financial protection and were forced to make OOP payments when they fell sick, as there is no social safety net from the public sector and very low private health insurance coverage. Often, families resort to borrowing money or selling assets to meet these expenditures. As cited above, remittances make major contributions to financing household spending, with one in five Somali households receiving them.

The Somalia Health and Demographic Survey (SHDS) 2020[91] collected information on OOP expenditure. In the household questionnaire, households were asked whether advice or treatment was sought for any household members' health conditions and the source of this advice or treatment. They were also asked how much money the household spent on treatment and healthcare services in the one month preceding the survey. SHDS showed that 19 percent of households had at least one household member sick in the last month preceding the survey and among these households, 66 percent sought advice or treatment for the household member. 71 percent of urban households and 64 percent of rural households sought medical advice or treatment for their health problems.

Figure 3-10 Household members who have been sick and where they sought advice / treatment



Source: SDHS 2020 op cit

Figure 3-10 reveals that the majority of Somalis access healthcare in private health facilities (27.4 percent) followed by the public facilities (14.9 percent) and pharmacy (13.6 percent). While 12.6 percent of the households had a member go to Mother Child Health (MCH) clinics and/or health centres (HC).

Table 3-2above presents data on the amount of money the household spent on treatment and healthcare services during the month before the start of the SHDS. The largest proportion of the respondents – 43 percent – reported that they had spent between US$1 and US$49 for treatment and healthcare services in this time. Twenty-four percent of the respondents spent between US$50 and US$99 for treatment and healthcare services during that month. Eighteen percent of the respondents had paid US$100-199 for treatment and healthcare services, and 13 percent of the respondents had paid US$300 or more for treatment and healthcare services during the month prior to the survey being conducted.

Client Interview Findings

Financial access to healthcare services: Of the respondents (72.7 percent) agreed or strongly agreed that they can access medical services without a financial setback, whereas 27.3 percent disagreed or strongly disagreed that they can access medical services without a financial setback. While 21.8 percent of

91 SHDS (2020), op. cit.

all respondents did not pay for healthcare services received at public facilities, majority of the respondents who received care at private facilities surveyed paid an average of US$55.24 (range US$5-US$200). Findings from the SHDS 2020 indicated that over 65 percent of households spend in the range of US$1-US$99 for health services in both urban and rural areas. The average cost for the outpatient visit was US$50.40 (range US$5-US$150) and for inpatient hospitalization was $167 (range US$100-US$200).

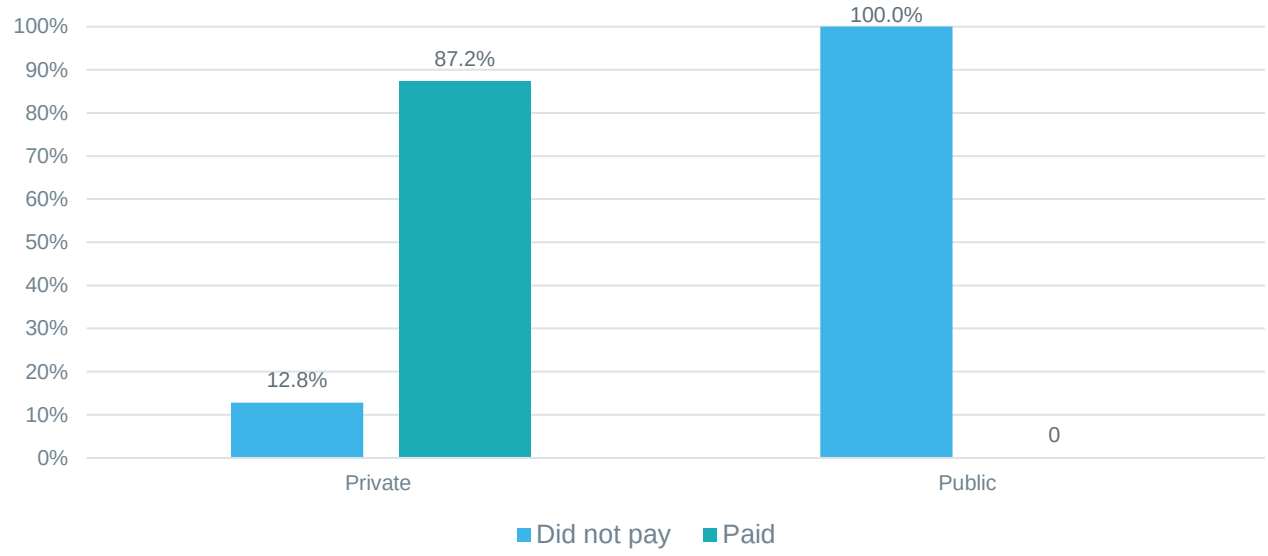
Disposable income and household spending: Interviewees reported monthly disposable income of approximately US$200 to US$500 of which they estimated 10 percent to 50 percent was used for healthcare spending. However, it should be noted that these are ballpark Figures and would require validation or a more in-depth household health expenditure and utilization survey for more accuracy. Interviewees did not save specifically for healthcare, but a number reported that they do save, and they use those savings for healthcare services when the need arises.

> "No, we don't do saving as our income is limited when compared to our expenses. When a member of our family gets sick, at that time we look for money, if we have sufficient money it is ok, but if we don't have we ask for contribution from relatives or debt it from friends or others."
> Womens group, Female, 36, Informal, Garsoor/Urban, Galkayo

3.A.1.c.ii How the target group pays for (or acquires) healthcare

All respondents who were surveyed at public facilities did not pay to access health services whereas 87.2 percent of respondents in private facilities paid for the health services they received (Figure 3-11). The average cost paid was US$55.24 (range US$5-US$200). The average cost for the outpatient visit was US$50.4 (range US$5-US$150) and for inpatient hospitalization was US$167 (range US$100-US$200).

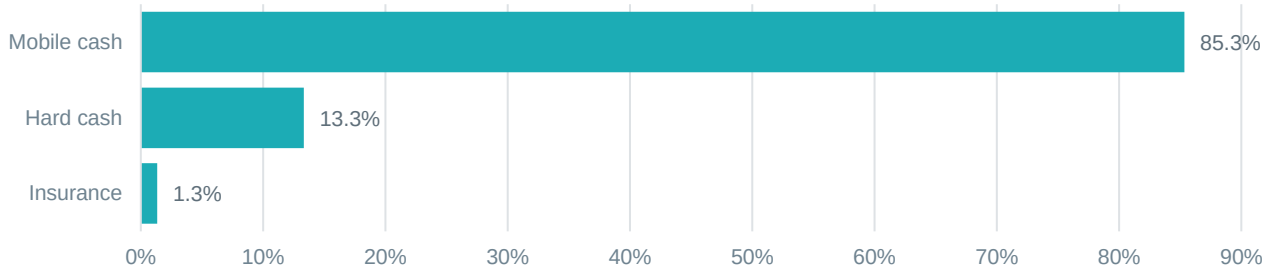
Figure 3-11 Who paid for health services received



The most common means of payment were through mobile money and physical cash, while only 1.3 percent reported paying with insurance (Figure 3-12) which tallies with the meagre 2 percent insurance coverage revealed in the secondary research (both SHDS 2020 and SLDHS 2020).[92 93]

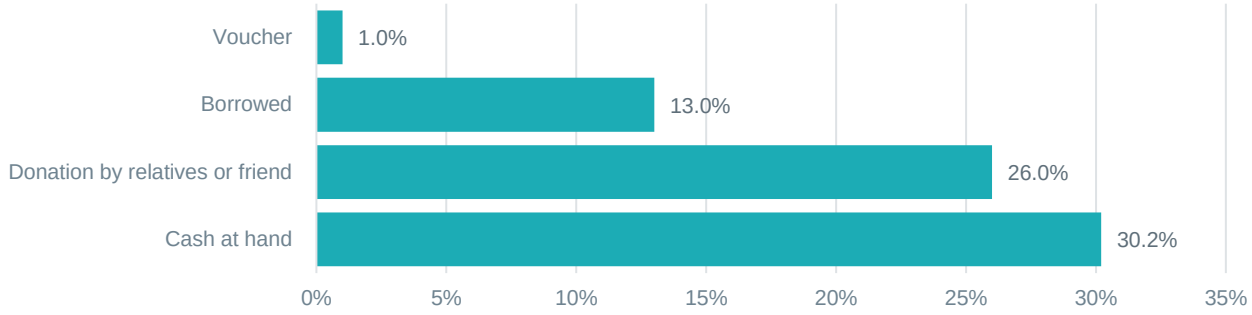
92 Ibid, p.258
93 Ibid, p.265

Figure 3-12 How healthcare services were paid for



On enquiry where the funds were sourced to pay for the services received, respondents most frequently cited cash at hand, donations and borrowing as the most common source of funds (Figure 3-13). None indicated selling an asset as the source of funds and it appears that they are able to leverage on social capital to borrow or receive donations from family or community.

Figure 3-13 Source of funds



Community Representatives Interview

Mobile cash was indicated by all interviewees in all three regions as the primary means of paying for healthcare costs in addition to hard cash. Similar to the client exit interviews, interviewees indicated that public facilities do not charge patients for healthcare services. A majority of interviewees indicated they have challenges paying for healthcare services that they perceive of good quality, inferring financial barriers to access of healthcare services when needed. This was more frequently reported in Mogadishu.

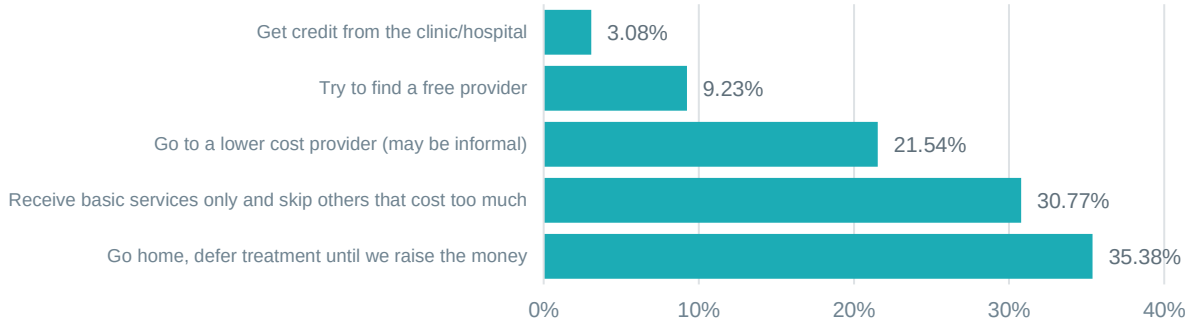
Out-of-Pocket (OOP)

Client Interviews

As there is no public social health insurance available and private insurance coverage is low, a vast majority of respondents surveyed at private facilities (98.7 percent) relied on OOP payments to meet the cost of health services. Fifty-nine percent of all respondents reported challenges paying for health services while 53 percent of all respondents stated that they had deferred or delayed treatment because of the inability to pay for health services.

When they are unable to pay, a majority defer treatment or forgo parts of the prescribed treatment while approximately 30 percent go to another lower-cost provider, who may be an informal provider, or go to a free provider (Figure 3-14). This would indicate a high burden of OOP to the population and an unmet need among the population for affordable healthcare services.

Figure 3-14 What happens when they cannot pay for services?



Third party payor

Only 1.3 percent of respondents surveyed in private facilities indicated insurance as the source of payment. This is consistent with the secondary data showing approximately a 2 percent insurance coverage as cited above.

Free and subsidised services

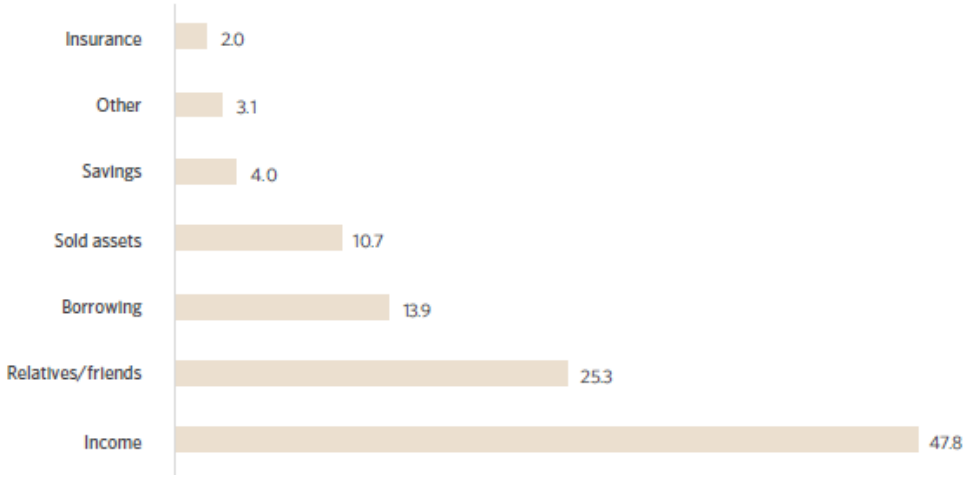
Respondents from all public facilities reported receiving free health services. In addition, NGO facilities also provide subsidised care and do not charge user fees.

3.A.1.c.iii Sources of funds for healthcare (where the money comes from)

The financial sources that households use to pay for health expenditure revealed in the SHDS largely mirror the primary findings. Forty-eight percent of households reported they pay for their health expenses from their income in both urban and rural households (Figure 3-15). Twenty-five percent of households reported their relatives or friends supported them to pay their health expenses. Fourteen percent borrowed money to pay for their health expenditure and 11 percent of the households sold assets to cover their health expenses. While the primary findings did not reveal sale of assets as a source to cover health expenses, the SHDS survey revealed 11 percent of the respondents having done so in the preceding month.

Only two percent of households used insurance for their health expenses again in both urban and rural households. Similarly, almost half of the urban and rural households—49 percent each—used their income to pay for medical expenses as compared to 26 percent of nomadic households (Table 3-3above). Overall, there was not much of a difference between sources of health expenditure in both urban and rural households as 23-26 percent of households used funds from relatives/friends to cover their medical expenses and 12-14 percent borrowed from other sources.

Figure 3-15 Distribution of financial resources used for health by source of funds (SHDS 2020)



Source: SDHS ibid p 257

3.A.2 Supply side (healthcare financing and service providers)

3.A.2.a Healthcare financing providers and their mechanisms

Key healthcare financing providers (demand side) are enumerated in Table 3-4below and then described in detail in the text that follows.

Table 3-4 Key stakeholders – healthcare finance (demand side)

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
Regulator					
Federal Ministry of Health	Regulation Monitoring Service provision	Federal Ministry of Health's role is to lead the health sector and develop regulations, policy and strategic development, financing, coordination, monitoring and evaluation of the health sector performance. Role also extends to supply side.	Somalia (Mogadishu)	Regulator of the health sector. There is no social health insurance. Financing is primarily provided by donors.	Private providers complement public service provision, supported by donor funding as humanitarian assistance. Regulation and providing the framework for service delivery and monitoring quality of care. There is currently no regulatory framework for health insurance.
Ministry of Health Develop-ment (Somaliland)	Regulation Coordination Service provision	The Ministry of Health Development of the Republic of Somaliland is a ministry of the government of Somaliland that is responsible for the health system; it is also responsible for proposing and executing government policy of health. Role also extends to supply side.	Somaliland (Hargeisa)	Regulator of the health sector Operates independently of the Somalia Federal Ministry of Health Recently signed MOU with World Bank	Somaliland has its own health regulatory regime that is in some ways more advanced than in the Federal region, although enforcement capacity is weak.
Ministry of Health, Puntland State of Somalia	Regulation Coordination Service provision	MoH Puntland works to support the Puntland people in attaining better health, improving health outcomes, and providing quality health services. Role also extends to supply side.	Puntland (Garowe)	Maintains independent relationships with multiple stakeholders such as UNICEF, WHO, UNFPA, IOM, WFP, World Bank, Save the Children, WVI, MSF, Tadadum Social Society, Care International and the Somali Red Crescent Society, who both finance and provide health services directly.	Focused on Puntland only.
Insurance Companies					
Takaful insurance	Insurance provider	Takaful Insurance of Africa is the largest insurance provider in the Somali region, and it also operates in east and central Africa. They provide different	Somali region They have branches in the main cities	They provide insurance services to I/NGOs. Also, they have relationships with private healthcare providers in most of the	They provide health insurance. Since they have an existing insurance system

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
		insurance services including medical insurance that they provide to INGOs staff and those who have high incomes.	(Mogadishu, Hargeisa, Kismayo, Galkayo, Garowe, Bossaso, Borama, Baidoa, and Burco).	cities, corporate business companies, and banks.	it may expand to serve poor people.
Amanah Insurance	Insurance Provider	Amanah Insurance company is one of the insurance providers in the Somali region. They have branches in Mogadishu, Hargeisa, Garowe and Nairobi. The company was established three years ago and it is the second most used insurance provider after Takaful. Similar to Takaful, they provide various insurance services, but their medical insurance is targeted mainly at those who are working with NGOs, individuals who have good income and companies.	Somali region	They have a relationship with private healthcare providers and INGOs (insurance services consumers). Also, they have relationships with banks.	Insurance service provider, it can be used to work with to create social insurance
Banking and Microfinance Services					
Dahabshil (Micro Dahab)	Banking and microfinance services	Dahabshil group of companies (MFI) programme in 2014. MFI offers microfinancing services to the community to create more jobs and to improve living conditions for women and youth.	Somali region	They work with the Central Banks. Also, they work with USAID, Adam Smith, Mercy Corps and local NGOs.	
Kaah Microfinance institution	Microfinance Institution	Kaah microfinance institution started their operation in 2014, and it is the one of the largest microfinance institutions in the Somali region. They provide different microfinance services to low-income people including IDPs and returnees. Since their establishment, they provide over 10M$ to finance different business.	Somali region	They have relationships with the central banks. They work with other local banks. They have relationships with the communities as they are the consumers of the microfinance services that the company offers.	
Darusalam Bank	Banking and microfinance services	Darasulam Bank was established in 2010 in Hargeisa. It provides baking services and also microfinance services. They have a programme called Kobciye that offers microfinance investment to the community to create more jobs for the poor	Hargeisa	They have a relationship with the central bank. They work with Telesom (mobile network provider), and Taaj.	

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
		people and reduce the unemployment rate. They provide group or individual microfinancing.			
Salam Somali Bank	Banking Services, Investments, Microfinance, Account Management, Mobile network, Remittances, TT- Telegraph transfer, Mobile money transfer/ DEEQTON-MMT	Specifically for health: Microfinance Investments in healthcare sector by individuals Banking services for health facilities Bulk salary payments Donation and support through Hormudsalam foundation	Mogadishu, other urban areas	Interface with health providers for banking services and Hormudsalam foundation	Access to credit for health providers Hormudsalam foundation subsidizing healthcare services for the poor or donations to providers
Mobile Network Operator (Mobile Money)					
Hormuud Telecom	Mobile network providers	The company was established in 2002 and it is the largest mobile network provider in southcentral (SCZ) Somalia. It provides GSM, internet and mobile money (EVC) services. The company has branches both urban and rural land in SCZ, and people living both areas use its services. The mobile money services they provide is widely used across the regions in SCZ. Launched Somalia's first indigenous mobile money app in April 2021, called WAAFI.	Somalia	It has close relationship with Taaj and Salaam banks, also they have relationship with the government.	Their mobile money service is widely used and it is the most method to pay for health expenses
Somtel	Mobile network providers	Somtel is mobile network provider that operates across the Somali region. Somtel is part of Dahabshil group of companies, it provides mobile money service called (E-dahab)	Somali region	They have a relationship with Dahabshil group of companies and the government.	Their mobile money service is widely used and it is the most common method to pay for health expenses
Telesom	Mobile network providers	It was established in 2002, and it provides mobile network services including GSM, internet and mobile money called Zaad.	Somaliland	They have relationships with Taaj money transfer, Darusalam Bank and the government.	Their mobile money service is widely used and it is the most common method to pay for health expenses
Remittances					
Dahabshil and Taaj money transfer	Remittance service providers	Dahabshil money transfer is the largest money transfer company in Somali region. It has been in existence for more than 40 years. It is part of Dahabshil group of companies. Taaj was	Somali region	Diaspora and local community, mobile network providers (Dahabshil money transfer use Somtel's mobile money 'E-dahab' to send money to their clients, while Taaj	Remittance is one of the main sources for the money used to pay for health services.

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
		established a few years ago, but it expanded into the whole Somali region providing money transfer.		money transfer uses Hormuud's (EVC) and Telesom's (Zaad) mobile money to pay the remittance money to their customer. Also, they have relationships with banks and government.	
Informal Healthcare Financing					
Informal social mechanisms	Cover user fees at health facilities as needed	"Qaaran" each member of the family contributes every month so that anyone who gets sick can access healthcare "Hagbad/ Ayuuto" family members each contribute for a family member's health expenses	Somali region	Informal social safety net	Opportunity to contribute for family members through informal mechanisms

3.A.2.a.i Formal

Insurance companies

There is no national health insurance scheme available for the Somali people. Private insurance companies exist, and they mainly provide policies/services to staff of international organisations and I/NGOs staff. They are profit seeking companies serving those who have good and stable incomes and they do not target poor people which means there is a significant underserved market across the Somali region.

Health insurance penetration is low across the entire Somali region (2 percent of households as cited above) and the market is in a nascent stage. From the insurance companies' KIIs, it was noted that the insurance companies cover a number of risks including health. Insurance company informants verified that current health insurance products are targeted to government, international NGOs and corporate organizations, serving a higher, formally employed socio-economic group – the "can pay" segment.

> "Good quality private health services are essential; This needs to be addressed by investing in health insurance companies that can be accessed by the poor and less privileged members of the community."
> Youth group, Male, 29, Post-Secondary, Hargesia

Insurance companies provide coverage for outpatient and inpatient services, including medical evacuation services. There are no pro-poor health insurance products, but there was interest in considering a more mass-market approach and products that may reach the poor. The insurance companies suggested that the government could establish and fund a pool for the extremely poor and link this fund to private health facilities but did not mention a source of funding for this. This may encourage further investment and development by the private sector in healthcare. Whether this would then directly have an impact on quality of care would need further examination.

In terms of provider contracting and negotiations, the insurance companies indicated they contract a wide range of private facilities and are able to negotiate favourable rates with providers. A reliable system is in place between insurance companies and private healthcare facilities whereby all payments are paid (via bank transfers or through cheque payment) to the private facilities sometimes at a reduced rate. This good practice of negotiating lower rates from providers could be extended to any new interventions supported by PSPH or to any government scheme.

For clients with smart phones there is the widespread use of mobile platforms for example “MEDI SMART” where clients can track their appointments, balance on their premium and payments made, etc. Clients can use mobile money to make payments to health facilities. It would need to be further examined if this system could be extended to the poor who may not have access to smart phones as well as the data network reach to remote areas.

However, there are a number of challenges or constraints in growing health insurance including lack of a clear regulatory framework, lack of standards for provision of health services, a strong social network and “traditional insurance” that supports healthcare costs for sick individuals. The insurance companies concurred with the health providers that short term improvements in healthcare will come about if the government encourages: the promotion of health investments, improvements to the medicines supply chain quality, regulation on costs and standards of care.

