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EDITION 6

Investing in health to anchor growth

2021

WORLD BANK GROUP
Macroeconomics, Trade & Investment

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Executive Summary

Somalia is still contending with an unprecedented health and economic crisis which began in 2020. The COVID-19 pandemic forced a national lockdown and mobility restrictions which had deleterious effect on the economy prompting a contraction. The containment measures implemented in 2020 were economically costly and plunged the vulnerable groups, such as the poor, informal sector workers, women, and youth, suffering disproportionately from reduced opportunities. Under the COVAX facility, the country has received 300,000 doses of vaccine to protect frontline workers and elderly population with chronic health conditions from COVID-19. However, vaccine hesitancy, the weak and overstretched healthcare system, and poor distribution infrastructure given the fragile environment, are hampering the vaccine rollout. As such Somalia will struggle to reach herd immunity before the end of 2023, leaving them exposed to new, more virulent strains of the disease, and raising the prospect that COVID-19 will become a permanent, endemic problem across the country.

Somalia's economy contracted by an estimated 0.4 percent in 2020, less severe than the 1.5 percent decline forecast in the 2020 *Somalia Economic Update*. The Somalia economy performed better than expected as a result of official aid flows, fiscal policy measures put in place by the government to aid businesses, and social protection measures cushion vulnerable households. Much of the economic contraction occurred in the second and third quarter. Economic activities were supported by stronger-than-expected recovery with the easing COVID-19 containment measures in August 2020 and rising credit to the private sector. Even though official data from the Central Bank shows that remittance inflows rose y-o-y by an estimated 18 per-cent in 2020, largely due to improvements in the recording of official flows, data from the Somalia High Frequency Poverty Survey show the frequency and the amount of remittances flows declined for households by 20 and 31 percent respectively.. Remittances provide an important source of financing for household consumption, business investment, and imports in Somalia, and historically they have been tightly linked to global economic performance.

Medium outlook and risks

The economy is expected to enjoy a moderate recovery over the medium term. Real GDP is forecast to grow by 2.4 percent in 2021 in the baseline scenario, accelerating slightly in 2022–23. As economic activities gain momentum, growth will reach pre-COVID-19 levels of 3.2 percent in 2023. The baseline scenario assumes Somalia will weather the pandemic without the need to reimpose the stringent lockdowns and serious travel restriction that were lifted in August 2020. It assumes a slow update of vaccinations due to hesitancy (even though vaccines are available under COVAX facility).[1] It assumes a gradual pick-up in economic activities and businesses and firms gradually return to their normal levels of sales—enabling steady recovery. It also assumes that there is continued support to firms and vulnerable households through the Gargaara lending facility and Baxnaano programs. Growth in remittances will help firms' recovery and boost households' incomes and livestock export demand will rebound. It also assumes no further climatic shocks affecting mainly the agricultural sector during this period.

In the downside scenario, the economy would grow at 1.1 percent in 2021, increasing to only 2.2 percent in 2023. This is premised on an upsurge in COVID-19 cases, suppressed rainfall and prolonged locusts' threat, and deterioration of the political climate. The delaying elections beyond 2021 as constitutionally

[1] It is assumed 500,000 vaccination in 2021 and 700,000 in 2022

mandated is likely to create political tensions leading to increased insecurity and insurgence activities. This will affect economic activities and erode business confidence. External assistance is assumed to decline in this scenario. In the upside scenario, growth will be more robust, at 2.8 percent in 2021. This is anchored on improved weather conditions, no further COVID-19 restrictions, and the election impasse is resolved and held in 2021. Economic recovery will be robust in 2021 if rainfall is adequate with less floods, no lockdowns and mobility restrictions, and the current social protection programs are expanded to include vulnerable households in urban areas. As a result, the economy will grow at 3.2 percent and 3.5 percent in 2022 and 2023 respectively.

Policy options for economic recovery

The COVID-19 global pandemic exposed the costs of not investing in a public health system. The near-term economic prospects for the Somalia depend on the pandemic's path. Added spending to contain the pandemic will necessarily come at the expense of other budget priorities, including vital spending on other key health areas and much-needed capital investment. The need for additional public spending on health, not only to scale up the resilience of local health systems and public infrastructure is key in supporting the testing and tracing, but also to ensure that the logistical, administrative, and financial requirements of mass vaccination are in place. The slower the pace of vaccination and larger the unvaccinated population, the greater the possibility that new variants of the virus will develop, adding to the prospect of a more protracted pandemic in the country.

Building a sustainable, resilient, and inclusive economy. With limited fiscal space, Somalia needs to prioritize reforms that boost resilience to future shocks, and that emphasize sectors with the greater return on growth and employment. Accelerating the pace of poverty reduction will require policy interventions to raise productivity, create jobs, and expand pro-poor programs. Such interventions could include, expansion of social protection programs, increased agricultural productivity through infrastructure and sanitation and increases in public investments. Creating a better investment climate is key. Reform initiatives to improve the country's business climate and attract more private investment should now be urgent for the post-election government. These reforms could include reducing the cost and improving the reliable of electricity, leveling the playing field among the private firms (new and old entrants into the market), aligning the treatment of firms in the formal and informal sectors, reducing red tape, and broadening financial inclusion. As Somalia embark on the road to recovery from the triple shocks, these structural reforms will enable jobs to be at the center of policy action and private sector response.

Supporting vulnerable population. The Baxnaano programme has highlighted the importance of being able to channel support quickly and efficiently to those most in need during the COVID-19 crisis and after the locusts infestation. Extending the reach and responsiveness of such social protection programs through the innovative and cost-effective use of mobile money, electronic cash transfers, and virtual engagement is key in supporting Somalia's vulnerable population. Building on the Baxnaano programme to further enhance the safety nets in Somalia is key. This could be done by adopting national social safety net strategy, which clearly sets out target populations and delivery mechanisms, and is capable of being scaled up rapidly in response to economic shocks or reforms.

