

ASSESSMENT OF THE PRIVATE HEALTH SECTOR IN SOMALILAND, PUNTLAND AND SOUTH CENTRAL

Final report: March 2015

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Executive summary

Background

This consultancy was commissioned by the Department for International Development (DFID) Somalia and contributes to the design of DFID Somalia's post-2016 health programming. It is an exploratory piece of work, with the following core objectives: (a) Achieve a deeper understanding of the role and current dynamics of the private sector in the health sector in Somalia; and (b) Develop recommendations for private sector engagement.

The questions asked of key stakeholders were framed around the following sub-objectives:

- A. Establish a working definition to categorise the various private sector health providers;
- B. Assess private provider networks;
- C. Outline the procurement, supply and distribution of medicines and medical supplies by the private sector and analyse whether there are any existing public–private partnerships (PPPs) in existence;
- D. Determine whether there are any further existing PPPs in operation;
- E. Clarify the current policy and regulatory mechanisms by which the private sector operates in Somalia; and
- F. Synthesise available information on relevant topics such as health-seeking behaviour, drivers of consumer choice, motivation of and constraints of for-profit providers and shops, the obstacles faced by investors¹, and constraints on effective legislation.

The consultancy was conducted between December 2014 and February 2015. The approach involved an inception phase followed by visits to Nairobi, Hargeisa, Garowe and Puntland and interviews. The primary groups of stakeholders who the team met with were: DFID; DFID donor partners; international non-governmental organisations (INGOs); national non-governmental organisations (NGOs); private sector health actors (including wholesalers, importers, and pharmaceutical providers); private sector health care service providers; training institutions, and government representatives. Data were triangulated, analysed and validated through a one-day consultative workshop and country-level debrief.

The field work was limited by the inability of the team to travel beyond primary urban areas, a lack of contact with consumers and/or patients of private sector health service providers and a lack of contact with informal (traditional) health service providers. The desk review was limited by the outdated secondary data and literature.

Context

DFID

Health is one of four pillars (alongside: governance and peace building; humanitarian; and wealth creation) in the DFID Somalia Operational Plan 2011–2015. There are currently two health programmes supported by DFID in Somalia.

The first is the Health Consortium for the Somali People (HCS). The HCS is piloting an Essential Package of Health Services (EPHS) through public and private sector approaches. The objective of the programme is to reduce maternal and new-born deaths mainly through the delivery of the EPHS. Five INGOs make up the consortium, with Population Services International (PSI) as the

¹ By which this study means private health care providers looking to resource new business ideas.

lead. Between them, the three zones in Somalia are covered but there is a stronger focus on Somaliland. DFID's engagement with private sector health care actors has been established via the PSI-led social franchising network – Bulsho Kaab. The pharmacies in the network offer an integrated package of high-quality services and products at affordable prices, while PSI provide training and demand generation.

The second programme is the Joint Health and Nutrition Programme (JHNP), which focuses on reproductive, maternal and neonatal health (RMNH), family planning (FP) and nutrition. The programme aims to deliver an EPHS, as well as health systems strengthening. This includes addressing: leadership and governance; the health workforce; systems for health financing; ensuring access to medical products, vaccines and new technologies; and improving the collection, quality and use of information for health planning. Each of the three health authorities across the three zones is involved. While some health authorities have indicated a strong desire to work with the private sector to monitor agreed standards of care and to increase affordable access to services, there has however been limited private sector work under this programme to date.

Private health care providers in Somalia

The private sector is the dominant provider of health care services in Somalia. It is a sector that is largely unregulated and in which there have been high levels of growth. As a result, there are concerns regarding the creation of adverse health outcomes as a result of poor-quality treatment and poor value for money being offered to consumers and patients who are paying out of pocket for service provision.

Due to a lack of data on the provision of health care services within the private sector, we cannot comprehensively quantify the value of the private health sector to patients and/or consumers. However, it is clear that the private sector is providing essential services that are often the first (and only) point of contact for consumers and/or patients seeking health advice and health products. This paper seeks to contribute to the understanding of the private health care sector in Somalia.

Key findings

The full report and annexes document the findings, conclusions and recommendations in greater depth. Summary findings, taken from each section of the report, are shown below.

Defining the private sector: The definition of the private sector results from a one-day workshop with local private sector health care service providers, other health care actors and government in Hargeisa. It was checked and validated with interviewees in Hargeisa, Garowe, Mogadishu and Nairobi. The definition is as follows: There are two forms of private health provider – informal (traditional) and formal (which is, however, only loosely regulated and controlled). The private sector does have a profit-seeking motivation but may also have social objectives. 'Public' relates to government ownership and control. The more of this there is, the closer to a public sector service it becomes. The private sector does not include NGOs, which are classified as charitable organisations that sit between the public and private (stakeholder definition).

Public and private provider network interconnectivity: While there are not formalised linkages between public and formal private service provision, there are informal linkages through systems of referral and dual practice, as well as supply chains. Service access is fluid, with the population moving between regions to access care (based on the services offered, travel security, perceived quality and proximity), as well as limited numbers accessing private health care services overseas.

Networks and associations: Associations are most commonly established to provide a group of medical practitioners, service providers or input providers with the means to lobby government in the interests of their members. Any resulting influence with government is, in practice, limited for the majority of associations and many associations are limited in terms of their active membership. This is particularly true in Puntland and South Central.

PPPs: There were no examples of PPPs in existence in Somalia. There were, however, a range of collaborative efforts (ongoing and planned) between the private sector and government and private sector and donor/INGO partners. Such collaborations encompassed efforts on accreditation, training, referral systems, social franchising, grant giving and a voucher referral system.

Procurement, supply and distribution: There is no domestic production of pharmaceutical products or medical supplies and equipment. Importation of pharmaceutical products and medical equipment occurs at multiple land and sea border points, with trade flows also taking place across each of the three zones and back out into neighbouring countries. This results in almost complete ease of entry and exit of pharmaceutical products and the circulation of counterfeit products.² There are few formal agreements between pharmaceutical suppliers and importers – reflective of importers' inability to predict demand or obtain working capital for larger orders and concerns about delays at border posts and the losses of uninsured shipments. There are preferred suppliers and manufacturers but there is no ability to check for quality in the private sector aside from using known suppliers and attempting to check barcodes with manufacturers remotely. Quality control is similarly lacking in the public sector, unless donor-led.

Policy and regulatory mechanisms: There is a body of laws and regulations that in theory provides for an overarching regulatory framework for private sector participation in the health sector. However, both adherence to regulations and the understanding of the policy and regulatory environment appear to be low, primarily because of poor dissemination, low accessibility and a lack of understanding as to what these texts mean. In addition, government and regulatory agencies have limited manpower and resources to implement their mandates and the judiciary system is weak.

Other formal rules governing the private health sector: Interviews with private sector providers and health care market actors indicate that entry and exit barriers are low, resulting in a fluid market. Although import licences are required, and there is some associated paperwork checked at some border crossings, the type of licence is not specific as to the type of importation taking place (i.e. pharmaceuticals).

Health-seeking behaviour: Price, proximity, perceived quality and the disease burden are the key drivers of consumer and/or patient choice. Treatment within the home is common. In contrast, treatment from a formal health care provider is often seen as a last step. Decisions as to the place of treatment are taken by the family, elders and traditional practitioners as well as the individual. Private for-profit providers have an objective of running a profitable business but also have the flexibility to offer differing prices to patients according to perceived need. Treatment at no cost was said by some participants to be perceived as lower quality.

The main constraints impacting for-profit providers are a lack of regulatory enforcement (the capacity for enforcement and negative outcomes for non-compliance is weak due to a lack of government capacity), a shortage of qualified personnel, and a lack of access to capital for expansion. Investors are also challenged by the limited access to affordable finance.

² There were also alleged links to money laundering (the verification of which was beyond the scope of this study).

Conclusions

Four key challenges emerged from this study: 1) lack of information; 2) poor-quality provision of health care services by the private sector; 3) weak regulatory framework; and 4) lack of understanding of the private sector.

Conclusions regarding the lack of information

There are limited data and information available on private health care service providers in the three zones and this prevents a clear picture as to the level and quality of provision available to consumers and/or patients. It is our view that there are three key areas for study. First, a basic health service mapping of public and private health care service providers would support better analysis and planning of health care interventions by government, donors and other agencies. Second, the willingness of consumers and/or patients to pay for private sector health care provision is contested and would benefit from an exploratory study into willingness to pay of the individual, as well as the ability of the individual to leverage social support networks to access financing for treatment. Third, a study to increase understanding as to the extent and preferences for health care funding by Islamic agencies with a view to better communication and coordination is desirable.

Conclusions regarding poor-quality provision of health care services by the private sector

Given the rapid growth of the private sector and the lack of effective regulation, other than commercial licensing and some taxation policies, the private sector represents some of the best and the worst of health care provision across the three zones. On the demand side, this is exacerbated by low levels of education on the part of consumers and/or patients, a reliance on word of mouth and a lack of branding and public sector guidance on where to access safe and high-quality medical treatment.

The private sector benefits from a population who predominantly seek treatment (informal and formal) in the private sector in the first instance. There is a risk that the lack of regulation and inspection, coupled with the large number of unqualified private sector providers, will lead to many people receiving the wrong or even dangerous treatments from unregulated, low-quality private sector providers, which in turn causes health complications and places an additional burden on the weak (public and private) health sector.

Conclusions regarding a weak regulatory framework

A lack of quality health care services stem in part from a weak regulatory framework and the limited enforcement capacity of the authorities in the three zones. Somaliland has made the most significant progress, but the authorisation body suffers from a lack of funding, personnel and support from the judiciary system. It is therefore essential to support the public sector in its efforts to establish regulatory institutions now and ensure that they are truly autonomous bodies.

The service providers, importers and pharmacies interviewed for this study all spoke of the need for improved regulation and enforcement. It is believed that this would help to distinguish quality providers, resulting in a more consolidated market in which there are increased business development prospects.

Conclusions regarding a lack of understanding of the private sector

This study found that there were differing views of, understanding of and ability to engage with the private sector across the three zones. In some cases government representatives saw leveraging private sector health care delivery capacity as essential to service provision as long as public sector provision was weak. Conversely, other representatives saw the private sector as contributing to enhanced drug dependency and poor health outcomes. There was also a lack of awareness on the part of donors as to how the private health care market operates and ways of working with private sector health care actors to ensure positive health outcomes. From the private sector side, a lack of formal engagement mechanisms with government, donors and consumers limited engagement opportunities.

At present there are no PPPs (as defined in the full report) in existence between private sector health care actors and government. However, there were multiple examples of informal collaboration between government and the private sector.

Recommendations

The recommendations resulting from the key challenges are categorised into four intervention objectives. These are to:

- A. Increase reliable information on the dynamics of the private health care market;
- B. Limit harmful practices and improve the quality of service provision in the private health care market;
- C. Strengthen the regulatory framework and its enforcement, and
- D. Develop cooperation between public and private health care providers.

Similarly, there are four intervention points, defined by the stakeholder group. These are:

- A. Policy-makers;
- B. Providers;
- C. Patients/consumers; and
- D. DFID.

The interventions outlined fall within supply-side strengthening and demand-creation approaches. In the table below, this is indicated by the letter in the bracket (S and D respectively). Regarding prioritisation, three tiers are recommended: tier one (priority interventions to begin immediately), tier two (secondary interventions), and tier three (longer-term interventions). These are denoted by the numbers (1), (2) and (3) respectively in Table 1.

Table 1: Summary of intervention strategies

Intervention objective	Interventions geared toward policy-makers	Interventions geared toward providers	Interventions geared toward patients	Interventions geared toward the donor community
<p>Increase reliable information on the dynamics of the private health care market</p>	<p>Assistance should be given to policy-makers to provide incentives for private health care providers to share data with government (S) (2)</p> <p>Policy-makers should develop and maintain a database of private sector health care providers (S) (1)</p>			<p>Donor agencies should undertake:</p> <ul style="list-style-type: none"> • A mapping of public and private health care facilities (S) (1) • A comprehensive study into consumer preferences³ (D) (1) • A study into willingness and ability to pay and linkages to remittances (D) (1) • Research into private sector financing with a focus on informal/traditional, Zakat, and charitable financing (S) (1)

³ Note that this is currently ongoing.