From the interviews with community representatives, respondents’ health insurance knowledge is limited. Among the client exit interviews only 1 respondent used insurance as a means to pay for health services. This may be due to the small number of products in the market, exclusion of the target group, or affordability challenges.

Public sector

The Federal Ministry of Health’s role is to lead the health sector and develop regulations, policy and strategic development, financing, coordination, monitoring and evaluation of the health sector performance. It is estimated that 79 percent of Somalia is currently underserved, not getting the healthcare services they require. A bottleneck analysis of the Essential Package of Health Services (EPHS) implementation found that Reproductive Maternal Child and Adolescent Health (RMNCAH) and communicable disease prevention and control are the major services provided to the community. Injury prevention and the prevention and control of non-communicable diseases are underserved areas.[94]

There are no public financial institutions that finance the health of the Somali population. Funding for the Ministry of Health in Somalia is very low at 2.0 percent of the annual budget. Tax administration capacity is very low limiting fiscal space and the ability to pool resources is currently limited. External sources from donors are the main source of financing public health services. There are no public prepayment systems.

The new EPHS is supposed to be a framework for provision of health services at both public and private health facilities. Providers are paid through line-item budgets through salaries and budgets for operation and maintenance. Somalia lacks regulation or a comprehensive partnership arrangement between the public and private sector for private sector contracting. However, there are exploratory attempts by the government to engage private service providers for immunization and malaria treatment following government protocols. This is a start that can be built on for contracting the private sector for service delivery. However, more is required to create the environment for private sector to invest to increase provision of healthcare services targeted to the mass market and not only targeted at the wealthy, and to cover areas and services not reached by the donors and public sector. A key comment coming through KIIs as a solution is cost sharing and finding a path to mobilise remittances.

The regulatory environment is weaker in the Federal region than in Somaliland; Somaliland is in the process of passing key legislation for the regulation of health workers and medicines. The government’s capacity to engage with the private sector needs to be strengthened to create not only a regulatory framework that allows private sector investment in health to meet the needs of the underserved market but also for a

> Insurer’s perspective on areas to improve the healthcare market in Somalia
> - ✓ Enhance quality of services
> - ✓ Supply chain quality and cost regulation
> - ✓ Regulations and standards to be created
> - ✓ Increase awareness to improve health seeking behaviour
>
> KII, Insurance Company, Mogadishu

94 From key informant interview with Dr Nur Ali Muhammad, Director of Policy and Planning, Ministry of Health and Human Services, Federal Government of Somalia, March 2021

partnership framework that can use the private sector capacity. The FGS Somalia enacted the Health Professionals Act through the parliament, and it was decreed by the President in 2020. The MOH is in the process of establishing the first ever Somalia National Health Professionals Council (NHPC), with the remit of licensing health professionals, hospitals and maintaining the quality of healthcare provision in public and private facilities.

NGOs

The Somalia NGO Consortium shows 95 members in 2020;[95] not all of these operate in healthcare although NGOs are prominent as the largest recipient of donor funds in the sector. Non-governmental organizations play a key role in the Somali health sector as they proxy for the government, playing the government role by directly providing and financing free healthcare services. However, their programmes depend entirely on external funding. Some of the NGOs that run livelihood projects provide food vouchers. No healthcare-specific voucher programmes providing healthcare financing have been identified.

Donor programmes

The Somali health sector is dependent on donor funding, a small portion of it through Federal budget support but most of it “off budget and off treasury” through direct support of service delivery. Unlike the private sector which raises its own revenue, public health financing is completely dependent on donors. Donor funding for service delivery goes directly to providers through intermediary organisations such as NGOs and multilaterals and bypasses individuals.

The Baxnaano project led by the Ministry of Labour and Social Affairs and implemented by World Food Programme uses the nutrition status of the household members as one of the criteria to target the poor. Such a proxy, perhaps coupled with employment status, could potentially be applied by PSPH to differentiate those who can pay and those who cannot pay in future healthcare financing interventions.

Community-based programmes

Somali communities are quite famous for initiating self-funded community-based programmes. Local businessmen and Somalis in the diaspora are the main source of the funding for these programmes. There are various community-based programmes including livelihood, education, and health programmes. In health, there are a number of district hospitals that receive funding from the community. These programmes provide basic health services for free, but they charge affordable rates for other services, such as surgery.

Microfinance lenders

Microfinance institutions in Somalia have been growing over the last five years. Many Somali people benefit from their financial services; they offer investments to small and medium scale businesses. To access their services, an individual needs to have a business plan and proposal and valid identification documents. Microfinance has little to offer in the way of demand-side healthcare support.

From the key informant interviews (KIIs) there were no specific health sector focused products. However, many of the existing products and services are relevant to the health sector, including formal banking services, bulk payment, access to credit and money transfer services. KII respondents noted opportunities to develop products to support the supply side of the health sector. This could include access to credit at favourable interest rates and reducing the entry requirements to access credit including the need for collateral. These measures will be helpful in growing private sector investment in healthcare, noting the capital-intensive nature of setting up health businesses, particularly large well-equipped health facilities.

95 http://www.somaliangoconsortium.org/membership/current-members/?y=2020 accessed April 15, 2021

3.A.2.a.ii Informal

Rotating savings clubs (Hagbad/Ayuuto)

There is a traditional financing mechanism known as *Ayuuto* or *Hagbad* that is widely used within the Somali community. Women mostly dominate the use of this financing method. A group of women organised by themselves create a funding pool and each of them contributes a fixed of money to the pool each month. One person will get the collected amount from the pool each month until everyone has taken it one time. People may use this money at their discretion for needs that include health issues, but the money is not ringfenced for health and may be consumed for other household needs that take priority at the time.

Pooling money for health under Rotating Savings Clubs was only reported by one community representative respondent in Hargeisa. In Mogadishu none of the community representatives knew of any pooling mechanisms by rotating savings clubs or insurers that were used exclusively for health.

However, one insurance interviewee mentioned the *"Qaaran,"* an informal mechanism where each family member contributes some amount of money every month so that anyone who gets sick can access healthcare using these pooled funds. It was suggested that these informal savings mechanisms at the community level makes it difficult for insurers to penetrate the market.

Mobile money

For the last 10 years, mobile money has become widely used across the country. The number of mobile connections in Somalia in January 2021 was equivalent to 45.3 percent of the total population, and 37.1 percent of the population above the age of 15 has a mobile money account.[96] Sixty-four percent of women aged 15 to 49 who own a mobile phone use it for financial transactions, although mobile money usage declines by household income, with 40 percent of women from the poorest households using a mobile phone for financial transactions, compared to 81 percent of women from the wealthiest households.[97]

People use mobile money to pay for household expenses, family health, education, family contributions, rotating savings contributions (ayuuto), and to save money. Mobile money is the predominant means of paying for health services in both the client exit interviews and community representatives' interviews.

The main Mobile Network Operators (MNOs) are Hormuud, Telesom, Somtel and Dahabshiil. In Hargeisa and Mogadishu, the MNOs provide banking services and mobile money services to facilitate payment, including but not exclusively for healthcare services (EVCPlus, Zaad, MMT, and E-Dahab, respectively). Mobile money is also linked to money transfer companies such as Dahabshiil and Taaj which deal with remittances. Hormuud launched what they described as Somalia's first indigenous mobile money app, called Waafi, in April 2021.[98] Somtel has developed the Kaabe service that allows clients to apply for mobile loans from the company, which can be used for interests that include healthcare.

Also, it is interesting to note that many people save money in mobile wallets (similar to Kenya's M-PESA), which has a limit of US$300. No fees are charged for sending, receiving, withdrawing, or paying for services. In some regions such as Hiran and Galgadud, there are no cash transactions at all and mobile money is the only payment method that exists, so mobile money is used for all bills including medical care.

Specifically, for healthcare, MNOs as some of the largest and wealthiest corporations directly fund health providers through foundations that support the healthcare system (Hormudsalam Foundation in Mogadishu) and corporate social responsibility (CSR) programmes where the MNOs fund hospital construction, purchasing of equipment, and donations to help the poor pay for hospital bills. In Hargeisa, an MNO has introduced the application 'Shaafi' that links the community to doctors in the region.

This leverages the high mobile phone penetration in the country and the high usage of mobile money across various segments of the population for all needs including health. There is the potential to create health-

96 https://datareportal.com/reports/digital-2021-somalia accessed April 16, 2021
97 SHDS (2020), op. cit. p.231
98 https://www.hiiraan.com/news4/2021/Apr/182394/hormuud_telecom_launches_somalia_s_first_mobile_money_app.aspx accessed April 23, 2021

specific products through linkage of the mobile money service and the remittances companies. All three MNOs have partnerships with banks for money transfer and micro-finance services.

MNOs serve all spectrums of society including the poor and those living in remote areas. Suggested opportunities to participate in the health sector include facilitating payments for the health sector, building on M-Health and the existing Shaafi applications, and payment support for insurance to enable improved coverage for the poor. Dahabshiil and Somtel noted that if the government introduces health insurance, they would welcome card holders onto their mobile service. The three MNOs agreed that the existing mobile services can be further improved to serve healthcare needs such as online appointments and direct access for the client to specialty treatment. Such products could be further explored with the MNOs and the related banks.

Lastly, the MNO informants concurred that there is a need to expand health services both in specialist care (examples given were ICU beds and dialysis) and access for the poor whilst ensuring standardised care and costs, and improved/new payment plans for the poor.

Remittances

Remittances are one of the main sources of income for many low-income Somali households. The primary use for remittances is to cover everyday household living expenses such as food and water. Remittances are also used to pay for education costs, health expenses, and other bills. It is common for people in the diaspora to send money directly into their relative's/family's phones, who in turn, use the funds to pay for different services (including health) with mobile money. Both urban and rural communities have access to remittances. The remittance companies use mobile money to transfer money to their beneficiaries. People receiving mobile money only need basic mobile phones and do not require smart phones. Hawala (informal money transfer through a network of brokers) is also used for remittances.

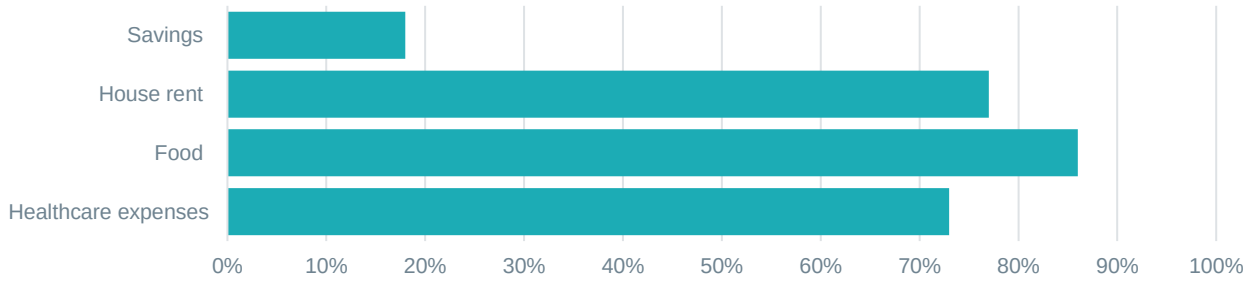
Client Interviews

Remittances for accessing healthcare services

Twenty percent of all respondents reported receiving remittances and using the funds received for paying for healthcare services. Of those who received remittances and used these funds for healthcare services (20 percent), 54.5 percent of them indicated that they received the funds through the bank while 40.9 percent received through their mobile phone. Further, 72.7 percent of the respondents indicated they received funds through remittances regularly, on a monthly basis. Healthcare services were one of the key reasons cited for use of funds received through remittances (Figure 3-16) but as noted there are other competing priorities including food and house rent.

> "Yes, my son sends me money, we receive it on cash from the Hawala or they send it to us by mobile money every month, but we do not use all of it into health service only, if a member of our family got sick he will send another money that time."
> Womens group, Female, 51, Informal, Nbada/Urban, Mogadsihu

Figure 3-16 How is cash received through remittances used? (multiple responses allowed)



Community Representatives' Interviews

Very few interviewees reported receiving remittances from overseas specifically to access healthcare services and most of those who did were from Mogadishu. Hawala was the most frequently cited channel for remittances. It should be noted that PSPH did not ask about remittances for other household needs or remittances from individuals within Somalia, and therefore this does not capture all potential inflows from relatives.

Money lenders

There are no formal money lenders available for low-income people in Somalia. The majority of Somalis get informal loans from friends, relatives, and owners of small shops in their neighbourhoods without any conditions. Bank institutions and business companies do not provide cash loans to their beneficiaries. They buy goods for their clients and the client must pay back the cost of the goods to the bank on agreed time frames and profit rates. To get loans from banks and companies, the individual has to have a reliable source of income, valid documentation and a guarantor.

Family and other sources

Within the Somali community, contributions from family and friends are a very common source of healthcare payment. There are monthly based contributions from members of the family/relatives and contributions which are made based on need. When a family member gets sick or is involved in an accident, relatives will raise money for him/her. Money is often transferred via mobile or hawala.

Social media and crowdfunding

In recent years, social media and crowdfunding has become significant among the community. One of the successful crowdfunding movements is Caawi Walaal ('Help a brother') initiative created by a group of Somali youth (local and diaspora) in response to 2016–2017 famine in Somalia. They crowdfunded around twenty thousand dollars used for water trucking services, food assistance and medical supplies for communities living in hard-to-reach villages across the country. In addition to that, there are other crowdfunding movements aimed at establishing businesses and supporting people's health expenses.

3.A.2.b Healthcare service providers

Key healthcare service providers (supply side) are enumerated in Table 3-5 below and then described in detail in the text that follows.

Table 3-5 Key stakeholders - healthcare service providers

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
Regulatory					
Federal Ministry of Health	Regulation and legislation Policy development Advocacy	Federal Ministry of Health's role is to lead the health sector and develop regulations, policy and strategic development, financing, coordination, monitoring and evaluation of the health sector performance. Role also covers demand side.	Somalia Federal member states	▪ Other government agencies, departments and ministries. ▪ Development partners ▪ NGOs and civil society ▪ Religious leaders ▪ Health care providers ▪ Medical insurance companies	▪ Improved health outcomes ▪ Reduced public health expenditure ▪ Equitable health services throughout the country ▪ Implementing Universal Health Coverage (UHC).

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
				▪ Agriculture sector ▪ Medical and health teaching & training institutions ▪ Regional and district administration	
Ministry of Health Develop-ment (Somaliland)	Regulation Coordination Service provision	The Ministry of Health Development is a ministry that is responsible for the health system; it is also responsible for proposing and executing government policy of health. Role also covers demand side.	Somaliland (Hargeisa)	▪ Regulator of the health sector ▪ Operates independently of the Somalia Federal Ministry of Health ▪ Recently signed MOU with World Bank	▪ Somaliland has its own health regulatory regime that is in some ways more advanced than in the Federal areas, although enforcement capacity is weak. Health agencies include the National Medicines Regulatory Agency (NMRA) and National Health Professions Commission (NHPC).
Ministry of Health, Puntland State of Somalia	Regulation Coordination Service provision	MoH Puntland works to support the Puntland people in attaining better health, improving health outcomes, and providing quality health services. Role also covers demand side.	Puntland (Garowe)	Maintains independent relationships with multiple stakeholders such as UNICEF, WHO, UNFPA, IOM, WFP, World Bank, Save the Children, WVI, MSF, Tadadum Social Society, Care International and the Somali Red Crescent Society, who both finance and provide health services directly.	Focused on Puntland only.
Public Hospitals					
The Somali Turkish Recep Tayyip Erdogan Training and Research Hospital	Health care services (in-patient, out-patient, diagnostic, specialized medical services, surgery, dental, ophthalmic, and other specialty services.	This hospital was built and funded by the Turkish government and reopened in 2015 (250 beds). The MoH considers it a public hospital. It is a hybrid publicly funded hospital but operating on a private subsidized manner. It reports to the Turkish Ministry of Health. It is partially staffed by Turkish health personnel with a training component for Somali doctors. Co-managed by Somali and Turkish authorities. The hospital offers specialised treatment within general surgery, thoracic surgery, orthopaedic care,	Mogadishu	▪ Health care providers ▪ Government institutions mainly Ministry of Health ▪ Pharmaceutical companies ▪ Turkey's ministry of health ▪ Turkey medical associations	People must pay for services and the majority of the clients are mothers and children as well as members of the diaspora (Somalis who live abroad). Patients have to pay a fee for services, but these fees are subsidised so that consultation prices are consistently cheaper than on the open market.

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
		neurosurgery, paediatric surgery, cardiovascular surgery, traumatology, obstetrics, gynaecology. urology, infectious diseases, cardiology, neurology, ophthalmology and pulmonology. The hospital also has a dialysis centre one psychiatrist.			
Banadir Hospital	Public Hospital	This is a public hospital built by the Chinese government in the early 1960s and reinitiated and renovated by the Ministry of Health in 2019. It is a 700-bed hospital which serves children and women's reproductive/gynaecological health and has a TB and an HIV centre.	Mogadishu	This hospital is largely supported by the Ministry of Health (MoH) and international agencies such as UNFPA, UNICEF and other NGOs.	The staff are mainly employed by the government and their salaries are paid through the civil servants' portal. This hospital is particularly sought by mother and children from poor households because of the free services.
Forlanini Hospital	Public Hospital	This public hospital was originally built in 1932 by the Italian Government as a referral hospital for tropical diseases, as well as for mental health and other diseases. Up until the fall of the Central Government of Somalia in 1991 it was Somalia's largest facility specialised in mental health (100 bed ward). Most of the buildings have not been rehabilitated since the end of the civil war.		The hospital is provided with medicines by WHO and receives other forms of support by other donors such as Muslim Aid.	▪ Specialised treatment within multidrug resistant TB, nutrition, and mental health. ▪ The mental health ward consists of one psychiatrist, a psychologist, a medical doctor, two nurses with formal degrees, two experienced nurses, a lab technician and a pharmacist as well as practical staff. ▪ Most of the patients are from poor households, those who cannot afford to pay consultation fees.
De Martino Hospital	Public Hospital	De Martino Hospital is the only tertiary hospital in the public sector with an intensive care facility for critical care.	Mogadishu	Funding, equipment, and HR support from donors including WHO, IOM, and the Government of Finland.	Main referral hospital in Mogadishu for the treatment of COVID-19 patients.
Medina Hospital	Public Hospital	Medina Hospital in the western part of the capital focuses on trauma and emergency maternal medicine.	Mogadishu	Supported by the International Committee of the Red Cross (ICRC). The ICRC supplies the hospital with surgical equipment and medicines, pays for running costs such as salaries and fuel purchases, and helps to repair and upgrade facilities. Also	Medina hospital treats all patients, regardless of their clan and religious or political background.

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
				receives support from the Government of Qatar.	
NGO, faith-based, and donor-funded					
Save the Children International (SCI)	Humanitarian relief	SCI is one of the biggest INGOs that works across the country. They are operating since 1951. They are part of SHINE consortium for Somali health and nutrition program funded by FCDO. They run many centres that provide basic health services across the country. They also have education and livelihood project. For their livelihood projects, they distribute food vouchers to their beneficiary.	Somali region	They have a relationship with government, with donors, with other INGOs. Also, they have relationships with local authorities and the communities since they are the beneficiary of the organizations projects.	They provide free primary healthcare services to the population.
Alight	Humanitarian relief	Alight was previously known as American Refugee council (ARC). They have been working in the country for many years. They provide health and nutrition services and support many health facilities in Mogadishu, Kismayo and Hargeisa.	Somali region	They are working with the government. Also, they have relationships with other NGOs, communities, and donors.	
International Committee of the Red Cross (ICRC), mostly works through the Somali Red Crescent Society	Humanitarian relief	ICRC works with the Somali Red Crescent Society to help provide humanitarian relief to the victims of conflict and natural disaster. Somalia is one of ICRC's largest operations globally with 11 offices in country.	Somalia	ICRC in Somalia largely works in collaboration with the Somali Red Crescent Society (SRCS).	They provide free primary healthcare services to the population. They provide medicines and medical supplies to some public hospitals in Mogadishu, Kismayo and Baidoa. ICRC provide emergency ambulance services in different parts of Somalia.
Action Against Hunger (AAH)	Humanitarian relief	AAH provides humanitarian assistance - mostly access to nutrition treatment and prevention programs through fixed and mobile treatment sites and access to quality primary healthcare services with a focus on children and women.	Somalia	Federal Ministry of Health, other NGOs like Concern Worldwide, UN bodies, International civil society organisations, national and local community-based organisations	They provide free primary healthcare services with a focus on nutrition and WASH programmes.
Population Services International (PSI)	Global health NGO	PSI is involved in marketing affordable health products and services e.g. mosquito nets, condoms, HIV testing. PSI works with the commercial sector in reproductive health, diarrhoea prevention & treatment, fever case management, and childhood nutrition and is often involved in direct interventions	Somali region		

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
		providing free or subsidised health commodities.			
UN Agencies (primarily UNICEF, UNDP, and UNFPA)	Humanitarian relief	UN agencies receive approximately 30% of donor funds targeting healthcare in Somalia and work with Somali health authorities to provide the Essential Package of Health Services (EPHS). The EPHS structure is an extensive range of free health services that will help establish a medical standard for the country.	Somali region	UN agencies provide a proxy public healthcare delivery system on behalf of the government.	UHC, supporting vulnerable populations, MNCH, childhood vaccines.
Donors (SDC, FCDO, USAID, WB, SIDA, Finland, Italy)	Donor agencies	They are the main stakeholders for funding NGO health providers, UN agencies, Red Cross/Red Crescent and supporting public healthcare provision. Also, they give support to the government.	Somali region	They collaborate with the Federal Ministry of Health, NGOs, UN agencies, and civil society organisations.	While they are not involved in direct delivery of healthcare services, a majority of the health programs in Somalia are direct delivery programs funded by donors with a primary focus on public health.
Private Sector (Independent Operators)					
Kalkaal Hospital	Private Hospital	Private healthcare facility founded and funded by some Somalis in the diaspora and businessmen in the country.	Mogadishu	There is not much engagement with other stakeholders, but the hospital is largely connected with the suppliers of pharmaceutical products and equipment. Sometimes they refer difficult cases and conditions requiring long time treatments such as cancer to other hospitals.	Many of the hospitals give incentives or commission to the foreign doctors who perform surgeries in their hospitals.
Ladnan Hospital	Private Hospital	Ladan was established in 2016, has a capacity of 25 beds. The hospital specialises in general medicine, obstetrics, gynaecology, general surgery, paediatrics and ear, nose, and throat. The doctors have facilities which can be used for laparoscopic and open surgery. It has a laboratory which is equipped with fully automated biochemistry and haematology analysers as well as doppler ultrasound with echocardiography and ECG.	Mogadishu		

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
Jazeera Hospital	Semi-private	This hospital was constructed by the government of Bahrain to support the Somali community through Manhal organization which is charitable hospital. It later became a hospital run under a Public Private Partnership arrangement with the Ministry of Health and some local Somali investors.	Mogadishu	They have relations with the government, suppliers, and experts from the Arab world in radiology (mainly from Emirates). Sometimes they refer difficult cases and conditions requiring long term treatments such as cancer.	The incentives given in most of the hospitals are based on the activities or the surgical interventions performed by the foreign doctors.
Private Sector Networks					
1.Commercial for-profit					
Caafinet	▪ Doctors' registration ▪ Capacity building of the doctors ▪ Emergency preparedness ▪ Creating partnerships with government	SDC funded the pilot testing of the Caafinet to test its viability. Caafinet is an independent network of private clinics, hospitals, pharmacies, and labs with 200 members serving approximately 250,000 Somalis monthly. Some of the member services the network provides include – training, quality assurance, clinical audits and other services in the pipeline include pooled procurement and insurance through a Third-Party Administrator (TPA).	Mogadishu, Kismayo, Galkayo	SDC; Federal Ministry of Health and independent commercial health providers.	Caafinet members are vetted to ensure credentials are of standing to be join. Caafinet is funded by its members
2.Donor- or government-subsidized					
Tunza	Donor subsidized social franchise	PSI- Tunza provides products and services in the areas of sexual and reproductive health, diarrhoea, pneumonia and malnutrition. Specific focus areas include reducing maternal mortality, promoting health of children under 5, birth spacing/family planning). Tunza provides subsidised commodities which are sold at below market rates through private sector delivery mechanisms. Programme ended in late 2020.	Somaliland	Federal Ministry of Health, PSI and other donors and NGOs	Tunza is donor funded (primarily UKAid and USAID)
Bulsho-Kaab	Social franchise network	Bulsho-Kaab is a PSI-led pharmacy social franchise that offers an integrated package of services that included a range of reproductive and child health interventions at affordable prices.	Somaliland	Federal Ministry of Health, PSI and other donors and NGOs	They are donor funded and serve low-income communities
Supply Chain					

Stakeholder	Function(s)	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
Drug import and wholesale organization (DIWO)	Pharmaceutical wholesalers and distributors	DIWO is a joint venture of 25 pharmaceutical wholesalers. DIWO covers most of the human and veterinary pharmaceutical needs of Somaliland. DIWO was established in 2010 by few import companies when drug importation was disrupted. DIWO is directly affiliated with reputable pharmaceutical companies globally, particularly India, Pakistan, Turkey, Cyprus, Greece, UK etc. DIWO has a self-regulated quality assurance mechanism. They also randomly select samples of frequently used medicines and send to Kenya Quality control labs to ascertain quality of their medicines.	Somaliland	Global pharmaceutical companies and local pharmacies	DIWO contributes urgent emergencies and community needs across Somaliland.

