



**Humanitarian
Policy Group**

Roundtable learning note

Strengthening Somalia's health systems: emerging stronger from Covid-19

Online roundtable, 2 September 2020

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Key recommendations

- Develop a unified vision for health service delivery in Somalia, in alignment with government policies, plans and programmes. All agencies should invest their support into the unified health sector support programme.
- Existing coordination mechanisms should be reinvigorated over the next 12 months to deliver on a unified plan for strengthening health systems.
- Donors and governments need to transition from humanitarian to medium- and long-term funding models for the health sector.
- The Federal Government of Somalia and the Federal Member States should increase the health budget to reinforce the government's commitment to deliver key services, including health.
- The international community should provide long-term investment in building government capacity, including the capacity to manage health procurement using the government's procurement regulations and procedures to the extent possible.
- The Ministry of Health should continue to explore new models of delivery, including private sector engagement, to complement existing structures incorporating the crucial work of NGOs that link policy conversations with grassroots networks.
- Donors must identify barriers currently preventing them from using country systems and support necessary developments to steadily increase use of these systems.

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Purpose of this note

This note summarises the findings of a roundtable held by the Federal Government of Somalia (FGS) Office of the Prime Minister (OPM) and the Humanitarian Policy Group (HPG) at ODI on ‘Strengthening Somalia’s health systems: emerging stronger from Covid-19’. On 2 September 2020, 31 national and international experts¹ examined how Somalia can build a sustainable health system for the longer term. The deliberations were informed by opening remarks from the Minister for Health for the Federal Government of Somalia, Dr Fawzia Abikar Nur; Health Advisor to the UK Government’s Foreign, Commonwealth and Development Office (FCDO), Amy Kesterton, and former United Nations Resident and Humanitarian Coordinator for Somalia, Peter De Clercq.

Key recommendations from the roundtable

- 1. Develop a unified vision for a health system in Somalia:** It is extremely important to continue to build consensus on the most effective and appropriate health system for Somalia. Programmes and agencies need to converge incrementally into a single, or at least more unified, health sector support programme that works through government and aligns with government policies and plans. For aid to be effective, the health sector should follow one plan and system with agreement on future delivery modalities. The developing health sector interventions through the World Bank and Global Financing Facility (GFF) offer a significant opportunity to pool funds, improve coordination, facilitate external fiduciary oversight of funds, and give a major boost to government progress on the Social Roadmap and the Essential Package of Health Services. All parties must commit to an inclusive consultation process on the World Bank project over the next six months.
- 2. Utilise existing coordination mechanisms:** The Somalia Development and Reconstruction

Facility (SDRF), the Mutual Accountability Framework (MAF) and High Level Partnership Agreements are useful coordinating frameworks in that they emphasise government ownership. The donor, government and key stakeholder coordination mechanisms should be reinvigorated and solidified within the next 12 months so that future programmes can be developed through this coordinated system.

- 3. Transition to medium- and long-term funding models for the health sector:** Donors and government need to discuss the move of health sector funding away from humanitarian funding. Transition financing should be used to shift towards a longer-term funding model for health provision. There is also a need to improve dialogue between humanitarian and development actors.
- 4. FGS should increase the health budget:** To promote the commitment of government to deliver key services such as health, the commitment of the FGS to increase their contribution to the health budget is key. This sets an important precedent and demonstrates the government’s political commitment to deliver key services. These factors are essential to strengthen donor confidence. When domestic revenue rises in future there must be incremental increases in domestic resources to the health sector.
- 5. Build government capacity with long-term investment:** The government’s Damal Caafimaad project has strong institutional capacity development plans for both the federal and state governments. The Ministry of Health (MoH) encourages the international community to support the rebuilding of health systems in line with the national health policy, strategies and plans. However, the capacity to manage procurement remains low in government and targeted support in this area is vital.
- 6. Explore new models of delivery, including private sector engagement, to complement existing structures:** Strengthen the current public–private health system delivery model, building from the current reality on the

¹ Participants came from a variety of backgrounds: Somali government; donors; non-governmental organisations (NGOs); United Nations (UN) agencies; and independents.

ground. This will require the MoH to develop stronger regulation, standardisation, and contracting capacities. NGOs and other civil society groups will still have a crucial role to play as a vital link between centralised policy conversations and grassroots networks.