Increasing exports of current products. In the short to medium term, Somalia's trade strategy should focus on increasing exports of products in which Somalia currently has a comparative advantage. Although most of these exports are primary products (like live animals and vegetables), other manufactured

products (like fish oil and processed fish) on the lower end of the complexity spectrum seem feasible given Somalia's capability stock. These products are within Somalia's current reach; fostering them would increase manufacturing skills that are a prerequisite for accelerated diversification into more sophisticated products. This strategy can lay the foundation for acquiring the more sophisticated technical skills necessary for large-scale manufacturing. Labor-intensive light manufacturing led the economic transformation of many of the most successful developing countries (see World Bank 2021).

Investing in health in Somalia

Investing in health in Somalia is a means to invest in the Country's economy and economic development. A recent study estimates that every dollar invested in health in a developing country yields between two to four dollars in economic returns.[2] Investments in health are demonstrated to increase life expectancy and productivity resulting in growths in GDP and economic development. The COVID19 pandemic has reminded policy makers of the importance of this sector and the country is currently well positioned to increase investments in its health system towards economic development. Robust health systems with the capacity to detect and respond cases are a cornerstone of pandemic and emergency preparedness towards maintaining economic stability and growth.

Somalia's health outcomes lag in comparison to neighboring countries, as demonstrated by low life expectancy (57 years, compared to 66.3 years in Kenya), high fertility rates (6.9 children per women, compared to 4.6 in Ethiopia), and high maternal mortality (692 per 100,000, compared to an average of 534 in sub-Saharan Africa). Poor health outcomes are underlined by lagging health service delivery. In Somalia only 32 percent of all births are delivered by a skilled health provider, 24 percent of women receive antenatal, preventative care visits during pregnancy, and 12 percent of children are fully immunized for Diphtheria, Pertussis, and Tetanus (DPT3).

Somalia's Ministry of Health is nascent and health governance and financing capacities are not yet fully developed. Somalia currently has limited capacity for health sector regulation, data collection and use, and oversight of health services. Similarly, Government health service delivery capacity is underdeveloped. Further, most health service financing is off the Government's budget. As a result, systems for fund flows through the Government have not been fully developed, leaving the Government with limited Public Financial Management (PFM) capacity.

Targeted investments in health service delivery, financing, and stewardship are needed to strengthen Somalia's health system towards improved health outcome and economic growth. Health service delivery investments focusing on high-impact, cost-effective services will help to improve health outcomes and attract additional resources to health services. Health services can be delivered through Government contracting of health service providers to rapidly accelerate health service outcomes in the context of limited Government capacity. Health service contracting is also a means to clarify health service delivery roles between the purchaser (the Government) and the provider (Contractor) towards improved PFM systems. Additionally, to strengthen health financing use of a harmonized, output-based formula for paying health service providers will help to ensure equity in health service delivery. Such a harmonized, output based formula for health service provider payments could be used to focus providers on health service outcomes, giving providers flexibility on inputs while holding providers accountable for health service results. Further, a harmonized, output based formula could be used both by the Government and

[2] Mckinsey Global Institute (2020). How prioritizing health could help rebuild economies.

partners as an interim step towards pooling of health resources. Capacity development to build Government stewardship would help to solidify the Government's role in guiding the health sector. Capacity development in public financial management, health management and information systems, and regulation would support the Government to execute its core functions to oversee and regulate the health sector. Core actions to strengthen the health sector in the short and medium term are detailed in Table 1.

Table 1: Summary of Recommended Actions in the Short and Medium Term

Area	Short Term Recommendations	Medium-Term Recommendations
Health Financing	• Use of a harmonized, output-based provider payment formula • Contracting of NGOs to deliver health services	• Harmonized, output based provider payment formula used by financers as a step towards pooling • Government contracting of for-profit, private sector health service providers using harmonized payment formula
Health Service Delivery	• Finance high-impact, cost-effective interventions to rapidly improve health outcomes	• Finance additional interventions as additional resources become available and health outcomes improve
Stewardship	• Capacity development of FGS and FMS • Delineation of service delivery roles and responsibilities • Contracting of health service providers by FGS with day to day monitoring from FMS	• Continued FGS and FMS capacity development • Increasing contracting role for FMS, dependent on direction of constitutional discussions

Investments in Somalia's health sector are expected to have long-term benefits towards economic growth in Somalia. Further, such investments can contribute to a stable and resilient health system to respond to health emergencies, such as the ongoing COVID-19 pandemic, which threatens to destabilize the Country's economic growth. Targeted investments in health service delivery, financing, and health sector stewardship are projected to strengthen the health sector, improving health outcomes and increasing emergency and epidemic preparedness towards economic stability and growth.

The Global and Regional Context

The global economy is projected to grow at 5.3 percent in 2021 after an historic contraction 3.5 percent in 2020 induced by the COVID-19 pandemic. This growth is forecasted to moderate to 4.2 percent in 2022Global Economic Prospects, June 2021) .[3] New data released in the first half of the year point to a somewhat less severe contraction in 2020 and much stronger growth in 2021 than was previously forecast. The higher-than-expected growth outturn is a result of easing of lockdowns and mobility restriction, strengthening external demand, rebounding of commodity prices, a faster start of vaccine rollout in early 2021, and the additional fiscal support provided by a few large economies. The outlook depends on expansion on vaccine rollout, the pandemic-induced disruptions and on how effectively economic policies deployed under high uncertainty can limit lasting damage from COVID-19.