3.A.2.b.i Public sector

The majority of the public health facilities in Somalia are located in the capital and larger cities with few facilities outside the urban areas. Public hospitals may be run by the Somali health authorities, international NGOs, the UN or in collaboration with other national governments (e.g. Turkey). None of the public hospitals provide the full range of secondary or tertiary services and are only functional for a limited range of services[99] especially maternal and child health services.[100] The six core programmes in Somali public health facilities are: 8 i) Maternal, reproductive health, neonatal health and nutrition; ii) child health and nutrition; iii) CDC (centre for disease control), surveillance and WATSAN (water and sanitation); iv) first aid and care of critically ill and injured; v) treatment of common illnesses; and vi) HIV, sexually transmitted infections (STI) and tuberculosis (TB).[101]

There are four different levels of public health facilities in Somalia:[102]

> Primary Health Units (PHUs): located in the rural areas and the most frequently found infrastructure
> Health Centres (HCs): at the sub-district level
> Referral Health Centres (RFCs): at the district level
> Regional Hospitals (RHs): located in the regional capitals.

According to the HIPS & City University of Mogadishu there were in 2019 a total of 661 operational public health facilities across the federal states of Somalia (Table 3-6). [103]

Table 3-6 Functional Public Health Facilities by State as of 2019

Banadir	Hirshabelle	Jubaland	Galmudug	Southwest	Puntland	Total

99 Finnish Immigration Service (2018). Somalia: Fact-Finding Mission to Mogadishu and Nairobi, January 2018, 5 October 2018.
100 Maternal health refers to measures taken for control and improve health during pregnancy,c hildbirth and the postnatal period. Newborn and child health consists of child immunisation, treatment of common diseases, nutrition. WHO, Maternal, Newborn, Child and Adolescent Health. https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing accessed April 28, 2021
101 HIPS & City University of Mogadishu (2020). Somalia's Healthcare System: A Baseline Study & Human Capital Development, May 2020, p.13 http://www.heritageinstitute.org/wp-content/uploads/2020/05/Somalia-Healthcare-System-A-Baseline-Study-and-Human-Capital-Development-Strategy.pdf p.13, accessed April 28, 2021
102 WHO (2016) op. cit. p.24
103 HIPS & City University of Mogadishu (2020), op. cit. p 41

Total	61	81	93	92	29	305	**661**

Source: HIPS & City University of Mogadishu (2020)

Banadir Hospital in Mogadishu is a public hospital and one of the largest hospitals in Somalia. The hospital was built by the government of China in the late 1970s and officially opened in 1977. It was later renovated and reconstructed by the government of Somalia through the support of international organizations.

The Somali Turkish Recep Tayyip Erdogan Training and Research Hospital (also referred to as either the Turkish Hospital or the Erdogan Hospital) in Mogadishu is considered by a UN source as the leading hospital in the country in terms of capacity. This hospital holds a special position in the health sector and the Ministry of Health considers it a public hospital. It was built and funded by the Turkish government in 2015, in a time where Turkey was investing considerably in Somalia. It is partially staffed by Turkish health personnel but has a training component to build the capacity of Somali doctors. It is co-managed by the Somali and Turkish authorities.

3.A.2.b.ii NGO, faith-based, and donor-funded

As cited above, there is a very large presence of development partners on the ground who run healthcare facilities in Somalia, in particular UN-run or NGO-run facilities.[104]

There is also a network of hospitals managed by Manhal Health Care, which is part of the bigger Manhal Charitable Organization. They provide standard primary and tertiary healthcare to general communities in different parts of the Somali region using local and international donations to build self-supporting healthcare projects that operate on non-profit cost sharing basis. Member hospitals operate as private enterprises and rates are the same as for-profit providers. Manhal supports the construction and maintenance of the building and in some sites provides the land where the hospitals are built.

Yardameli Foundation from Turkey also runs a mother and child hospital in Mogadishu. The hospital operates as private, but the construction and operations are supported by the foundation. Some of the projects Yardameli Foundation supports includes covering the cost of certain services in public hospitals, similar to UNFPA that supports comprehensive emergency obstetric, maternal and neonatal care programmes.

The HIV treatment section in some of the public hospitals is largely supported by UNICEF and tuberculosis by World Vision under the partnership of the Global Fund.

All the implementing local NGOs interviewed are funded from external funding sources and provide healthcare including emergency services to the vulnerable across the country including marginalised areas. All the NGOs are offering free services. Patients do not pay any OOP charges.

104 Danish Immigration Service (2020), op. cit. p.26

There did seem to be a network of NGOs under the Somali National Consortium which informs other NGOs what the premise of work is for each NGO. NGOs working in the humanitarian field are associated with the health clusters up to national level using the DHMIS under MOH.

Health NGOs and faith-based implementers have a good working relationship with the government, but no mention was made as to whether the government was involved in the decision making when a new project was being developed. Instead, it seemed that the geographical location of projects is primarily donor-driven and based on population needs once a needs assessment has been conducted by the donor and community. The community leaders are called upon to identify those in their community who are in the greatest need of healthcare.

> "I encourage health insurance, its more effective that could allow to buy $20 insurance package for up to $3000 health service. It's difficult to use out of pocket money to pay for health facility"
> "The community contributed one year running cost for a facility built in their village, the running cost included the salary of the staff, cost of the medicine and equipment. The facility was providing free health services to the community. When the year ended, we couldn't proceed as the community did not pay their contribution.
> Somali Red Crescent

Projects have specific objectives and vary in duration from annual to multi-year programmes. The humanitarian programme run by Somali Red Crescent has no life span and runs an annual budget of around US$1.2 million – US$1.5 million. Some of the local NGOs specialise in specific health sub-sectors. For example, the Somali Red Cross focuses on primary care, Water and Sanitation Hygiene (WASH) and Maternal and Childhood Health (MCH). New Ways Organisation provides secondary and tertiary care including surgical interventions. It was still felt that basic healthcare including addressing malnutrition, reproductive health and immunization of children are areas which, despite the NGO services, are still under served especially for the poor.

All the NGO and faith-based providers had a system in place for referring cases they could not handle which was to send clients to the largest or nearest Government hospital. There was a mixed response on finance from the NGOs who use vouchers and cash transfers for other activities but not for healthcare, as services at their facilities are free.

All supplies (medical and non-medical) are from the local commercial market where the NGOs have formed links with supply companies. Health insurance was seen to be a good idea to help the poor and underserved. The NGOs mentioned that to achieve sustainability the government will need to fund healthcare services. This could be managed through cost sharing and local fundraising and ownership.

3.A.2.b.iii Private sector

The private healthcare sector is the main provider of health services in Somalia as 90 percent of the population is estimated to use private healthcare facilities. Between 60 to 80 percent of all curative services are estimated to be covered by private health facilities. A study by Oxford Policy Management in 2015 identified approximately 3,289 private health facilities in Somalia. The 2,253 confirmed private health facilities included 1,279 in states controlled by the Federal Government of Somalia (FGS), 228 in Puntland, and 746 in Somaliland. Overall, 79 percent of private facilities are in urban areas and 20 percent in rural areas, although Puntland has a significantly higher proportion of facilities in rural areas than states in the FGS or Somaliland.[105] The large majority of private health facilities (79 percent) are located in urban areas and only a small minority in the rural areas.[106] Private healthcare may be provided as commercial for-profit hospitals (e.g. Ladnan Hospital), clinics, and pharmacies, as well as by the previously described semi-public arrangements (e.g. Somali Turkish Recep Tayyip Erdogan Training and Research Hospital), or as UN-run or NGO-run facilities. [107]

105 Buckley, O'Neill, and Aden (2015), op. cit.
106 HIPS & City University of Mogadishu (2020), op. cit. pp.14-15
107 UNFPA: 4, Tana Sub-Study: Mogadishu

The Ministry of Health considers the private sector to be dominant because of their better capacity, service delivery, diagnostic equipment, and experienced staff. Dual practice is common (professionals operating in both public and private sectors). However, the private sector operates mainly in urban areas and have limited reach in rural areas similar to public health facilities. Private facilities offer specialised and sometimes advanced treatment, but treatments such as a minor operation may be expensive, which means that only higher-income Somalis can afford them. Due to lack of regulatory oversight, there is evidence of prescription of inappropriate treatment, tendency to conduct unnecessary laboratory tests, excessive use of higher diagnostic technologies and overcharging – including the widespread practice of further appointments for follow-up – which inflates costs.

3.A.2.c Independent operators

3.A.2.c.i Hospitals

Private hospitals are mainly located in urban areas and have limited reach in rural areas. The establishment of a hospital requires minimum or no registration and accreditation. The quality of the services is virtually uncontrolled by the government authorities and there are reports of malpractice and negligence amongst private healthcare service providers. Access to private hospitals is difficult for the poor as services are frequently unaffordable to them.

Interview Findings

Hospital Directors interviewed at the three hospitals in Mogadishu and Hargeisa stated that payment for care is mostly OOP; 85 percent by mobile transfer or cash, and a few by insurance (Takaful and Amaanah). The use of hospital insurance cards was mostly limited to international staff and charities. While some Somalis had insurance cards the numbers were few. The two private hospitals give credit to clients who do not have cash ready at the time they require care. For patients that truly cannot afford to pay, there are discounts, and some facilities have a CSR/donation programme which can be operationalized once an evaluation of the client's financial and family status has been undertaken. From this evaluation, it is determined if the client can pay partially or needs full financial support. The cost of any service is the same irrespective of the purchasing power of the client – there is no price differentiation.

The hospitals provide services including some specialty services (the exact depth of specialty is not known) whether they are government or privately owned. Both the public and private sectors provide services according to the needs of the people, but private ones tend to have more specialist services. A hospital in Mogadishu provided free maternal and childcare but whether this hospital is funded or subsidised by an NGO is unknown.

The health service packages are based on the EPHS in the public sector and on market demands in the private sector. New specialists' services are continually being introduced (measured by demand and hospital business plans) and there is room for growth in fertility/IVF, cardiology, MRI, and pediatrics as well as geographic expansion. If a specific service is not found, Somalis who can afford it travel overseas for treatment.

Respondent hospitals also agreed that there was need to strengthen supply chain mechanisms for all hospital consumables including laboratory reagents for private hospitals. All the laboratory services are profitable; however, the most profitable services are for patients undergoing surgery as an inpatient. Any outpatient investigation such as an endoscopy is not profitable.

The private hospitals felt that it was the lack of financial ability of many Somalis to pay for healthcare or the lack of good governance that mainly affects the country's health sector. Overall, the suggestion made by private hospitals to improve the quality of services for the poor is to provide financial protection through insurance and fundraising. Additionally, respondents noted medical transportation services to hospitals for patients living in remote areas would also improve the delivery of healthcare to Somalis.

In Mogadishu some of the private hospitals belong to the Caafinet network; however, this was not the case in Hargeisa where none of the hospitals were part of any network. There appears to be an unclear referral system, but the private hospitals have inward and outward referrals based on the client's need and their own

knowledge and, it is assumed, experience of knowing where the services can be found. All the hospitals agreed that they have a good business working relationship with other hospitals. No charge is made for referrals.

Respondents agreed that the public largely depends on the government for healthcare services. And while this is the case, the private sector is expanding using their own market strategies both by service level and geography. Having said this, the private hospitals also noted that there are limited suppliers of pharmaceuticals and constant uncertainty of their quality remains a major challenge. This shows a need to strengthen the pharmaceutical supply chain. It is important to note that Somalis are not very trusting of foreigners, especially with insecurity issues associated with foreigners. This is relevant because within Somalia there is a limited number of skilled health workers and there are often needs to bring in foreign medical personnel. This shows that there are opportunities to employ more properly skilled Somalis within the private health sector.

To reach the remote population, the private hospitals strongly felt private facilities can conduct outreach programmes to reach marginal areas and serve the poor. Respondents suggested it could be a partnership between the government and private facilities which would help offset the costs. It was mentioned that only government and NGOs can serve rural and marginalized regions as they are known and recognized in comparison to private health providers who have limited presence in those areas.

3.A.2.c.ii Clinics

These are small hospitals, and they are mostly located in major cities and some rural areas. There is no comprehensive mapping of the numbers and locations of private clinics. They are frequently set up by diaspora returnees with health qualifications.[108] However, the interview findings revealed that clinics are operated mainly by non-medical professionals and businessmen investing in the sector as a source of income generation. As a health facility, the clinics provide primary (due to the referral system not being fully functional) and some secondary care.

They mainly operate as general and dental clinics and do not provide in-patient services and operating theatre services. Clinics are often able to deal with minor emergency and wound care services. Access to the clinics by the poor is typically good, giving a significant market to clinics within the mass market. The rates for services are also generally lower compared to the private hospitals.

3.A.2.c.iii Pharmacies

The pharmacy sector is a major industry in Somalia as their establishment requires only investment since regulations are virtually non-existent. Local pharmacies are one of the fastest growing types of business in the Somali health sector across Somalia – even in Puntland and South Central. They often act as de facto health service providers, with patients going to ask for advice on how to diagnose and treat their symptoms – often because they are seen as more cost-effective or quicker alternatives to public clinics, and they tend to have much longer opening hours. Some pharmacies have responded to this trend by introducing laboratory and basic outpatient facilities, and a minority also employ a resident doctor or nurse (thereby offering secondary as well as primary facilities).[109]

Private pharmacies are described as ubiquitous and offer a range of services that are accessible to a wide proportion of society. Several studies have suggested they are the most used source of health care in all zones of Somalia. Private pharmacies are present in nomadic and settled rural areas, as well as in every corner of urban centres.[110]

The existence of a pharmacist, or other qualified medical practitioner, within a pharmacy is rare and there is a clear need for more adequate training. There are evidently a huge number of private for-profit pharmacies

108 Buckley, O'Neill, and Aden (2015), op. cit.
109 Ibid
110 Mazzilli, Caitlin, Austen Davis, and Dr. Rehana Ahmed (2009). The Private Sector and Health: A Survey of Somaliland Private Pharmacies, UNICEF

and some of the data on these numbers, relays that there are over 780 sites (private pharmacies) in Somaliland and 392 pharmacies on the main roads of Mogadishu alone.[111]

There is no medicine manufacturing in the Somali region; all medicines are imported. The pharmaceutical products can be procured from any place and storage can be done without reference to any standard protocols. Also, the administration of the drugs and prescriptions can be done by sellers who are not educated. The pharmacies are mainly connected to major suppliers who import the products to Somalia. The costs at which drugs are retailed is determined by the seller and they are typically not favourable to the poor populace.

3.A.2.c.iv Laboratories

Many hospitals have their own diagnostic centres, especially laboratories. As mentioned earlier, some pharmacies also set up laboratories as part of the services offered. There are few standalone laboratories but there are some advanced ones which have entered the market recently that are performing pathological and histological examinations of tissues, which enhances the diagnostic capacity for cancer related conditions. The quality and the accreditations of these diagnostic centres is of huge concern and the staff are largely undertrained or lack the capacity to handle complex cases.

3.A.2.c.v Informal practitioners

Informal practitioners are a trusted source of healing from disease by many in the Somali community, especially for the uneducated. There are many different types of these informal practitioners, among them traditional healers, Islamic healers, traditional midwives who operate as gynaecological specialists and use some burning methods for healing certain diseases.

Traditional Healers: Unlike privately owned clinics, hospitals, and pharmacies that offer 'modern scientific medicine', traditional medicine practitioners provide herbal and other traditional treatments at the primary facility level. Some of these traditional healers are well trusted by Somalis because they distinguish themselves as coming from a long history of healers. Traditional healers are one of the most neglected and overlooked private sector health actors despite approximately 60 percent of the population seeking care from them before resorting to the formal health sector.[112] People distinguish one traditional healer or Islamic healer from another by word of mouth; as one person gets better or is healed, the word spreads about their efficacy. These traditional healers also use social media to publicize their services, citing examples of what they have done/people healed etc. There are examples of very profitable, almost famous, traditional healers across Somalia who can receive up to 150 patients a day.

In addition to the prominent role that the traditional healers are thought to play in rural areas, where alternative options are fewer and health education levels are lower, there is an emerging trend of the diaspora increasingly turning to traditional practitioners. Seeking care from traditional healers is common in rural areas and increasingly in the major cities.

Somalis have for ages believed in natural ingredients and herbs for treatment. These traditional practitioners prescribe certain herbal medications made of combinations from plant extracts and some oil extracted products. Traditional healers have evolved into more conventional modern-day medicine practice like packaging their products as pharmaceutical companies. Supplements from Asia have infiltrated the market and most herbalists now market these products, mostly from India (Ayurvedic medicine) and China.

A few traditional healing practitioners do referrals as a way to look formal, e.g. they might refer a client to a formal lab for tests in a bid to look formal or credible. They make patients believe they can interpret medical results such as lab tests, x-rays and other diagnostic results.

111 Clark, R. (2010) A Condom Distribution Strategy for AIDS Control and Prevention in Somalia, A Proposal for UNICEF/Somalia
112 Affara, F. (2011) Operationalising the Somaliland National Health Professions Council

There are no laws or rules that currently prohibit the practice of traditional healers in Somalia. Herbal institutions are not regulated, and medications and qualifications of practitioners are highly questionable. There is also concern with their pricing which has can be extortionist in cases.

Islamic Spiritual Healers: They are healers grounded in Islam and favoured among the Somali community. Like traditional healers, Islamic healers provide acceptable alternative treatments and highly recognised in Somalia. Some people leave formal hospitals and go to Islamic healers who operate like traditional healers. Islamic healers are usually Islamic leaders or elders in the community and the charges for their services are not uniform; they have no fixed rates for the services. In some cases, like the traditional healers, Islamic healers have been known to charge exploitative amounts.

3.A.2.d Networks

3.A.2.d.i Commercial for-profit

The only known commercial for-profit healthcare provider network in Somalia is Caafinet which was established in 2017. Caafinet was set up with funding from the SDC with Cardno Emerging Markets (EA) as the technical assistance partner and advisor, while the local implementing partner was Hode Consulting. The objective of the pilot was to test the market viability of a private for-profit health provider network as a means to expand access to quality and affordable healthcare to Somalis. Using an MSD approach, the commercial health network was intended to introduce a new approach to expand affordable healthcare service delivery to Somalia's mass market – the poor – using sustainable business models.

Caafinet's network is composed of independent hospitals, clinics, laboratories and pharmacies providing primary and secondary healthcare services in Somalia. The logic is that by networking together trained professionals, a uniform brand can be created which healthcare consumers will recognise and under which quality will be controlled. Further, consumers (i.e. patients) will be more likely to access a recognised brand that represents quality and affordability, thereby increasing positive health outcomes.

Caafinet has a secretariat which manages the network's administrative tasks and coordinates the for-profit member hospitals, clinics, and pharmacies. Prospective commercial providers who want to join Caafinet submit an expression of interest after which Caafinet conducts a due diligence investigation. In the due diligence process, a Caafinet secretariat staff visits the applicant's facility with a checklist of requirements, which if fulfilled, qualifies them for network membership. Once the applicant meets the requirements such as having all valid medical qualifications and operational licenses, they sign an MOU and pay their membership dues to become Caafinet members. During the one-year pilot period, 134 members joined the franchise network and began operating under the network banner, exceeding the 100 members targeted for the first year.

Technical assistance to set up the Caafinet network included strategic planning, brand development and adoption, business skills training, member training, and facilitation of pooled procurement formation. The pooled procurement has not yet started as of early 2021; however, this is still an area that Caafinet is intending to pursue to ensure quality assurance and address gaps that currently exist in the pharmaceutical supply chain. Another key area that Caafinet has not yet been able to address is the development of a consumer financing model for its members, which will still need to be explored as this will help ease the OOP burden by using innovative models to structure financing that takes into account current savings and expenditure habits.

Caafinet has used its strategic placement to provide a coordinated platform and formidable voice for the private sector to influence and impact public sector health policies. Caafinet leadership is recognised by the MOH and regularly participates in public-private policy dialogue. Benefits of being part of the Caafinet network beyond strong representation at the national policy level include business skills training and mentoring, branding, and marketing support under the Caafinet brand.

Caafinet's membership has grown since the SDC-funded pilot ended and the network now has 200 member facilities in Mogadishu, Kismayo, Baidoa, and Galkayo. Caafinet members serve between 200,000 and

250,000 Somalis per month.[113] On an annualized basis, this is 2.4 million to 3.2 million patient visits per year; while there are no reliable statistics on how often Somalis visit health facilities, the most recent statistics from an African country are from South Africa in 2012, where 2.5 annual doctor's consultations per capita were reported.[114] Using this number as a rough benchmark for Somalia, Caafinet members serve approximately one million Somalis annually. The network started with a modest investment of CHF 200,000 in technical assistance from SDC.