<p>Limit harmful practices and improve quality of service provision in the private health care market</p>	<p>Government should establish drug-testing laboratories and requisite staffing (S) (3)</p>	<p>Standard curricula should be developed by government and private sector training institutions (S) (1)</p> <p>Funding should be provided to scale up existing training practices that are effective and endorsed by government (S) (2)</p> <p>Training providers should be supported in the development of specialist cadres (S) (2)</p> <p>Support should be given to help to network together pharmacies, clinics and hospitals to identify them as quality providers (S) (1)</p> <p>Non-clinical and clinical private providers should be supported to formalise referral systems</p>	<p>Consumer understanding of the importance of seeking qualified medical advice, through educational campaigns, should be increased (D) (1)</p> <p>Education should be provided around the dangers of self-medication practices and incorrect drug-use (D) (1)</p>	<p>Options for financing private sector health providers and actors should be explored (S) (1)</p>

		<p>between public and private providers (S) (2)</p>		
<p>Strengthen the regulatory framework and its enforcement</p>	<p>Government should prioritise policy and legislation for development, endorsement and implementation (S) (2)</p> <p>Government should bolster the Ministry of Justice and the Courts system to enable legal weight to be given to findings of non-compliance (S) (2)</p> <p>Government, in particular the Ministry of Health (MoH), should aim to make regulatory authorities independent (S) (3)</p> <p>Funding should be provided to enable regulatory authorities,</p>	<p>Support and incentives should be given to private health care providers to conform to licensing and accreditation norms (S) (2)</p>		<p>Donor agencies should prioritise policy and legislation for development and endorsement (S) (1)</p>

	<p>such as the National Health Professions Commission (NHPC) in Somaliland, to develop inspection teams and hire full-time staff (S) (2)</p>			
<p>Develop cooperation between public and private health care providers</p>	<p>Sensitisation should be provided for the MoH on private sector involvement in health care delivery (D/S) (1)</p> <p>Increased networking and dialogue and the participation of private sector representatives in decision- and policy-making forums should be supported (D/S) (1)</p>			<p>Sensitisation for other donors and United Nations agencies on the extensive role the private sector is playing in health care delivery and ways to work with the private sector to improve health care delivery should be conducted (D/S) (1)</p> <p>Donor agencies should create forums and avenues for dialogue with private sector representatives (D/S) (1)</p>

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List of abbreviations

DFID	Department for International Development
DHB	District Health Board
DWO	Drug Importers and Wholesalers Organisation
EPHS	Essential Package of Health Services
FGD	Focus Group Discussion
FP	Family Planning
GBP	Great British Pound
HCS	Health Consortium Somalia
HEART	Health and Education Advice and Resource Team
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPA	Health Poverty Action
IDSR	Integrated Disease Surveillance Programme
INGO	International Non-Governmental Organisation
JHNP	Joint Health and Nutrition Programme
KII	Key Informant Interview
MoH	Ministry of Health
MOU	Memorandum of Understanding
NGO	National Non-Governmental Organisation
NHPC	National Health Professions Commission (Somaliland)
NHPC	National Health Professions Council (South Central)
NPRA	National Pharmacy Regulatory Authority
OPM	Oxford Policy Management
PPP	Public–Private Partnership
PSG	Peace and Stability Goals
PSI	Population Services International
RMNH	Reproductive, Maternal and Neonatal Health
SC-UK	Save the Children, UK

SDC	Swiss Agency for Development and Cooperation
SLNMA	Somaliland Nurses and Midwifery Association
SMA	Somaliland Medical Association
SOMA	Somali Midwifery Association
SOMIDA	Somali Medicine Importers and Distributors Association
SOMLA	Somaliland Medical Laboratory Association
TCMP	Traditional and Complementary Medicine Practitioners
THET	Tropical Health Education Trust
UAE	United Arab Emirates
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
US\$	United States Dollar
USAID	United States Agency for International Development
WHO	World Health Organization

1 Introduction

1.1 Project features

DFID Somalia⁴ is in the process of gathering information to inform the potential design of new support for the health sector in Somalia after 2016. The primary audience for this report is therefore DFID. An additional audience is the partners, governments and INGOs involved in similar initiatives or interested in engaging with the private sector.

The project objectives for this consultancy were to: (a) Achieve a deeper understanding of the role and current dynamics of the private sector in the health sector in Somalia; and (b) Develop recommendations for private sector engagement. Annex A contains the full Terms of Reference for the assessment.

The sub-objectives were to:

- A. Establish a working definition to categorise the various private sector health providers;
- B. Assess private provider networks;
- C. Outline the procurement, supply and distribution of medicines and medical supplies by the private sector and analyse whether there are any existing PPPs in existence;
- D. Determine whether there are any further existing PPPs in operation;
- E. Clarify the current policy and regulatory mechanisms by which the private sector operates in Somalia; and
- F. Synthesise available information on relevant topics such as health-seeking behaviour, drivers of consumer choice, motivation of and constraints of for-profit providers and shops, the obstacles faced by investors, and constraints on effective legislation.

The primary groups of stakeholders who the team met with were: DFID; DFID donor partners; INGOs; NGOs; private sector health actors (including wholesalers, importers and pharmaceutical providers); private sector health care service providers; training institutions, and government representatives.

The approach involved an inception phase, during which a data and document review took place, visits to Hargeisa (Somaliland), Garowe (Puntland) and Mogadishu (South Central), including interviews and a workshop, and follow-up correspondence and phone calls with interviewees. The field visit was undertaken from 7 January to 23 January 2015 by a team of three consultants. During the field visit, data gathered in the inception phase were triangulated, analysed and validated through a one-day workshop in Hargeisa. Key informant interviews (KIIs) were used to gather more information and also for an iterative process, whereby the summary note from the workshop was shared with interviewees, to enable findings to be compared across each of the three areas focused upon. At the end of the field visit, the team provided a debriefing for DFID. The assessment made predominant use of primary data collection and, due to the exploratory nature of the work, was qualitative in nature. This was undertaken through KIIs, focus group discussions (FGDs), and a workshop.

The consultation was partially limited by the inability to travel beyond primary urban areas, a lack of contact with consumers and/or patients of private sector health service providers and with informal (traditional) health service providers and due to the outdated secondary data and literature

⁴ While noting that Somaliland declared its independence from Somalia in 1991 and that Puntland is semi-autonomous, this report follows the DFID convention of using the terminology 'Somaliland', 'Puntland' and 'South Central'.

– there have been major changes in practices, population and society in the geographical areas since the data were collected and literature written.

1.2 Context

This section provides an overview of current DFID programmes in order to form the background for our recommendations for changing DFID's approach to private sector engagement.

1.2.1 DFID-funded health care programmes in Somalia

Health is one of four pillars (along with: governance and peace building; humanitarian; and wealth creation) in the DFID Somalia Operational Plan 2011–2016.⁵ There are currently two health programmes supported by DFID in Somalia. They are:

HCS

DFID approved GBP 13 million between July 2010 and April 2013 to the HCS to pilot an EPHS through public and private sector approaches. DFID provided an additional GBP 24.6 million between October 2012 and June 2015 and GBP 7.5 million up to March 2016 to enable an extension of the HCS.

Five INGOs make up the consortium, with PSI as the lead. Between them, the three zones in Somalia are covered but there is a stronger focus on Somaliland (where PSI, Tropical Health Education Trust (THET) and Health Poverty Action (HPA) operate) compared to the operation of only Save the Children, UK (SC-UK) in Puntland and Trocaire (Ireland) in South Central. The objective of the programme is to reduce maternal and new-born deaths mainly through the delivery of the EPHS.

The HCS consortium has led on DFID's engagement with the private sector through the establishment of a social franchising network by PSI in Somaliland. There are 68 pharmacies in the franchise network across four regions. As at June 2014, 14 were PSI-trained private pharmacies providing basic health information and socially marketed products. PSI reported, in the 2014 Annual Review, that this number was lower than anticipated but that it is expected to rise due to the signing of a previously pending MoH Memorandum of Understanding (MOU) with PSI.

JHNP 2012–2015

DFID has provided funding of GBP 38.8 million⁶ between March 2012 and March 2016 to a RMNH, FP and nutrition programme, delivering the EPHS, as well as health systems strengthening, which aims to rebuild the health system through a long-term health system approach.⁷

The JHNP will improve access to services but also focus on five other areas necessary for a functioning health system: leadership and governance; the health workforce; systems for health financing; ensuring access to medical products, vaccines and new technologies; and improving the collection, quality and use of information for health planning. Each of the three health authorities across the three zones is involved.

The JHNP includes support to health authorities on innovative financing mechanisms, including social franchising, maternity voucher schemes and contracting out through PPPs. Further work on

⁵ DFID (Updated December 2014).

⁶ DFID (Updated January 2015).

⁷ See DFID (2012).

the accreditation of private sector facilities to ensure a high quality of care has been targeted in order to reduce harmful practices (such as female genital mutilation/ cutting). Some health authorities have indicated a strong desire to work with the private sector to monitor agreed standards of care and to increase affordable access to services. However, DFID indicated that there has been limited private sector work to date, with resistance to working with the private sector from some MoH representatives.

The JHNP is funded through a pooled approach. Funding is predominantly provided by DFID with confirmed commitments from other donors as follows: Sweden: US\$ 10.36 million (2012–2014); DFAT: US\$ 3.13 million (2012–2013); and the United States Agency for International Development (USAID): US\$ 2.54 million (2012–2015). The new commitments from donors are: Sweden: US\$ 31.5 million (2014–2016); Finland: US\$ 8.16 million (2014–2016); and Swiss Agency for Development and Cooperation (SDC): US\$ 5.58 million (2014–2016).⁸

1.2.2 Private health care providers in Somalia

The private sector is the dominant provider of health care services in Somalia despite the population having among the lowest gross domestic product per capita in the world. Large-scale growth in private sector health care providers has already taken place, and indeed is still taking place, throughout the three zones in Somalia. The private sector is estimated to deliver over 60% of health care⁹ and it has been stated that less than 15% of the rural population are able to use¹⁰ the public system.¹¹ Not only is it growing, the private sector is also a fluid and heterogeneous sector with low barriers to entry and large variations in service quality. As summarised by Pavignani (2012), 'commercialisation of healthcare provision has advanced to such an extent that it has become irreversible... The healthcare business involves many entrepreneurs and workers, and moves large monies, which shield it from public competition, and make it indifferent to technical considerations'.

A core area of concern is the creation of adverse health outcomes as a result of poor-quality treatment and poor value for money being offered to consumers and patients who are paying out of pocket for service provision. This can arise due to: treatment being initially sought from a non-clinical provider (such as a pharmacist or traditional healer) who is unable to treat the disease, or who is unwilling, or unable, to refer the patient to an alternative provider; a lack of qualified medical practitioners; self-medication; and a lack of alternative treatment options (most notable in rural areas).

While there are concerted efforts underway to improve data collection in the Somali health sector, the lack of consensus on the size, efficiency and quality of the private sector is indicative of the lack of engagement with it to date. Data collection exercises are primarily donor driven or funded, and as such they focus on data directly related to ongoing programmes. There has therefore been very little effort made to understand the private sector in its entirety.

Despite this lack of data, while we cannot comprehensively quantify the value of the private health sector to patients, it is nevertheless clear that the private sector is providing essential services that are often the first (and only) point of contact for consumers and/or patients seeking health advice and health products.

⁸ DFID (2014b).

⁹ Affara (2011), p. 5.

¹⁰ Note that DFID has commissioned a study on demand-side health care-seeking behaviour.

¹¹ UNICEF (2009a).

2 Findings

This section provides the team's findings in the order of the sub-objectives outlined in Section 1.1.

2.1 Defining private health care providers

This section defines private health care providers within the Somali context.

Summary finding: There are two forms of private health provider – informal (traditional) and formal (which is, however, only loosely regulated and controlled). The private sector does have a profit-seeking motivation but may also have social objectives. 'Public' relates to government ownership and control. The more of this there is, the closer to a public sector service it becomes. It does not include NGOs, which are classified as charitable organisations that sit between the public and private (stakeholder definition).

In order to better understand the structure, actors and dynamics of the private health sector in Somaliland a workshop was held in Hargeisa, Somaliland on 10 January 2015. The workshop was attended by 43 members of the public and private health care sector in Somaliland. This included: government representatives, private, public and private not-for-profit hospitals, importers and wholesalers, pharmacies, a waste management company and the University of Hargeisa. A summary note from the workshop is contained in Annex C.

The totality of the sessions resulted in a definition (shown in the summary finding in this section) to categorise the various private sector health providers. This was important as a basis of shared understanding, consideration of policy options and in order to appropriately contextually define the various private sector health providers.

The definition takes into consideration the informal (where informal refers to traditional, curative medicine) and formal provision of health care in the private sector as well as the nuances around ownership and profit motivations. In the formal private sector there was agreement by stakeholders that the team met with that a profit motive is sought but that this can be balanced against social objectives that result in free service provision for lower-income groups within the population. The participants at the workshop, and subsequent interviewees, were clear that the private not-for-profit sector as well as INGOs sit in a grey area between the private and public. This is discussed further in Section 2.2.2. Having tested the definition's validity in Puntland and South Central as well as Somaliland it was concluded that this definition holds for Somaliland, Puntland and South Central. There were no regional disparities noted.

Other key findings emerging from the workshop were the local stakeholders' understanding of the differences in public and private health providers. These are summarised in Table 2 below:

Table 2: Differences in private and public health providers

Characteristics of the private sector	Characteristics of the public sector
<ul style="list-style-type: none"> • Work according to their budget and profit margin. • Services offered are not determined by government. • Costs are not determined by government but by the market, customers' ability to pay and profit margin. • Training is not standardised for service providers. • Coverage is mostly limited to urban areas, but there are some exceptions (Manhal was noted). • Sometimes quicker in responding to patients/customers when they present themselves. • Quality of medicine, or choice of quality of medicine, is sometimes perceived as being better than the public sector. • Quality of services and levels of staff training varies greatly – from most specialist to none at all. • Management is perceived better, due to the profit incentive. • Other than their business registration (and possibly an import licence), there is little oversight or regulation from the government, although NHPC is beginning to register professionals. • No way to test the quality of medicines. • Provide specialist services that public sector does not (e.g. cleft lip surgery). 	<ul style="list-style-type: none"> • Funded mostly through government, with some cost recovery from patients. • The more government intervention in the running of a facility, the more it can be said to be public (this is often linked to the proportion of government funding). • Training standards are often higher as there is no enforcement of standards in the private sector. • Standardised curricula for some cadres. • Services are usually lower cost (or free, e.g. caesarean or Tuberculosis (TB) treatment) due to government policy. • Quality is variable, sometimes perceived to be lower and with longer waiting times. • There should be more equity, in terms of geographical coverage (quality varies so this is not guaranteed). • Can test the quality of medicines by using the World Health Organization's (WHO) laboratory in Nairobi (perception not fact¹²). • Considered better for emergency care – e.g. Hargeisa Group Hospital's Intensive Care Unit (ICU) – and for prolonged illnesses.

Private sector health care providers

There are three main types of private health care providers in Somalia:

- A. **Privately owned clinics and hospitals.** There is no comprehensive mapping of the numbers and locations of such facilities. They constitute profit and not-for-profit facilities and are frequently set up by diaspora returnees with health qualifications. As a health facility they provide primary (due to the referral system not being fully functional), secondary and some tertiary care.
- B. **Pharmacies** (including those with outpatient and laboratory services). Local pharmacies are one of the fastest growing types of business in the Somali health sector across the three regions. They often act as *de facto* 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

¹² In reality, this is a common misperception. No systematic testing takes place and that which does is for UNICEF-procured pharmaceuticals rather than within the public system.

laboratory and basic outpatient facilities, and a minority also employ a resident doctor or nurse (thereby offering secondary as well as primary facilities). The existence of a pharmacist, or other qualified medical practitioner, within a pharmacy is rare. It has been estimated that there are perhaps as few as four trained pharmacists in Somaliland¹³ and there is a clear need for more adequate training. There are evidently a huge number of private for-profit pharmacies. Clark (2010: 13) summarises some of the data on these numbers, relaying that there are over 780 sites (private pharmacies) in Somaliland, with about 50% more private pharmacies in Puntland than Somaliland, which suggests that the total for Puntland now may be over 1,000, with 392 pharmacies on the main roads of Mogadishu alone.

