SOMALIA'S HEALTH SECTOR

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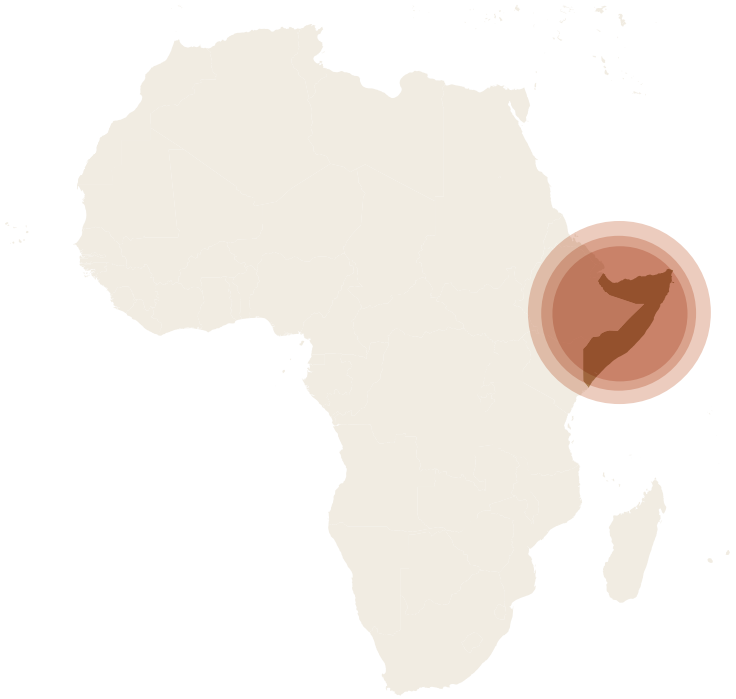
Contents

1. Country Overview



The Federal Republic of Somalia is a sovereign state with an estimated population of 15,442,905 [1]. During the colonial period, Somalia's western border was arbitrarily determined by colonial powers. As a result, Somali communities are also found in Djibouti, Ethiopia and Kenya, with the border still a source of dispute. The official languages are Somali and Arabic while the foreign languages spoken are English and Italian [1, 2].

Somalia has suffered from civil strife and insurgency caused by terrorist organization attacks. This has impacted healthcare in terms of access to facilities, nutrition and mortality rates. Despite civil unrest, Somalia has maintained a healthy informal economy. Agriculture is the most important sector, with livestock normally accounting for about 40% of GDP and more than 50% of export earnings. It is a member of the United Nations, the Arab League, African Union, Non-Aligned Movement, and the Organization of Islamic Cooperation [5-7].

Somalia's economy has faced several challenges, such as population growth that has a higher growth rate than the economic growth. Other challenges are acute poverty and vulnerability to recurrent external trade and climate shocks. However, the country has several opportunities as it is transitioning from traditional, rural pastoralism to urban, trade and services economy. Somalia's economy has remained resilient and is realizing moderate growth despite ongoing threats to stability, including drought and insecurity. Somalia's growth in 2019 was estimated at 2.9%, following slow recovery from a prolonged drought in 2016/17 [8].

Somalia is strategically located at the mouth of the Bab-el-Mandeb, which acts as a strategic link between the Indian Ocean and the Mediterranean Sea via the Red Sea and the Suez Canal [1]. Possessing the longest coastline on the continent, Somalia has several major seaports. Sixty-two airports across Somalia accommodate aerial transportation. There are no railways in Somalia [1].

1.1. Key Country Statistics

55.4 years Life expectancy, 2018 [10,11]

2.9 GDP growth (annual %), 2019 [8]

Imported products- Rolled tobacco **($280M)**, Raw sugar **($192M)**, Rice **($158M)** [15]

22.67 Exports of goods and services as a % of GDP, 2019 [12]

111.32 Imports of goods and services as % of GDP, 2019 [14]

Live animals **($78.8M)**, Gum, resins and other vegetable saps **($36M)**, Oil seeds **($35.3M)** [13]

Balance of trade, 2019 **Deficit of 1.942 USD Billion** [16]

GDP ranking, 2018 **158** out of 196 countries [9]

2. COVID-19

Somalia has experienced a whirlwind of challenges in 2020, ranging from the worst locust outbreak to date, floods, and the COVID-19 pandemic [17]. The first positive case was announced on 16th March 2020. As of 10th March 2021, almost a year since the first case was announced, Somalia has reported 8,577 cases, with 4,031 recoveries and 319 deaths [18].

The World Health Organisation (WHO) has played an integral role in helping the country respond to the COVID-19 outbreak. In January 2021, the WHO began training health workers and provided personal protective equipment (PPE). Additionally, the WHO flew in Ethiopian virologists to help strengthen and set up testing facilities. They have also facilitated training for 4,000 community workers on case management [17].

Like other African countries, the government has enforced curfews and used mass media channels like radio and billboards to educate the population on prevention methods. Public toll-free lines were established so that asymptomatic/symptomatic people can remotely consult with medical specialists [19].