3.A.2.e Donor- or government-subsidised

Tunza

Between 2018 and 2020, donors (USAID and DFID/FCDO) funded the establishment of Tunza in Somaliland, a social franchise network of independent pharmacies that sell a variety of subsidized and non-subsidized quality medicines and supplies to low-income communities. Tunza was implemented by Population Service International (PSI), an INGO. The network was set up as a 9-month pilot consisting of 17 independent private sector pharmacies under the Tunza brand name, 10 in Hargesia and 7 in Berbera and Sheikh. The pharmacies were selected to implement and deliver a standardized package of quality health services aligned with the EPHS framework. Tunza's most common service offerings included maternal services, diarrheal disease, respiratory tract infections (RTI's), gastrointestinal (GI), family planning (injectables and contraceptive pills, primarily), and non-communicable diseases (NCDs) serving 20-50 clients on average daily.

Benefits to members are listed as:

> Business and health trainings
> Clinic and quality improvement
> Health service consumption reporting
> Tunza branding for demand creation
> Professional networking
> Supportive supervision

The Tunza pilot was designed to answer three key questions designed as case studies:

> Case Study 1: Does the private sector have the capacity to collect and report high quality health service data that will be linked to the National HMIS and demonstrate the private sector's contribution to coverage and utilization rates?
> Case study 2: Does the private sector have the capacity to provide quality and affordable services to the different levels of the socioeconomic quintiles?
> Case Study 3: What are the factors that attract and keep clinic owners in the franchise network?

Preliminary findings showed a willingness of the private sector to share data, comply with the national treatment guidelines and to invest in improving quality of care.

PSI worked with the commercial private sector using a proprietary variation of the MSD approach which PSI calls MDA. However, the question of sustainability within the programme is of concern (which has more to do with how the programme was implemented than what it was intended to do; for example, subsidised commodities were used, and it is unclear what the members contributed to running the network and how it was governed). There is no information publicly available as to how much funding USAID and the DFID (FCDO) SHINE Supply Programme put into the pilot and information on whether the member pharmacies broke even or made a profit between 2018 and September 2020 when the pilot ended.

Field visits to a Tunza location in Hargeisa in April 2021 showed that post-Tunza funding, the subject private sector pharmacy has reverted to a commercial business model selling at current retail market prices. Subsidised medicines provided through Tunza were finished except for some leftover stock of family

113 Interviews with Caafinet management, March – April 2021
114 http://stats.oecd.org accessed April 20, 2021

planning commodities. Subsidised services were over, and they now provide similar services to those that other local retail pharmacies offer to the community. It was mentioned that their business volume has been affected negatively post-subsidy, as they missed the large number of customers, particularly children and mothers, who had become dependent on the subsidised goods. A Tunza member in Berbera indicated during a field visit that they were working well with PSI support, but they have now lost the partner's support and encouragement. Patients were particularly attracted to Somali language instruction written on family planning labels.[115]

No new source of donor funding has been identified, and as a result the Tunza network is currently no longer operational.[116]

Bulsho-Kaab

In July 2011, PSI Somalia funded the design and set up of a social franchise network—Bulsho-Kaab, translated as "community helper"—to harness the potential of private pharmacies and contribute to the provision of high-quality services and products. The Bulsho-Kaab network was designed to offer an integrated package of services that included a range of reproductive and child health interventions, offered at affordable prices for low-income communities. Bulsho-Kaab clinics also allow private providers to generate increased revenue from an expanding clientele, which is generated by media and community awareness for Bulsho-Kaab products and services. PSI also provides on-the-job supervision for Bulsho-Kaab health providers with its team of trained medical detailers.[117] There is no public data available on the funding, membership, or coverage or Bulsho-Kaab which makes it difficult to assess the sustainability of its business model.

3.A.2.e.i Supply chain

Pharmaceutical importers, wholesalers, distributors

Somalia does not produce any pharmaceutical products, medical supplies, or equipment. Importation of products and equipment occurs at multiple land and sea border points with neighbouring countries, resulting in free-flowing distribution of goods and the circulation of substandard and counterfeit products. The pharmaceutical products in Somalia are imported from foreign countries like Turkey, India, Egypt, Bangladesh, UK and others; Most medicines are imported via air.[118] Hospitals may get their medicines from various sources: one is procured directly by UNICEF, another by WHO and yet another hospital imports its medicines directly from Turkey and therefore follows Turkish quality guidelines and standards.[119] They are imported by a group of local companies who are run by businessmen. The drugs are given to wholesalers and distributors who supply the whole country.

There are no regulations and restrictions governing which drugs are to be allowed in and which ones are not. No quality control is conducted at the ports of entry to ascertain the quality of the imported drugs neither are storage conditions for the pharmaceuticals verified by any authorities. The Federal MOH has the authority to grant licenses to private health facilities, but the ministry has not yet started to issue these licenses to companies or to pharmacies who import medicines because of limited technical capacity and insufficient legal framework.[120]

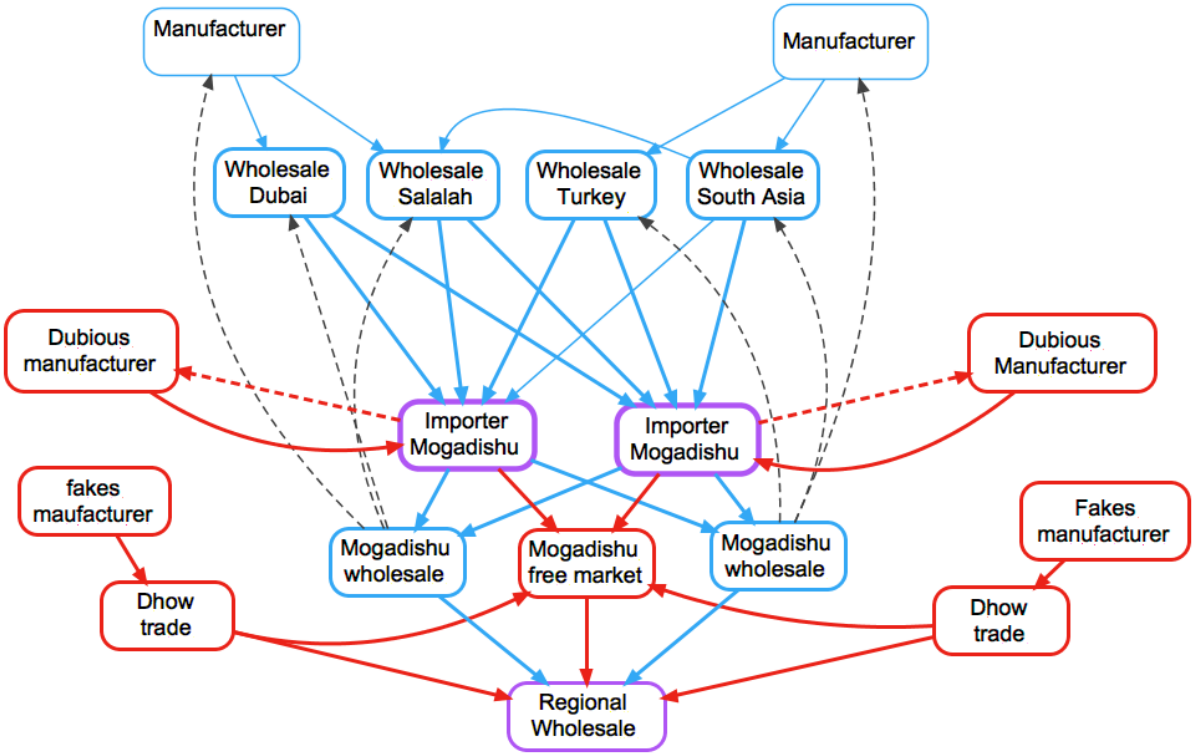
The cost at which the pharmaceutical products are sold in the market is purely determined by the owners and the importers as there is no regulatory board.

A 2017 study of the pharmaceutical supply chain in Somalia showed that medicines enter Somalia through three distinct channels: supply lines where at least the intention is to buy medicines of quality (shown in blue in Figure 3-17below); supply channels where quality either has a low or no priority; and the dhow channel

115 Field visits to Tunza locations in Somaliland, April 2021
116 Interviews with former Tunza staff in Somaliland, April 2021
117 PSI Somalia https://www.psi.org/country/somaliasomaliland/, accessed April 17, 2021
118 Danish Immigration Service (2020), op cit.
119 Ibid
120 Tana Sub-Study: Mogadishu: p. 10

that is perceived to be deliberately criminal (both shown in red in Figure 3-17).[121] The study found that it was very likely that substandard drugs were present in Somalia as there is no quality assurance mechanism, though possibly at a lower level than the 30 to 50 percent often mentioned in informal discussions.[122]

Figure 3-17 Schematic diagram of the pharmaceutical supply chain in Somalia



Source: Jeene (2017)

Equipment and supplies

Many companies import their medical equipment into Somalia; their main source is China. The biomedical engineering knowledge and companies offering these services in Somalia is limited (i.e. engineering as it is applied to clinical practice, in this case including the service and maintenance of high technology equipment such as CT scanners and MRI). The availability of recognised international brands in Somalia is limited and the products of global companies are transferred from the neighbouring countries where they have branches.

3.A.3 Competitive dynamics within the core functions

3.A.3.a Dominant or controlling players in the healthcare market

3.A.3.a.i Healthcare Funding

Public sector

Only 2 percent of the interviewed households reported that they could draw on a health insurance to pay for health expenses. Therefore, OOP expenditure is very high, and most people rely on services provided free of charge at public or not-for-profit private health facilities.

121 Jeene, Harry (2017), Strengthening affordable access to quality essential medicines in the private health sector of Somalia, Swiss Development Cooperation
122 Ibid

It is estimated that half of healthcare funding comes from external donors, who contributed US$92.1 million to the Somali health sector in 2020. As reported, the leading donors in 2020 were Thani Bin Abdullah Bin Thani Al-Thani Humanitarian Fund (Qatar), the United States Government (USAID/ODA), the Government of Germany, the European Commission, and the World Bank.[123]

Private sector

This sector is characterized by disjointed private investors holding equity in single hospitals. There are no private hospital or clinic chains across in Somalia funded or owned by major equity financiers. The nascent health insurance industry covers only 2 percent of the population as shown in the SHDS 2020.

In the health Insurance sector, Takaaful Insurance Company is dominant followed by Amaanah Insurance. Both the companies have presence across the Somali region including Kenya, while Amaanah claims presence in Ethiopia as well with referral benefits of its members to India for specialized treatment. Takaaful is reported to cover more private health facilities in the country due its early entry into the market – first mover advantage. Precise market share statistics are not available.

3.A.3.a.ii Service Delivery

Public sector

Donor money is predominantly spent to finance direct delivery of services through NGOs, UN agencies, and the Red Cross/Red Crescent, which proxy for the public sector.

In 2020, NGOs received US$56.4 million or 61.2 percent of funding, followed by UN agencies which received US$27.4 or 29.8 percent of funding, and Red Cross/Red Crescent which received US$5.4 million or 5.9 percent of funding.[124]

There are no dominant NGOs in the crowded field. Some leading International NGOs in the health sector include Save the Children International (who received the most donor funding in 2020), Médecins Sans Frontières (MSF), International Rescue Committee, and World Vision.

Proxy public sector service delivery covers basic or primary healthcare services at no cost to the population in both urban and rural areas. Public secondary health facilities located in Federal or State capitals operate on a cost recovery model despite receiving some funding and supplies support from external partners. The scope of services is limited to the available expertise. Some leading public secondary facilities include Digfer Hospital (managed in partnership with Turkish Government), Benadir Hospital (Mother and Child) and Hargeisa Group Hospital.

Private sector

Private healthcare service delivery is fragmented and there are no dominant players. In the private sector, the client's choice of where to seek services is informed by loyalty to individual doctors. For instance, Nur's Eye Hospital's popularity is dependent on loyalty to Dr. Dalmar and the Guled Specialist Hospital on Dr. Ahmed Guleed, the founder and renowned chest specialist.

Caafinet is the only functioning commercial private sector service delivery network currently operating in Somalia.

Shifa Pharmacy is a chain of pharmacies in South Central Somalia with about 15 branches in Mogadishu and the regions. All the pharmacies have harmonized prices for products with known discounts. This pharmacy chain was established about five years ago by Somali businessmen from the diaspora. They import their products largely from Turkey in bulk either by courier services or by sea. One of the main challenges they encounter is the supply of products that require cold chain. They also have a challenge in the lack of regulations of the market and the low capacity of employees from the local market.

123 https://fts.unocha.org/countries/206/flows/2020?f%5B0%5D=destinationGlobalClusterIdName%3A7%3AHealth op. cit.
124 Ibid

3.A.3.b Porter 5-Forces profile of the market

Harvard Business School Professor Michael Porter's "5 Forces" model[125] helps describe the competitive dynamics of an industry. The five forces are:

1. Barriers to entry
   How difficult or easy is it for new competitors to enter the market?
2. Supplier power
   How powerful is the supply side vs. the demand side?
3. Buyer power
   How powerful is the demand side vs. the supply side?
4. Rivalry among competitors
   How fierce is competition amongst players?
5. Substitute products
   What alternatives are available?

Table 3-7shows the 5 Forces model as applied to the Somali healthcare sector, broken down by the healthcare financing and service delivery subsectors.

Table 3-7 Porter's "5 Forces" model as applied to the Somali healthcare sector

Porter's 5 Forces	Healthcare Financing (Demand Side)	Service Delivery (Supply Side)
Barriers to Entry	**HIGH** Barriers to entry are high as it is difficult for new entrants to enter the health financing market. Finance/Insurance sector requires long and deep investments and the risks and time needed to develop and roll out insurance products are high. Insurance requires substantial customer numbers to function, as risk must be pooled and shared across a large number of policyholders. Insurance is also most profitable when there are good volumes and economies of scale due to high customer acquisitions costs. There is also a need for up-front capital to set aside a risk reserve. Mobile models have substantial software development and testing costs.	**LOW** Barriers to entry are low as it is easy for new entrants to deliver healthcare services in Somalia. With the weak and loosely regulated market, entrepreneurs with minimal investment can set up a health facility without having the necessary clinical qualifications. Informal providers can enter the market virtually at will. Pharmacies can sell medicines from various sources without quality assurance.
Supplier Power	**LOW** Supplier power for health financing companies is weak, as healthcare can be sought in Somalia without it. The health financing suppliers are few in number as most Somalis do not consider health insurance or health savings necessary at present. Consumer education is expensive and difficult.	**HIGH** Supplier power for private clinics, hospitals, pharmacies) is strong because private sector health delivery dominates the Somali health system. The private healthcare delivery system is "take it or leave it" as those who cannot pay either do not seek service or may be turned away. Providers decide what products/services to offer and set their own prices.
Buyer Power	**HIGH** Buyer (customer) power is high as private healthcare financing is nascent in Somalia. Customers determine whether they want to seek formal healthcare financing or continue covering their healthcare costs same way they have been doing over the years. Buying healthcare finance products is both optional and not well acculturated.	**LOW** Buyer (customer) power is weak; often the private clinic or hospital is the only available provider of a specific specialised service and the consumer has no choice. Consumers have virtually no influence on the products/services available nor the prices they pay.
Rivalry among competitors	**LOW** Rivalry among competitors in the health financing market is low as insurance coverage is nascent (about 2 percent); the market is immature with only three formal insurance providers. Most of the market is uncovered	**LOW** Rivalry among competitors amongst private providers in the Somali health sector is low as there are many private clinics, hospitals, and pharmacies as well as informal providers in all regions. There is a large underserved/potential

125 Porter, M. E. (1979). "How Competitive Forces Shape Strategy." Harvard Business Review 57, no. 2 (March–April 1979): 137–145

Porter's 5 Forces	Healthcare Financing (Demand Side)	Service Delivery (Supply Side)
	and suppliers do not need to cannibalise each other's business to find new customers.	market. Providers do not need to cannibalise each other's business to create demand.
Substitute Products	**LOW** Availability of substitute products is low, as there is no social health insurance and commercial insurance coverage is low with few offerings, particularly for lower income Somalis. Available substitutes may not be optimal from an equity perspective. Over the years, paying OOP for health expenditure has become the norm and raising money from family and friends to pay for medical bills is widely acceptable. Informal means substitute for formal ones. As a result, healthcare consumers often forego service when they cannot pay.	**LOW** Substitute products may be unavailable for clinical services when cost and quality of care are considered; many specialised services are unavailable at all. Those substitutes that are available may not be optimal from a health outcomes perspective. Many in the lower income groups choose informal service providers over formal ones. Many choose Islamic, herbal, or traditional remedies over clinically tested pharmaceuticals.

Source: Cardno analysis

3.B Supporting Functions

Key healthcare support functions are enumerated in Table 3-8 below and then described in detail in following text.

Table 3-8 Key stakeholders - support functions

Stakeholder	Functions	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
Industry/professional associations and advocacy groups					
Somali Medical Association (SMA)	Training, capacity building, advocacy.	Association of Medical doctors and dentists in Somalia. independent not for profit NGO registered under the laws of Somalia. Approximately 300 members.	Somalia, branches in south, central, eastern and north regions.	Collaboration with: -Pharmaceutical - Universities -Medical providers	Continuous education through training for Somali medical professionals
Somali Midwives Association (SOMA)	Improved maternal health through midwifery profession.	Independent, non-governmental and non-profit.	Somalia, both urban and rural areas	Collaboration with: -Other associations -Midwifery training institutions	Reducing maternal mortality and morbidity in Somalia.
Somali Dental Association (SDA)	Promoting dental practice in Somalia through innovation, research, education and advocacy.	Network of practitioners	Somalia	Collaboration with: -Health service providers -Insurance companies -Educational institutions	-Being a welfare organ for dental practitioners in Somalia. -Promoting oral health awareness in Somalia.
Somali Medical Laboratory Association (SOMLA)	Networking, capacity building and advocacy	Networking Somali medical laboratory professionals in Somalia and US for cross-learning	Somalia	Collaboration with: -Other associations	Organize clinics where patients without means can access quality lab care
Somali Pharmacists Association (SPA)	Networking, training, capacity building and advocacy	Membership-based professional association established in 2012	Somalia	Collaboration with: -Pharmaceutical companies -Educational institutions	Continuous upskilling and training for Somali pharmacists.

Stakeholder	Functions	Description	Location(s)	Relationship to other Stakeholders	Specific Incentives or Special Interests
				-Other medical related associations	
Medical education and training institutions					
Erdogan Teaching and Research Hospital	Training, education, and teaching hospital	Owned by the government but students pay fees for their studies	Mogadishu		
Banadir University	Training and education	Private institution	Mogadishu		
Somali National University (SNU)	Training and education	Public institution- owned by the government. Training and education and leader in curriculum development of higher studies.	Mogadishu		
SOS College of Nursing	Training and education	Public non-governmental institution. Training and education of registered nurses and midwives. Students pay for cost recovery	Mogadishu		
Mogadishu University	Training and education	Private institution	Mogadishu		
SIMAD University	Training and education	Private institution. Constructed and manages one of the biggest COVID-19 hospitalization centres in the country.	Mogadishu		
Jazeera University	Training and education	Private institution	Mogadishu		
Somali International University	Training and education	Private institution	Mogadishu		
University of Somalia	Training and education	Private institution.	Mogadishu		
Ambulance and transport services					
Amin Ambulance	Patient transportation from home, road or other places to healthcare facilities.	A privately owned ambulance services that operates in Mogadishu.	Mogadishu	Hospitals and other types of healthcare facilities.	Purely commercial service
Inspection, testing and certification organizations					
National Medicines Regulatory Authority (NMRA)	Ensures all pharmaceutical products in circulation are safe, effective and consistently meet approved quality standards.	Established in 2016 as a result of the National Medicines Policy. Implementation of their identified key regulatory functions is weak and institutional strengthening is required.	Somaliland	Somaliland Ministry of Health and WHO.	

3.B.1 Industry/professional associations and advocacy groups

Associations of healthcare industry professionals that exist in Somalia include the Somali Medical Association (SMA), Somali Midwives Association (SOMA), Somali Dental Association (SDA), Somali

Pharmacists Association (SPA), and Somali Health Workers Union (SOHWU). In Somaliland they include the Somaliland Medical Association (also SMA), Somaliland Pharmacists Association (also SPA), and Somaliland Nursing and Midwifery Association (SLNMA).[126] Membership is not exclusive to the private sector. The main functions of these professional associations are training and capacity building, professional development, and advocacy. None of them have business-related functions such as running a service delivery network. Some of these associations like the Somali Medical Association (SMA) are led by experts in the health sector, are long established, and have more influence within the government than others. The Federal Parliament of Somalia (FPS) recently enacted the National Health Professionals Council (NHPC) Act. This Act is an important step towards regulating health professionals, practice, ethics, education and provide guidance to the health professionals in the country. The NHPC Act was passed in July 2020 but is yet to be fully implemented.

A 2020 UK study surveyed the key priority areas identified by three health professions associations, although note that the respondents used different ranking scales which puts the total ranking into question.[127] The Somali Medical Association (SMA) identified service delivery as a top priority. Table 3-9 below shows the survey responses:

Table 3-9 Health priority areas of health professionals' associations

SUMMARY OF HEALTH SYSTEMS PRIORITY AREAS BY THE HEALTH PROFESSIONS ASSOCIATIONS

Professional Associations	Somali Medical Association	Somali Midwifery Association (SOMA)	Somali Health Workers Union (SOHWU)	Total (Lowest score = highest priority)
Human Resources for Health	1	4	2	7
Health Information Systems	2	6	6	14
Health Financing	3	2	1	6
Medical Products and Technologies	2	5	3	10
Governance and Leadership	2	1	5	8
Service Delivery	1	3	7	11
Health Emergency Preparedness	1	7	4	12

Source: THET/LSTM

3.B.2 Government bodies covering the health sector

Over the past thirty years, there has been limited government funding for healthcare delivery in Somalia. As covered in detail, healthcare in Somalia is financed through OOP payments, international aid and/or development funding and other non-governmental sources such as charity and other mechanisms. There are, however, some improvements over the last decade regarding healthcare funding, as a small percentage of the national budget (2 percent) has been allocated for healthcare expenditure by the Federal parliament although this does not go into service delivery at present.

Federal Ministry of Health (MOH): Leadership and governance of the healthcare sector in Somalia involve three levels: the Federal Government (FGS), the Federal Member States (FMS) governments and the regional authorities. The FGS has, together with the FMS, the responsibility for building the health system ensuring that an appropriate strategic framework and regulatory mechanisms exist.[128] This ministry is responsible for the regulation of the health sector across Somalia, including quality control of health services and medicine distribution and policy, oversight of human resource capacity development as well as

126 Sources include key informant interviews and internet and social media searches conducted in March and April 2021
127 Tropical Health and Education Trust (THET) and the Liverpool School of Tropical Medicine (LSTM) (2020). UKPHS Scoping Assessment Report Somalia, UK Foreign, Commonwealth and Development Office, p.10
128 WHO (2016). Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals, pp. 6 – 10. https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf accessed April 28, 2021

coordination between the different health sector actors.[129] According to the MOH website and in collaboration with the federal member states, a roadmap towards Universal Health Coverage (UHC) is being developed and the Ministry is also in the process of reviewing the existing essential package of health services (EPHS) so that it becomes better aligned with the UHC.[130] It must be recognised that UHC is a very long process, reflecting incremental development of financing and delivery systems,[131] and it is at a nascent stage in Somalia, currently taking the very first steps of roadmap development.

Somalia is currently part of an ongoing Primary Health Care Measurement and Improvement (PHCMI) initiative led and coordinated by the World Health Organization (WHO). One of the major objectives of this initiative is to advance countries who did not have the capacity to implement UHC adapt it easily.