- C. **Traditional and complementary medicine practitioners (TCMPs).** Unlike privately owned clinics and hospitals and pharmacies that offer 'modern scientific medicine' TCMPs provide herbal and traditional treatment at the primary facility level. Traditional healers are one of the most neglected and overlooked private sector actor despite approximately 60% of the population seeking care from them before resorting to the formal health sector.¹⁴ In addition to the prominent role that they are thought to play in rural areas, where alternative options are fewer and health education levels are lower, there is also an emerging trend of the diaspora increasingly turning to traditional practitioners. Tilikainen and Koehn (2012) conclude that 'going back to practices perceived as ancestral strengthens their cultural identity and the bonding with the country left behind when they emigrated'. There are examples of very profitable, almost famous, traditional healers across the three zones.

Key health care actors

- D. **Training providers.** Public and private training providers are in existence. For example, there are two public universities with medical facilities in Somaliland but training courses are also provided by private not-for-profit facilities such as Edna Hospital and private training schools. While the number of providers has grown there is an imbalance in the quality of the training offered and there is a lack of overarching, enforced and standardised curricula, meaning many schools are offering unregulated courses.
- E. **Pharmaceutical product and medical goods importers, wholesalers, distributors and retailers.** These businesses are discussed further in Section 2.2.2.

Private financial support to non-state initiatives

There is private financial support to non-state initiatives run by third parties or by the funder themselves. In the first instance, delivery usually takes place in conjunction with NGOs or other charitable organisations and religious bodies. The funding provider is typically the diaspora or Islamic donors and organisations (such as Kuwait, Turkey, Saudi Arabia and the United Arab Emirates - UAE). Such financing of charitable services falls within a grey area that is neither public nor private. This is discussed further in Section 2.2.1.

Religious organisations have influenced the course of the private sector's development in supplying health services, particularly Islamic organisations. However, defining a 'religious' organisation is troublesome, and some are given the label simply on the basis that their founders are religious. Le Sage (2007) found that: 'Possibly the most important aspect of Islamic charity work in Somalia has been the development of an aid delivery strategy that has created self-sustaining social service enterprises. The key to this success has been the charities' ability to provide public funds to support private sector activities that in turn provide public goods'. In practical terms, this manifests itself in a business being established that requires user fees to be

¹³ Handyside (2008).

¹⁴ Affara (2011), p. 5.

paid for its services. Fees may be subsidised or some consideration given to patients' ability to pay. Once the business becomes sustainable, further investment may be given for expansion or upgrading, or the charity may withdraw altogether. If it is the latter, this is the point where potential conflicts between the aims of providing a public good (i.e. health care) and profitability are manifest. As such, this is not necessarily an optimal long-term solution for the provision of equitable health care.

It is clear that the role of the diaspora and returnees has been important in the recent growth of the private sector. Raising funds for welfare and investment is a particularly prominent role played by the diaspora, be that through private means or official aid channels. With remittances of up to US\$ 2 billion per annum,¹⁵ they are an essential source of funds for both individual patients, clan groups and for private sector providers.

2.1.1 Efficiency, equity and pricing

Efficiency, equity and pricing were discussed in detail in the workshop in Hargeisa, to better understand the differences between public and private sectors in these regards, as well as in the Klls. Below is a summary of the responses from the workshop – supplemented by further interviews:

Price: It does not necessarily hold that the private sector is more expensive than the public, or that the public sector is always free. In public facilities, the government policy of cost sharing should be followed, with treatments being free for the poorest and for certain diseases and services, e.g. RMNH, Human Immunodeficiency Virus (HIV) and TB. However, it was reported that a lack of oversight results in some staff and/or facilities charging additional (unauthorised) fees and, where the public drug supply is limited, patients may have to buy them in the private sector. Conversely, the management of private facilities may agree to provide free services on a needs basis. This is a policy that these providers set themselves, sometimes with quotas and sometimes on a discretionary basis. This was true in the private for-profit and private not-for-profit facilities.

Generally speaking, the private sector will charge for its services, particularly where it is believed that the patient can afford it. Private sector organisations' pricing structure will also tend to reflect their cost structure, which is not necessarily the case in the public sector. There were suggestions that, culturally, people expect to receive better quality services if they have paid for them than if they are free – the general price differential between the public and private sectors can therefore cause bias in terms of perceptions of quality.

Equity – access to health facilities: In theory, every district has a functioning district health facility and every village has a health post to ensure that public services are equally distributed (although these are not always functional and quality varies, as does population density). The formal private sector establishes in areas that are considered profitable (with the exception of reported charitable actions, such as emergency response and occasional outreach). Due to higher population density in urban areas this results in a clustering in these areas. Smaller private sector health operators can be seen in rural areas (e.g. rural vendors stocking small quantities of medicines) but these tend to have even less quality control or ability to provide adequate service provision. The informal private sector (traditional) is present in both urban and rural areas, and is sometimes the only option in rural areas. There are, however, no data on the proportionate size of each category.

Equity – other considerations: Health education and messaging remains the domain of the public sector, although it was not clear whether this was because it is considered to be only their mandate or that the private sector did not consider it profitable. There was general agreement that

¹⁵ Figures vary, but there are estimates that remittances contribute between US\$ 1.3 billion and US\$ 2 billion per year. See Chatham House (2012).

the public sector is better at providing equitable health promotion/messaging across the whole country and to all socioeconomic groups. Given that the private sector only offers a limited amount of free services, the public sector was considered to be the only option for the poorest and rural dwellers (not including the informal private sector). However, it was agreed that even though an individual may not have the ability or access to private services, they can leverage family and clan networks to fund private access. There was no mention of specific marginalised groups, other than those from lower socioeconomic groups.

Efficiency: It was agreed that the private sector has to be efficient to maintain its profit margin (which can both negatively and positively impact on the quality and accessibility of services). The public sector does not have that same incentive and job security can be a disincentive to efficiency for both delivery and support staff in the health sector. Of course, it should be noted that efficiency alone does not result in higher-quality or cheaper services.

2.2 Networks and associations

This section explores the interconnectivity between public and private provider networks and then moves into an overview of the associations and networks in existence in Somaliland, Puntland and South Central.

2.2.1 Public and private provider network interconnectivity

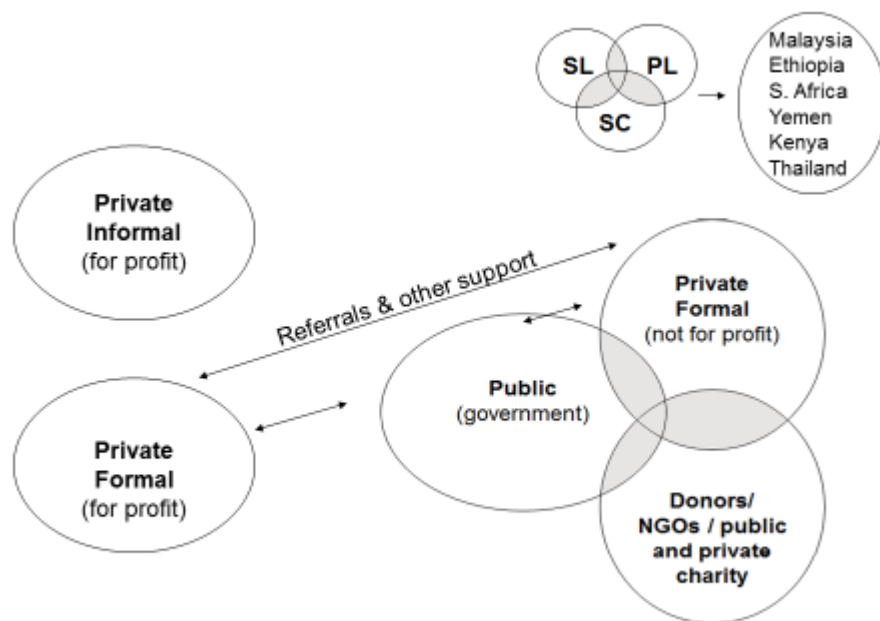
Summary finding: While there are not formalised linkages between public and formal private service provision, there are informal linkages through systems of referral and dual practice. Service access is fluid, with the population moving between regions to access care (based on the services offered, travel security, perceived quality and proximity) and limited numbers accessing private health care services overseas.

In terms of the categorisation of provision, Figure 1 shows the overarching network of public and private service provision. The key elements are as follows:

- In the centre there is public (government) service provision. This represents those facilities that are *de facto* owned by the national or local government, with administrative functions controlled by national or local government. This circle links to donors/NGOs and public and private charities due to the latter providing funding for public health services (commonly infrastructure and equipment).
- Likewise, the public sector links to the private formal not-for-profit sector through a process of referrals, whereby the public or private formal not-for-profit organisations recommend clients access services in an alternative, more appropriate location (linked to the disease burden in question), and due to training provided in the private formal not-for-profit sector that follows government-set curricula.
- The private formal for-profit segment of the market sits at the bottom left. Again, there are linkages to the public sector, as well as the private formal not-for-profit sector, due to referral systems and the operation of dual practice (whereby staff working in the public sector also offer services in the private for-profit sector).
- The private informal for-profit sector sits at the left hand side of the diagram. There are no linkages to the private for-profit and not-for-profit sectors, or to public services. However, treatment is commonly sought at the private informal level prior to accessing the other service options.

- Somaliland, Puntland and South Central are indicated in the top right trio of circles. These circles indicate an overlap wherein the populations in each zone access health care services as well as access overseas services. For the latter the most commonly cited locations for treatment were Malaysia, Ethiopia, South Africa, Yemen, Kenya and Thailand.

Figure 1: Networks



2.2.2 Somaliland, Puntland and South Central zonal associations and networks

Summary finding: Associations are most commonly established to provide a group of medical practitioners, service providers or input providers with the means to lobby government in the interests of their members. Any resulting influence with government is, in practice, limited for the majority of associations and many associations are limited in terms of their active membership. This is particularly true in Puntland and South Central.

Table 3 shows the associations and networks that were identified in Somaliland, Puntland and South Central. In more than one instance, the association has been created but is not currently operational (e.g. the Laboratory Association in South Central).

Table 3: Somaliland, Puntland and South Central zonal associations and networks

Somaliland	Puntland State of Somalia	South Central
National Pharmacy Regulatory Authority – NPRA (not yet established)		
NHPC	Puntland (Bari) Medical Association	National Health Professionals Council (NHPC)
Drug Importers and Wholesalers Organisation (DIWO)	Pharmacies and Wholesalers Association	Somali Medicine Importers and Distributors Association (SOMIDA)
Somaliland Nurses and Midwifery Association (SLNMA)	Nurses and Midwives Association	Somali Medical Association
Somaliland Medical Association (SMA)	Mudug Medical Association (disputed)	Somali Midwifery Association (SOMA)
Somaliland Medical Laboratory Association (SOMLA)		Nurses Association (established but not active)
Somaliland Pharmacists Association (established but not active)		Pharmacists Association (established but not active)
		Laboratory Association (established but not active)

Somaliland

- NHPC.** Under the Health Professions Act number 19/2001, the NHPC is mandated to: Register and license all health care facilities; Enter and inspect any health facility to ensure that provisions of the Act are complied with; Exercise disciplinary control over health professionals; Determine fees for application, registration and renewal of health facilities; Regulate the practice of health professionals through registration and issuance of licences; and Monitor and evaluate the performance of all health professionals to safeguard the public from unethical practices. To date, NHPC has registered 600 local professionals and about 70 foreign professionals. However, they estimate that 4,500 professionals are waiting for registration and verification. At least 230 practitioners in the health sector have been unable to prove their qualifications. However, the NHPC’s ability to enforce compliance is weak. The following associations are represented on the board: SOMLA, the Pharmacists Association, SMA and SLNMA. NHPC is currently in the process of trying to develop guidelines on standard training curricula with the SMA and SLNMA.
- DIWO.** Established in 2010, DIWO has over 20 members, all of whom are individual businesses (importers), working in the import and/or wholesale of pharmaceutical products. They do not import collectively. DIWO estimates that its members supply up to 90% of the pharmacies in Somaliland. The organisation was set up both to create a mechanism for lobbying government around joint interests and to minimise the negative effects on the pharmaceutical import business sector resulting from the importing of counterfeit drugs. The association would like to see quality control systems (including testing laboratories) set

up to help limit the numbers of counterfeit and low-quality pharmaceutical products entering the market, as well as improved capacity within the NHCP.

- **SLNMA.** Established in 2004, SLNMA is both a peer network representing the interests of nurses and midwives in Somaliland and an organisation seeking to develop and build the capacity of these professionals to deliver quality health care services. In 2012, its membership amounted to 3,600.¹⁶
- **SMA.** Established in 2004, SMA is a professional association of medical doctors with approximately 160 members (in 2013).¹⁷ As with the SLNMA, the objectives are both to represent member interests from a collective standpoint and to provide services that enhance the provision of quality in health care delivery.
- **SOMLA.** Established in 2006, SOMLA promotes member interest and seeks to enhance the competence, coordination and integrity of its membership. One means of doing this is through the Continuous Professional Development training programme, which seeks to enhance and standardise the knowledge and skills of laboratory technicians working in different health care facilities in Somaliland.

An additional association, the **Somaliland Pharmacists Association**, has been established by recent graduates from Edna Adan University. It has a constitution but is not currently active.

Puntland

- **The Puntland (Bari) Medical Association.** This association was established in 2013 out of three existing (and now defunct) medical associations in Bosaso, Garowe and Galkayo. There are currently 112 members, with the main objectives being to register and issue licences to those practising medicine in Puntland (in the absence of an NHPC), promote the medical skill sets of its members, and actively participate in research on disease outbreaks.
- **Pharmacies and Wholesalers Association.** Based in Garowe, the association has 11 members from Garowe, Bosaso and Galkayo and has been operational for five years. The organisation was set up to create a mechanism for lobbying government around joint interests. They do not import collectively. The association is facing challenges due to the lack of a regulatory framework within which to formally operate (despite government being seen as supportive), unregulated drugs entering the market, and the need for improved managerial skills within the association.
- One additional association that is believed to exist but about which little is known is the **Nurses and Midwives Association.** KII findings were that it was in existence but was limited in its operations.
- **The Mudug Medical Association** has been established in a disputed region of Puntland. As part of their claim to independence, the people of this region have set up independent institutions, such as the Mudug Medical Association. Very little information was available on how functional it is.