Despite a more buoyant external environment, sub-Saharan Africa will be the world's slowest growing region in 2021. The region is forecast to grow by 2.6 percent in 2021, up from 2.4 percent projected in October, supported by improved exports and commodity prices, along with a recovery in both private consumption and investment.[4] Sub-Saharan Africa is still in the grip of COVID-19 health and economic emergency. After implementing national lockdowns to contain the virus and spare the region from the worst of the crisis, these measures had a dramatic impact on local economies, prompting the region to shrink by an extraordinary 2.4 percent in 2020—the worst outcome on record. This contraction in 2020 was less severe than the 3.3 percent anticipated in October 2020 reflecting a slower spread of the virus and lower COVID-19-related mortality in the region, strong agricultural growth, and a faster-than-expected recovery in commodity prices. For the region as a whole, per capita output is not expected to return to 2019 levels until after 2022—and in many countries, per capita incomes will not return to pre-COVID-19 levels until 2024 or later. Cumulative output losses from the pandemic will amount to almost 12 percent of GDP over 2020–21. As a result, vulnerable groups, such as the poor, informal sector workers, women, and youth, are suffering disproportionately from reduced opportunities and unequal access to social safety nets.

The pandemic hit fragile countries hard, and their recovery is set to be even more sluggish. Fragile and conflict-affected low-income countries (LICs) have been particularly hard hit by the pandemic, with activity contracting by an estimated 3.9 percent.[5] The resultant fall in per capita GDP is expected to set average living standards back by at least a decade, or more in 25 percent of fragile and conflict-affected LICs. The adverse effects of the pandemic have been exacerbated by the underlying vulnerabilities of these economies. Weak state capacity and limited fiscal space have constrained the scope for authorities to respond decisively to the pandemic. As a result, gains in living standards have been eroded, tipping tens of millions of people into extreme poverty cumulatively in 2020–21. The recovery among fragile and conflict-affected LICs is projected to be slow, with growth resuming at 1.7 percent in 2021, before firming to 3.4 percent in 2022. Despite the pickup in growth, activity in these economies will remain at 5.6 percent in 2022, below its pre-pandemic level.

[3] The World Bank's January 2021 *Global Economic Prospects* estimated that the world economy contracted by 4.3 percent in 2020 and forecast that it would rebound with growth of 4.3 percent in 2021 and 3.8 percent in 2022. The World Bank is likely to revise these estimates upwards in June 2021.

[4] World Bank, *Africa's Pulse,* April 2021 and October 2020.

[5] World Bank, Global Economic Prospects June 2021

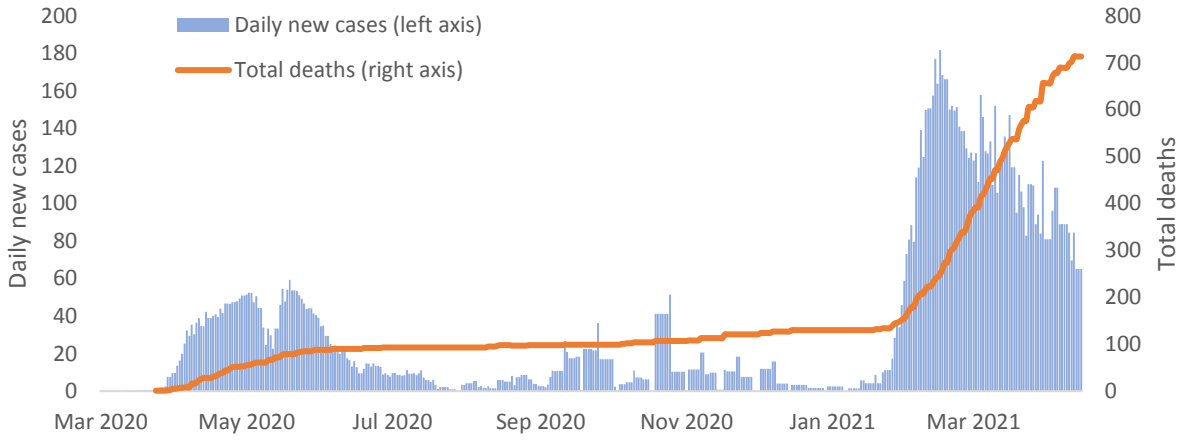
Part I: The economy is recovering from the triple shocks

COVID-19 Pandemic Developments

Somalia is still contending with an unprecedented health and economic crisis caused by the COVID-19 pandemic which began in 2020. Like other countries world-wide, Somalia swiftly implemented national lockdowns and other containment measures to control and contain its spread. While vital in saving lives, these measures had a deleterious effect on the local economy prompting it to contract. However, with the decrease in the number of cases and amid the mounting economic and social costs of the lockdowns, Somalia cautiously reopened its economy in August 2020.

In March 2021 the country was hit with a second wave of the pandemic. Average daily new cases surpassed 180 per day in early March before beginning to subside, and total reported deaths have exceeded 700 as of end-April (Figure 1)**.** Compared with the first wave, the containment measures implemented during the second wave have been less restrictive to avoid a repeat of the economically costly measures deployed in 2020. In addition, the country has no fiscal buffers to cope stricter containment measures. However, the social protection measures put in place last year through the Baxnaano programme helped in cushioning vulnerable rural households from falling into poverty.