Regional Health Authorities

The absence of a strong state with strong line ministries means that the centralised health governance structures are weak. Therefore, donors and development partners have acted without government coordination at regional and district level.[132] For almost 20 years, the health sector has been administratively divided by donors and development partners into three zones: Somaliland, Puntland and South Central. In Somaliland and Puntland, the ministries of health have developed their capacities in service delivery and have decentralised health governance structures to the regions and districts. In these two zones, the situation for primary healthcare has dramatically improved over the past decade.[133]

3.B.3 Development partners and projects

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service (FTS), which tracks financial funding flows, shows total incoming funding to Somalia's health sector as US$92,095,628 in 2020, funding 81 initiatives. Thirty-two of the initiatives totalling US$32,797,040 were dedicated to COVID response while the balance of 59 initiatives totalling US$59,298,588 were not categorized for COVID.[134]

Twenty-eight funding agencies contributed to this total, alphabetical by name followed by number of projects in Table 3-10[135]:

Table 3-10 Incoming funding to Somalia's health sector, 2020, by funding organisation

Funding Organisation	Number of Projects
Bill and Melinda Gates Foundation	1
Canada, Government of	5
Central Emergency Response Fund	6
China, Government of	1
European Commission's Humanitarian Aid and Civil Protection Department	3
Finland, Government of	1
France, Government of	1
GAVI Alliance	1
Germany, Government of	13
Ireland, Government of	2
Italy, Government of	3

129 Danish Immigration Services (2020), op.cit.
130 Ministry of Health Somalia, Programmes, https://moh.nomadilab.org/articles/ accessed April 13, 2021
131 Bump, Jesse B. (2015) The Long Road to Universal Health Coverage: Historical Analysis of Early Decisions in Germany, the United Kingdom, and the United States, Health Systems & Reform, 1:1, 28-38. Bump's study showed that "the arrangements that covered nearly all Germans or Britons were built over about a century in each case."
132 Danish Immigration Services (2020) op. cit. p.35
133 Ibid
134 https://fts.unocha.org/countries/206/flows/2020?f%5B0%5D=destinationGlobalClusterIdName%3A7%3AHealth op. cit.
135 Ibid

Funding Organisation	Number of Projects
Kuwait, Government of	1
Luxembourg, Government of	1
Private (individuals & organizations)	2
Qatar, Government of	1
Qatar Charity	1
Saudi Arabia (Kingdom of), Government of	2
Save the Children	5
Somalia Humanitarian Fund	14
Sweden, Government of	2
Switzerland, Government of	1
Thani Bin Abdullah Bin Thani Al-Thani Humanitarian Fund	2
United Arab Emirates, Government of	3
United Kingdom, Government of	2
United Nations Children's Fund	1
United States Agency for International Development	1
United States of America, Government of	3
World Bank	2

Source: OCHA-FTS

The largest five funding organisations in order of amount contributed were the Thani Bin Abdullah Bin Thani Al-Thani Humanitarian Fund (Qatar), the United States Government (USAID/ODA), the Government of Germany, the European Commission, and the World Bank.[136]

Funding went to the following categories of organizations, in descending order (Table 3-11):[137]

Table 3-11 Incoming funding to Somalia's health sector, 2020, by type of destination organisation

Funding Destination, by Type of Organisation	Number of Projects	Amount (US$m)	Percentage
NGO	43	$ 56.4	61.2%
UN agency	28	$ 27.4	29.8%
Red Cross/Red Crescent	5	$ 5.4	5.9%
Government	5	$ 3.0	3.2%
Total	**81**	**$ 92.1**	**100%**

Source: OCHA-FTS

Only five of 81 projects went to government organisations, totalling US$2,965,407, indicating that fully 96.8 percent of funding inflows to the health sector in Somalia in 2020 were "off budget and off treasury," flowing through NGOs, UN agencies, and the Red Cross/Red Crescent. NGOs were the largest recipients of funding, receiving US$56,392,129 or 61.2 percent of funding, followed by UN agencies which received US$27,399,068 or 29.8 percent of funding.[138]

Up until this point, the World Bank has been a relatively minor player in Somalia's health sector, contributing US$3.1 million in 2020 for COVID response;[139] however, WB is planning the first health programme of its own in Somalia in 2021, entitled "Damal Caafimad", which is funded at US$100 million over five years. From

136 Ibid
137 Ibid
138 Ibid
139 Ibid

the Project Information Documents, “The proposed project will be developed in strong partnership with the FGS and the Federal Member States (FMS) to rapidly expand the coverage of a prioritized package of essential primary and secondary healthcare services. The proposed project design focuses on building the government capacity and institutions to ensure a visible Government role in managing service delivery for the population. A specific service delivery modality will be agreed between WB and the Government: (1) contracting out service delivery to non-state actors, such as UN, NGOs and **private sector networks**; and (2) strengthening existing government service delivery in government facilities to expand service delivery in targeted areas. As a component of contracting out of service delivery, **contracting to existing private sector providers through private sector networks in select urban areas will be piloted**.”[140]

It has been reported in April 2021 that the WB has reached an understanding with the MOH in Somaliland, where they had not previously been operating, to support government healthcare efforts in Somaliland in the future.[141]

The UK Foreign, Commonwealth and Development Office (FCDO) recently completed its five-year Somali Health and Nutrition Programme (SHINE) 2016-2021, which was funded at a total of GBP 89 million and ended on March 31, 2021.[142] The programme worked with the Ministries of Health to deliver an EPHS through sub-contracting of NGO partners, with the objective of improving maternal and child health outcomes. The CHANGE programme component has had the longest implementation period having begun as the Health Consortium for the Somali (HCS) People in June 2010. Managed by PSI, a consortium of NGOs provides essential health service delivery and regional and district system strengthening. In 2020, the CHANGE component implemented an approach to working with the private sector to deliver essential services.[143] It was under the SHINE programme that the Tunza network mentioned above was funded. After 11 years, the effort still required donor funding to operate.

USAID shows US$27.8 in US Government support for healthcare in Somalia in 2020, using implementing partners to provide medical supplies, support health centres, and train community health workers.[144] USAID implementing partners are primarily NGOs and they rarely work with the commercial private sector, although globally USAID has recently shown interest in market systems approaches.

Other than PSPH, none of the donor-funded health sector projects in the Somali region that work with the private sector employ a MSD approach, instead primarily using private sector players as direct delivery mechanisms (i.e. government contractors). It is significant to note that the WB plans to work with private sector networks in Somalia as SDC-facilitated Caafinet is the only functioning service delivery network at present.

3.B.4 Medical education and training institutions

There are a number of medical institutions including universities, technical schools, training centres/institutes who provide technical skills to large number of youth who are interested in medical and paramedical education. There is existing government regulation and legislation providing licenses to institutions in some of the regions. It is in question whether the quality of materials at the institutions and the content of the curriculum is controlled and regulated by the federal government and member state authorities.

3.B.5 Ambulance and transport services

Transportation to healthcare facilities must be found by the individual by any means available. Ambulance services in Somalia are either voluntary-based or privately owned; they are used mainly for transportation of mass casualties when there are vehicular accidents or fire incidents. Private hospitals usually procure their

140 The World Bank (2020), Project Information Document (PID) Improving Healthcare Services in Somalia (“Damal Caafimad” Project) P172031, prepared January 5, 2020; emphasis added by Cardno
141 Interview with Somaliland MOH personnel, April 2021
142 FCDO (2020). November 2020 Annual Review Summary Sheet, Somali Health and Nutrition Programme (SHINE), available at https://devtracker.fcdo.gov.uk/projects/GB-1-204903/documents accessed April 21, 2021
143 Ibid
144 USAID Bureau for Humanitarian Assistance (USAID/BHA) (2021). Somalia – Complex Emergency Fact Sheet #1 Fiscal Year (FY) 2021, January 8, 2021

own ambulance vehicles. Some NGOs who provide healthcare services also procure or rent ambulances. Ambulances are also used to transport the dead from homes to the cemetery.

It is important to note that there seems to be a growing number of privately owned and run ambulances. Some of these ambulances might be in form of a minibus renovated as an ambulance which does not have all the features of an ambulance. Required amenities such as ventilators, cardiac monitors, and skilled medical personnel with at least first aid training are usually lacking.

3.B.6 Inspection, testing and certification organisations

The lack of inspection bodies for testing and certification in Somalia is a significant gap in the health system. Typically, third party parastatal bodies play the role of regulators and quality control enforcers for both the public and private sector, including checking at ports and quality distribution through accredited and qualified transport providers with cold chain capacities. However, in Somalia, the MOH is expected to play this role for which they currently lack sufficient capacity. The MOH is already challenged providing oversight and stewarding the public sector, and so the task of regulating the expansive and active private sector would be arduous.

On the other hand, Somaliland is a bit more advanced than the other regions of Somalia as regards enforcement of regulations in the health sector. The National Medicines Regulatory Authority (NMRA) in Somaliland was established in April 2016 with the objective of ensuring all pharmaceutical products in circulation are safe, effective and consistently meet approved quality standards.[145] NMRA was created to provide medicines regulation in line with the National Medicines Policy (NMP), Article 6.3 which aims “to ensure that medicines on national markets are safe, effective and of good quality, are accompanied by complete and correct product information, and are manufactured, stored, distributed and used in accordance with good practices”. The NMP was formulated by the Ministry of Health with the support of the WHO in 2015. The NMRA has made some achievements such as conducting pharmacovigilance training for its staff, technical reviews of the essential medicines list (EML), reactivated the Minilab for testing quality of medicines after receiving in also with the support of the WHO. However, based on an assessment for the status of NMRA’s key functions using WHO’s Global Assessment Tool in 2017 (Table 3-12),[146] it was evident that implementation capacity is low, and a number of things need to be put in place to strengthen the NMRA to perform its function. Some of NMRA’s planned activities between 2019 and 2023 include, formulating National Medicines Act based on the National Medicines policy, developing guidelines and SOPs for priority regulatory functions, quality control and product quality surveillance, pharmacovigilance, medicines registration, licensing of importer, wholesale, and retail pharmaceutical premises.

145 Nuh, Saed, Head of MRA (2019). Status of Medicines Regulatory Authority (NMRA), Progress Updates, December 2019. MoHD, Somaliland.
146 Ibid

Table 3-12 Summary of the key functions status of NMRA as per WHO's Global Assessment Tool

Regulatory Functions	Indicators Implemented	Expected	% Impl.	ML
01-NATIONAL REGULATORY SYSTEM (NRS)	2	10	16%	1
02-REGISTRATION AND MARKETING AUTHORIZATION	2	6	15%	1
03-VIGILANCE (PVL)	1	6	0%	1
04-MARKET SURVEILLANCE AND CONTROL (MSC)	4	6	0%	1
05-LICENSING PREMISES (LIC)	4	6	17%	1
06-REGULATORY INSPECTION (RI)	4	6	20%	1
07-LABORATORY ACCESS AND TESTING (LAT)	0	10	30%	1

Source: NMRA/WHO/IGAD Assessment Report (March 2017)

3.B.7 Financial institutions

The Central Bank of Somalia (CBS) was re-established in 2009 and is slowly developing the capacity to oversee the licensing and supervision of money-transfer businesses and commercial banks. The CBS has registered seven hawalas and 11 banks to provide financial services.[147] [148] The licensed and operating commercial banks are listed below.

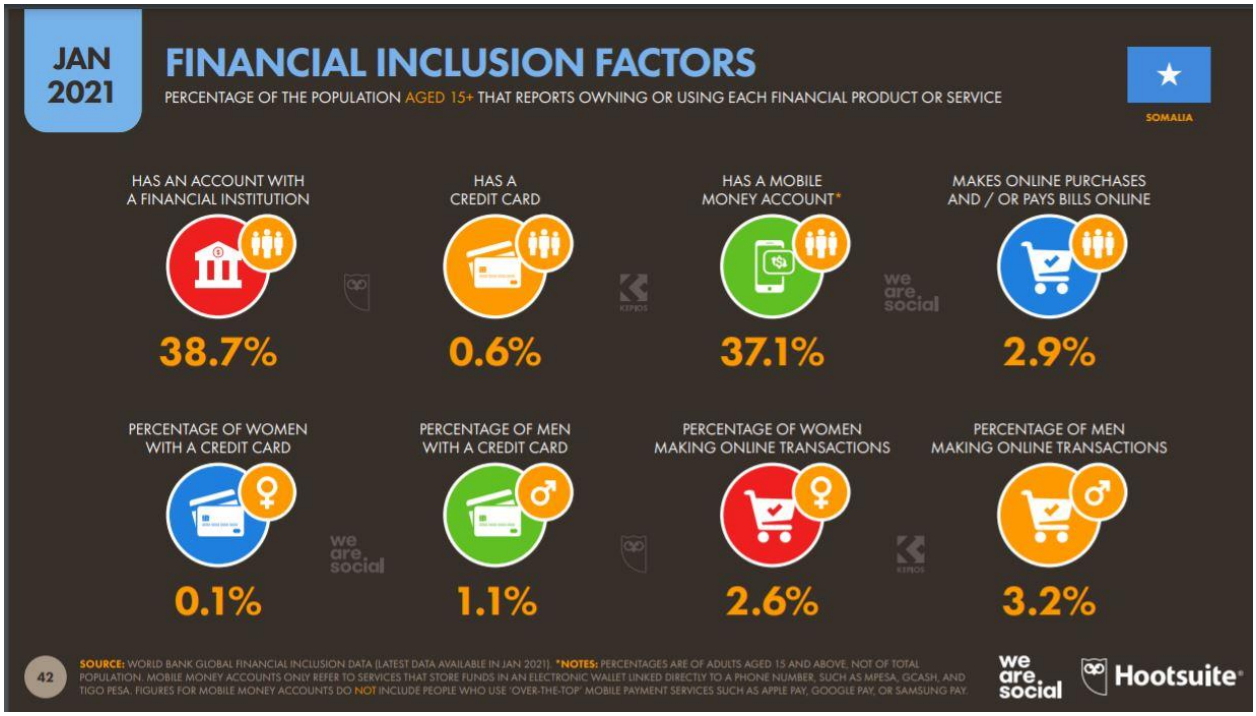
> Agro Africa Bank
> Amal Bank
> Amana Bank
> Dahabshiil Bank International
> Daryeel Bank Ltd
> Galaxy International Bank
> International Bank of Somalia
> Mybank Limited
> Premier Bank
> Salaam Somali Bank
> SomBank Ltd

All are headquartered in Mogadishu except for Amal Bank in Garowe and Daryeel Bank in Bosaso. Amal Bank claims to have more branches and more agents across Somalia than any other bank, making them the largest bank in Somalia. Although several banks offer modern banking services like online banking, mobile banking, and ATM/debit cards, the banks have few if any any health-specific financing products for either demand or supply side, and banks cater to the upper income groups. Dahabshiil provides mobile telephone services in addition to banking.

Of adults in Somalia above the age of 15, 38.7 percent have an account with a financial institution, as shown in Figure 3-18.[149] This is well below the global figure, with 69 percent of adults considered banked globally in 2017.[150]

121 US Department of State (2020), op.cit.
148 https://centralbank.gov.so/licensed-banks/ accessed April 16, 2021
149 https://datareportal.com/reports/digital-2021-somalia op. cit.
150 https://ufa.worldbank.org/en/ufa accessed April 16, 2021

Figure 3-18 Financial inclusion in Somalia January 2021



Source: DataReportal

Somalia's financial risk profile remains high due to legitimate concerns about money laundering and terrorism financing. The financial system is stymied by the lack of any national identification, creating challenges for banks and money transfer services to verify client identity. In 2019 the government finalized anti-money laundering/countering terrorism financing (AML/CFT) regulations that will require banks to implement stricter know your customer (KYC) controls. As of September 2019, all licensed banks were providing suspicious transaction reports to the government's Financial Reporting Center (FRC).[151]

3.B.8 Security providers

Somalia is ranked at the top of the list of fragile states, which is defined as a state that is "unable to perform basic functions such as maintaining security, enabling economic development, and ensuring the essential social and health needs of the population. [152] The three different entities that exercise political authority within Somalia, namely the Federal Government, Puntland, and Somaliland have all contracted private security companies, primarily to prevent piracy and illegal fishing in their coastal waters.[153] The turmoil in Somalia continues to offer lucrative investment opportunities for private security and military companies of various sorts. While it cannot be uniformly concluded that private security serves to weaken already fragile public authorities, the activities of private military companies have served to strengthen the power of local authorities. For individual healthcare providers, security must be supplied privately and is a significant business expense that raises the cost to consumers.

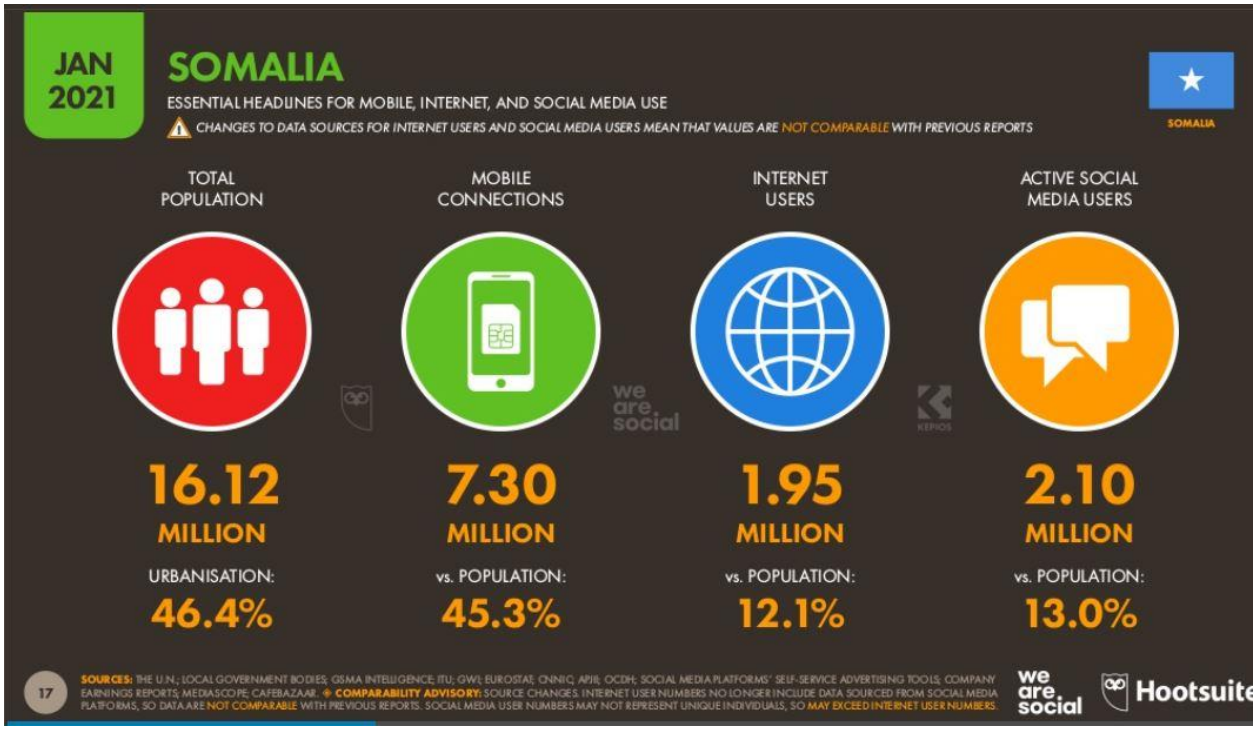
3.B.9 IT and telecoms

Somalia has high mobile phone connectivity; although 45.3 percent of the population has a mobile connection as reported above and shown in Figure 3-19,[154] SHDS 2020 reports that three-quarters of

151 US Department of State (2020). Investment Climate Statements: Somalia. op.cit.
152 Haar RJ, and LS Rubenstein (2012). *Health in Postconflict and Fragile States.* United States Institute of Peace, Washington DC.
153 Review of African Political Economy (2008). Vol. 35, No. 118, Public/Private, Global/Local: The Changing Contours of Africa's Security Governance (December 2008), p. 585-598
154 Ibid

households have at least one mobile device; even 59 percent of the nomadic household have a mobile device.[155] Internet use is reported at 12.1 percent.[156]

Figure 3-19 Somalia mobile connections, internet, and social media use January 2021



Source: DataReportal

3.C Rules and regulations

3.C.1 Formal

3.C.1.a Government healthcare legislation and regulations

The FGS has, together with the FMS, the responsibility for building the health system ensuring that an appropriate strategic framework and regulatory mechanisms exist. In Somalia, there are health sector policies which can guide the managers of health service delivery at the lower levels of the health sector pyramid. These policies include the Somali Human Resources for Health Development Policy (2016-2021) and a Health Sector Strategic Plan (2017-2021). Somalia also has a WHO recognised national essential medicines list.

Health service delivery is the constitutional mandate of the Federal Ministry of Health and Human Resources (MOH). This ministry is responsible for the regulation of the health sector across Somalia, including quality control of health services and medicine distribution and policy, oversight of human resource capacity development as well as coordination between the different health sector actors. The Ministry has developed a roadmap towards Universal Health Coverage and the Ministry is also in the process of reviewing the existing essential package of health services (EPHS).

According to a 2020 baseline study of Somalia's health system, the overall capacity of the Somali health sector to regulate and prevent, detect, and respond to health emergencies is 'minimal.' This assessment was confirmed by the interviewed health sector actors who concurred that the capacity of the Federal MOH is

155 SHDS (2020), op. cit. p.XXVI
156 https://datareportal.com/reports/digital-2021-somalia op. cit.

weak. This was already the case before COVID-19 but this health emergency has, according to a well-informed UN organisation, been a particular challenge and has strained the Ministry's already limited capacity.[157]

One of the major challenges is that the health sector has so far remained unregulated. Due to the paucity of health professionals, many unskilled workers have found themselves to be 'health professionals'. Pharmacies and other health facilities are often licensed to and run by unprofessional staff.

The proliferation of unregulated and unaccredited health institutes has further complicated the health sector. The health training institutes, many of them private and unrecognised by the government, still continue to produce fresh graduates without accreditation. Healthcare quality measurements are not often applied. Drugs including significant number of counterfeit drugs and other medical consumables are sold like any other commodity in the market. All of these ills contribute to the violations of patient rights. Many patients have been harmed as a result of poor services provided by unskilled health workers. If not regulated and accredited, the problems which Somali citizens are facing will continue and will put many other lives at risk. Therefore, developing and enforcing accreditation and regulation structures and registration systems will help the government in general, and the MOH and NHPC in particular, to address these formidable challenges.

In 1999 an act was passed in Somaliland to establish the National Health Professions Commission (NHPC). The mandate of the organization is to register, license and accredit health professionals, health training institutions and health service facilities. As a regulatory body, with the Act 19/2001 amended in 2013 and passed into law in January 2013, NHPC's goal is to ensure that health cadres, health training institution and health service provision meets the standard requirements expected of them in order to provide quality health services to citizens.[158]

3.C.1.b Licensing requirements

To import, an import license is required. However, the license is not specific as to the type of importation taking place – i.e. it is possible to get a license regardless of whether the goods being imported are pharmaceutics or vehicles.