7. **Identify current barriers to using country financing systems and support necessary development:** Donors may wish to consider how their investments in health can eventually make more use of country systems to strengthen MoH capacity. Donors need to be clearer about the current barriers to using country systems in the health sector, given the progress that has been made by the FGS in public financial management (PFM) reforms in recent years. Learning could be drawn from the provision of on-budget support in other sectors. Once weaknesses in capacity are clear, donors can then target technical support to build in oversight and accountability, ultimately increasing donor confidence in the government and ensuring value for money. As a corollary, interventions must have clear entry and exit arrangements, performance indicators and aligned funding. From the perspective of the federal government, the need for donors to support government systems, processes and mechanisms to deliver services to its people cannot be overemphasised.

Background

Somalia is among the countries least able to cope with Covid-19 due to poverty-related deprivation, longstanding conflict, low levels of access to healthcare and limited state capacity (Herring et al., 2020). The triple impact of the Covid-19 global pandemic, recent flooding, and infestations of desert locusts has had a devastating impact on every aspect of Somalia's economy and the delivery of basic services. Remittances to Somalia have fallen: 48% of remittance recipients reported a substantial decrease² in the amounts received between March and July 2020 compared to the same period in 2019 (Nexus, 2020).

Box 1: Health system strengthening: key building blocks

- Health workforce.
- Service delivery.
- Health information systems.
- Access to essential medicines.
- Financing.
- Leadership/governance (stewardship).

Source: World Health Organization (n.d.)

On 5 March 2020, the FGS cleared its arrears to the International Development Association (IDA), completing the process of normalising its financial relationship with the World Bank Group. With this clearance, Somalia fully re-established its access to new resources from IDA and paved the way to receive debt relief under the Heavily Indebted Poor Country (HIPC) Initiative and Multilateral Debt Relief Initiative (MDRI). On 25 March 2020 the Executive Board of the International Monetary Fund (IMF) approved three-year arrangements under the Extended Credit Facility (ECF) and the Extended Fund Facility (EFF) for Somalia to the amount of \$395.5 million. However, the IMF has not provided any specific funding for Covid-19.

Despite improvements in revenue collection over the past four years, the government's fiscal position remains highly constrained and the economic impacts of Covid-19 have created further pressure. As a result, Somalia's health sector has faced chronic shortfalls in capacity, equipment, infrastructure and medical personnel (Warsame, 2020), while medical supply chains have been disrupted. This has seriously impacted maternal and child health. The World Health Organization has identified the key building blocks for strengthening health systems in Somalia (see Box 1) and the government's focus remains on primary healthcare. However, the 2020 Somali Health and Demographic Survey results have clearly shown that recent investments have not delivered (Directorate of National Statistics, 2020).

Most funds for the health sector come from donors and are outside the budget (see Box 2). UK support for health professionals, for example,

2 CBS data does not reflect this – it shows remittances holding firm. This may suggest distributional changes at the household level.

is channelled through a network of NGOs, not through the government. The sustainability of outsourcing healthcare to both humanitarian actors and the private sector is a major challenge.

The World Bank is currently developing a health project for Somalia with an estimated value of \$100 million, which will combine GFF and IDA financing. The Global Fund is also entering a new funding round with proposals currently under development, while GAVI will do the same a year later. The biggest health sector donors, FCDO, the Swedish International Development Cooperation Agency (SIDA) and the World Bank will need to decide how they propose to set up and channel future funding. The time is right to consider future funding modalities.

The government's priorities for the health sector are set out in multiple policy and strategic documents developed by the MoH, including:

1. National Health Policy – addressing key priority areas for health systems.
2. National Health Sector Strategic Plan (HSSP-II) – addressing strategic objectives and activities under nine areas for health systems.
3. National Reproductive Maternal, New-born, Child and Adolescent Health (RMNCAH) Strategy – addressing the challenge of morbidities and mortalities.
4. Nutrition Strategy – developed separately but as part of and implemented jointly with the RMNCAH Strategy.
5. Roadmap towards Universal Health Coverage (UHC) – addressing priority areas of service package (Essential Package of Health Services (EPHS) Framework), with equity and population coverage and financial protection.
6. EPHS Framework – currently being updated.