Figure 1: New cases and cumulative deaths from COVID-19



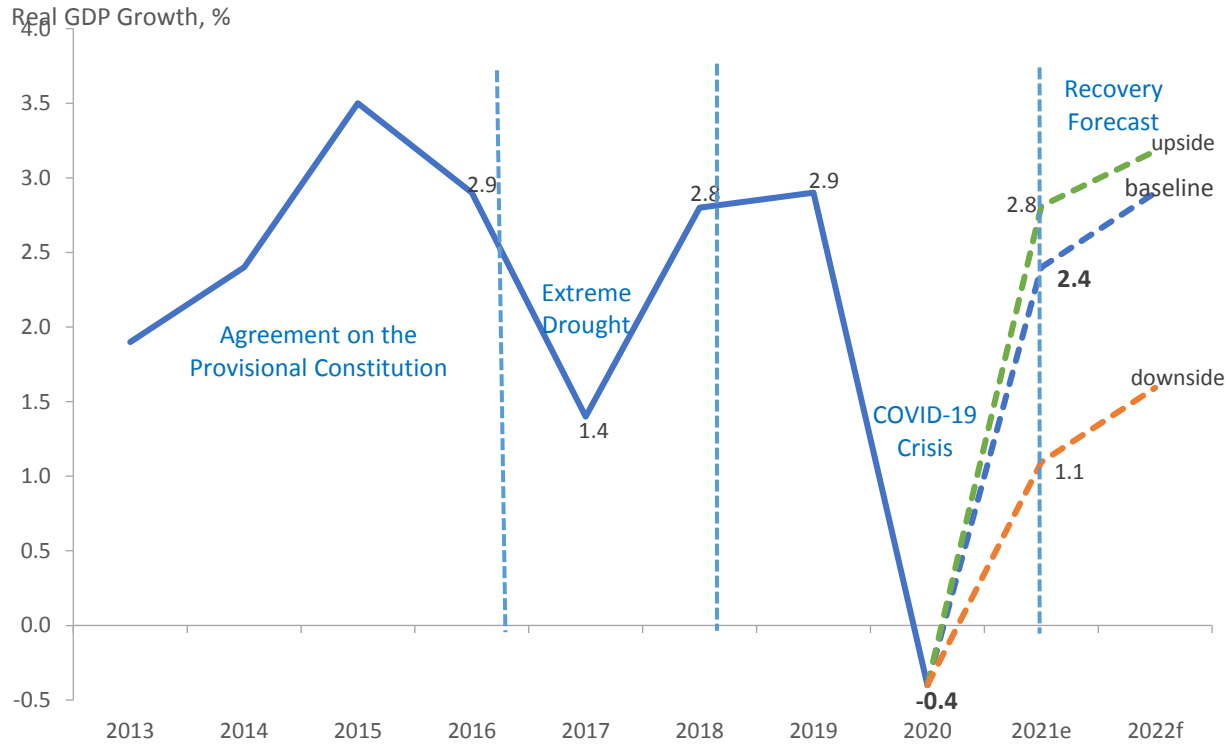
Source: World Health Organization
Notes: Latest observation in April 30, 2021.

Somalia has secured limited amount COVAX vaccine. On 15 March 2020, Somalia received 300, 000 doses of Oxford AstraZeneca vaccines from the COVID-19 Vaccines Global Access COVAX Facility to protect frontline workers and elderly people with chronic health conditions. The program will support the procurement of vaccines for 20 percent of the eligible adult population (1,044,000 doses). In addition to the weak and stretched health system, the success of the vaccine rollout also depends crucially on the distribution infrastructure that the Somalis have put in place. If supply, distribution and slow uptake of the vaccine continue, Somalia will struggle to reach herd immunity before the end of 2023, leaving them exposed to new, more virulent strains of the disease, and raising the prospect that COVID-19 will become a permanent, endemic problem across the country.

The triple shocks dampened growth in 2020[6]

Somalia's economy contracted by an estimated 0.4 percent in 2020, less severe than the 1.5 percent decline forecast in the 2020 *Somalia Economic Update* (Figure 2). The Somalia economy performed better than expected because of increase of official flows, fiscal policy measures put in place by the government to aid businesses, and social protection measures to cushion vulnerable households. Much of the economic contraction occurred in the second and third quarter. The economic performance was supported by stronger-than-expected recovery with the easing COVID-19 containment measures in August 2020 and rising credit to the private sector. Even though data from CBS show remittance inflows rose y-o-y by an estimated 18 per-cent in 2020, largely due to improvements in the recording of official flows.[7] data from the Somalia High Frequency Phone Survey show the frequency and the amount of remittances flows declined for households by 20 and 31 percent respectively. Remittances provide an important source of financing for household consumption, business investment, and imports in Somalia, and historically they have been tightly linked to global economic performance. Remittances are relatively more important for the bottom 40 percent as income from remittances represent 54 percent of their total consumption, while remittances represent about 23 percent of total consumption for the upper 60 percent.[8]

Figure 2: Somalia's fragile economic recovery amid recurrent shocks



[6] The triple shocks in 2020 were floods, locusts' infestation, and COVID19 pandemic.

[7] Remittances may be countercyclical, as relatives and friends often send more during economic downturns, disasters, conflicts, or other negative shocks (World Bank 2019).

[8] According to *Somalia Poverty and Vulnerability Assessment* (World Bank 2019), only 1/5th of households receives remittances and that these households are less poor than other households and are concentrated in Mogadishu and rural areas of the northeast, IDPs and many other groups.

Source: World Bank and IMF Staff Estimates

Table 2: Selected Economic and Financial Indicators, 2018–23

	2018	2019	2020e	2021f	2022f	2023f
GDP, nominal (millions of dollars)	4,721	4,942	4,975	5,402	5,672	5,976
real GDP growth	2.8	2.9	-0.4	2.4	2.9	3.2
per capita GDP, nominal (dollars)	332	338	331	350	359	369
Poverty incidence (US$1.90/day PPP)	69					
Money and prices						
CPI inflation rate (e.o.p)	3.2	3.1	4.1	2.5	2.1	2.1
Private credit (growth, percentage)	9.2	11.8	6.5			
Private credit (share of GDP)	2.3	3.9	4.2			
Fiscal (central government)						
Total revenue and grants	5.7	6.8	10.1	10.0	11.5	12.5
o/w external grants	1.8	2.2	5.8	5.2	6.2	6.7
Total expenditure	5.7	6.4	9.9	9.6	10.8	11.9
o/w Compensation of employees	3.0	3.3	4.6	4.8	5.1	5.5
o/w Purchase of non-financial Assets	0.2	0.3	0.4	0.6	1.0	1.0
Overall balance, net	0.1	0.5	0.2	0.4	0.7	0.6
External						
Current account balance	-7.5	-10.5	-13.3	-12.2	-11.9	-11.9
Trade balance	-84.8	-83.0	-91.3	-85.8	-86.9	-83.5
Exports of goods and services	23.7	22.6	14.3	21.8	22.2	22.6
Imports of goods and services	108.5	105.6	105.5	107.6	109.1	106.1
Remittances, private transfers	31.4	31.9	30.8	31.3	31.9	31.4
Official grants	46.6	41.3	47.9	42.9	43.8	40.7
FDI	8.6	9.1	9.4	9.2	9.3	9.7
External debt	111.3	107.4	39.3	36.7	35.5	29.4
Exchange rate (shilling/dollar) (e.o.p)	23,954	25,065	25,761			