¹⁶ See SLNMA (Last updated 2014). About Us. Available at:

http://slnma.org/slnma/index.php?option=com_content&view=article&id=46&Itemid=57

¹⁷ See SMA (Last updated 2013). About SMA. Available at: <http://somalilandma.org/index.php/2011-08-17-08-00-23/objectives>

There are plans to form an NHPC but this has not yet materialised.

South Central

- **NHPC.** For the last two years, voluntary health professionals have worked to develop an act to establish the NHPC in Mogadishu. The volunteers have no office or other resources to facilitate acceleration of the setting up of the council. The International Organisation for Migration provided some support to the council in September 2014 while drafting the NHPC Act. The act has been drafted and endorsed but the voluntary health professions involved in its formation believe there is long way to go to complete the setting up of the council for operationalisation.
- **SOMIDA.** Established in 2014, SOMIDA currently has 120 members with 18 executive committee members. The association was established with the objectives of ensuring a supply of good quality medicines, advocating and lobbying for SOMIDA members, providing humanitarian support to poor communities, and responding to emergencies throughout the country.
- **Somali Medical Association.** Representing those involved in the medical profession (including medical students, doctors, dentists, pharmacists, lab technicians, radiologists, nurses and health workers), the goal of the association is to provide a forum for discussion and interaction between members and to create a united front when lobbying on behalf of member interests. Established in 2014, there are 180 current members.
- **SOMA.** SOMA was initially established in 2000 but was forced to cease operations due to ongoing conflict. Reformed in March 2013, with an announcement from the Federal MoH, SOMA has 137 professional midwives as members from 11 regions. In each region and town there is a contact focal person from the identified midwives. However, there are no offices. The objectives of SOMA include promoting health information and education to mothers, educating midwives and traditional birth attendants and minimising mother and child mortalities.

Additional associations that are believed to have been formed but that are not active and which do not have available information attached to them are:

- The Nurses Association;
- The Pharmacists Association; and
- The Laboratory Association.

Cross-cutting organisations

NPRA¹⁸. The Somali National Medicines Policy¹⁹ provides a framework that seeks to coordinate the activities of all participants in the pharmaceutical sector in order to 'meet the requirements of the entire population in the prevention, diagnosis and treatment of diseases, using efficacious, quality, safe and cost-effective essential medicines, and medical supplies; and the rational use of drugs by prescribers, dispensers and consumers'. Within this policy there is provision for a NPRA. The NPRA is envisaged as being established to regulate the practice of pharmacy and the

¹⁸ See Ministry of Health and Human Services (2014).

¹⁹ See Lewa (2013).

manufacture and trade in essential medicines. However, while it has been endorsed, at present this framework has not been printed, disseminated or resourced.

Box 1: The clan and private sector health delivery

The clan and private sector health delivery

In Somali culture, family and clan support are an integral part of the health care system for both patients and providers. Clan members and relatives (including diaspora members) pool funds to cover treatment costs when the patient or her/his family cannot afford to pay. Elders and respected members from the clan fundraise to collect such contributions (known as Qaadhaan). Non-financial support is also offered by the clan. Patients who have to travel to get health care usually stay with relatives or, for those without family members in the area, sub-clan or clan members.

While in rural areas it is common for patients to choose to visit physicians, practitioners and TCMP of their clan first, this appears to be less common in the urban areas focused upon as part of this study. There were no explicit linkages articulated between clinics and hospitals and clan groups in terms of their client base. Instead patients' choices were said to be based predominantly on reputation, services offered (expertise and equipment) and location (proximity).

Regarding private provider networks and associations, these were found to be resource driven, rather than clan-based alliances.

There were some linkages reported between raising start-up capital within the family/clan base, but this did not extend to capital for expansion and was limited in scope (i.e. for start-up of smaller businesses).

2.3 PPPs

This section focuses on the team's attempt to identify PPPs and wider collaboration between (a) the Somali Government(s) and the private sector; and (b) donors and the private sector.

Summary finding: There were no examples of PPPs in existence in Somalia. There were, however, a range of collaborative efforts (ongoing and planned) between the private sector and government and private sector and donor/INGO partners. Such collaborations encompassed efforts on accreditation, training, referral systems, social franchising, grant giving and a voucher referral system.

2.3.1 Collaboration: government and the private sector

While identifying existing PPPs in operation was one of the sub-objectives of this work (objective D), in practice the term was found to be unhelpful by the team and interviewees. The World Bank's definition of a PPP is: 'A long-term contract between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility.'²⁰

The stakeholders we interviewed, however, differed widely in their interpretations of the term, with some including a foreign government agency (e.g. DFID) and NGO/INGO partnership as a PPP. Part of the reason for this was a general lack of understanding and misuse of the term. The confusion is no doubt exacerbated by the weak legal and regulatory framework generally, and

²⁰ World Bank (2014), p. 28.

specifically with regards to defining and governing PPPs. This is discussed at length in Section 3.1.3. It may also be that with such weak tax bases and limited (if any) revenue sharing between the three zonal governments, the MoHs are constrained in their ability to fund PPPs. Reasoning aside, based on the team's and interviewees' understanding of the Somali private sector (defined in Section 2.1 and emerging from the workshop and interviews), as well as consideration of the proper meaning of the term 'PPP', collaborations between NGOs/INGOs and foreign governments' donor agencies and entities do not fall into the definition of a PPP.

Disregarding such collaborations then, the research uncovered no examples matching the accepted definition of a PPP, i.e. between the zonal government(s) and the private sector. Consequently, there were no examples of PPPs that met the team's criteria for inclusion. Instead, research focused on other forms of collaboration between zonal governments and private sector organisations, as well as collaborations between donors and other international agencies and INGOs/NGOs. The latter are discussed in Section 2.3.2.

There were numerous examples of collaboration between zonal governments and the private sector. These ranged from government procuring services from the private sector (without any transfer of project financial, technical or delivery risk or other characteristic normally associated with PPPs) to informal and *ad hoc* arrangements for service provision. Aspirations for more frequent and formalised engagement were expressed from both the public and private sector sides. The identified examples of collaboration between the public and private sector are shown in Box 1:

Across the three zones, from the private sector perspective, willingness to engage with the public services sector was most notable where there was a resulting improvement in the business, i.e. in market share and/or profit. From the public sector perspective, willingness to engage was most evident in Puntland where the government was most keen to take advantage of the strengths and goodwill in parts of the private sector to complement, enhance and reduce the burden on the public sector. In Somaliland, the tendency seemed to be toward regulating, as opposed to engaging with, the private sector as part of comprehensive health care delivery and improved quality. In the South Central region, the government's limited capacity (financial, regulatory and supervisory) resulted in a lack of systematic engagement with the private sector in the delivery of health services.²¹

The only example of a contractual agreement between government and the private sector was seen where the MoH in Puntland had contracted a private firm (from 2015) to manage a database of service providers and to print the certificates for accredited staff (the accreditation process itself was led by the MoH). In all other cases, it was informal and/or *ad hoc*, as the following examples demonstrate.

In all three zones, the agencies responsible for setting and enforcing standards on training, staff and facilities were largely advancing based on voluntary support from a few prominent private sector actors. Without such support, it is difficult to see how these authorities would be able to operate due to a lack of internal capacity and resources. Similarly, some private sector actors in Somaliland and Puntland, in particular, were voluntarily enforcing government standards on quality of care and following standardised curricula for training.

Informal referral systems were found to be in operation in Somaliland and Puntland, whereby the private sector would typically send emergency cases and chronically ill patients to the public sector, and the public sector would pass on cases requiring specialist skills and equipment that the private sector could supply, if only through short-term arrangements with visiting foreign doctors. In

²¹ It should be noted that some of the impressions given may have been personality-driven as opposed to official government positions, given that we were only able to speak to a select number of government officials.

Hargeisa Group Hospital, they were keen to formalise this relationship with a select number of private clinics so that basic systems, such as checking on the availability of beds before referral, could be established and efficiencies gained.

In terms of the sharing of skill sets and information on service provision, the team found one case, in Somaliland, whereby a private sector clinic (Manhal Hospital) was voluntarily providing information to the MoH for the Health Management Information System (HMIS). It was the only private actor reported to be doing so and we found no other cases of public sector data collection on the private sector. Secondly, in some cases, such as in Garowe Hospital in Puntland, the public hospital management were actively managing shift schedules to enable staff to also work in the private sector. This was in recognition of their need to supplement their income and in some cases continue to practice specialist skills that they could not in the public sector, and also in recognition of the need to not undermine the private sector.

There were many cases of planned collaborations between the public and private sectors, some of which needed start-up funding or the identification of a suitable private sector partner. For example, Hargeisa Group Hospital spoke of building a 'VIP' ward, in which patients would pay to stay in a private room with more amenities. This money could be channelled back into the hospital for service expansion and to pay off the private sector contractor who built it. They had also considered engaging a private sector partner to conduct palliative care or run mobile clinics so as to reduce the burden on the hospital, which was built at a time in which the local population was approximately five times smaller than it is today. Both of these two initiatives appear to be similar to a Private Finance Initiative – a way in which PPPs can be created.

The Somaliland MoH representative spoke of building a 'super' warehouse, in which they would store the national public pharmaceutical supply (before distribution to regional stores and onwards) and in which they could rent out additional space to the private sector for them to store their drugs. This would supposedly result in a guaranteed standard of storage and stock management. It was said that this had been discussed for the last two years, and that a private sector partner has expressed interest. However, this was not evidenced or verified by other interviewees.

Within the three zones there is a dependency on imported drugs and associated quality control issues. In response, there were two examples given of plans to produce some commodities locally. In Hargeisa, Edna Aden was trying to establish production of intravenous fluids but had, so far, been inhibited by start-up costs. In Puntland, there was some indication that an Italian-supported operation was looking to produce antibiotics, but it was not clear whether this has passed the research/planning phase.

There were many other forms of engagement between the public and private sectors worth understanding and appreciating, given their widespread use. For example, district health boards (DHBs) are reported to fundraise, often among local businesses and diaspora networks, for a particular need, e.g. an emergency response to procure a specific piece of equipment. In addition to this, there is a lot of private sector finance being put into construction of large hospitals and clinics, particularly in urban areas. This is sometimes through the Islamic principle of Zakat (a form of obligatory alms giving – mandatory for all Muslims based on their income and wealth above a minimum amount), but not always. It is not clear if such hospitals are to be privately run or handed over to government upon completion. Even within the MoHs there was much confusion over a number of these investments, which could prove to be significant assets to the health system if utilised properly.

2.3.2 Collaboration: donors and the private sector

The most prominent example of donor-led private sector engagement in the health sector is PSI's Bulsho Kaab pharmacy social franchise in Somaliland. Through this franchise PSI provides some branding (usually a logo on the exterior wall), training for staff and support for the sale of three commodities (water purification sachets, oral rehydration salts and contraceptives). In return, the Bulsho Kaab pharmacies are expected to provide a certain quality of service to customers, and to stock and sell the three commodities at a recommended price to ensure they are affordable. The Bulsho Kaab pharmacists interviewed for this study were all very positive about the franchise model and the resulting positive impact on their business – a result of increased professionalism and a growing number of clients and sales.

The Global Fund's malaria programme plans to pilot a PSI-style engagement with private sector pharmacies specifically to ensure that the national malaria treatment guidelines are followed and artemisinin-based combination therapy is available. They will expand on this, however, using the engagement with pharmacies to better understand their business models and supply chains. They intend to work with 64 pharmacies across the three zones.

A second DFID HCS partner (Trocaire) has proved very innovative, essentially developing a voucher referral system with a Kenyan hospital bordering the area of Gedo in which they work. Mothers with labour complications obtain a referral form from a local doctor and an agreement has been reached with the immigration/border authorities that this suffices for them to cross the border and stay in the hospital for the duration of their labour and subsequent treatment. The hospital provides the care for free and invoices Trocaire after treatment, with the referral slip and all details of the treatment given to be reviewed before payment is made.

The Somaliland Business Fund, which is ongoing, supports private sector development (note that NGOs are excluded) by offering grants ranging from US\$ 15,000 to US\$ 150,000 for acquiring physical assets and/or business development services as part of a small- to medium-sized business project. Within the health sector, grants were awarded to 10 private sector entities, two of which had grant agreements that lapsed due to under budgeting the project and the grantees' inability to obtain additional funding from other sources. Both of these grants had been awarded for the production of intravenous fluids. The implemented grant-funded projects have predominantly financed the purchase of medical equipment. Examples include equipment for a pathology lab, digital X-ray, computerised tomography scanning, a dental laboratory, and an operating theatre for minor surgery. However, funding has also, to a more limited extent, supported skills training and consultancy services.²²

Also focused on investment in the private sector, Shuraako, in conjunction with the US Embassy in Nairobi, is hosting a Somali investment forum in March 2015. The forum will examine trends, opportunities, challenges and needs in health care as one of six sectors for investment.²³

The United Nations agencies were identified as being engaged in two areas. UNICEF is working with Dahabshiil to pay core public sector health workers, in order to ensure payments are timely and transparent. Falling on the periphery of the health sector, UNHABITAT is funding two private sector companies – one in waste management and one in water supply in Somaliland.

There is other work by Western and Islamic donors with the private sector, which should be noted as donor coordination in this area could yield efficiency gains. For example, Edna Hospital has been supported by multiple Western donors, such as in the construction of their outpatient ward,

²² Information provided on behalf of the World Bank by the Somaliland Business Fund Team Lead.

²³ See Shuraako (2015).

the donation of equipment and training costs. Manhal Hospital, also in Hargeisa, receives similar support but from mainly Islamic sources, particularly the (FIMA).