Issues and challenges for longer-term health system strengthening

The roundtable discussed a complex set of issues that will need to be addressed to strengthen the health system in the long term. It was the view of all participants that there is not currently a Somali-led, collectively agreed vision for the future health system and that current health sector management

Box 2: Health sector funding for Somalia

The Somalia 2020 Humanitarian Response Plan (HRP) appeal target is over \$1 billion, of which \$225.6 million is requested to fund the plan's Covid-19 Global HRP. To date, the Covid-19 appeal has raised \$44.3 million (FTS, 2020).

Health sector support from donors (both development and humanitarian spending) was \$113.9 million in 2017, \$120.7 million in 2018, and \$133.1 million in 2019 (MoPIED, 2020).^{*} FCDO and the Global Fund are the largest donors, accounting for 40–45% of donor funding and 21% of humanitarian funding (Global Financing Facility and World Bank Group, 2020).

The FGS has recently managed to secure additional budget support from the World Bank and African Development Bank due to the Covid-19 pandemic. The 2020 supplementary budget (FGS, 2020) therefore significantly increases FGS transfers to the Federal Member States.

^{*} Note: It has not been possible to assess the contribution of individual development partners broken down by sector. However, we can assume this breakdown is available in the database of the Ministry of Planning (MoPIED).

systems, funding and delivery of services do not work and require substantive change. All parties agreed that the current reliance on humanitarian funding and delivery is insufficient and must transition to a longer-term, more sustainable approach.

Tackling poor health sector coordination – the key to more coherent delivery

The lack of an agreed vision for the health sector is compounded by poor coordination among the myriad Somali government stakeholders, donor partners and implementing actors, many of which work to different plans, promote different approaches and use different financing channels.

The current poor coordination is problematic as it does not fully align with National Development Plan (NDP) funding and health sector policy. Roundtable participants pointed to several other problems in the coordination of support to health systems strengthening. These include a patchwork of plans and proposals; lack of

consistency in health sector salary support; different donor approaches; and little consensus on policy and implementation. Moreover, there are challenges with the largely dysfunctional intergovernmental coordination. There is a draft functional assignment between the FGS MoH and FMS MoHs, but this has not been endorsed and the FMS MoHs currently operate autonomously, paying little attention to the FGS MOH. Some participants also drew attention to the importance of regional cooperation, such as the support provided by the EU through the Intergovernmental Authority on Development (IGAD).³ Countries do not stand alone in the fight against Covid-19.

These problems are not uncommon in a situation where funds are provided off-budget through multiple instruments and projects. Somalia's Health Sector Donor Group has had a patchy record on meeting and coordinating since 2014 but appears to be reviving. Roundtable contributors claim little has been done to address the long-term sustainability of the sector, as donors focus on delivery and projects outside government. Prioritising humanitarian delivery undermines leadership by the Somali government, particularly problematic as Somalia develops greater stability. Recent efforts by the federal MoH and the GFF have revived an inclusive coordination mechanism, which held its first meeting in late June 2020. The MoH remains optimistic in making it operational, despite the hesitancy from some partners.

Options for improving service delivery

Roundtable participants highlighted the fundamental, over-arching need to use currently available resources (existing funds and partners) most efficiently, expanding government ownership and empowering the regional administrations. One of the goals of the FGS Health Sector Strategic Plan is to further promote the private sector as the main deliverer of affordable public health services.

Currently, most healthcare provision through donors is outsourced to NGOs and CSOs, although the private sector has historically been involved in providing most basic social services (de Clercq and Valbuena, 2020: 4). Despite claims regarding a historic lack of formal engagement with the private sector, the World Bank, UNICEF and FCDO are looking to work more closely with the private sector and have produced a paper outlining their plans, *Strategic guidance for engaging the private sector through private partnerships in health services in Somalia*, in July 2020.⁴

Participants emphasised the need to recognise what is happening on the ground. The current public-private mix of delivery is a reality and, rather than trying to fundamentally change this, the focus should be on government regulation and appropriate systems. Alignment, standardisation and service agreements at federal and sub-federal levels are key. The case study of Afghanistan was offered as a model for long-term investment and the use of public-private partnerships (PPPs).