3.C.1.c Fees, taxes and customs duties

In 1960 Somalia was declared independent and the Government established a customs law for all the UN agencies and other emergency and humanitarian organizations requiring humanitarian cargo to be exempted from taxes. The Federal Government continues to observe and follow that law, which is article No 14. The Government institution that handles tax exemption is the Customs Department of the Ministry of Finance. Without the clearance of this department, no imports or exports are permitted, as it is the sole agency that deals with the customs for both the Sea Ports and Airports.

Normally the Customs department operates under a national law and is authorised to examine the cargo in order to ascertain actual description, specification volume or quantity, so that the value and the rate of duty may be correctly determined and applied. However, as a result of the civil war from 1991, Somalia has remained without a centralised Government. The instability led to the formation of semi-autonomous states such as Somaliland and Puntland, which opted to independently develop their institutions and communities. This has also resulted to the existence of minor differences in Customs Procedures in the Sea Ports and Airports.

157 Danish Immigration Services (2020), op. cit. p.35
158 Somaliland National Health Professions Commission (2021). Background of Somaliland and NHPC, http://www.nhpcsomaliland.org/nhpcbackground.php accessed 1 April 2021

Customs

The Somalia Customs tariff is based on the Customs Cooperation Council nomenclature for imports classification. Duties range between 5 percent and 100 percent for items not eligible for preferential treatment. Customs duties collected at the Mogadishu port and the Mogadishu International airport is the government's main source of revenue, averaging about $6.5 million per month in mid-2013. The basic tariff rates are unit based per 50 kg bag, per carton or per litre, with rates for only about 150 categories of goods. Two surcharges are imposed on the unit-based duties; a 5 percent sales tax and 2 percent stamp duty. Port fees that are also collected are retained by the Port management for running costs.[159]

There are four documents that customs check on arrival at a port/border. These are the:

> commercial invoice
> certificate of origin
> transport document (e.g. bill of lading including the names of the shipper)
> certificate of product analysis.

At land borders, documentation checks are less rigorous and frequent, and all four documents will not necessarily be requested. [160]

Humanitarian aid items are duty and tax-free so long as the proper government requirements have been met. It may be possible to obtain a 'blanket clearance', for which customs clearance is processed per shipment and allows the right to import, clear the cargo from the port and store it.

The Federal Government of Somali rejoined the Common Market for Eastern and Southern Africa (COMESA) community in July 2018. As a member, Somalia is required to undertake several institutional, policy, and regulatory reforms to meet COMESA free trade protocols and to trade with its member countries.[161]

3.C.1.d Quality standards

In a functioning system, quality standards on medicines, medical supplies, and equipment must be enforced at port of entry since there is no domestic production in Somalia. In September 2014, the state-owned Mogadishu Port was leased to Albayrak Group for 30 years.[162] Albayrak Group has several companies operating in different sectors including logistics and maritime. Since Albayrak took over port management in Mogadishu, the port mainly handles containerised cargos from various ports. Four shipping liners fully operate in Mogadishu Alport (MAP) and they include MSC, CMA, CGM and Sima Marine.

Containers are emptied out inside the port which means the open spaces in the port serve as a container yard with full and empty containers. All incoming cargo are 80 percent containerised, apart from fuel, cement, and other construction items. The exact taxation and duties for various products in the port and the airport are not transparent.

In February 2020, both houses of the Federal Parliament approved standardization and quality control legislation, which is currently with the President for signature. This will pave the way for the formation of the Somalia Bureau of Standards (SBS) as the enforcement authority for quality control. According to the US Department of State, "There are no official reports on seizures of counterfeit goods. However, the perception is that almost all the goods coming into the country are counterfeit". The government has little capacity to seize or track counterfeit goods entering the country.[163]

159 https://dlca.logcluster.org/display/public/DLCA/1.2+Somalia+Regulatory+Departments accessed April 17, 2021
160 Buckley, O'Neill, and Aden (2015), op. cit.
161 US Department of State (2020). Investment Climate Statements: Somalia, op.cit.
162 http://www.portofmogadishu.com/en/company/
163 US Department of State (2020), op. cit.

3.C.2 Informal

3.C.2.a Cultural norms, traditional practices, and community standards

The 2015 Assessment of the Private Health Sector in Somaliland, Puntland and South Central analysed cultural practices as they pertain to health seeking and health spending behaviours.[164] As cultural practices and traditions are deeply embedded and change slowly, these finding remain relevant in 2021.

Pavignani (2012) found that the determination of the right action to take for the patient is conducted by relatives, religious leaders, and elders. Traditional home healthcare practices are followed first, with prayers playing a prominent role. Buying medicines usually comes before a visit to a health facility, because the health facility service is not seen as offering more than a mere prescription.[165]

FAO (2007) also found that most health-seeking responses are based on traditional knowledge, beliefs, and the perceived causes of specific illnesses. Across all livelihood zones, these responses tend to follow a generalised pattern of prayer, traditional home health practice, a traditional healer, the purchase of medicine, prayer again, then visiting a health facility.[166]

WHO (2011) highlights that gender segregation is deeply rooted in traditional Somali socio-cultural structures and remains a formidable barrier to women's participation in decision-making processes and access to – and control of – resources. [167]

Regarding consumer and/or patient choice and health-seeking behaviour, Mazzilli and Davis (2009) review the evidence and conclude that while women may have a higher degree of influence over decisions regarding children's health care, there appears to be greater control of husbands and communities in decisions to seek care for women.[168]

3.C.2.b Enforcement of formal laws and regulations (including corruption)

Corruption is rampant in all sectors of the Somali government, particularly government procurement. Transparency International ranked Somalia 179 out of 180 countries in its widely accepted Corruption Perceptions Index 2020, tying South Sudan for the worst in the world.[169] Somalia's procurement legislation has provisions to address potential conflicts of interest in awarding government contracts, but enforcement is weak. Somalia's current government has waged a campaign against public corruption and graft, resulting in high profile dismissals and arrests over the past three years. However, without a robust asset declaration mechanism, an updated penal code, and a functioning criminal justice system, including police and prosecutorial services, very few penalties exist for corrupt activities.

According to the US State Department, legislation on government procurement was passed in 2015 and officially all government contracts must go through an open tender process unless they meet specified conditions for limited competition. However, in practice this has been slow to be implemented and lucrative contracts are still awarded based on close relationships and favours. Also, it is important to note that the Federal Government is yet to establish a Procurement and Concessions Board as required in the Procurement Act, which makes it difficult to ensure transparency and accountability in government procurement activities. There is an interim Procurement Board in place, but it meets irregularly.

164 Buckley, O'Neill, and Aden (2015), op. cit. p.25
165 Pavignani, E. (2012) The Somali Healthcare Arena: A (Still Incomplete) Mosaic.
166 FAO (2007). Infant and Young Child Feeding and Health Seeking Practices. Somali Knowledge Attitude & Practices Study.
167 WHO (2011) op. cit.
168 Mazzilli, C. & Davis, A. (2009), op. cit.
169 https://www.transparency.org/en/cpi/2020/index/som accessed April 18, 2021

4 Sustainability Analysis (Who Does/Who Pays?)

The definition of sustainability in the context of market systems development applies to PSPH programme interventions:

> "Behaviour change among market participants that survives the intervention without further subsidy or dependence on external support, incorporating a customer-driven business model that replenishes capital and attracts new investment."[170]

The following sustainability analysis uses the MSD "Who Does/Who Pays" framework to compare the current Somali healthcare market to a vision of a properly functioning market where both public and private sectors play economically viable, sustainable roles in the absence of external financial support. The analysis is presented in a tabular format in Table 4-1 and Table 4-2 below.

4.A Current market

The current Somali healthcare market is characterised by a miniscule government healthcare budget bolstered by external donor support, with the private sector dominating service delivery but paid almost entirely OOP wherever donor subsidy does not pay directly (Table 4-1). The healthcare market system is not functioning well, and current finance sources are both inequitable and unsustainable.

Table 4-1 Who does and who pays in the current Somali healthcare market

Value Chain Step (Core)	Who Does?	Who Pays?	The Problem?
Healthcare finance:			
Revenue raising	Individuals	Individuals, Families	Many individuals cannot afford proper treatment and defer or go to unqualified providers.
	Communities (informal mechanisms)	Individuals, Families	Informal community revenue raising measures are frequently used when individuals cannot pay on their own
	Donors	Donors	Government has no substantial tax base and is entirely dependent on external funders to pay for public healthcare, which is prima facie unsustainable
Pooling	Communities (informal mechanisms)	Individuals, Families	Pooling mechanisms are largely informal based on traditional community practice, and not ringfenced for health. Pooled funds can be and are often pulled for other uses based on priorities at the time.
	Insurers	Individuals	Commercial health insurance coverage targets the top end of the market and few low-income Somalis have any coverage whatsoever.
	Donors	Donors	There is no social health insurance.
Purchasing	Individuals	Individuals, Families	Individual payment results in unpredictable costs and high OOP.
	Insurers	Insurers	Insurers rarely pay for services used by low-income groups.
	Government Donors and NGOs	Donors	Donors purchase services for their own project implementation through contractors, NGOs, and multilaterals, as well as public healthcare delivery through MOH and proxy entities. The government does not pay its own bills, which is prima facie unsustainable.

170 Ashkin, Ronald (2014), op. cit.

Value Chain Step (Core)	Who Does?	Who Pays?	The Problem?
Service delivery:			
Supply chain (medicines, supplies, equipment)	Private importers and distributors	Private providers	Private supply chain is largely uncontrolled by government. Business finance is largely informal as that sector is underdeveloped.
	Donors	Donors	Donors supply commodities to their projects and implementers which is not market sustainable.
Diagnostics and testing	Private laboratories and diagnostic centres (often within private hospitals)	Individuals OOP	Private laboratory and diagnostic standards are largely unregulated.
		Insurers	Insurers cover a minor part of the market and seldom for low-income groups.
	NGOs and multilaterals	Donors	Donors fund public and proxy-public diagnostics which is prima facie unsustainable.
Primary care	Private clinics and hospitals	Individuals OOP	Private clinics and hospitals are largely unregulated; both service quality and pricing are variable.
		Insurers	Insurers cover a minor part of the market and seldom for low-income groups.
	Informal providers	Individuals OOP	Informal providers are trusted by many in the community and low-income consumers often do not follow a proper path to treatment, preferring traditional methods.
	Public and proxy-public hospitals	Donors	Donors fund public and proxy-public primary care clinics and hospitals run by NGOs and multilaterals which is prima facie unsustainable.
Secondary and tertiary care	Private hospitals	Individuals OOP	Private hospitals are largely unregulated; both service quality and pricing are variable.
		Insurers	Insurers cover a minor part of the market and seldom for low-income groups.
	Public and proxy-public hospitals	Donors	Donors fund public and proxy-public secondary and tertiary hospitals which is prima facie unsustainable.
	Overseas providers (medical tourism)	Individuals OOP Insurers	The wealthy travel overseas (e.g. UAE, India, Kenya) for specialised care. Some of the wealthy carry private health insurance.
Retail medicines	Private pharmacies	Individuals OOP	Private pharmacies and the medicines they sell are largely unregulated. Drug quality is uncertain with a high proportion of substandard and counterfeit medicines.
	Informal providers	Individuals OOP	Informal providers sell traditional cures and herbal medicines with no clinical evidence.
	Public and proxy-public pharmacies	Donors	Donors fund medicines for their public and proxy-public facilities which is prima facie unsustainable.

Source: Cardno analysis

4.B Sustainable vision of the future market

A well-functioning healthcare market in the future will feature the public and private sectors acting in coordination to progress towards Universal Health Coverage to all Somalis, with the public sector fulfilling a strong regulatory role and providing care for public health priorities in terms of disease burden and vulnerable populations, supporting this with social health insurance funded out of tax revenues; while a well-regulated private sector will invest in sustainable healthcare finance and service delivery models which avoid

moral hazard while ensuring coverage for all. External support from donors is no longer necessary. Informal and unlicensed providers have largely exited the market (Table 4-2).

Table 4-2 Who does and who pays in a future sustainable Somali healthcare market

Value Chain Step (Core)	Who Does?	Who Pays?
Healthcare finance		
Revenue raising	▪ Individuals ▪ Communities ▪ Government through tax revenues	▪ Individuals, voluntary contributions either to health savings or private insurance ▪ Individuals, voluntary contributions ▪ Individuals, mandatory contributions within tax framework
Pooling	▪ Private insurers ▪ Social insurance fund	▪ Policy holders ▪ Government budget funded by individual tax contributions
Purchasing	▪ Individuals ▪ Private insurers ▪ Social insurance fund	▪ Individuals OOP (by choice) ▪ Private insurers ▪ Government
Service delivery		
Supply chain (medicines, supplies, equipment)	▪ Private providers ▪ Public facilities	▪ Private providers (supported by a well-functioning business finance sector) ▪ Government out of budget funded by tax revenues
Diagnostics and testing	▪ Private laboratories and diagnostic centres (licensed and qualified) ▪ Public facilities	▪ Individuals OOP (by choice) ▪ Private insurers ▪ Social insurance fund ▪ Government out of budget and social insurance fund
Primary care	▪ Private providers (licensed and qualified) ▪ Public facilities	▪ Individuals OOP (by choice) ▪ Private insurers ▪ Social insurance fund ▪ Government out of budget and social insurance fund
Secondary and tertiary care	▪ Private providers (licensed and qualified) ▪ Public facilities ▪ Overseas providers (medical tourism)	▪ Individuals OOP (by choice) ▪ Private insurers ▪ Social insurance fund ▪ Government out of budget and social insurance fund ▪ Individuals OOP and private insurers (only in rare cases)
Retail medicines	▪ Private pharmacies (licensed and qualified) ▪ Pharmacies at public facilities	▪ Individuals OOP (by choice) ▪ Insurers ▪ Social insurance fund ▪ Government out of budget and social insurance fund

Source: Cardno analysis

4.C Implications

Implications of the Who Does/ Who Pays analysis are profound and outline what needs to be done in the long run to move from the current state to meet the vision of a sustainable future:

> The Somali healthcare sector is severely underfunded. To meet the long-term vision of UHC, the healthcare system must be funded from domestic revenue. The government needs to move away from heavy dependency on external donor funding which is dependent on the whim of the international community and outside the direct control of the Somali people.

> This means the establishment of the basic political consensus and will to establish a sustainable, equitable healthcare system for all Somalis, regardless of income level.

> Once that is fixed, the tax base and revenue collection capacity of the government must be strengthened to where domestic revenue sources can fund the government's fiscal contributions to the healthcare system, whether they are regulatory, financing, or delivery mechanisms.
> Simultaneously, healthcare service delivery systems and their supply chains must be strengthened to meet the needs of the population. This shall be done in coordination and cooperation of the public and private sectors, with full engagement and input of the private sector beyond CSR initiatives and government contracting.
> As public sector funding is currently lacking, the private sector must play a role in delivering services that the public sector cannot pay for, or may not place a high priority on.
> The regulatory environment must be developed with full input of the private sector to assure quality control and value for money.
> These long run changes will be implemented through a series of small, consistent, coordinated steps and cannot be accomplished all at once through fiat.

The PSPH programme contributes to achieving this future vision by engaging the private sector to use the resources that are available now to better coordinate healthcare financing and help the private sector improve its service delivery systems to bring better value for money, quality, and coverage of healthcare needs to all Somalis, without depending on external donor financing. This not only takes steps towards UHC, but it is also fully sustainable. It is a win-win approach.

5 Constraints Analysis

Based on the information gathered in the research phase of the market systems assessment, the team analysed and identified the constraints most relevant to a properly functioning Somali healthcare market. The first-hand information gathered through key informant interviews, consumer surveys, and direct observation was supplemented by an extensive review of recent literature covering the Somali healthcare sector, focused on healthcare finance and service delivery network subsystems.

The team went through a process of prioritisation to emphasize the constraints both within the scope of PSPH and actionable within the programme's human and financial resources and its time frame.

Constraints are also known as issues, problems, obstacles, bottlenecks, roadblocks, market failures, et al. but importantly also include unmet opportunities. Constraints have been viewed through the lens of the market with heavy consideration of the private sector's perspective. The purpose of this constraints analysis is to discover where the programme might potentially have the highest sustainable impact on the Somali healthcare market system. Only constraints that are considered strategic (i.e. the programme will not meet its objectives if they are not addressed) are included in this analysis.

Please keep in mind that constraints are a two-sided coin: not only (negative) problems and obstacles, but also (positive) opportunities. The private sector constantly searches for opportunities to fill unmet needs, and where the public sector may see a problem, the private sector often senses opportunity. It is the obligation of this programme to direct these opportunities to where they can provide greater access to quality and affordable healthcare for all Somalis. Properly directed, the private sector will invest its own resources to serve public health objectives. Not all private sector players are sharks and vultures.

In this analysis, priority constraints are presented under three sub-headings:

> Cross-cutting constraints that pertain to both the healthcare finance and service delivery network subsystems (both Outcomes 1 and 2, Lots 1 and 2);
> Constraints relevant to demand-side healthcare finance (Outcome 1, Lot 1);
> Constraints relevant to healthcare service delivery networks (Outcome 2, Lot 2)

There are instances where the constraints overlap, and these will be pointed out in the text wherever possible. The healthcare market is a complex, interrelated system, a web of webs, and it is sometimes not possible to entirely describe one aspect of the system without referring to other aspects.

5.A Cross-cutting constraints

5.A.1 Consumer behaviour (health seeking, health spending, awareness and knowledge of path to treatment and payment options)

Disposable income in Somalia is low given the high level of poverty, however there is high cash velocity as there is significant amounts of money circulating the local economy especially in Mogadishu and other cities. Between monetary exchanges for trades and remittances, money is actively moving through the private sector which undoubtedly affect health seeking and spending behaviours. The high cash velocity could be harnessed and directed towards covering health expenditure and investment into private healthcare delivery. Another factor that affects consumer behaviour is the cost of care which often cannot be anticipated and as a result there is uncertainty on how much money to save for healthcare.

Generally, there is scepticism largely stemming from a lack of knowledge about health insurance, especially within the poor and vulnerable groups. There is also a low level of trust Somalis have towards existing private health providers/institutions. Public awareness on health seeking behaviour and knowledge of the proper path to treatment is low and there is significant trust by Somalis on traditional healers in comparison to formal medical practitioners. These constraints present an opportunity to reach customers who are ready to embrace new concepts in healthcare financing and delivery.

While the programme cannot directly influence the amount of disposable income that Somali families have, the programme can definitely work to both better organise existing financial resources and provide better value-for-money clinical services through the private sector by better understanding consumer health spending and health seeking behaviour.

5.A.2 Market distortion (aid dependency drives out private sector)

The availability of free health services through long term donor support in Somalia over decades has led to a continued dependency on external aid funding by the government. This market distortion, created by aid dependency and no domestic revenue, has affected the sustainability of the health insurance finance system. There is a lack of coordination among the different donor health- funded programmes to synergise health programming across Somalia which ultimately influences healthcare delivery and financing options on the ground. Similarly, the lack of coordination by the government of the donors (and vice versa) affects consumer behaviour of the Somali mass market. Coordination mechanisms can be put in place to ensure donor funded health programming prevent further market distortion by leveraging Somalia's private sector and focusing on the attainment of sustainability in healthcare delivery that can meet the needs of Somalia's mass market.

5.A.3 Human resource capacity

Generally, there is low capacity within existing professional Somali medical professional associations with limited opportunities for medical personnel to have clinical and other necessary updates. Professional association leadership is voluntary with only rudimentary governance structures and secretariats in support. Low human capacity also exists in healthcare finance as there is low insurance coverage and no government social health insurance at present, which has resulted in limited demand for the necessary skills. Medical school curricula are clinically focused and do not include any business or administrative modules that teach the skills necessary to run a successful medical practice. Business skills training that addresses critical modules necessary for private health providers can be explored to address this constraint. There is also a huge problem with the high number of unemployed medical personnel in Somalia who often seek opportunities abroad. Creating employment opportunities for Somali medical personnel will largely be through private health sector opportunities.

5.A.4 Unmet opportunities for network-building and technical skills transfer

Professional associations in Somalia do exist, providing aggregations which can be leveraged to meet unmet opportunities for network-building and technical skills transfer. Community models for fund pooling already exist which can be explored to target healthcare spending. The expansion of established practitioners from the region into Somalia is possible by exploring regional skills transfer through networks like the medical

professionals and professional organisations that exist in the region (e.g. East Africa Healthcare Federation, Kenya Healthcare Federation) as well as private insurance companies and pharmaceutical/equipment suppliers that may be interested in expanding their markets.

Somalia has a devolved system of governance, which makes it easier to implement new ideas in health. Similarly, the predominance of private sector players and the adaptability of the Somali population makes it easy to introduce new concepts in healthcare provision and financing.

5.B Constraints pertaining to healthcare finance (Lot 1)

5.B.1 Low insurance coverage from both public and private sectors

There is no government provided social health insurance. The private insurance market in Somalia is in the formative stages and currently only serves a small cross-section of the society, leaving out the poor. The insurance products available are limited and target individuals working for INGOs, government and private companies. Generally, most Somalis surveyed paid OOP at the point of care and did not rely on health insurance. Respondents indicated that family savings are not usually set aside specifically for health, and health competes with other uses of cash. This means that at the point of care Somalis are either forced to seek free care from public facilities or forgo care. Although it was cited that not many respondents experienced financial hardship due to healthcare costs, a number also said they did not access care when they needed it and when they could not afford it, they went to free providers.

Insurance companies surveyed do not target products for lower income groups because they believe “the poor can’t pay” and the government needs to step in to support the poor. The culture of informal pooling mechanisms at community or family level meets the gap of formal pooling mechanisms and have been cited as a reason for the disinterest in insurance. These informal pooling mechanisms also present an opportunity if individuals are already used to pre-paying and pooling resources or contributing for others as these contributions could be channelled to more formal institutions if organised well and trust is built in the community. This can present new underwriting opportunities for insurance underwriters in these communities.

5.B.2 High mobile penetration underutilised for healthcare

Somalia has a high mobile phone penetration that cuts across socio economic groups and geography. There was widespread use of mobile money to pay for goods and services, including healthcare services. MNOs partnership with banks, MFIs and remittance companies provide a seamless service for cash handling both domestically and from international funds transfers that can be tapped into further for healthcare services. Further MNOs CSR programmes and foundations could provide funding for further private investments, such as seed funding for private businesses that can combine the philanthropy with direct investments that can grow health infrastructure into services that are lacking or into developing health infrastructure in underserved areas.

Mobile health technology can be leveraged for multiple purposes:

> Mobile money services as currently being used to channel funds from users to healthcare providers.
> Mobile health financing models – this can support the health insurance value chain e.g. aggregating premiums, ringfencing mobile payments for health needs, and developing mobile financing products such as dedicated medical savings accounts.
> Mobile applications such as Shafi for booking appointments, health promotion messaging, hotlines, phone consultations etc.
> Partnerships with banks, MFIs, remittance companies to channel contributions to a health financing product, provide credit for health financing products or channel remittances into dedicated savings accounts.