Table 4: Private sector engagement in health by the governments of each zone

	Somaliland	Puntland	South Central
Contracting out		Registration and issuing accreditation certificates – ‘B-Tech’	
Collaboration	Voluntary support for NHPC; Informal referral systems; Enforcing standards, including training; Support data collection (HMIS); Government-led policy consultation	Informal referral systems; Enforcing standards, including training; Voluntary support/time to Medical Association; Government-led policy consultation; shift management in hospitals	Voluntary support for NHPC
Aspirational	Boroma Hospital voucher scheme; Hargeisa Group Hospital VIP rooms and mobile clinics/ palliative care; Government-owned warehousing; production of infusions	Medical Association request: to train pharmacy workers; production of antibiotics	
Other	Fundraising by DHBs	Galkayo Hospital	Turkish-built hospitals

2.4 Procurement, supply and distribution

Summary finding: There is no domestic production of pharmaceutical products. Importation of pharmaceutical products and medical equipment occurs at multiple land and sea border points with trade flows also taking place across each of the three zones and back out into neighbouring countries. This is the result of almost complete ease of entry and exit of pharmaceutical products and the circulation of counterfeit products.²⁴ There are few formal agreements between pharmaceutical suppliers and importers, which is reflective of importers’ inability to predict demand or obtain working capital for larger orders and concerns about delays at border posts and uninsured shipments. There are preferred suppliers and manufacturers but there is no ability to check for quality in the private sector aside from using known suppliers and attempting to check barcodes with manufacturers remotely.

2.4.1 Import routes

While it is not clear what volumes of pharmaceuticals are being imported into Somalia, with no domestic manufacturing taking place it can be assumed to be 100% of the pharmaceuticals in circulation in the country are imports.

For all importers, the main sea ports are Berbera and Seila in Somaliland, Bosaso in Puntland, and Mogadishu and Kismayo in South Central. In addition to this, numerous smaller ports along the coast are in regular use. Road transport costs from Mogadishu’s port were noted by interviewees

²⁴ There were also alleged links to money laundering, but an investigation of these is beyond the scope of this study.

as being particularly high, largely due to the security situation. There are no data collected on import volumes, thus making it virtually impossible to estimate the flow of trade.

Land borders with Ethiopia, Kenya and Djibouti are used for the import and export of pharmaceuticals. These porous land borders also provide traders in counterfeits with opportunities and were cited by interviewees as major contributors to the counterfeit trade. No quantitative information is available on this. Insecurity can lead to seemingly inefficient supply routes being used and it appears that there is a lot of cross supply between the three zones and the ports.

Interviews with wholesalers and retailers show that there are clear preferences regarding the source of pharmaceuticals, stemming partly from the knowledge of importers and wholesalers and also in response to consumer demand. In the private sector in particular, where there tends to be more choice in terms of price and quality available to consumers, the UK, Germany, Holland and Belgium were all considered to be the highest quality sources. Egypt, Jordan, UAE and Turkey were cited as being generally trusted and more affordable, but not necessarily in such high demand with those with the greatest willingness to pay. In almost all cases, Pakistan, India and China were regarded as providing the lowest quality (and the majority of counterfeit) drugs.

2.4.2 The public health sector supply chain

UNICEF has been the principal agent in procuring pharmaceuticals for the public sector to supply the EPHS. UNICEF's supply chain depends on multiple sources and import routes and a conclusive mapping was not attained. Due to recent UNICEF budget cuts, as humanitarian funds have been shifted to other priority countries, the UNICEF-led public sector pharmaceutical procurement system is under a great deal of pressure and some stock-outs are being reported. This results in the INGO partners procuring from the local market.

In addition to UNICEF, the Global Fund programme procures HIV, malaria and nutrition supplies and the United Nations Population Fund (UNFPA) procures some maternal health products. Although no quantitative data were collected, INGOs/NGOs do have their own regular procurement systems and there were also reports that they and public facilities procure drugs from the private sector or receive donations from third parties when stock shortages arise.

The infrastructure for storage is all government-owned, with warehouses generally being considered to be in good physical condition across the three zones. However, stock management is weak and can result in waste. WHO is highly involved in the distribution from zonal central warehouses to facilities. Private providers may also be contracted for transportation.

In terms of quality control, where suspicions are raised by UNICEF or partners drug samples can be sent to WHO's minilab in Nairobi. However, this is not done systematically and must be based on a valid suspicion that a batch is of low quality or unsafe.

2.4.3 The private health sector supply chain

While private sector importers and wholesalers have established associations, members and non-members alike view each other as competition and we found no examples of joint procurement between association members. Similarly, there seemed to be no coordination between importers and wholesalers to share storage space. There was very little information on distribution networks, with no reports of businesses procuring jointly from wholesalers in order to benefit from economies of scale.

There were very few examples of private sector pharmacies, clinics and hospitals having contractual arrangements with wholesalers. Most small businesses monitor their stock without any formal stock management systems, buying as and when they see a need. Some larger facilities, with greater cash flow, arranged their own consignments for certain items (especially less perishable ones) direct from foreign manufacturers, as that way they could guarantee the quality and economies of scale. However, lead times in procurement and the costs of shipping make this very expensive and so this is only an option for the most profitable private sector actors.

When procuring locally, most pharmacies, clinics and hospitals have preferred suppliers. However, in terms of ensuring the quality of their purchases, private sector actors are restricted. Interviews with importers and private sector health care providers indicated that a small minority check the batch or serial numbers of pharmaceutical products online. Most, if they checked for quality at all, depended on general impressions, e.g. whether the packaging had been tampered with or whether brand names were spelt correctly. Generally, the reputations of the wholesaler, importer and manufacturer are the only indicators of quality that the private sector uses.

There is some seasonal variation in the disease burden and subsequent demand for certain supplies, e.g. an increase in diarrhoea leading to increased demand for oral rehydration salts during the rainy season. This can contribute to shortfalls in the supply from private sector wholesalers although there are a myriad of other factors. For example, although some importers used to rely heavily on Syrian products, they have had to change supplier in response to the recent crisis there. Furthermore, importers reported not being able to get insurance for their consignments to Somalia and so any losses in transport were highly detrimental.

2.5 Policy and regulatory mechanisms

Summary finding: There is a body of laws and regulations that in theory provides for an overarching regulatory framework for private sector participation in the health sector. However, both adherence to regulations and the understanding of the policy and regulatory environment appear to be low, primarily because of poor dissemination, low accessibility and a lack of understanding as to what these texts mean.

The team sought to clarify what current policy, legislative and regulatory mechanisms guide the operations of the private sector in health in Somalia.

Table 5 provides a summary of the policy framework. The top row indicates policy that cuts across each of the zones. The subsequent rows show policy that is specific to each zone.

It should be noted that there was a lack of publically available information, as well as understanding by interviewees, as to the status of proposed and existing laws and regulations. The circles shown in the table below indicate the status of the policy/regulation where:

Green = In the process of implementation

Amber = Endorsed by government but not yet implemented

Red = Unknown status

Table 5: Policy and regulatory mechanisms under which the private sector operates

Somaliland	South Central	Puntland
Somalia National Health Policy (passed 2014)		
WHO Essential Drug List (2003)		
WHO Standard Treatment Guidelines (2007)		
WHO Somalia National Medicines Policy (endorsed 2014)		
New Deal for Somalia (2013) ²⁵		
Somaliland Health Sector Strategic Plan (2013–2016)	South Central Health Sector Strategic Plan (2013–2016)	Puntland Health Sector Strategic Plan (2013–2016)
Somaliland Health Policy (2012)	Health Sector Strategic Plan	Health Policy Framework (draft)
HPC/ Law 19 (2013, updated from 2001)	National Health Professional Act	Puntland Health Act (Law 6) 2012
Human Resources for Health Strategy	Public Health Act	Strategic Plan for Leadership and Management Capacity Building
	Reproductive Health National Strategy and Action Plan 2011–2015	National Drug Policy (under review)
	Communications for Health (C4H) Strategy	Infant and Young Child Feeding Strategy
	Drug Act	

The policy that is most relevant to the work of the private health care service sector is the Health Professional Committee Act/Law 19, which established the NHPC’s mandate in Somalia. In spite of this mandate, NHPC has limited capacity to register and license health care practitioners and service providers. Nor does NHPC have the legal weight to enforce disciplinary action when non-compliance is found. NHPC does not have a regional presence and nor is there a field team to undertake registration and licensing. Instead, compliance visits are being supported by voluntary health care professionals. While the dedication of time by volunteers has been extremely useful, it is not a substitute for putting in place a standalone field team that can conduct compliance checks on a regular and sustained basis. At the same time, as enforcement potentially increases, NHPC

²⁵ The Federal Government of Somalia signed the ‘New Deal for Somalia’ Compact at the Brussels conference in September 2013. The New Deal defines priorities for the next three years, including six ‘Peace and Stability Goals (PSG)’ of which PSG 5 addresses revenue and services and is relevant to the health sector. No evidence was found that the New Deal is influencing private sector engagement in health care provision. See WHO (May 2014). Somalia Country Cooperation Strategy. Available at: www.who.int/countryfocus/cooperation_strategy/ccsbrief_som_en.pdf

will need to find the correct balance between enforcement and improving minimum acceptable standards, especially in geographical areas where there is no alternative health care provision.

In each of the three zones the lack of an effective policy or regulatory framework was cited as a major constraint. It was noted that there is no form of guidance on the engagement of private sector providers by government (e.g. through a PPP) and that there was a weak regulatory framework regarding the quality control of pharmaceutical imports.

2.6 Other formal rules governing the private health sector

Summary finding: Interviews with private sector providers and health care market actors indicate that entry and exit barriers are low, resulting in a fluid market. While import licences are required, and there is some associated paperwork checked at some border crossings, the type of licence is not specific as to the type of importation taking place (i.e. pharmaceuticals).

2.6.1 Business registration and licensing

Somaliland. The necessary steps for registering and licensing an import business in Somaliland are as follows:

1. Establish company or partnership MOU in Somali and English languages;
2. Notarise at a public notary;
3. Register membership at the Somaliland Chamber of Commerce;
4. Submit an application to the Ministry of Trade and Investment (including the MOU and Chamber of Commerce membership registration). The Ministry of Trade and Investment will review the application and refer you on to the Attorney General's office; and
5. The Attorney General's office issues certificate of company incorporation to secure the name, logo and the shares and refers you back to the Ministry of Trade and Investment.

In order to receive a licence the additional steps are that:

1. The Ministry of Trade and Investment issues a document that enables you to pay the licence fee to the Ministry of Finance;
2. The receipt of payment to the Ministry of Finance together with a tax clearance certificate from Ministry of Finance Inland Revenue is returned to the Department of Commerce within the Ministry of Trade and Investment;
3. The Department of Commerce issues a licence;
4. A licence is requested at the municipality and issued at the respective district administration.

Puntland: The necessary steps for registering and licensing an importation business in Puntland are as follows:

1. Register at Puntland Chamber of Commerce and Industry;
2. Request letter of support and approval from the Puntland MoH;
3. Take the approved letter to the Puntland Ministry of Commerce (trade department); and
4. Get a separate licence from the municipality at the respective local administration.

South Central: The necessary steps for registering an importation business and obtaining a licence in South Central are as follows:

1. Support or approval letters for trade from Federal MoH (only for importers). This was noted to have only gained prominence in 2014, with enforcement being very weak; and
2. Apply for the licence at the Ministry of Trade and Industry (for importers only) and get a separate licence from the municipality at the respective local administration.

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

- A. Commercial invoice;
- B. Certificate of origin;
- C. Transport document (e.g. bill of lading including the names of the shipper); and
- D. Certificate of product analysis.

This is true for each of the three zones. At land borders, documentation checks are less rigorous and frequent and all four documents will not necessarily be requested.

To import, an import licence is required. However, the licence is not specific as to the type of importation taking place – i.e. you can get a licence regardless of whether you are importing pharmaceuticals or vehicles.

In Somaliland, the Ministry of Trade and Investment issues export and import licences, in Puntland the Ministry of Commerce issues export and import licences, and in South Central the Ministry of Commerce and Transport issues import and export licences.

2.7 Health-seeking behaviour

Summary finding: Price, proximity, perceived quality and the disease burden are the key drivers of consumer and/or patient choice. Treatment within the home is common. In contrast, treatment from a formal health care provider is often seen as a last step. Decisions as to the place of treatment are taken by the family, elders and traditional practitioners as well as the individual. Private for-profit providers have an objective of running a profitable business but also have the flexibility to offer differing prices to patients according to perceived need. Treatment at no cost was said by some participants to be perceived as lower quality.

The main constraints impacting for-profit providers are a lack of regulatory enforcement (the capacity for enforcement and negative outcomes for non-compliance is weak due to a lack of government capacity), a shortage of qualified personnel and a lack of access to capital for expansion. Investors are also challenged by the limited access to affordable finance.

This section looks at health-seeking behaviours from the perspective of public vs. private and is not intended to be a literature review. The challenges with doing the latter are: the limited secondary data sources; the limited geographical coverage of existing studies; the focus on limited areas of disease burden of existing studies; and the largely outdated literature. This section considers secondary data from 2006 onwards.

For each of the areas listed below, we state our findings followed by reference to any wider reading that was found to be relevant.

Drivers of consumer and/or patient choice

The drivers emerging from the field work were proximity to the service, the nature of the illness (e.g. presence of a specialist medical professional or piece of equipment at a facility) and word of mouth/marketing (with a direct link to the quality of provision). Price was a consideration,

particularly for lower socioeconomic income groups who are more likely to try to access lower cost care in the first instance. Within the wider literature:

- Mazzilli and Davis (2009: 46) found that the major obstacles to seeking care are distance, cost and trust in the service/staff, quality and availability of medicines for treatment.
- Pavignani (2012: 29) found that the determination of the right action to take for the patient is conducted by relatives, religious leaders and elders. Traditional home health care practices are followed first, with prayers playing a prominent role. Buying medicines comes usually before a visit to a health facility, because the health facility service is not seen as offering more than a mere prescription.
- FAO (2007: 6) also found that most health-seeking responses are based on traditional knowledge, beliefs and the perceived causes of the 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.
- WHO (2011: 20) 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. Regarding consumer and/or patient choice and health-seeking behaviour, Mazzilli and Davis (2009: 28) 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.