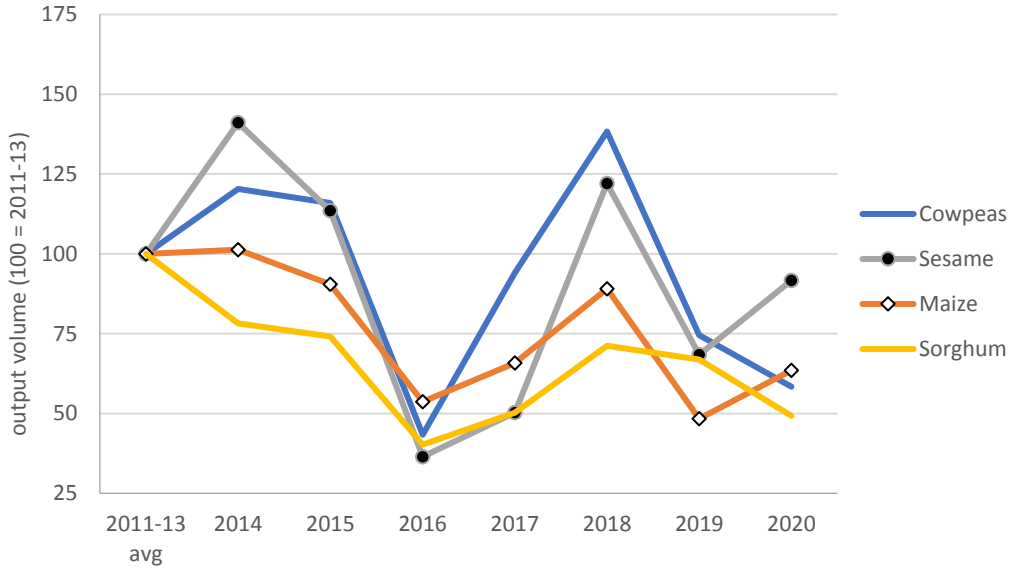
Sources: FGS, IMF and World Bank estimates.

Agricultural production slumped

Poor and erratic rains led to lower agricultural production in 2020. Overall total crop production declined by 5.8 percent in 2020 compared to the previous year, with cereals (sorghum, maize, and cowpeas) falling by 9.6 percent (Figure 3).[9] Delayed and erratic rainfall distribution characterized the October to December 2020 *Deyr* season, resulting in below-average, cumulative rainfall across most regions (FNAU, March 2021). The poor rains led to inadequate replenishment of pasture and water resources and below-average Deyr crop production. In addition, recurrent floods between July and early November caused further population displacement and damaged crops and farmland in riverine areas of Hiiraan, Shabelle, and Juba regions. Despite favorable *Hagaa/Karan* (July–September) rainfall in agropastoral and pastoral livelihood zones in the Northwest, the rains could not compensate for crop losses caused by poor *Gu* (April–June 2020). Similarly, pastoral areas faced water scarcity and pasture shortages, prompting atypical, earlier-than-normal livestock migration to distant grazing areas, and milk availability for consumption and sale became limited. Additionally, a sharp decline in livestock exports since August 2020 adversely affected pastoralists and other households who work in the livestock value chain. Finally, in late November, Cyclone Gati caused significant damages and livestock deaths in northeastern coastal regions, although the rains alleviated dry conditions.

[9] FAO database

Figure 3: Agricultural production remained subdued in 2020



Source: FAO database

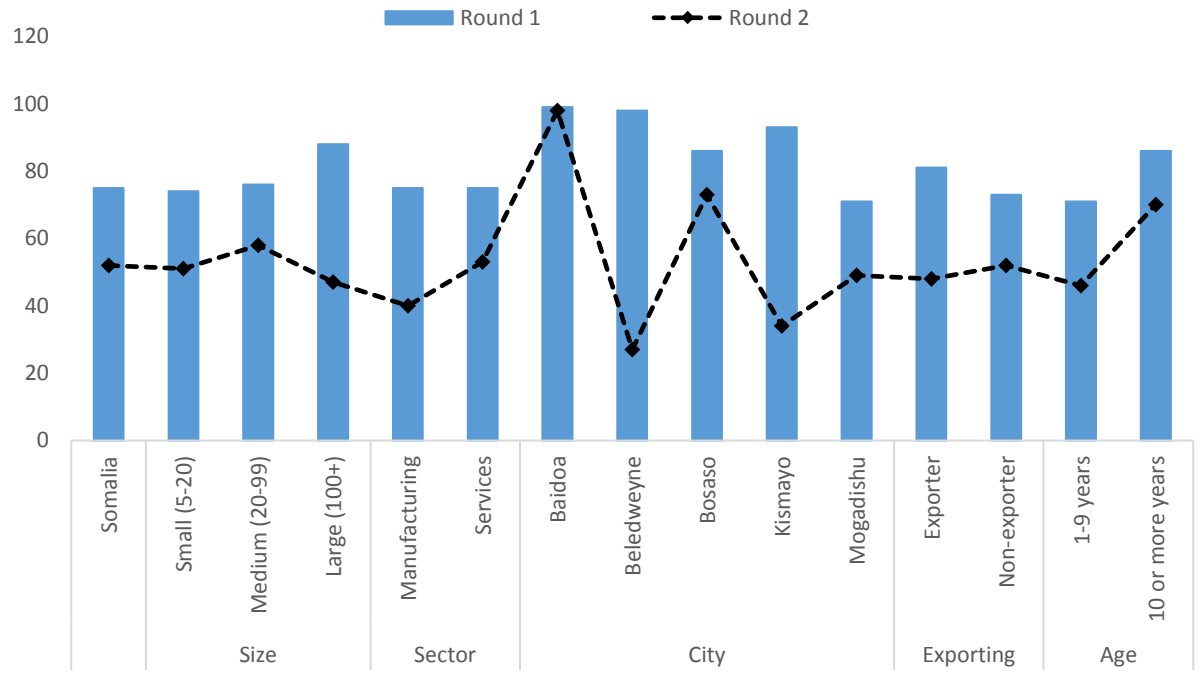
Businesses were adversely affected by the COVID-19 pandemic