However, this vision is not yet universally agreed. The MoH's own report, *Somali roadmap to universal health coverage* (MoH, 2018), claims there is no reliable information on current levels of private sector involvement in health provision and is unclear on the private sector's role in future provision, still less a strategy to achieve that. Moreover, there is interest on the part of the MoH to take over the management and delivery of health in up to 10 hospitals across Somalia, despite the lack of resources, capacity and recent experience in management. In any event, private sector engagement, such as through partnerships, would necessitate a review of current contract management capability in the MoH and the possible creation and operation of a Contracting and Procurement Unit – a specialist PPP Unit.⁵

3 The IGAD, with €14 million of EU support, is coordinating support to overcome the logistical difficulties in the region, including shortages of laboratory test kits, Infection prevention and control (IPC) materials and logistics for patients care. See www.igad.int/coronavirus/2501-first-batch-of-eu-support-against-covid-19-reaches-igad-2.

4 Many people/institutions do not consider NGOs as part of the 'private sector' but the IFC defines all non-state providers as private. Private can further be broken down into for-profit and not-for-profit.

5 Such a unit would be necessary to ensure sufficient internal expertise to create and manage partnerships and complex contracts with the private sector.

Greater on-budget health financing to FGS institutions requires greater donor confidence

The 2019 PFM Law now requires all donor aid to FGS institutions to be appropriated in the FGS Budget ('on budget') and to be paid into an account held in the Treasury Single Account ('on treasury'). It also requires that all donor grants to FGS institutions are signed by the Minister of Finance and registered with the Auditor General. Despite this, it is likely that few agencies will place their funds on treasury or use government systems in Somalia in the health sector,⁶ leaving the World Bank as the only possible vehicle for working through government.

Despite the PFM Law, donors or their implementing partners often provide financing to FGS institutions outside of government systems, and the MoH has been no exception. Typically, such funding is not reflected in the FGS budget and is disbursed to a bank account in a commercial bank that is not subject to FGS budget execution procedures and was opened for this specific purpose. This is due to concerns about the reliability and dependability of government systems (particularly in light of recent fraud investigations), as well as challenges in navigating these systems and a lack of knowledge of government procedures. Unfortunately, these practices undermine the longer-term development of accountability systems. The recent forensic audit of international support to MoH by the FGS Auditor General led to several government officials being convicted for misuse of funds that had been provided to MoH off-budget. The establishment of parallel structures and systems by aid agencies, which bypasses the government institutions and delivery channels, has further weakened the capacity of the nascent MoH to manage the health sector.

Improving public finance, government systems and procurement

Improving PFM is core to progress on UHC as it allows donor funds for health to be channelled through a common system, reducing problems of fragmentation and lack of co-ordination, and

possibly also reducing implementation costs. Robust PFM systems can optimise how public funds for health are raised, as well as how they are allocated, managed and accounted for (Barroy et al., 2019). Procurement is perhaps the most significant component of the health supply chain. However, the respective MoHs currently have little involvement to date in procurement of medicines, diagnostics and devices because so much money is spent outside of government systems by civil society organisations (CSOs), NGOs and others.

The Covid-19 crisis has shone a light globally on the critical importance of speed and flexibility in government procurement during emergencies, while highlighting the fiduciary risks associated with faster and more flexible procurement approaches. The World Bank notes that procurement during the Covid-19 pandemic has been a significant bottleneck in many countries. However, they note, 'As many countries are still heavily affected by the Covid-19 crisis, it is too early to draw conclusions on the best practices to conduct timely and efficient emergency procurement' (Cocciolo et al., 2020).

The Somalia 2016 Procurement Act establishes the basic principle of altering procedures and processes in emergency situations but does not provide guidance on how procedures and processes should be altered. The Financial Governance Committee (FGC), together with the World Bank's procurement team, is supporting the FGS to develop policy guidance on this issue. The aim is to strengthen the FGS's ability to achieve the required speed and flexibility in emergency procurement, while continuing to ensure accountability and achieve value for money in the use of public resources.⁷ PFM digital solutions, such as financial management information systems (FMIS), procurement platforms and fiscal transparency portals, are critical for smooth, efficient and transparent implementation of Covid-19 emergency responses (see IMF, 2020). In the longer term it is vitally important to invest in the government's capability to manage its own procurement.

6 GPE has put some of its funds on budget in education and the European Union provides some budget support to FGS.

7 For the time being, under the Interim Public Procurement Requirements, the Ministry of Finance undertakes all procurements above \$100,000 on behalf of line ministries until such a time when they have certified procurement units.

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