Motivation of and constraints of for-profit providers and shops

The findings from this study are, unsurprisingly, that the main motivation of for-profit health care service providers is a net profit that results in a continued ability to operate. However, as outlined in Section 2.1.1, the management of private facilities may agree to provide free services on a needs basis. This is a policy that these providers set themselves, sometimes with quotas and sometimes on a discretionary basis. This was true in the private for-profit and private not-for-profit facilities. The rationale is a combination of anticipation that the socioeconomic status of the population at large will improve – resulting in more ability to pay and subsequent business – generation of positive word of mouth and resulting opportunities to provide paid-for services, and altruistic motivations. Within the wider literature, PSI (2012), in an overview of pharmacies in Somaliland, found that some were selling products for higher than the recommended price. However, whether this was simply profit-seeking or for some other purpose (e.g. a reflection of the higher costs of doing business in Somaliland) was not noted.

Of note was that this study found that the provision of services at no cost is less valued by some population groups. This was also found by World Vision (2006). While the costs of provision in the private sector are noted to be prohibitive²⁶ private sector providers remain hugely popular. FAO (2007: 62) found that private health facilities are preferred by the majority of people in urban areas yet are not affordable in terms of cost.

The main constraints impacting for-profit providers were, firstly, that while the private health care sector has been growing, a lack of oversight and regulation have resulted in a proliferation of low-

²⁶ See, for example, Mazzilli and Davis (2009), p. 7.

quality providers with low cost structures who are able to undercut more reputable service providers. Secondly, there is a shortage of qualified personnel and thirdly a lack of access to capital for expansion.

Obstacles faced by investors

The key obstacle for investors was a lack of access to finance. While capital was available to the majority to start up a business via family resources, expansion is beyond the range of family financial resources. Formal sector SME finance is largely unavailable and has high associated costs. There were no findings found within the wider literature looked at as part of this study.

Constraints on effective legislation

The findings from the fieldwork were that health practitioners and training providers want to have a regulated market in which existing legislation is enforced. The reason is that enforcement would distinguish quality providers from the mass market, resulting in a more enabling business environment in which patients would turn to quality providers. At present anyone can claim to offer a service and the general population is unable to distinguish between providers.

The constraints to effective legislation are a lack of capability and capacity for enforcement and punishment for non-compliance of legislation by government agencies, a lack of publicly available information on existing policy and regulation, and the competition for resources to finalise, endorse and implement existing legislation.

- Lewa (2013: 36) found that most of the providers of services in the private health sector are inadequately trained, hence the prevailing lack of professional ethics and standards of practice in the country.
- Pavignani (2012) concluded that 'Regulation is increasingly critical, in light of the remarkable spontaneous expansion of health services (regardless of their public or private label). In the absence of any coercive capacity, technically sound behaviours must be bought from business-oriented healthcare providers. The holders of most public funds, in other words donor agencies, look to be the natural candidates for this soft-regulation role'.

3 Challenges and recommendations

3.1 Challenges

The challenges have been grouped under four thematic areas: i) lack of information; ii) poor-quality provision of health care services by the private sector; iii) weak regulatory framework; and iv) lack of understanding of the private sector. These areas emerged strongly from the field research and enable clear recommendations for interventions to be developed.

3.1.1 Lack of information

Being conflict-affected, the three zones of Somalia all suffer from a lack of both basic data and more specialised research and analysis to inform health programming, particularly concerning the private sector. Given the rapid recent investments in health, from both public and foreign, domestic and international sources, information from just a few years ago needs to be treated with caution as it is likely to be outdated.

One of the most important efforts to address the information gap is the development of each zone's working HMIS, which interviewees indicated is having most success in Somaliland. Even there though, by no means all facilities are reporting and the quality of data is variable. HMIS is not currently used in any of the three zones for planning purposes by the MoHs or for district-level planning.

Given the infancy of the HMIS, the private sector has not yet been included. One exception to this would be Manhal Hospital in Hargeisa, a private not-for-profit hospital, which voluntarily contributes data to the Somaliland HMIS. Given the size and scope of the private health sector (which some estimates put at providing 60% of all services²⁷), this is a very large and important information gap.

The Integrated Disease Surveillance Programme (IDSR) is also being rolled out. For the purposes of this study, less emphasis was placed on understanding the IDSR than the HMIS, given the lower relative use and interest to the private sector, which does not tend to respond to disease outbreaks, unless in a charitable form.

A further gap that inhibits analysis and subsequent planning is that of basic health service mappings. This should include both public and private health facility and Human Resources for Health mappings, which would need to be updated on a regular basis. While the NHPC in Somaliland and its counterparts in the other two zones are attempting to accredit qualified staff, there is also little (or no) information on the capacities of health workers in the public and private health care service sector, or of clinics' specialist care infrastructure and equipment.

There has never been a comprehensive study on the willingness to pay of patients or their access to financing sources, such as remittances. Opinions differ enormously as to what extent cost is a barrier to access, with some stakeholders citing it as one of the main barriers and others placing less importance on cost due to most people's access to family and clan network support. From our preliminary research, there is no clear trend determining which types of stakeholders sit on which side of this debate, with a mix of views in government, development partners and private sector alike. There are, therefore, interesting linkages to be explored here around willingness and ability to pay of the individual and ability to access services through clan-based, family or other sources of funding.

²⁷ Affara (2011), p. 5.

Additionally, despite clear evidence of significant investments²⁸ from Islamic donors into the private health sector, there is limited understanding of financing models, be they philanthropic, diaspora-led, Islamic, formal or other.

Generally speaking, qualitative data are easier to obtain than quantitative, given security and logistical constraints, but it is the latter that would be invaluable for intervention planning.

3.1.2 Poor-quality provision of health care services by the private sector

Given the rapid growth of the private sector and the lack of effective regulation, other than commercial licensing and some taxation policies, the private sector represents some of the best and the worst of health care provision across the three zones.

Low levels of education and lack of any guidance from the public sector regulators mean that most members of the population are unable to distinguish the qualified, safe and effective service providers from the rest of the market. People tend to rely on word of mouth, experience and/or perception when choosing a pharmacy or clinic from the private sector. Although the public sector is often perceived as providing a consistently safe standard of treatment, it is not necessarily viewed as the best and is often not the first point of call, especially for more specialist services. It is estimated that 60% of the population visit traditional (informal private) practitioners before going to the formal private or public sectors.²⁹ Proximity and opening hours give the private sector an advantage over the public sector in some cases. There is a risk that the lack of regulation and inspection, coupled with the large number of unqualified private sector providers, will lead to many people receiving the wrong or even dangerous treatments from unregulated, low-quality private sector providers, which in turn causes health complications and places an additional burden on the weak (public and private) health sector.

Part of the reason for the low standards in the private sector, aside from the lack of regulator supervision, is the fact that there are so few qualified personnel to staff facilities. There are a number of training institutions (again, this is a growing area), but many of them do not follow standardised curricula and offer courses of varying quality. In addition, there is a lack of a plan to train sufficient persons in each cadre to meet expected health system needs. These problems are the most acute in South Central.

As the influence of the diaspora's exposure to 'western' medicine and urbanisation seem to have impacted on a significant proportion of the population's health-seeking behaviour, there is a growing preference for 'modern' medicines. This has been met by a rapid growth in supply by the private sector, but not necessarily in a growth of quality supply. Currently, attempts to train health workers and regulate the private health sector are unable to catch up with demand. This disparity in demand and supply is well understood by both public and private health care sector actors and undermines the incentives for poor-quality private sector institutions to attempt to reform themselves in the face of weak regulation.

Even for the higher-quality private sector providers, though there may be a desire to improve and expand their operations and to maintain market share, a lack of finance for expansion places limits on these plans. Most of the business owners we spoke to had accessed finance from their family and other personal networks to establish their businesses. However, once in operation they were expected to begin contributing to others in their family network in the same fashion. Therefore, for

²⁸ Note that a per capita investment figure is not known.

²⁹ Affara (2011), p. 5.

expansion financing, their options were mostly limited to formal financing, which was prohibitively expensive. Additionally, the repayment terms demanded under formal sector loan agreements did not match the forecasted cash flow generated from the expanded operations.

Lack of access to finance also appears to have a negative impact on maintaining support equipment. For example, with no known bio-medical engineers operating in the areas visited, specialist equipment usually has to be sent abroad when repairs are needed or is simply replaced. These capital investments are beyond the scope of many of the interviewees and some mentioned having broken equipment that sits unused due to a lack of funds for repairs.

This may be symptomatic of the low profit margins that most private sector health providers operate on as a result of such fierce competition in the market. With the licensing processes' main purpose currently being to afford the three zonal government authorities a source of income, there is very little control over the standards of the businesses being set up. There is little incentive for these businesses to self-regulate and the quality of service can be compromised by profit motivations – e.g. some pharmacies will not refer a patient to a clinic or hospital in the hope that they will purchase medicine instead.

One of the key factors, which also seems especially problematic in pharmacies, is the quality of drugs entering the three zones and being sold/prescribed commercially. Again, estimates of the proportion of counterfeit drugs on the market vary, and even drugs which enter through reputable sources may still be available long past their shelf life or mis-prescribed. In none of the three zones could ministry or government actors convincingly explain quality assurance systems. Rumour seemed to overtake fact, with talk of WHO testing services and laboratories in the main ports, which are in fact non-functional or non-existent. In the case of WHO, they will only test UN-procured drugs and, even then, only when there is suspicion over their quality, i.e. not as a matter of routine. There are therefore a host of mechanisms through which the lack of control over the pharmaceutical supply chain can have a damaging effect on public health.

3.1.3 Weak regulatory framework

Many of the above challenges stem from a weak regulatory framework and the limited enforcement capacity of the authorities in the three zones.

Somaliland's NHPC, Puntland's Medical Association and South Central's NHPC are at various stages of establishing themselves as the health sector regulators, with Somaliland the furthest advanced. All suffer from a lack of funding, lack of personnel (especially inspection teams) and a reliance on weak judiciary systems for enforcement of their mandates.

They largely rely on prominent private sector actors to volunteer their time and resources and have very few official and funded staff. At the moment, such actions by the private sector are commendable and clearly in line with their repeated message that they are trying to rebuild the health sector for the people of Somalia. However, it is easy to see how, in the future, such concentrations of power could generate conflicts of interest and undermine regulatory efforts. It is therefore essential to support the public sector in its efforts to establish regulatory institutions now and ensure that they are truly autonomous bodies.

As well as limited staffing and a weak judiciary system to support enforcement, the challenges facing regulatory agencies are so large and pressing that prioritisation is often replaced with fire fighting. This is understandable but is not effective.

Given that the legal system is also very weak, it is not clear how successful any of the zonal governments and related authorities have been in enforcing their regulatory mandates. It seems that there have been some successes in Puntland in particular, but even there it is not clear whether non-compliant (and unsafe) facilities were closed or simply moved to another location to avoid the authorities. Without proper data, as described above, it is impossible to track the impact of any interventions on non-compliant health service providers on any scale.

Furthermore, formal relationships between health and non-health public authorities are not strong enough to enable a joined-up approach to enforcement. These weaknesses are evident to citizens and the private sector actors, and can embolden the less scrupulous to continue their activities unimpeded. The situation certainly provides no incentive to reform.

It should be noted that for some qualified and high-quality health service providers, better regulation and enforcement would help distinguish them from their unsafe competitors and they therefore do have an incentive to encourage improvements in the regulatory environment. However, at present they are in the minority.

3.1.4 Lack of understanding of the private sector

In developing any private sector engagement strategy, it should be noted that there are differing views of, understandings of and ability to engage with the private sector across the three zones.

For example, in South Central, the MoH is particularly weak and the NHPC is very much in its infancy, making engagement and regulation extremely challenging. In Somaliland, there was a sense that the private sector, particularly the pharmacies, was the root of many problems, such as developing drug resistance and poor health education and messaging leading to confusion that inhibited good health-seeking behaviour. Regulation as opposed to engagement seemed to be the suggested solution. In Puntland, the government took a more proactive approach to engaging the private sector, for example during policy-making processes and in establishing informal referral systems to share treatment burdens.

It should be noted that this summary is the result of a short period of consultation and is therefore partially influenced by the individuals who participated in the interviews, as opposed to government policy more broadly. Indeed, all three zonal government authorities have expressed in their strategy or policy documents (in various stages of enactment) that that they would like to seek greater engagement with and oversight of the private sector.

Regarding PPPs, this research led clearly to the conclusion that the use of the term 'PPP' was unhelpful. It is somewhat of a trending topic in development but largely misunderstood or deliberately misinterpreted in the Somali context. For example, some donor agencies would consider their contracting of NGO partners for implementation as a PPP, which this study does not agree with. For the purposes of this work, a PPP is considered to be a contract between the domestic government and a private sector actor (non-NGO, in line with the workshop definition). Following this definition, there were very few ongoing PPPs in health in the regions. There were, however, some examples of government contracting out services to private sector organisations where they were better equipped for the task. There were also many examples of informal collaboration between government and the private sector. Overcoming such semantics in order to fully understand the nature of engagements between government and the private sector needs to be approached carefully so as to avoid confusion.

There is also a general lack of understanding of how the private sector operates, both from donors and government (as well as lack of consumer and/or patient awareness). This lack of clarity

extends to its fee structures, the integration of charitable work in for-profit entities, the nature of collaboration with the public sector, sources of funding and profit margins, and the types and varieties of services on offer.

For the private sector itself, one clear challenge was the lack of formal networks or forums in which actors could network and support one another, or engage more cohesively with donors and the public sector. An example of this came in the feedback from the workshop in Hargeisa, among which there were many comments of a key advantage of the workshop being that it afforded participants a first opportunity to meet and get to know one another. In what can appear to an outsider as a very integrated, networked community, the fragmentation (and irrational nature) of the market should not be underestimated.

Such a large but incohesive private sector cannot be expected to engage effectively with the public sector or donors on issues of reform, policy-making, regulation enforcement and quality control. This therefore presents a crucial challenge to engaging with the private sector to sustainably improve health outcomes.

3.2 Recommendations for engagement

Table 6 shows the recommendations resulting from the key challenges outlined in the prior section. There are four intervention objectives listed, these are to:

- A. Increase reliable information on the dynamics of the private health care market;
- B. Limit harmful practices and improve quality of service provision in the private health care market;
- C. Strengthen the regulatory framework and its enforcement; and
- D. Develop cooperation between public and private health care providers.

Similarly, there are four intervention points, defined by stakeholder group:

- A. Policy-makers;
- B. Providers;
- C. Patients/consumers; and
- D. DFID.