5.B.3 High cost of piloting financing innovations ("too expensive to try and too risky to guess")

Based on the initial landscaping of health financing innovations and the unique Somali context, it may be best to test one or two health financing models and determine their potential to scale in phase 2. PSPH recognises the high cost of piloting health financing innovations and setting up the required structures for sustainability beyond the project life, as well as the extended time horizon required to establish a functioning system. Health insurance is largely data-driven (i.e. utilisation rates and cost of service delivery must be known) and insufficient data exists in the market at present to encourage investment beyond "cream skimming" the wealthiest consumers.

PSPH proposes testing both health insurance and mobile-based health financing products which both have potential in Somalia and can build on existing opportunities presented by the high mobile phone penetration and informal community pooling that can be formalised in partnership with existing formal insurance pools.

Further, PSPH can build on best practices on contracting with private provider networks and negotiating provider payment rates that assure the financial viability of the health financing products. There are close linkages between Somalia and Kenya which PSPH can leverage to encourage investment from companies in Kenya and the region in Somalia to develop products targeted at the mass market or borrowing innovations from the region targeted at the mass market such as health maintenance organization models like Avenue Healthcare, health micro-insurance products like Afya Poa and mobile based freemium models like MTN in Uganda and Tanzania, mobile savings accounts like m-Tiba among others.

5.B.4 Inadequate benefit packages

There is an Essential Package of Health Services (EPHS) defined by the Federal Ministry of Health that is provided at public providers. INGOs provide a disease specific package while private providers aim to provide what is specified within the EPHS while meeting existing gaps in healthcare services. Private insurers provide a package of services that meet the needs of the elite. It was not possible to ascertain if the current packages have been costed and/or the basis of setting reimbursement rates. Private insurers indicated they were able to negotiate favourable terms of payment with private providers, but it is not clear how private providers arrive at their service rates/rate card. It is difficult to determine a fair reimbursement rate when the cost of providing services has not been determined objectively and this may be an area needed for PSPH to undertake as the project considers how to contract private providers.

From the survey, most respondents indicated that public services are free at the point of care, but the challenge is the availability of all required services due to the limited nature of the public sector service delivery. It should also be noted that respondents indicated that they were able to get a consultation and medicines but any other services particularly laboratory and imaging diagnostics, surgical services were less available. This meant respondents had to look elsewhere spending more time and money accessing necessary services. This could be an opportunity for the private sector to better map gaps in private service delivery and create niche packages of services that are unavailable at public and INGO facilities.

5.C Constraints pertaining to service delivery networks

5.C.1 Access

Access to healthcare has proven to be one of the biggest constraints in Somalis getting care. Factors such as cost of healthcare at private facilities can pose a constraint where they are high as customers are mostly paying OOP. The proximity or distance to a health provider, which again has a cost and time factor can be a constraint or upside to Somalis seeking care. The waiting time spent at health facilities is also of key consideration for health seekers. In the survey conducted, 57 percent of respondents bypassed their nearest facility and three of the biggest reasons within private facilities included unaffordable fees, uncourteous staff, and long wait times in that order. Each of these factors, could either be a deterrent/constraint to seeking care from a health provider or alternatively they could be drivers that attract customers to health providers. Uncourteous staff, long queues and unaffordable fees are all constraints that can be addressed using an

MSD approach. Insecurity in parts of the country also pose a constraint to healthcare access which is a factor that can only be controlled by the State.

Limited-service ability by private providers in small cities and rural areas also presents a constraint to access private healthcare because the providers cannot profitably service them as there is no critical mass and disposable income is low amongst rural dwellers. The rural populace mostly depends on NGOs, UN agencies, and faith-based organisations for the delivery of free services as they serve as a proxy for the public sector.

5.C.2 Weak regulation

Somalia's regulatory system and enforcement over the healthcare sector is weak. This is particularly evident in the private sector which is largely unregulated. As a result, the lack of accreditation of health/medical professionals is rife with unqualified practitioners providing care within the system. Also, the lack of standards approved by the government to the providers (standard operating procedures or SOPs) affects the quality of care being delivered to Somalis. This presents an opportunity for private health networks to administer SOPs which can be applied across board in all their member facilities, and audits for compliance can be carried out annually. This will ensure quality assurance within the networks is being maintained and can serve as a first level of oversight that the authorities can leverage on since their capacity in this area is low. Also, the weak regulatory system affects quality control on medicines and medical supplies as there is poor control over import/entry of medicines into the supply.

5.C.3 Business model issues

There is a lack of business capacity and little business model innovation amongst private health providers in Somalia; this is partly evidenced in the high cost of services in private facilities which is a major barrier to healthcare access. A possible opportunity to address this constraint would be to pilot and test innovative business models with the support during the implementation of the PSPH programme. Successful business model innovations post pilot can be scaled across the network to other service providers enabling them to improve their service delivery and widen access to care whilst remaining profitable. Well documented low-cost, high quality service delivery models exist in other developing economy contexts that can potentially be adapted to the Somali political economy.

The lack of harmonised rates for health services between provider network members because of the lack of cost transparency is a constraint which can also be addressed with adequate business capacity building within the networks.

Inadequate specialised health services in Somalia and the lack of partnerships and referral systems amongst providers present a constraint to healthcare delivery. However, it also presents an opportunity to introduce new and differentiated health services and the opportunity to develop partnerships and a proper referral system, particularly between the private and the public health systems.

5.C.4 Low supply chain integrity

The low integrity of the pharmaceutical supply chain fosters the uncertainty around the quality of medicines purchased in Somalia. Due to the weak regulatory system, quality control of pharmaceuticals which are all imported into Somalia are non-existent. The lack of a pooled supply chain within provider networks means quality assurance of pharmaceutical supplies is hardly possible. This presents an opportunity to explore the development of a pooled supply chain within a private network provider which could provide benefits such as large volume discounts for essential medicines and quality assurance on pharmaceuticals purchased. The market is open to entry for huge distributors and suppliers of medical products in Somalia.

Hospital equipment calibration and repair is a challenge in Somalia as a lot of machines that get spoilt are not able to get fixed locally. Medical equipment varies but is often very expensive and not being able to get local maintenance and repairs poses a constraint.

6 Identifying Intervention Opportunities

Following analysis of priority constraints to proper market function in Section VI above, the team identified areas of potential intervention opportunity for the private sector. Interestingly, using the lens of the private sector, the team was able to uncover areas of intervention opportunity that address every one of the priority constraints. Although interventions that would clearly be out of scope or beyond the programme's resource base or time frame have been eliminated, the intervention areas listed below have not been strictly prioritised, as under an MSD approach, it is up to the market to speak, for potential partners to be found that can turn opportunity into sustainable, scalable, systemic actions. Overall, the assessment found vast areas that can be addressed through the private sector using the MSD approach within the programme's scope.

6.A Intervention areas of highest potential

For the overall implementation of Phase 1, suggested intervention areas of highest potential are listed in Table 6-1 below. Some potential intervention areas address multiple constraints and may be repeated in the table against the corresponding constraints. These are illustrative areas that require private sector partnership to become operational but illustrate the wide applicability of the MSD approach to Somali healthcare system strengthening. It is not a marginal approach.

Table 6-1 Potential Intervention Areas Against Constraints Addressed

Constraint	Areas of Potential Intervention that Address This Constraint
Cross-cutting (Outcomes 1 and 2, Lots 1 and 2)	
Consumer behaviour (health seeking, health spending, awareness and knowledge of path to treatment and payment options)	▪ Raise the awareness of the community of the service options that are available ▪ Advocate to communities to improve health seeking behaviour (proper path to treatment) ▪ Formalise existing community fund pooling practices to fund healthcare ▪ Map and identify referral paths for consumers
Market distortion (aid dependency drives out private sector)	▪ Facilitate roundtable for private sector health donors ▪ Work in clinical areas not covered by free healthcare
Human resource capacity	▪ Introduce business-related courses for healthcare providers ▪ Build business capacity of existing professional associations ▪ Transfer knowledge on low-cost models from other environments ▪ Build capacity of private sector to focus on quality ▪ Support development of local medical engineering industry
Unmet opportunities for network-building and technical skills transfer	▪ Assist existing healthcare-related associations to build sustainable business networks among their members ▪ Match and introduce professional associations to their regional counterparts ▪ Map, identify and structure referral paths for providers – e.g. between labs and clinicians, clinicians and pharmacies ▪ Coordinate provider networks and create partnerships serving complementary functions ▪ Match provider networks to insurance companies ▪ Pre-pooling funds at Govt level, mapping donor investment in healthcare
Healthcare finance subsystem (Outcome 1, Lot 1)	
Low insurance coverage from both public and private sectors	▪ Assist insurance companies to target products and market to lower income communities ▪ Introduce tested low-cost financing innovations from other countries (e.g. Afya Poa from Kenya) ▪ Develop provider-based membership packages (similar to Avenue Health in Kenya) ▪ Build on existing informal finance pools (merry-go-round/Ayuuto) to ringfence healthcare spending ▪ Formalise community funding practices that fund healthcare
High mobile penetration underutilised for healthcare	▪ Pursue mobile health finance models (e.g. mobile insurance platforms, network services locator) ▪ Explore mobile health savings platforms
High cost of piloting financing innovations ("too expensive to try and too risky to guess")	▪ Collaborate with provider networks on reimbursement rates for services and medicines ▪ Work with external finance providers (e.g. from Kenya) to expand their business into the Somali healthcare sector

Constraint	Areas of Potential Intervention that Address This Constraint
Inadequate benefit packages	▪ Assist private insurers to develop costed benefit packages around clinical needs ▪ Help service provider networks develop packages to sell to individuals or insurers ▪ Collaborate with networks to develop harmonised, affordable rates for defined benefit packages
Service delivery network subsystem (Outcome 2, Lot 2)	
Access	▪ Raise the awareness of the community of the available service options, including pricing ▪ Pursue mobile health and eHealth models (e.g. telemedicine, mobile prescriptions, appointment reminders) that can be used anywhere ▪ Promote mobile health savings ▪ Utilise outreach and mobile clinics (hub-and-spoke incorporating technological solutions)
Weak regulation	▪ Promote self-regulation within private sector networks and their supply chains ▪ Develop private sector quality accreditation system (within/between networks) ▪ Develop pooled procurement for providers within the networks with focus on supply chain integrity ▪ Use project as leverage to donors, government, private associations, pharmacies to set standards ▪ Support accreditation and licensing by government by setting minimum network entry requirements ▪ Dialogue with MOH to advocate for rational, enforceable regulatory framework, taking private sector input into account ▪ Leverage private sector to assist MOH on implementation of the Professional Health Commission Act
Business model issues	▪ Transfer knowledge on low-cost models from other environments ▪ Introduce low-cost high-quality providers to the Somali healthcare sector ▪ Design services specifically for and market to lower income communities ▪ Help providers with cross-subsidy pricing models based on the Aravind model from India ▪ Work with external service providers (e.g. from Kenya) to expand their business into the Somali healthcare sector ▪ Support development of specialist clinics for underserved clinical areas of high demand (e.g. fistula) ▪ Help providers with economic analysis to understand costing and pricing ▪ Develop provider-based membership packages (similar to Avenue Health in Kenya) ▪ Help service provider networks develop packages to sell to individuals or insurers ▪ Support development of local medical engineering industry
Low supply chain integrity	▪ Develop pooled procurement for providers within the networks (medicines, equipment, supplies) ▪ Build network of quality assured suppliers/providers who can self-regulate ▪ Introduce quality assured suppliers from outside the Somali region ▪ Standardise pricing for essential medicines within network

Source: Cardno analysis

Appendix A PSPH Risk Matrix

Once identified, risks have each been assessed in terms of probability and potential impact and are then rated for overall intensity on a three-step traffic light system (green for low – amber for medium – red for high). The results of this assessment are presented in a risk rating matrix which illustrates the overall distribution of risk.

Probability

High	Very likely to occur and partner ability to actively manage the risk is limited.
Medium	Could go either way, or partner can have some influence in managing the risk but cannot control it completely.
Low	Unlikely to occur or the risk is fully manageable by partner.

Impact

High	Risk factor may lead to considerable impact on the achievement of the results as set out in the project logframe, for example results not being achieved in relation to time, quality/quantity to an acceptable standard or to an acceptable cost.
Medium	Risk factor may lead to moderate impact on the achievement of the results in the logframe, for example in relation to time and/or loss of quality/quantity or to an acceptable cost.
Low	Risk factor may lead to no or only tolerable delay in the achievement of results in the log frame or minor reduction in quality/quantity or to an acceptable cost.

Overall risk rating matrix

		PROBABILITY		
		Low	**Medium**	**High**
IMPACT	**High**	**High Impact Low Probability**	**High Impact Medium Probability**	**High Impact High Probability**
	Medium	**Medium Impact Low Probability**	**Medium Impact Medium Probability**	**Medium Impact High Probability**
	Low	**Low Impact Low Probability**	**Low Impact Medium Probability**	**Low Impact High Probability**

Key Risks Identified for the PSPH Programme

Risk	Probability	Impact	Mitigating Actions	Notes
Contextual Risks				
COVID-19 COVID-19 pandemic continues to surge in Somalia; COVAX facility cannot reach significant numbers. ▪ Patients avoid healthcare facilities for non-COVID-related illnesses for fear of transmission. ▪ Providers are busy with critical COVID crisis and cannot introduce new business models. ▪ Programme staff cannot meet face-to-face with partners, beneficiaries, and government counterparts.	**High**	**High**	▪ Meet online only. ▪ Use technological solutions such as mobile health, e-health, and telemedicine wherever possible.	▪ At time of writing, COVID is surging in Somalia and Somaliland. ▪ COVAX covers only a fraction of the population with vaccine. ▪ Preliminary research shows many patients deferring essential services for fear of contracting COVID at medical facilities. ▪ Many private providers were unavailable for research interviews due to heavy COVID case load.
Security Security situation deteriorates, restricting the areas where programme can operate safely. - Movement, particularly travel to regions, becomes difficult. - Public meetings are not advisable due to security threats. - International experts cannot travel to Somalia.	**High**	**High**	• Constantly monitor security situation through third party sources. • Restrict travel to high-risk areas. • Lower programme profile when traveling. • Avoid large gatherings. • Use only national consultants in the field.	• Programme follows Cardno corporate as well as third party security advice. • Programme maintains vigilance in light of continuing international security risks due to terrorism. • International experts may not be allowed to travel to Somalia due to their own security regulations
Institutional Risks				
Corruption Certain stakeholders may demand “Pay to play” in order to participate. ▪ Stakeholders have come to expect inducement to participate in donor-funded activities. ▪ Certain approvals and permits may be obstructed.	**High**	**Medium**	▪ Do not use any cash payments. ▪ Emphasize importance of stakeholder participation in programme activities. ▪ Emphasize non-monetary benefits for participants. ▪ Have clear policy in place.	▪ High risk of corruption in the environment; Somalia rated dead last in the world in the Transparency International 2020 Corruption Perceptions Index. ▪ Absence of strong governance structures and leadership at high levels of government adds to risk of corruption, especially with other donor projects bringing large amounts of external funds into the sector. ▪ Conflicts of interest common as public sector actors often have private interests. ▪ Many stakeholders have developed bad habits and expect monetary inducement from donor projects. ▪ Cardno has a restrictive policy on when payments may be appropriate. ▪ Programme will not pay for participation or attendance.

Risk	Probability	Impact	Mitigating Actions	Notes
Fraud Programme assets are misappropriated or deliberately mismanaged. ▪ Partner organisations do not use programme contributions for their intended purpose. ▪ Purchases and other financial transactions are not conducted in an arms-length manner.	**Low**	**High**	▪ Design interventions so no cash changes hands. ▪ Conduct open tenders for important procurements, with a team responsible for evaluation and selection rather than an individual. ▪ Pay only after delivery and verification of goods and services. ▪ Have robust verification and approval procedures in place prior to executing payments and financial transactions, with post-audit.	▪ Programme interventions are not grants to partners; PSPH and partners agree on mutual activities and each funds its own contribution, so no cash is given to partners. ▪ This greatly reduces the risk of fraud by design, and fewer resources need to be committed to due diligence and financial monitoring.
Politically Exposed Persons (PEPs) Programme supports PEPs, causing reputational damage to SDC and the programme.	**Low**	**High**	▪ Actively screen for the presence of any Politically Exposed Person (PEP) within proposed partner organisations prior to investing in an intervention. ▪ Reject support to any intervention that involves PEPs in any manner. ▪ Continually monitor partner organisations for involvement of PEPs. ▪ Notify SDC of any PEPs that are encountered during programme activities.	▪ Programme uses the R-I-E-D screening model to pre-screen interventions. ▪ The Engagement and Do No Harm steps of the screening process serve to pre-empt dealing with PEPs; these potential interventions will be rejected before they start.
Programmatic Risks				
Donor Distortion Donor interventions and competing priorities distort health markets and undermine the MSD approach to health. ▪ Sustainable outcomes in focal sub-sectors undermined. For example, the introduction of subsidized projects in core programme market areas distorts market incentives for private sector players and crowds out private investment. ▪ Other donor health programmes overlapping the same private sector "innovation space" as PSPH offer grant funding, free or subsidised commodities, or payment of operating costs to the same limited universe of private sector partners, which takes partners' eyes off of the need to reach sustainability based on market activity alone. ▪ Donors view private sector healthcare providers only as government contractors.	**High**	**High**	▪ Adjust programme interventions to focus on less "crowded" clinical areas and health sectors, those clinical areas, supply chain elements, or funding elements either underserved or not covered by donor-funded and free service delivery. ▪ Seek partnerships with private sector organizations that are not currently participating in other donor programmes and wish to move from crowded health areas. ▪ Continue high-level dialogue with relevant donor organisations to map existing projects and coordinate future programme design to avoid overlap/clash. ▪ Coordinate with other programme implementers funded by donors who may use different approaches.	▪ The World Bank has developed a programme that substantially overlaps PSPH in scope but does not follow an MSD approach. ▪ Grants, subsidies, donated health commodities, and payment of operating costs present a real risk to the programme's approach. Risk is particularly acute because Somalia's public health service does not have its own budget and external donors pay all the bills. ▪ PSPH is staying away from health areas that are crowded with programmes utilising direct delivery of services, subsidies and free products. ▪ Grants from other programmes to health sector innovators make the light-touch TA-based

Risk	Probability	Impact	Mitigating Actions	Notes
				MSD approach less attractive to recipients of donor funds. ▪ There is a risk that current partners such as Caafinet could receive funds from other donor projects since in many ways they are “the only game in town”, which would undermine not only sustainability but also attribution according to the DCED standard. ▪ There is a limited universe of potentially sustainable innovative private sector healthcare businesses in Somalia and Somaliland; those identified by PSPH may become attractive subjects for other donor programmes. ▪ Other donor programmes with more funding could poach PSPH staff who have been highly trained to engage with the private sector and have specialized skills; those we trained can be lured away with offers of more money since they are also the “only game in town.”
Political Interference Government bureaucracy creates obstacles, and multiple political entities cause unmanageable complexity. ▪ Need for additional approvals, permissions may delay implementation of the programme. ▪ Power structures in flux; unclear and authority uncertain. ▪ Public sector stakeholders do not understand programme’s MSD approach and have an inappropriate view of the private sector. ▪ The Ministries of Health may undermine the programme as they have come to expect financial support from donors whereas they are not receiving money from SDC.	**Medium**	**High**	▪ Continuously liaise with government officials and include government as stakeholders. ▪ Develop easily understandable fact sheets about programme. ▪ Communicate the message that healthcare is a complex ecosystem where public and private sector players co-exist, and that the private sector complements and supplements the public sector rather than competing with it. ▪ Communicate to government entities that strengthening private sector healthcare financing and provision is a win-win and in the national interest. ▪ Start approval processes early. ▪ Participate in MoH dialogue and working groups as policy is being formed. ▪ Begin direct dialogue with all political entities on private sector engagement.	▪ Other donors pressure government to give priority to their projects with monetary inducements. ▪ Government and the private sector misperceive and misunderstand each other. ▪ Multiple governments add additional layers of bureaucracy, and structures are ill-defined. ▪ Somaliland operates as independent state and does not cooperate with entities registered in Somalia. ▪ Need for approval on research projects adds considerable delays and costs. ▪ There may be friction with the programme as its support goes to the private sector and bypasses direct support to the government.
Insufficient Demand for Programme Services Lack of private sector ‘buy-in’; shortage of interested partners willing to engage and invest.	**Low**	**High**	▪ Perpetually look for new programme partners; re-visit stakeholder analysis to identify new partners.	▪ Experience from predecessor programmes shows that demand is not an issue.

Risk	Probability	Impact	Mitigating Actions	Notes
▪ Programme does not offer a sufficient value proposition to potential partners. ▪ Limits the prospects for strategic market innovations. ▪ Leads to inappropriate / ineffective partnerships.			▪ Keep high-visibility social media presence. ▪ Broadcast success stories and promote benefits of programme participation. ▪ Utilise existing stakeholders, including end users, to identify new partners. ▪ Conduct substantial outreach and dissemination activities to reach those who are not readily identifiable (the “unknown unknowns”). ▪ Constant feedback loop reflections: alter focus (e.g. activity, timeframe, region) if no suitable partners found.	▪ Somalia and Somaliland healthcare sectors are already heavily private sector driven. ▪
Cultural Intransigence Entrenched cultural practices related to healthcare may be impossible for the programme to overcome within its time frame. ▪ Health seeking behaviour. ▪ Health spending behaviour. ▪ Healthcare decision-making within the family.	**Medium**	**Medium**	▪ Promote proper path to treatment at community level. ▪ Make sure that interventions offer superior value proposition compared to existing mechanisms. ▪ Match new products to existing behaviour patterns. ▪ Organize existing community financing mechanisms to focus on health. ▪ Ensure that community leaders are kept informed of the programme’s benefits to their communities in a manner that recognises existing cultural orientation, focusing on better health outcomes.	▪ Preliminary research shows a high level of community trust in informal providers who may not be healthcare professionals. ▪ Preliminary research shows that satisfaction with healthcare providers is not a main concern. ▪ Lower income groups do not typically follow proper path to treatment. ▪ Communities already have some informal mechanisms in place to pay for healthcare needs.
Inability to Reach Marginalized Areas and Disadvantaged Groups Programme may not be able to reach into some difficult access areas and cannot meet the objective of serving disadvantaged groups. ▪ A corollary of security concerns and political complexity.	**Medium**	**Medium**	▪ Use technological solutions that work on basic mobile devices. ▪ Promote outreach from population centres. ▪ Explore low-cost telemedicine models. ▪ Explore cross-subsidy pricing models such as Aravind.	▪ A limitation to the MSD methodology is that the most marginalized groups who have no disposable income are dependent on public sector services, which are sustainable only if the government has its own tax base.
Sustainability Some essential services may not be profitable for the private sector. ▪ The private sector must make a profit to survive. ▪ Private sector investment in healthcare must compete with other potential investment returns.	**Low**	**Medium**	▪ Introduce low-cost business models proven to work in other difficult environments and adapt them to Somali context. ▪ Help private sector providers understand the extent and buyer power of the “mass market”. ▪ Match organized consumer finances to value-for-money providers.	▪ There is a lower limit to where the private sector can operate a service profitably. ▪ Healthcare finance and service providers may not understand the actual size of their potential market. ▪ Services may not be priced appropriately.