3. Health Overview

Current public spending priorities focus on the security and administrative services, which account for almost 90% of total spending. This has crowded out provision for economic and social services, including healthcare expenditure.

Most of Somalia does not have adequate water supplies or sanitation. This has influenced the disease pattern in the region. The lack of health or welfare infrastructure has left organisations struggling to provide essential services that are usually provided by the government. Their efforts are hindered by continuing violence. Consequently, most Somali nationals have little or no access to healthcare [20-24].

Limited access due to insecurity in central and south Somalia has restricted health activities, contributing to the spread of diseases such as acute respiratory tract infections, obstetrical problems, anaemia and sexually transmitted infections. In addition, injuries resulting from armed conflict are common, but few health facilities have the capacity to treat them [21, 24]. The establishment of the Health Sector Strategies Plans (HSSP) 2013-2016 shows there is good will to improve health. The Essential Package of Health Services (EPHS) was later created within the framework of HSSP [4].

There are 23 medical schools in Somalia. The public health sector collapsed with the civil strife, creating a gap that was filled by the private sector. This saw an increase in life expectancy from 47 to 55. Although healthcare is now largely concentrated in the private sector, the country's public healthcare system is in the process of being rebuilt and is overseen by the Ministry of Health [21, 24]. Somalia has the highest rate of mental illness in the world [25]. In Kenya, the government provides public health insurance through a state corporation known as the National Health Insurance Fund (NHIF). The organization manages payroll contributions from the formal sector i.e. salaried individuals and voluntary contributions from the informal sector. These form a funding pool that collects revenue on a monthly basis. The members can then access healthcare from both government and private hospitals. [15]

Health systems in low- and middle-income countries (LMICs) are still heavily dependent on people making out-of-pocket (OOP) payments to cover the costs of healthcare at the time when they are using the services. Despite the abolition of user fees at community level dispensaries and public health centers, OOP payments continue to be a problem in the Kenyan health system. OOP payments deter some Kenyans from seeking care and cause others to become impoverished as a result of paying high hospital bills. [16][17]

An Essential Package of Health Services (EPHS) was originally designed in 2008 by the Somali Ministry of Health, with the goal of establishing standards for national health services vis-a-vis governmental and private healthcare providers, as well as for partnered United Nations agencies and NGOs. It aims to provide a holistic spectrum of free health services to all citizens, both in rural and urban areas. With a focus on strengthening reproductive and emergency obstetric care services for women and children, the EPHS's core programmes are to eliminate communicable illness; ameliorate reproductive, neonatal, child and maternal health; improve health control and surveillance, including water and sanitation promotion; supply first-aid and treatment to the

terminally ill or wounded; and to treat common illnesses, HIV and other STDs, and tuberculosis.

The funders and strategic partners include UNICEF, UNFPA and WHO representatives providing additional support [23, 23].

The healthcare strategic priorities are aligned with the EPHS as well as partner funding priorities as below [22, 23]:

- Strengthen provision of basic health services including returnees, refugees, IDPs, and the host community.
- Increase access in specific underserved areas as well as appropriate services for disabilities.
- Ensure appropriate monitoring and control of outbreaks.
- Increase Expanded Programme on Immunization (EPI) coverage by 20% for children below the age of one.
- Maintain zero incidence of wild polio virus.
- Increase integrated reproductive health services and information availability as well as access to emergency obstetric care.
- Achieve a recovery rate of at least 75% in selective feeding programmes.
- Develop/strengthen the capacity of local health staff and management structure and maintain an effective and regular link between health sector interventions with HIV/AIDS.
- Ensure policy documents and systems are in place to support the management and implementation of humanitarian health response.

The top ten causes of mortality are [26]:

1. Lower respiratory infections
2. Tuberculosis
3. Neonatal diseases
4. Diarrheal diseases
5. Stroke
6. Protein energy malnutrition
7. Measles
8. Ischemic heart disease
9. Congenital defects
10. Meningitis

3.1. Key Health Statistics

1,600 [28]
Maternal mortality rate (national estimate per 100,000 live births), 2020

117[29]
Under 5 mortality rate (per 1,000 live births), 2019

4. Challenges Facing the Private Health Sector [30]

Limited access to health services due to insecurity.

Lack of basic data and more specialized research and analysis to inform health programming.

Poor provision of quality health services due to the lack of effective regulation.

Lack of understanding of the private sector and ability to engage the private sector across the three zones.

5. Opportunities for the Private Health Sector [31]

- Developing a regional focus and leveraging on it. Levels of conflict vary across Somalia. For instance, Somaliland and Puntland have been essentially operating as relatively stable and independent in recent years.
- Invest in technical assistance to build pre-investment pipeline. Somalia has very few intermediaries providing any advisory and business development services to local enterprises.
- Working together with the government in achieving the objectives of the Global Action Plan for Health and Well-Being for All (GAP). GAP agencies are exploring opportunities to support the development and operationalisation of a strategy for the private health sector, to assess its current role in service delivery and implementation of regulatory frameworks and contracting mechanisms [3].
- Fill the challenge of human resources that is currently facing the public sector, which leads to underutilization of public resources [4].

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