The interventions outlined fall within supply-side strengthening and demand-creation approaches. This is indicated in Table 6 by the letter in the bracket (S and D respectively). As is shown in Table 6 the majority of interventions fall within a supply-side strengthening approach. The key recommendations on the demand side relate to consumer awareness, market research and sensitisation on the role that the private sector is playing in augmenting public sector health delivery.

Regarding prioritisation, we would propose a tiered approach (within a typical five-year programming timeframe). Three tiers are recommended: tier one (priority interventions to begin immediately), tier two (secondary interventions), and tier three (longer-term interventions). These are denoted by the numbers (1), (2) and (3) respectively in Table 6. The interventions are listed by

tier after Table 6. It is our team's view that the most effective level for pursuing these interventions is at the regional, sub-zonal level.

Table 6: Matrix of intervention strategies

Intervention objective	Interventions geared toward policy-makers	Interventions geared toward providers	Interventions geared toward patients	Interventions geared toward donor agencies
<p>Increase reliable information on the dynamics of the private health care market</p>	<p>Assistance should be given to policy-makers to provide incentives for private health care providers to share data with government (starting with HMIS) (S) (2)</p> <p>Policy-makers should develop and maintain a database of private sector health providers (S) (1)</p>			<p>Donor agencies should undertake:</p> <ul style="list-style-type: none"> • A mapping of public and private health care facilities, including staffing, services, capacity and legal status (S) (1) • A comprehensive study into consumer preferences³⁰ (D) (1) • A study into willingness and ability to pay and linkages to remittances (D) (1) • Research into private sector financing with a focus on informal/traditional, Zakat and charitable financing from Arabian countries (S) (1)

³⁰ Note that this is currently ongoing.

<p>Limit harmful practices and improve quality of service provision in the private health care market</p>	<p>Government should establish drug-testing laboratories, and requisite staffing, at land and sea borders (S) (3)</p>	<p>Standard curricula should be developed by government and private sector training institutions (S) (1)</p> <p>Funding should be provided, including grants, to scale up existing training practices that are effective and endorsed by government (S) (2)</p> <p>Training providers should be supported in the development of specialist cadres, e.g. technical engineers, who can maintain and repair health care equipment (S) (2)</p> <p>Support should be given to help to network together pharmacies, clinics and hospitals to identify them as quality providers and create associated branding (S) (1)</p> <p>Non-clinical and clinical private providers should be supported to formalise referral</p>	<p>Consumer understanding of the importance of seeking qualified medical advice, through educational campaigns – in particular via radio and SMS, should be heightened. This could be linked to messaging on nutrition, prevention and sanitation (D) (1)</p> <p>Education should be provided around the dangers of self-medication practices and incorrect drug-use (D) (1)</p>	<p>Options for financing private sector health providers and actors, e.g. returnable capital and challenge funds should be explored (S) (1)</p>
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Intervention objective	Interventions geared toward policy-makers	Interventions geared toward providers	Interventions geared toward patients	Interventions geared toward donor agencies
		systems between public and private providers (S) (2)		
Strengthen the regulatory framework and its enforcement	<p>Government should prioritise policy and legislation for development, endorsement and implementation (S) (2)</p> <p>Government should bolster the Ministry of Justice and courts system, to enable legal weight to be given to findings of non-compliance (licensing and professional accreditation) (S) (2)</p> <p>Government, in particular the MoH, should aim to make regulatory authorities independent (S) (3)</p> <p>Funding should be provided to enable regulatory authorities, such as NHPC in Somaliland, to develop inspection teams and hire full-time staff (to move away from volunteerism from private sector actors) (S) (2)</p>	<p>Support and incentives should be given to private health care providers to conform to licensing and accreditation norms. This could be linked to in-service training and the formation of branded networks of quality providers (S) (2)</p>		<p>Donor agencies should prioritise policy and legislation for development and endorsement. Work on collective donor agreement on key areas and stop funding for fringe policy development (S) (1)</p>

Intervention objective	Interventions geared toward policy-makers	Interventions geared toward providers	Interventions geared toward patients	Interventions geared toward donor agencies
<p>Develop cooperation between public and private health care providers</p>	<p>Sensitisation, through training and in the course of regular meetings, should be provided for the MoH on private sector involvement in health care delivery (D/S) (1)</p> <p>Increased networking and dialogue and the participation of private sector representatives in decision- and policy-making forums should be supported (D/S) (1)</p>			<p>Sensitisation for other donors and United Nations agencies on the extensive role the private sector is playing in health care delivery, and ways to work with the private sector to improve health care delivery, should be conducted (D/S) (1)</p> <p>Donor agencies should create forums and avenues for dialogue with private sector representatives (D/S) (1)</p>

Tier one:

- Donor agencies should undertake a mapping of public and private health care facilities, including staffing, services, capacity and legal status.
- Donor agencies should undertake a study into willingness and ability to pay and linkages to remittances.
- Donor agencies should undertake a comprehensive study into consumer preferences.
- Donor agencies should undertake research into private sector financing with a focus on informal/ traditional, Zakat and charitable financing from Arabian countries.
- Policy-makers should develop and maintain a database of private sector health providers.
- Donor agencies should prioritise policy and legislation for development and endorsement. Work on collective donor agreement on key areas and stop funding for fringe policy development.
- Standard curricula should be developed by government and private sector training institutions.
- Consumer understanding of the importance of seeking qualified medical advice, through educational campaigns – in particular via radio and SMS, should be heightened. This could be linked to messaging on nutrition, prevention and sanitation.
- Education should be provided around the dangers of self-medication practices and incorrect drug-use.
- Support should be given to help to network together pharmacies, clinics and hospitals to identify them as quality providers and create associated branding.
- Options for financing private sector health providers and actors, e.g. returnable capital and challenge funds should be explored.
- Sensitisation, through training and in the course of regular meetings, should be provided for the MoH on private sector involvement in health care delivery.
- Increased networking and dialogue and the participation of private sector representatives in decision- and policy-making forums should be supported.
- Sensitisation for other donors and United Nations agencies on the extensive role the private sector is playing in health care delivery, and ways to work with the private sector to improve health care delivery, should be conducted.
- Donor agencies should create forums and avenues for dialogue with private sector representatives.

Tier two:

- Assistance should be given to policy-makers to provide incentives for private health care providers to share data with government (starting with HMIS).
- Funding should be provided, including grants, to scale up existing training practices that are effective and endorsed by government.
- Training providers should be supported in the development of specialist cadres, e.g. technical engineers, who can maintain and repair health care equipment.
- Non-clinical and clinical private providers should be supported to formalise referral systems between public and private providers.
- Government should prioritise policy and legislation for development, endorsement and implementation.
- Funding should be provided to enable regulatory authorities, such as NHPC in Somaliland, to develop inspection teams and hire full-time staff (to move away from volunteerism from private sector actors).
- Government should bolster the Ministry of Justice and courts system, to enable legal weight to be given to findings of non-compliance (licensing and professional accreditation).

- Support and incentives should be given to private health care providers to conform to licensing and accreditation norms. This could be linked to in-service training and the formation of branded networks of quality providers.

Tier three:

- Government should establish drug-testing laboratories, and requisite staffing, at land and sea borders.
- Government, in particular the MoH, should aim to make regulatory authorities independent.

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Annex A Terms of Reference

Background

Somalia has some of the worst health indicators in the world. Despite a very fragile health system, with significant dependence on external funding sources, the current government is determined to strengthen and rebuild. The majority of health services in Somalia are provided through the private sector and NGOs. It is estimated that 80% of Somalis use some form of traditional and/or private sector health service. The private health care delivery system involves many of the healthcare workers that already work for the public sector. The quality of care provided through the private sector has not been documented.

Recently, Somali health authorities developed health sector strategic plans and the Federal government is mounting efforts to create the required policy environment and needed resources to improve health outcomes. The role and extent of coverage that the private sector provides in Somalia needs to be furthered studied.

Under PSG 5 of the Somali Compact the government is committed to build partnerships with non-state and/or private sector actors in order to increase the provision of equitable, accessible and affordable social services.

While some attempts have been made previously to engage the private sector in other sectors, efforts within the health sector remain quite limited. Effective collaboration between the public and private sectors is crucial to ensure a coherent health system, and improve coverage of health, especially for reducing maternal and neonatal mortality and strengthen basic service provision.

Objectives of the Consultancy

The main objectives of this consultancy are to provide an assessment of certain elements of the private health sector in Somalia to enable the health authorities to develop an engagement strategy with the private sector to complement and augment public health sector services. DFID will also use the findings of this study to develop recommendations for DFID/private sector engagement as part of the design of its next stage of support to the health sector.

Scope

To achieve this objective, the consultancy scope will focus on two levels:

A. Achieve a deeper understanding of the role and current dynamics of the private sector in the health sector in Somalia.

This will entail a review of the role of private sector in the supply of health services, plus an assessment of the overall governing environment within which the private sector operates, including existing public private partnerships:

- Establish a working definition to categorize the various private sector actors engaged in the supply of health services, developing a series of categories for non-government not for profit and for-profit institutions, distinguishing between procurers and wholesalers of medicines and supplies as well as privately run service providers such as private hospitals, pharmacies, shopkeepers, and community health providers.

- Assess what types of private provider networks that are in operation (including professional associations, training and social franchises, etc.), and review the feasibility of creating entry points to work on issues of quality assurance, access to training and provider inputs (?), data collection, etc.
- Clarify the current policy, legislative and regulatory mechanisms which guide the operations of the private sector in Health in Somalia, plus comment on what happens in practice.
- Identify the types of existing public private partnerships in operation in health and assess their relative effectiveness.
- Review and outline the role of the private sector in the procurement, supply and distribution of medicines and medical supplies, plus assess the relative effectiveness

B. Develop recommendations for private sector engagement. This should include:

- Recommendations on various scenarios for public private collaboration including roles and responsibilities, and include recommendation of specific business models for the market including cost effectiveness of the models.
- Identify potential intervention points and incentives for improving the delivery of private services.
- Determine means by which the policy and regulatory environment can be strengthened to support an effective public private collaboration
- Identify key information gaps which must be filled in order to build an evidence base for the development of coherent public-private partnership policies.

Methodology (to be suggested by the consultant but could include)

General background research, document review and preparatory work:

Conduct background research using secondary research sources on Somalia and other severely disrupted health sectors of relevance to the Somalia situation.

Qualitative interviews with private providers:

Conduct interviews with private providers, focusing on:

- a) Skills/education of health workers
- b) Business licensing and operating permits
- c) Health regulations/regulatory frameworks
- d) Access to financing

National Key Informant interviews:

Conduct interviews with key stakeholders including:

- MoH

- Ministry of Finance
- Regulatory bodies
- Development partners
- Institutions
- Professional bodies

Travel to Somaliland and Puntland is recommended but open to consultant recommendation.

Specific deliverables

- Develop detailed study design in collaboration with DFID 1 week post contract start date.
- Organise a briefing of initial results to key stakeholders in Nairobi 6 weeks post contract start date.
- Submit draft report of the study, including recommendations, for consultation 10 weeks post contract start date.
- Submit final draft 8 weeks post contract start date
- Organize a workshop with representatives from the government and the private sector to disseminate findings.

Timing:

8 Weeks

Qualifications and selection of the contracted agency/consultants

The Consultancy or consultants will be a professional consumer or market research personnel/organization with track record of at least 5 years of consumer studies in East Africa with experience in countries of conflict being an advantage. The Consultant's team will need to demonstrate their experience both in quantitative and qualitative research techniques and strategy formulation. Private sector experience is essential. Previous experience with health systems in fragile states is favourable. Previous experience of Somalia is preferred.

Annex B List of persons met

Somaliland (9–13 January)³¹

Khadar M. Ahmed – Somhealth – Deputy Chairperson

Dr Lula Jiredeh Hussein – NHPC – Executive Director

Dr Ahmed Hashi Oday – NHPC – Chair

Dr Abdirashid Hashi Abdi – SMA – Chairman

Dr Abdikarin M. Gas – Somhealth – Chairperson

Yusuf Duale Barre – DIWO – Chairman / Mubarak Co (MUBCO) – General Manager

Donato Gulino – PSI – Country Representative

Dr Yasin Abdi Arab – Director – Manhal Hospital

Jumcaan Yussuf Mohamed – Deputy Director – Manhal Hospital

Adan Mahamoud Ali – Dalsal Pharmaceutical Company – General Manager (DIWO member)

Mubarik Omar Hassan – Alla-Aamin Pharmaceutical Import Co – General Manager (DIWO member)

Fauzi Omer Deria – Beder Pharmaceutical Import Co – Managing Director (DIWO member)

Dr Farhan Liiban Ahmed – Liiban & Iman Medical Wholesaler – Manager (DIWO member)

Yusuf Ismail – DIWO Association – Secretary

Abib Aden Nur – MoH Somaliland – Director of Public Health

Dr Zianab M Magan – MoH Somaliland – Director of Medical Services

Hussein Ahmed Hashi – MoH Somaliland – Director of Human Resources

Rohit Odari – HPA – Country Director

Edna Adan Ismail – Edna Aden Hospital – Founder/Director

Tom Kreamer – Edna Aden Hospital – Consultant

Dr Ahmed Omar Askar – Director – Hargeisa Group Hospital

Abdikadir Ahmed Mohamed – Finance Officer – Hargeisa Group Hospital

³¹ See Annex C, Section C.4 for the list of workshop participants in Hargeisa on 10 January, which is not included here so as to avoid duplication.