Source: Cardno analysis

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Appendix C Research Guides

Client Exit Interview

Date of interview_____

Time of interview _____

Interviewer's name and signature _____

Name of facility _____

Type of Facility

a. Private for profit
b. Private not for profit
c. Public
d. Location of facility _____
e. Rural
f. Urban

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that Somalis encounter as they and their families seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how you seek and pay for your healthcare.

I will ask you specific questions on your hospital visit today, the kind of services you received, and how you paid for it. We shall discuss each item one at a time.

Your answers will be kept confidential. The results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

The participation in this survey is voluntary. Also, if there is a question you do not want to answer, just tell me and we will skip to the next one; if you no longer want to continue, you can also tell me and we will stop the interview.

May I have your consent to proceed with the interview?

Bio Data

What is your Age?

☐Under 18

☐19-24

☐25-30

☐31-40

☐41-50

☐51-60

☐above 60

Gender: ☐ Male ☐ Female

Access to Care - General

1. When you or any of your family members fall sick, where do you usually go first for treatment/cure?
   a. This clinic
   b. Other private clinic closer to my home

c. Nearest public clinic
d. Pharmacy
e. Neighborhood provider, who may not be a doctor
f. Other (specify _____)

2. Why do you usually choose this treatment path?
   a. Proximity/convenience (close to home)
   b. Cost
   c. Quality of care
   d. Customary in my family/community ("we've always done that")
   e. Other (specify _____)

Access to Care – Today's visit

1. How long did it take you to reach this hospital?
   a. Less than 10 min.
   b. 10-30 min
   c. 30 min – 1 hour
   d. More than 1 hour
2. Is this the nearest facility from where you live? Yes (*Go to 5)* / No (*If No Go to 6*)
3. Was the nearest facility private or public, or don't know?
4. What were the main reasons for by passing the facility nearest to your home? Allow multiple responses. Do not prompt.)
   a. Unaffordable fees
   b. Unavailability of drugs
   c. Long waiting time
   d. Discourteous staff
   e. Not conveniently located
   f. Didn't have the services I need
   g. Don't know or no reason
5. Do you know what type of facility this is?
   a. Private
   b. Public
   c. Don't know
6. Why did you come to this particular facility? (Allow multiple responses. Do not prompt.)
   a. Affordable services
   b. Available drugs
   c. Short waiting time
   d. Courteous staff
   e. Conveniently located
   f. Had no choice
   g. Emergency
   h. Quality of clinical staff and services
   i. I've been here before, this is where I always come
   j. No reason
7. What services did you get in your treatment?
   a. Outpatient (did not sleep in the hospital).
   b. Inpatient (slept in the hospital). If inpatient, how many days were you admitted? _
8. How many other times have you or a member of your household visited a hospital in the last 12 months (past year)?

> None

   a. 1-4
   b. 5-9
   c. More than 10
   d. Don't know/ cannot remember

Quality of Care (in this visit)

Please share your feelings on the quality of service you received

1. How satisfied were you with the care given?

5=Very satisfied, 4=satisfied, 3=neither satisfied or not satisfied, 2=not satisfied, 1=Not sure

2. How long did you wait before being seen by the clinician? ,

5=Not long, 4=fairly long, 3=very long, 2=unacceptably long, 1=Don't know

3. The clinician answered my questions in a way I could understand.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

4. The clinician listened carefully to what I had to say.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

5. The clinician explained problems and treatments clearly.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

6. The clinician was careful and thorough.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

7. I am satisfied with amount of time the clinician spent with me during my visit.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

8. The clinician showed me respect and courtesy.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

9. The office staff showed me respect and courtesy.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

10. I feel confident that I can get the medical care I need without being set back financially.

5 = Strongly Agree, 4 = Agree, 3=Neither agree nor disagree, 2 = Disagree, 1 = Strongly disagree

11. Did you need or were prescribed any of these services today or during your hospitalization? Yes /No

Service	Yes /No
Medicines	
Laboratory tests	
Imaging (*X-ray, CT Scan, Ultrasound)*	
Specialist Consultation	
Surgery /Theater	

12. Was any of the services that you needed not available?

Service	Check if Not Available
Medicines	
Laboratory tests	
Imaging (*X-ray, CT Scan, Ultrasound)*	

Specialist Consultation	
Surgery /Theater	

13. I would tell a family member or friend to use this clinic.

5 = Definitely Yes, 4 = Probably Yes, 3 = Not Sure, 2 = Probably Not, 1 = Definitely Not

14. I will probably use this clinic again.

5 = Definitely Yes, 4 = Probably Yes, 3 = Not Sure, 2 = Probably Not, 1 = Definitely Not

COST OF CARE. This is for this particular visit

1. Did you pay out-of-pocket for any of the services provided? Yes (Go to 26 next) / No (Go to 29 next)
2. If yes, how much did you pay? _____

Total cost _____

3. How did you pay for the care?
   a. Hard Cash
   b. Voucher
   c. Mobile cash
   d. Insurance (if insurance, name company)
   e. In-kind payment
   f. Others (Name it _____)
4. What was the source of your payment for these costs?
   a. Cash on hand/household cash
   b. Self-savings
   c. Borrowed from individuals / money lenders / banks / mobile (if borrowed, specify which source)
   d. Given by relatives / friends
   e. Voucher (if voucher, from where?)
   f. Sold household assets
   g. Mortgaged household assets / put assets/property in pawn
   h. Was given opportunity to pay later
   i. Any other
5. Have you or any of your family members ever deferred treatment because you could not pay for it? Yes/No
6. Have you or any of your family members ever had problems paying for treatment (at any clinic/hospital)? Yes/No
7. If yes, what happens when you cannot pay?
   a. Go home, defer treatment until we raise the money
   b. Receive basic services only and skip others that cost too much
   c. Get credit from the clinic/hospital
   d. Go to a lower cost provider (may be informal)
   e. Try to find a free provider
   f. Other (specify _____)
8. Can you estimate the portion of your household disposable income that goes towards family healthcare? How much do you spend on health per year?
   a. Under 10%
   b. 10% - 25%
   c. 25% - 50%
   d. Over 50%
   e. Don’t know/cannot estimate

Remittances

1. Does your family receive remittances from overseas and use the money for health?

a. Yes
b. No- If No Stop here
c. Don’t know/not sure

2. How do you receive your remittances?
   a. Bank
   b. Mobile
   c. Cash transfer
   d. Others
3. How often do you receive the remittances?
   a. Annual
   b. Monthly
   c. Only when needed
   d. Not sure
4. What do use the money received through remittances for?
   a. Healthcare expenses
   b. Food
   c. House rent
   d. Savings
   e. School fees
   f. Other (please specify)
   g. Don’t know/not sure
5. Anything else you would like to tell us about your family’s healthcare experience?

Thank you for your valuable time.

End of interview

Provider Network – Interview Guide

Interviewee Market Position	
Institution	Location
Interviewee Name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that low economic power Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you specific questions about the how patients pay, how a health providers are paid, the kind of services provided and the support if any you have or know that can to cater for this group of patients.

We shall discuss each item at a time. All of your answers will be kept confidential. The results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

1. What is your network's role in the Somali healthcare market?
2. What services does your network provide to patients?
3. How was your network formed?
4. Where are your members drawn from? Are professional credentials a requirement? If so, which?
5. Where are your members located?
6. Do members pay network membership fees?
7. What services do you provide to your members (e.g. training, pooled procurement of medicines and supplies, quality control)?
8. Are there other institutions or associations that can contribute to a profitable network of healthcare providers that offers high quality of care at affordable prices?
9. How can private provider networks reach rural and marginal areas?
10. Is there an institution that provides quality assurance that links service quality to provider payment?
11. What self-regulatory mechanisms (quality control) can be explored within your network to complement public sector regulatory enforcement?
12. How can healthcare financing mechanisms like insurance companies link to healthcare service provider networks to benefit more Somali consumers?
13. Do you see a role of mobile network providers in improving care provision in or access to your network?
14. Do you have harmonized rates for services across the network, or are individual providers allowed to set rates? Probe
    a. Are they the same rates for insurance companies versus fees charged to individuals?
    b. Are these rates for insurers harmonized by the insurer or by the association?
    c. Do your members charge differential fees for poor people?
15. From your perspective, what are the main challenges for poor and vulnerable Somalis in accessing care, and how can these be addressed by your network?
16. What are the biggest obstacles to expanding and growing your network? Where do you see opportunities for growth?
17. Currently, for many in the mass population, the private sector is the last resort due to the general impression of high cost. How can you overcome this impression so more Somalis of all income levels can access private care?
18. What is the relationship between associations and networks (e.g. pharmaceutical association vs Somali Medical Association)? Or between any other associations? How does this relationship impact the services provided by each party? Is there formal agreement between parties? (Partnership between networks and associations).
19. Do you have patient referral mechanisms when you cannot provide required services? If so, to whom? Do you get paid for referrals?
20. Which services are profitable for you and which are not?

21. Do you receive any outside funding for your network, for example from donors or foundations?
22. What is your relationship with government regulatory authorities?
23. In your view, what needs to be done over the next three years to improve access to healthcare for low-income Somalis, and what role does the private sector play in this?
24. Is there anything else we have not mentioned that you think is important in improving the healthcare market in Somalia?

End of Interview

Thank you for your time

Community Key Informant – Interview Guide

Interviewee Market position	
Institution (if any)	Location
Interviewee name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that low economic power Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you specific questions about the how patients pay, how health providers are paid, the kind of services provided and the support you have or know of, if any, that can cater to this group of patients.

We shall discuss each item at a time. All of your answers will be kept confidential. The results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

Gender: Male / Female

Age _____

Level of education: Formal (Primary, Secondary , Post-secondary); Informal

Area of residence _____ Rural or urban?

1. When someone in your family falls sick, where do you usually go to get treatment?
   a. Private clinic
   b. Public clinic
   c. Pharmacy
   d. Neighborhood provider, who may not be a doctor
   e. Other (specify_____)

Probe if the choice is a formal or informal provider

2. Why do you choose this facility?
   a. Proximity/convenience (close to home)
   b. Cost
   c. Quality of service
   d. Don't have to wait
   e. Customary in my family/community
   f. Other (specify _____)
3. What types of healthcare providers do you know? (can be more than one answer) By ownership (private/public/NGO)
   a. Pharmacy
   b. Clinic
   c. Hospital
   d. Laboratory
   e. Traditional medicine
   f. Other
4. When you choose a provider, how do you identify who is qualified to provide a certain service?
5. What are your key challenges in accessing healthcare? Probe
6. How do you address them now?
7. From your perspective, what needs to be done to overcome these challenges in the future?
8. How do you pay for healthcare?

a. I go to a free clinic or hospital
b. Hard Cash
c. Voucher
d. Mobile cash
e. Insurance (if insurance, name company)
f. In-kind payment
g. Others (Name it _____)

9. Do you have problems paying for quality healthcare?

5=Always, 4=Frequently, 3=Occasionally, 2=Seldom, 1=Never

10. What happens when you cannot pay for treatment / healthcare?
    a. Go home, defer treatment until we raise the money
    b. Receive basic services only and skip others that cost too much
    c. Get credit from the clinic/hospital
    d. Go to a lower cost provider (may be informal)
    e. Try to find a free provider
    f. Other (specify_____)
11. Do you pool resources for health as a community? Rotating savings clubs (Hagbad/Ayuuto), fundraising. Are you aware of any health insurance provider and have you used it?
12. How much disposable income is available in your household? _____ How much of this do you spend on healthcare?
    a. Under 10%
    b. 10% - 25%
    c. 25% - 50%
    d. Over 50%
    e. Don't know/cannot estimate

Can you estimate how much your family spends on healthcare in a year? _____

13. How do you decide to allocate your household's resources for healthcare? Probe. Do you save for healthcare?
14. What other ways do you have of catering for healthcare and how can they be improved?
15. Do you use money from overseas remittances to pay for health services? If so, how do you receive it? How often do you receive it?
16. What challenges to do you have in accessing healthcare? Other than an infusion of cash, what needs to be done over the next three years that will best improve access to healthcare for your family/community?

Is there anything else we have not mentioned that you think is important in influencing how you access to healthcare in an affordable manner whenever you need it?

End of Interview. Thank you for your time

Interview Guide - Insurance

Institution	Location
Interviewee Name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that low economic power Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you open questions about the how patients pay, how a health provider is paid, the kind of services provided, and the support you have or know of, if any, that can cater for this group of patients.

All your answers will be kept confidential. The interview will be recorded and results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

1. What is the role of health insurance companies in Somalia? Probe
    a. What are your current offerings and where do you see gaps?
2. Who do you see as your current market?
    a. Where or what are the growth areas?
    b. Are there opportunities to serve more Somalis of lower income levels?
    c. What are your expansion plans?
3. How do you currently sell your product?
4. What are your obstacles to growth?
5. How can healthcare financing mechanisms (*pooling revenue and payments*) and healthcare service provider networks be linked to benefit more Somali consumers?
6. Is there an institution that provides quality assurance to link service quality to provider payment? What self-regulatory mechanisms can be explored within the private sector in the absence of strong public sector enforcement?
7. Right now, who provides healthcare services and who currently pays for them? What is your vision of who will do and who will pay in a sustainable future not dependent on external support?
8. Which services and cost items do your insurance products pay for? Which services are economically viable for private sector providers?
9. Which provider types are paid? How do you deal with private provider networks?
10. How is the payment made to providers? Are you able to negotiate and bring down rates from the private sector? What has the experience been in this regard?
11. Do you link to mobile platforms or do you see a way to use mobile services to increase your business?
12. Are there innovative healthcare financing mechanisms you know of that you recommend that our project should explore?
13. What is your relationship with government regulatory authorities?
14. What needs to be done over the next three years to improve the healthcare market system in Somalia?
15. Is there anything else we have not mentioned that you think is important in improving the healthcare market in Somalia?

End of Interview

Thank you for your time

Key Informant Interview Guide – Mobile Network Operator / Banks

Interviewee Market position	
Institution	Location
Interviewee name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that low economic power Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you specific questions about the how patients pay using mobile phones, your interaction with healthcare providers, your market interaction with the low income groups, and the support you have or know of, if any, that can cater to this group of consumers.

We shall discuss each item one at a time. Your answers will be kept confidential. The results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

1. What are your key services? Does your company play a role in the healthcare system?
    a. Are there mobile-based financial services that are currently used for healthcare payments and savings in Somalia, or existing services that can be leveraged? (from your company or others)
    b. What are these and how do they function?
    c. Do you deal in remittances, and is there potential to link them to healthcare delivery and payments?
2. What is your current market? Do you reach the poor? Do you see further opportunities to reach the poor?
3. What are your expansion plans? Do they include more healthcare-related services?
4. Do you have partnerships with, or see some partnership opportunities with: (if yes, probe with whom)
    a. Healthcare providers or provider networks?
    b. Insurance companies?
    c. Banks?
    d. Community groups?
    e. Government?
    f. Donors or NGOs?
    g. Others (specify)?
5. Are you aware of any innovative mobile-enabled healthcare finance products or platforms from overseas that might be applicable to Somalia?
6. Is there anything else we have not mentioned that you think is important in improving the healthcare market in Somalia?

End of interview

Thank you for your time

Key Informant Interview Guide – Federal /Regional Ministry of Health

Interviewee Position	
Institution	Location
Interviewee Name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that economically disadvantaged Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you open questions about how patients pay, how health providers are paid, the kind of services provided, and the support you have or know of, if any, that can cater to this group of patients.

We shall discuss each item at a time. All of your answers will be kept confidential. The interview will be recorded and results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

1. What role does your agency play in the Somali healthcare system?
2. When it comes to financing healthcare for the poor and vulnerable: (Probe)
    a. What is your standard definition of the poor?
    b. Are there existing social safety net targeting mechanisms and do they target the poor?
    c. How can we best use existing mechanisms to target the poor?
    d. What mechanisms can be used to differentiate those that can pay from those who cannot?
3. What is your agency's capacity to carry out health financing functions of revenue generation, pooling purchasing and monitoring? Probe
    a. Where does the money to spend come from?
    b. Where is the money pooled?
    c. How is payment made to providers? Direct purchases of inputs including salaries?
4. How can PSPH build on existing and potential programs financed by other donors, e.g. the World Bank?
5. Are you aware of any sustainable health financing models elsewhere that provide access to quality health services to the poor that may be adaptable to the Somali context?
6. How are remittances used to access health services in Somalia? Are there mobile-based financial services that can be leveraged?
7. What are the minimum needs for a basic healthcare services package? Probe
    a. What is the cost of delivering this basic package?
    b. Which services can the private sector providers offer profitably?
8. What is the size of the underserved market? Which healthcare needs are well-met and which are underserved or unserved?
9. Are there institutions or networks that can contribute to an economically sustainable network of healthcare providers that can offer high quality of care at affordable prices? Probe
    a. Are there existing partnerships with the private sector to provide services to the underserved? Do these go beyond contracting out government services? Are there areas the private sector can serve well without external support?
    b. How can private provider networks better reach rural and marginal areas?
    c. Are there specific private sector associations or entities that have potential to bring expanded healthcare access to more Somalis?
10. Is there an institution that provides quality assurance to link service quality to provider payment? Probe
11. What regulatory mechanisms does the government have in place to enforce quality control?

a. Do you have issues with compliance and enforcement?
b. Are there self-regulatory mechanisms that can be explored within the private sector to leverage government enforcement capacity?

12. Who currently gives or supplies healthcare to Somalis? Who does what, and who pays for it? Probe
    a. Who are the major service providers? Who pays for their services?
    b. What is your vision of who will do and who will pay in a sustainable future?
13. How can healthcare financing mechanisms and healthcare service provider networks potentially be linked to benefit more Somali consumers?
14. What are the financial constraints to more equitable and universal healthcare access? Knowing that finances are often limited how do Somali households decide to allocate resources for healthcare?
15. What should be done over the next three years to best improve healthcare access for poor Somalis? What are the government's priorities for the private sector? How can the private sector best be engaged?
16. Is there anything else we have not mentioned that you think is important in improving the healthcare market in Somalia?

End of Interview

Thank you for your time

Implementing Partners (INGOs, e.g. Concern Worldwide, Save the Children, donor contractors) – Interview Guide

Interviewee Market position	
Institution	Location
Interviewee name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that low economic power Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you specific questions about the how patients pay, how health providers are paid, the kind of services provided and the support if any you have or know that can to cater for this group of patients.

We shall discuss each item at a time. All of your answers will be kept confidential. The results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

1. What is your institution's healthcare mandate in Somalia? What overall role do you play in the healthcare system?
2. What health services do you provide?
3. Where does your funding come from?
4. When did your project start and when will it end? What is the budget? (may be multiple projects, get answers for each)
5. How do you choose the location of your services?
6. How do you identify the poor (those who qualify as beneficiaries)?
7. How are targeted benefits given to the poor? Do you use vouchers or cash transfers? If so, are cash transfers/vouchers unconditional or conditional when it comes to use for health?
8. Do you have referral system for what you do not offer? Where do you refer?
9. Do your patients pay any out-of-pocket charges? Do you leverage on existing formal financial services by mobile phone services providers, banks, or informal systems like saving clubs (Hagbad/Ayuuto) and local money lenders?
10. Do you have any linkages to the commercial private sector in terms of provision of financing, supplies, or patient care? Probe relationships with other independent providers, pharmaceutical distributors, medical suppliers, insurance companies, etc.
11. What is your relationship with the government?
12. Do you coordinate your services and programmes with any other institution(s), donors, or entities that have not been mentioned?
13. What is your long-term plan for sustainability, beyond your current funding?
14. In your view, what are the underserved needs in the healthcare market and are there ways the commercial private sector can contribute to serving them?
15. Is there anything else we have not mentioned that you think is important in improving the healthcare market in Somalia?

End of Interview

Thank you for your time

Interview Guide – Healthcare Providers

Interviewee Market Position	
Institution	Location
Interviewee name	Position /Designation
Interview Date	Interviewed by

Interviewer Introduction

"Hello, my name is _____. I am visiting you on behalf of the Private Sector Partnerships in Health programme sponsored by Swiss Development Cooperation. We are conducting a market assessment on the barriers that low economic power Somalis encounter as they seek treatment in private hospitals, outpatient clinics, and other private healthcare facilities. We are gathering information on your experience and practice in how they seek and pay for their healthcare.

I will ask you specific questions about how patients pay, how a health provider is paid, the kind of services you provide, and the support you have or know of, if any, that can cater to this group of patients.

We shall discuss each item at a time. All of your answers will be kept confidential. The results of all of the interviews will be analyzed together and used to better understand what is working well now and what may need to be changed."

May I have your consent to proceed with the interview?

Optional - May I have your consent to use your name in conjunction with specific responses?

1. What kinds of services do you provide? How do you decide what to provide?
2. What is in your basic healthcare services package and what is the cost of delivering this basic package? Probe
    a. What are the opportunities to expand your services to meet the needs of the market?
    b. Which needs are well-met, and which are underserved or unserved?
    c. What are your growth areas?
    d. What are the problem areas?
3. Who do you provide services to? What is your customer profile (probe)?
4. How do your patients pay for your services? (multiple answers acceptable – if multiple answers, probe proportion of each)
    a. Out-of-pocket (cash or mobile money)
    b. Insurance - ask for the names
    c. Credit from your clinic/hospital
    d. Through existing government, donor, or NGO programs – ask which and how – if so, are there opportunities for partnership with these programs?
    e. Other
5. Do you have patients who cannot pay? How do you deal with them?
    a. We must turn them away
    b. We reduce our rates
    c. We take partial payment
    d. We give them credit
    e. We refer them to a public facility
    f. Other (specify _____)
6. From your perspective, what are the challenges for lower income groups in accessing care and how can these be addressed? Is there a way our project can help facilitate access without directly providing money?
7. How do you set your rates? Probe
    a. Are they based on your costs, on what your competitors charge for the same services, or what the market will bear?
    b. Are they the same rates for insurance companies versus fees charged to individuals?
    c. Do you charge differential rates for poor people?
8. Which services are profitable for you and which ones are not?
9. Do you belong to a provider network? If not, would you be interested in joining a provider network?

10. Do you have referral system for what you do not offer? To where do you refer? Do you get paid for the referrals?
11. How do you describe your business relationship with other market players like medical supplies and pharmaceutical distributors, banks, insurance companies, etc. (Local or foreign)?
12. Do you have expansion plans? What and or where?
13. What are the biggest challenges of running a healthcare business in Somalia?
14. How can private providers reach rural and marginal areas better?
15. What is your relationship with government regulatory authorities?
16. In your opinion, what needs to be done over the next three years to improve the healthcare system in Somalia?
17. Is there anything else we have not mentioned that you think is important in influencing the healthcare market in Somalia?

End of Interview

Thank you for your time

About Cardno

Cardno is a global provider of integrated professional services which enrich the physical and social environment for the communities in which we live and work. Our team of multidisciplinary specialists around the world has almost 75 years' experience in designing, developing and delivering sustainable projects and community advancement programs. Cardno is listed on the Australian Securities Exchange (ASX: CDD).

Cardno's approach to international development

Cardno believes innovation is informed by the past; not limited by it. We have decades of experience in over 100 countries working on projects ranging from expanding trade and investment opportunities to increasing girls' enrolment in schools to improving access to healthcare to rehabilitating water systems and roads. Every project—no matter the size, donor or country—receives a rigorous approach informed by past work but tailored for a sustainable and effective solution.

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