COVID-19 mobility restrictions severely disrupted businesses activity 2020 but conditions became less severe toward the end of the year. The Somalia Enterprise Survey (2021) reports that about 75 percent of the firms surveyed in June/July 2020 suffered a drop in sales compared to a year earlier—and in some parts of the country, virtually all firms lost sales—but that this share fell to around 50 percent at the end of 2020 (Figure 4a).[10] Although sales at year's end remained below their levels a year earlier, Figure 4, panel b, shows a lessening in the severity of firms' sales declines in almost all parts of the country. The slight easing up of the impact is reflected in the financial health of the business. The share of firms reporting liquidity and cash flow shortages has gone down from to about 50 percent in Round 2 (December/January) from 90 percent in Round 1 (June/July).

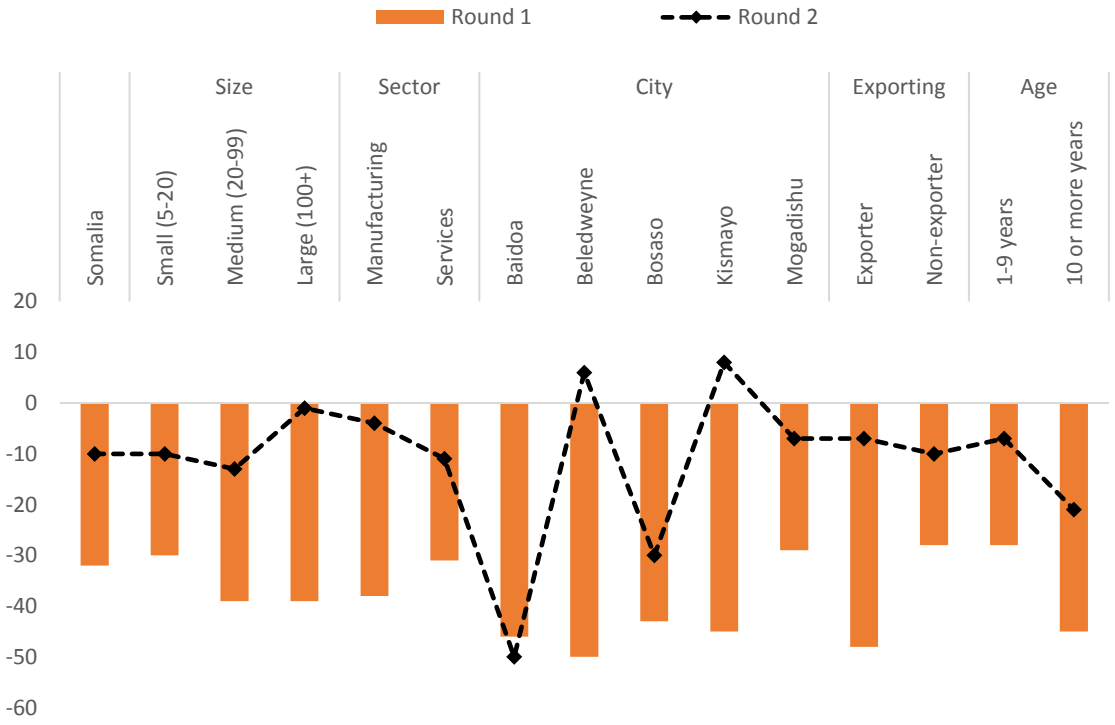
[10] Enterprise Survey 2020: "Coronavirus and the private sector in Somalia: Results from Wave 2 of COVID-19 focused Enterprise Survey" FGS, World Bank, IFC and UNIDO. The first wave of the survey was conducted between June 14 and July 30, 2020. Wave 2 was conducted from December 15, 2020, to January 30, 2021.

Figure 4: Shocks to sales have been widespread, but eased toward the end of 2020

a. Firms reporting decreased monthly sales compared to the same month in 2020 (Percent)



b. Average change in monthly sales compared to the same month in 2020 (Percent)



Sources: Somalia Rapid Business Survey

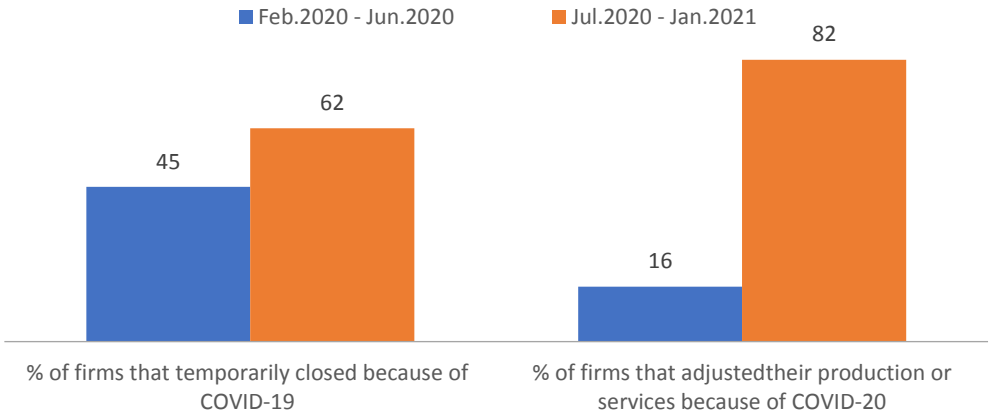
Notes: Round 1 (February to July 2020) and Round (July 2020 to January 2021)