Puntland (13–15 January)

Dr Abdi Artan – Dur Dur Health / Garoowe Diagnostic Centre – Owner/MD and Medical Association Chairman

Abdirisak Hassan – MoH – Director of Planning

Dr Abdisamad Ahmed Jama – Garowe hospital – Director

Ali Mohamud – Puntland Pharmacy and Wholesalers Association – Executive Committee member

Mohamed Ali – Kismayo Pharma Company – Manager (Pharmacies Association member)

Faysal Ahmed Warsame – Qaran Health Centre and Qaran Pharmacy – Owner/Director (Pharmacies Association member)

Jama Mohamed Da'ar – Save The Children International – Health Programme Manager

Dr Mohamed Hussein Adan – Galkayo General and Teaching Hospital – Director

South Central (16–20 January)

Dr Abdikani Sh Omar – Federal MoH – Director General

Abdihamid Ibrahim – Federal MoH – Director of Policy and Planning

Dr Abdi Awad – Federal MoH – Senior Adviser

Abdikani Ahmed Jama – Nomad Pharma Importer – Foreign Trade and Sales Manager

Abdirizak Zahid Mohamoud – Aden Ade Hospital – Hospital Director

Hassan Osman Ali – Caafi Clinic and Pharmacy – Owner and Manager

Abdi Abdiqani Jama – Nomad Pharma – Manager

Abdikadir Mayow Mahad – Liban Drug Co – Managing director

Ahmed Sheikh Ibrahim – Al-Ancam Drug Co – Sales Executive

Warsame Mohamud Ibar – Barwaqo Drug Co – Manager

Mohamed Dahir Nor – Somal Pharma Co – Sales

Hassan Absuge Guure – Al Hijaz Drug Co – Sales

Faarax Cusman Maxamed – Balsam Pharma Co – Manager

Ahmed Ali Sultan – PharmaSom Co – Sales Executive

Mohamed Ghedi – Al Mustakbal – Manager

Abdi Moh'ed Garabey – Shafici Pharma – General Manager

Ismail Muse – SOMIDA – Secretary

Ismail M Hassan – SOMIDA – (job title not known)

Mohamed Abbas Osman – Daru Al Shifa Specialised Hospital – Director

Halima Abdi Sheikh – SOMA – Chairwoman

Hawa Abdullahi Elmi – Midwifery School Mogadishu – School Principal

Dr Yasin Ahmed Nur – University of Somalia/Medical Association – Lecturer

Dr Deqo Aden Mohamed – Dr Hawa Abdi Hospital and Foundation – Executive Officer

Hassan Nour – NHPC – Team Leader

Nairobi (16–23 January)

Muna Shalita – UNICEF – Programme Manager, Global Fund Malawia Programme

Ombretta Mazzaroni – Trocaire – Health Programme Manager

Esther Waters Crane – UNICEF – Joint Programme Coordinator, Somalia Support Centre

Raza Zaidi – UNICEF – Senior Programme Manager, Somalia Support Centre

Jullianne Rugasira Birungi – UNICEF – Somalia Support Centre

Cormac O’Sullivan – UNICEF – Supply Division

Katja Schemionek – WHO Somalia – Country Programme Adviser, Health Systems Strengthening

Catherine Wangechi – SDC – Health Programme Officer

Agiso C. Odhuno – USAID – Regional Global Fund Liaison Specialist

Barni Nor – Embassy of Sweden – Second Secretary for Health

Geoff Handley – World Bank – Senior Economist

Marybeth McKeever – USAID – Somalia Economic Growth Team

Ombretta Mazzaroni – Trócaire, Somalia – Health Programme Manager

Per Karlsson – Embassy of Sweden – Senior Programme Manager, Somalia Section

Ron Ashkin – PSI4H – Team Leader

Naidu Udayraj – Save the Children – Somalia Programme

Karen Stephenson – DFID – Health Adviser

Katie Bigmore – DFID – Health Adviser

James Hamilton Harding – DFID – Social Development Adviser

Follow-up consultations / fact checking post field work

Xavier Modol – Consultant – Health financing

Martin Odiit – UNAIDS – Country Coordinator

Lee Sorensen – One Earth Future – Director

Wario Guracha – THET – Somaliland Country Representative

Huihui Wang – World Bank – Health Economist

Dr Harry Jeene – RALSA Development Practitioners – Director

Hassan Elmi – WHO – Regional Coordinator

David Mitchell – World Bank – Consultant

David Phillips – World Bank – Consultant

Annex C Workshop summary note

C.1 Overview

The workshop was hosted by a team of three consultants hired by DFID, through the UK-based Health & Education Advice & Resource Team (HEART) team at the consultancy firm Oxford Policy Management (OPM). The consultants were: Joanna Buckley (team leader and private sector development consultant), Liz O'Neill (health consultant) and Ahmed Aden (private sector development consultant).

The workshop was attended by 43 members of the public and private health care sector in Somaliland. This included government representatives, private, public and private not-for-profit hospitals, importers and wholesalers, pharmacies and the University of Hargeisa.

The main objective of the workshop was to better understand the structure, actors and dynamics of the private health sector in Somaliland. DFID currently funds the HCS and the JHNP. DFID is in the process of gathering information to inform the potential design of new support for the health sector in Somaliland and Somalia post-2016. As part of this DFID wants to ascertain the role that the private sector could play on the supply side and to use the analysis to aid in policy design and recommendations for the health sector as a whole.

The participants were split into four groups:

- A. Hospitals and waste management;
- B. Government, university and regulatory authorities;
- C. Pharmacies; and
- D. Wholesalers and importers.

Section C.2 provides a summary of each of the sessions held during the workshop. The agenda is shown in Section C.3 and the participant list is shown in Section C.4.

C.2 Summary of sessions

Session 1: Differences between private and public health sector providers

The definition of the private sector resulting from the workshop was as follows:

There are two forms of private health provider – informal (traditional) and formal (which is, however, only loosely regulated and controlled). The private sector does have a profit-seeking motivation but may also have social objectives. 'Public' relates to government ownership and control. The more of this there is, the closer to a public sector service it becomes. It does not include INGOs. INGOs are classified as charitable organisations that sit between the public and private.

The joint feedback from the groups was as follows:

Session 1: Differences in private and public health providers

Characteristics of the private sector	Characteristics of the public sector
<ul style="list-style-type: none"> • Work according to their budget and profit margin. • Services offered are not determined by government. • Costs are not determined by government, but by the market, the customers' ability to pay and profit margin. • Training is not standardised. • Coverage is mostly limited to urban areas, but there are some exceptions (Manhal was noted). • Sometimes quicker in responding to patients/customers when they present themselves. • Quality of medicine, or choice of quality of medicine, is sometimes perceived as being better than the public sector. • Quality of services and levels of staff training varies greatly – from most specialist to none at all. • Management is perceived as better, due to profit incentive. • Other than their business registration (and possibly an import licence) there is little oversight or regulation from government. NHPC is beginning to register professionals. • No way to test the quality of medicines. • Provide specialist services that public sector does not. 	<ul style="list-style-type: none"> • Funded mostly through government, with some cost recovery from patients. • The more government intervention in the running of a facility, the more it can be said to be public (this is often linked to the proportion of government funding). • Training standards are often higher as there is no enforcement of standards in the private sector. • Standardised curricula for some cadres. • Services are usually lower cost (or free, e.g. caesarean or Tuberculosis treatment) due to government policy. • Quality is variable, sometimes perceived to be lower with longer waiting times. • There should be more equity, in terms of geographical coverage (quality varies so this is not guaranteed). • Public sector can test the quality of medicines by using the WHO lab in Nairobi. • Better for emergency care – e.g. Hargeisa Group Hospital's intensive care unit – and for prolonged illnesses.

Session 2: Comparison of private sector providers

This session discussed the effectiveness of the private sector and efficiency and equity considerations. It should be noted that there are exceptions and no hard and fast rules. A summary from the breakout session is provided below.

The end user: For the private sector, the end user is anyone who seeks care (private sector actors mostly do not do outreach). Sometimes they will provide free or discounted services for those most in need. In public facilities, the end user is sometimes perceived to be those who need longer-term treatment and cannot afford to go abroad or to the private sector, although this is not always the case. Emergencies will usually go to the public sector.

Type of treatment: Patients at government facilities come for general services in line with the general service offered by public facilities. Private hospitals are usually specialised. They may not offer all the facilities a public service offers.

Quality of service: Variable in both. It cannot categorically be said that all private hospitals offer the better service, although the profit motivation and competition was thought to incentivise customer satisfaction. There was some consensus that the public sector was safer, due to the proliferation of private sector actors without the requisite qualifications, but that the salary level was a disincentive to performance. In each case the service was not consistent and was said to depend on the staff and timing of the service.

Price: Public does not necessarily mean free and private does not necessarily mean expensive. In public facilities, the government policy of cost sharing should be followed, with treatments being free for the poorest and for certain diseases and services (e.g. mental health, HIV/AIDS, Tuberculosis and caesareans). However, a lack of supervision means that sometimes staff charge additional (unauthorised) fees. Conversely, the management of private facilities may agree to provide free services on a needs basis – it is a policy they set themselves.

Geographical location: Every district has a district health facility and every village has a health post so it is equally distributed on public side – officially at least. The private sector goes where there is money (more urban than rural). The informal (traditional) sector is in both rural and urban areas, and is sometimes the only option in rural areas.

Equity: The public sector is better at providing equitable health promotion/messaging across the whole country and all socioeconomic groups. Some perceive the public sector as the only availability for the poorest/marginalised/rural dwellers. However, equity considerations are variable.

Efficiency: The private sector has to be efficient to maintain its profit margin. The public sector does not have that incentive. It should be noted that efficiency alone does not result in quality services.

Session 3: Do patients distinguish between private and public and, if so, on what basis?

The following criteria were said to be the main distinguishing features. However, it was noted that many of these are assumptions rather than the actuality on the ground:

- Who runs the facility – government or not.
- Payment. People think the private sector is where you pay and that the public sector is always free.
- People assume those with longer opening hours are private.
- Proximity and distribution throughout the city can be a factor in choosing a service provider. Government facilities are often in one place so not accessible to those far away. The private sector can be spread all over so is often easier to access.
- The nature of illness may determine where a patient seeks care, with people often choosing public facilities for longer-term, more chronic conditions.
- Often the patient is not the decision-maker – their family or carer will decide where to take them.
- People use word of mouth to choose service providers, as well as adverts and prior experience (advertising works best through radio and maybe also TV and mobiles).

Session 4: Innovations, gaps and opportunities

Innovations

- Private sector sometimes acquires better/specialist equipment (but not necessarily the staff to use it).
- Private sector has made specialists available in Somaliland that would not have been otherwise.

- Private sector has sent some students abroad for training and introduced specialist training courses.

Gaps

- There is no private sector HMIS and no other official data source on their activities, impact, gaps, etc.
- Unregulated competition is not sufficient to improve health standards – anyone can claim to offer superior services and the general population is unable to distinguish between the genuine and not: *'When you eat with the blind you can eat as much as you want'*. The process of registration/licensing is, in practice, more a commercial exercise than a regulatory one. Some people prefer the private sector for this very reason – it is easier to get the treatments they think they need (but sometimes they may not need treatment and mis- or over-prescribing of medicines is a big problem in the private sector). This is reported to be a growing problem.

Opportunities

- Regulation, inspection, quality control and licensing all need to be strengthened and/or enforced to be a true regulatory and quality control framework.
- The private sector is providing health services to a large number of beneficiaries and is continuing to grow. Working with the private sector is an opportunity for the government to enhance the delivery of public health outcomes.
- There is a need for quality control labs at pharmaceutical entry points and in the capital.
- There is a need for qualified personnel and increased capacity to implement reforms, e.g. in the NHPC.
- There is scope to introduce commercial licences on a product-by-product basis.
- Establishing business links to internationally recognised manufacturers of medicine and pharmaceutical products could improve the quality of prescribed products.

Closing session

The areas for donor consideration were listed as follows:

- Better data (starting with the HMIS in both sectors) on the outcome and impact of private sector health provision.
- Expanded research on the role of the private sector.
- Supporting the implementation of existing policy and regulation in conjunction with the MoH.
- Supporting collaboration between the public and private sectors. Public and private stakeholders are only just getting to know and understand each other, their constraints, strengths, motivations, etc. Many met for first time at this workshop. Donors could facilitate relationships and make new introductions. It is vital to build trust and understanding.
- PPPs supporting the pharmaceutical supply chain, a quality control lab, pharmaceutical storage and distribution, and training are all needed.
- Supporting resource and expertise gaps – training, curricula development, in-service training. Donors could also facilitate introductions to foreign universities, hospitals, training centres, etc. with whom strategic partnerships could be made.
- Formal finance is very expensive – the donors could offer financing mechanisms such as returnable capital for high-impact investments.
- Maintenance is costly and largely unavailable. Equipment is frequently sent overseas for repair or bought anew. This is costly and results in periods where the service is unavailable.

Closing comment

Before any of the regulation discussed during the workshop can be enforced, there must be a critical mass of actors in the health sector that meet the minimum standard, otherwise the government will have to enforce regulation that could mean shutting down facilities that are the only accessible option or limiting the range of health services available. Edna Adan Hospital is training pharmacists and wants to have 500 qualified pharmacists prior to lobbying for the implementation of regulation on the qualifications of private sector pharmacy staff.

It is in the private sector's interest to see regulation and policy enforced as it will remove poor-quality competitors and distinguish them as the leads in their sector. To ensure coverage in rural areas a suggestion was to bring and train students from their homes in rural areas, restabilising them there after qualifying.

Next steps

The team will be presenting to DFID on Friday 23 January and will submit a report that will be finalised by March 2015. This is the first step in a longer process that is likely to see DFID continue to explore options and opportunities for future funding (2016 and onwards).

We thank you all for your contributions and participation during our visit.

C.3 Agenda

0800 Arrival

0830 Introductory Session (plenary)

- Who the team are and their objectives
- Any questions for the team

0900 Session 1: Differences between private and public health sector providers (group)

- Who makes up the private sector (characteristics and examples)?

0930 Presentation by groups back to workshop

0945 Session 2: Comparison of private sector providers (group)

- A breakout group session on how effective (advantages/disadvantages) the private sector is in delivering health outcomes/impact compared to the public sector.
- How do private sector actors promote/hinder equity? Access – who can and can't access?
- How economical are private sector actors, i.e. how careful are they in the use of resources to minimise expense, time or effort?

10.30 Presentation by groups back to workshop

10.45 Coffee break

11.00 Session 3: Do patients distinguish between private and public and, if so, on what basis? (Plenary)

11.15 Session 4: Innovation, opportunities and gaps (plenary)

- What forms of innovation has the private sector fostered?
- What scope is there for PPPs? What challenges are there to collaboration?
- What gaps exist in the private sector?

1200 Presentation by groups back to workshop**12.15 Lunch****1300 Closing Session (plenary)**

- A summary of the sessions so far
- How should donors work with the private sector for health care provision? In which areas?
- Is there really a need for donor support? To which of the private sector actors listed?

1345–1400 Question and answer session (plenary)**C.4 Participants**

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