Firms made numerous adjustments to cope under COVID-19 conditions. For businesses in fragile economies like Somalia that already face a plethora of existing structural challenges, recovering from such a systemic shock could be slow and protracted. The disruptions to supply and demand as a result of the pandemic have persisted, although eased with the reopening of the economy compared to the lockdown period. In November/December 2020, 44 percent of the firms faced disruptions to their supply of inputs, raw materials or finished goods purchased for resale, down from the 71 percent in June/July2020. Changes in production and ways of delivering goods and services was the most common adjustments mechanisms made by firms as opposed to employment related cuts which happened at the beginning of the pandemic. About 82 percent of businesses adjusted their product or services since the pandemic while about 70 percent adjusted ways of delivering good or services.[11] Eighty percent of firms have delayed payments to their service providers and tax authorities. Most firms still report reducing wages following the pandemic, particularly large firms and exporters. However, comparatively only 46 percent of firms reduced the number of full-time permanent employees compared to the level in February 2020. One year into the crisis, employment contracted on average by 37 percent with medium, large, and older firms shedding most of the jobs (see Table 3).

Table 3: Impact of COVID19 on Firms Operations

	Round 1	Round 2	**change**
% of firms with decrease in supply of inputs compared to a year ago	71	44	**-27**
% of firms experiencing decrease in monthly sales compared to a year ago	75	52	**-23**
% change of permanent full-time workers since February 2020	-31	-37	**-6**
% of firms experiencing liquidity or cashflow availability	90	49	**-41**
% of firms delaying payments to supplies, landlords or tax authorities	89	80	**-9**
% of firms that have temporarily closed because of COVID19	45	37	**-8**

Figure 5: Effects of COVID19 on Firms Operations



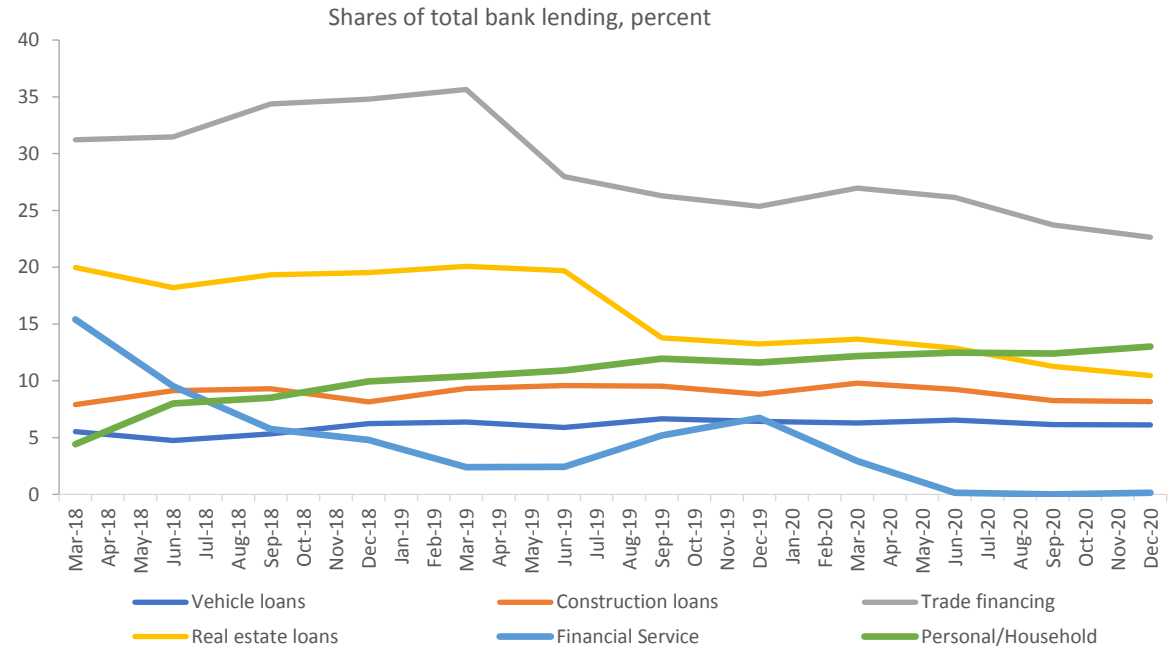
Source: Somalia Enterprise Survey, 2021

[11] Sixty-nine percent of firms started or increased online business activities since June/July, while 21 percent report starting or increasing remote work arrangement for employees.

COVID-19 crisis heightened liquidity challenges among businesses. The depth and breadth of the impacts of the pandemic points to a need for a broader and inclusive assistance to businesses. There is also a growing importance of accessing external finance since the initial periods of the crisis. Bank loans is now the most common means of bridging liquidity and cash flow shortages for most firms, 46 percent) up from 14 percent in June/July 2020. However, firms face difficulty accessing credit with 68% of the firms considered credit constrained across five cities in Somalia. One year into the crisis, only a very small share—less than 3 percent—of firms have received or expect to receive government support with delaying payment to service providers and tax authorities cited as the most desired policy support from the government (see Table 3)

Distribution of bank credit remained unaffected during the crisis. Data from the Central Bank of Somalia (CBS) show that the sectoral allocation of bank loans remained relatively the same in 2020. Households' share of loans rose from 11.6 percent in December 2019 to 13 percent in December 2020. These was continuation of pre-pandemic trends in loans to other major sectors (vehicle, trade, and construction) with a marginal drop recorded in financial services and real estate sectors (Figure 6). Loans for "trade financing"—which includes letters of credit for importers and exporters and lending to the retail and wholesale trade sector—and construction were steady. Therefore, the expected decline in lending to these sectors did not materialize even with the lockdown/mobility restrictions.

Figure 6: COVID-19 disruptions and restrictions did not greatly interrupt credit to the private sector.



Source: Central Bank of Somalia database

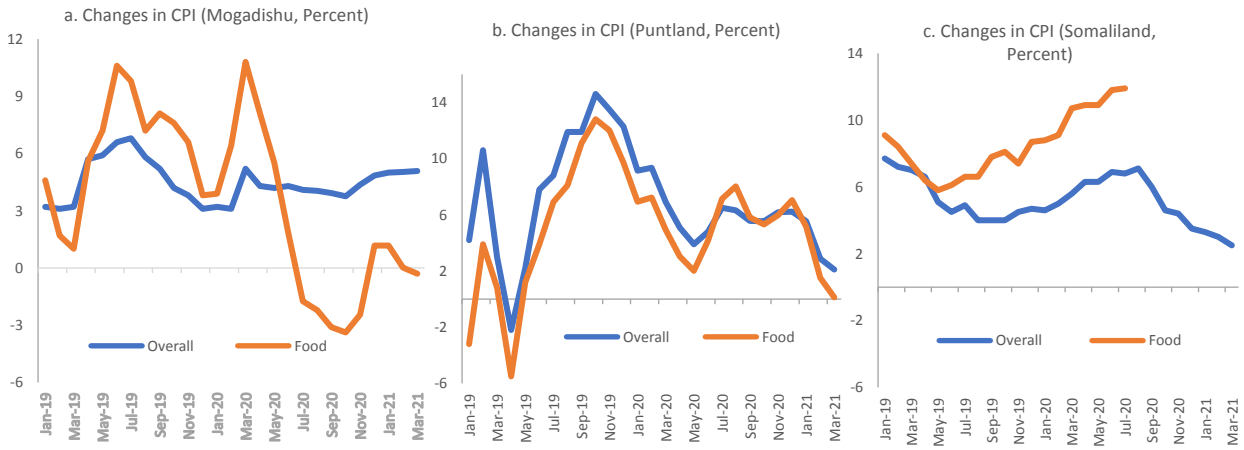
The roll-out of pro-poor programs are providing welcome relief to households and businesses. The Ministry of Labor and Social Affairs launched the "Baxnaano" program in April 2020. This delivers cash transfers to vulnerable households and provided a platform to support households suffering losses caused by locusts and weather shocks. About 100 thousand households have benefited under the Baxnaano program. The Gargaara Company Limited (Gargaara), was established [in 2019] as an apex institution to increase credit to micro, small and medium-sized enterprises (MSMEs). It expanded the MSME Financing Facility in light of COVID-19 concerns, and with the objective of supporting economic relief and recovery

of MSMEs by enhancing liquidity and supporting de-risking in 2020 to mitigate negative effects of COVID-19 pandemic. As of September 2020, Gargaara had on-boarded three Somali financial institutions to participate in the US$15 million MSME Financing Facility, with a total US$1.45 million having been disbursed to 76 beneficiaries; a further US$0.85 million is expected to be disbursed by 2021.

Inflation has remained low

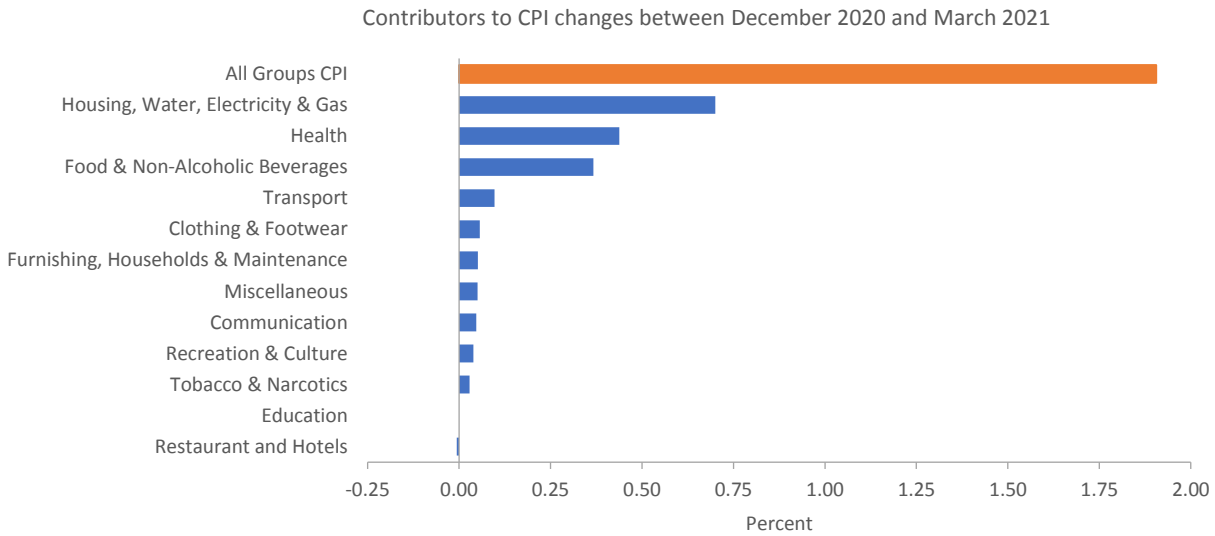
Inflation remains low. Overall inflation in Mogadishu increased from 3.1 percent in 2019 to 4.8 percent in 2020, and further rose to 5.1 percent in March 2021 (Figure 7a). However, food price inflation declined to 1.2 percent in December 2020 from 3.8 percent in December 2019 and declined further to -0.3 percent in March 2021. This is attributable to increased supplies from crops harvest from the dyer rains in December 2020 and enough food imports to meet domestic demand. The increase in overall inflation is driven by higher prices of health services due to COVID-19 crisis and higher prices of housing, water, and electricity and gas—mainly driven by higher costs of international oil prices (Figure 8). De facto dollarization tends to keep overall price inflation at relatively low levels.

Figure 7: Inflation has remained low driven by lower food prices



Source: Somalia National Bureau of Statistics, Somaliland Ministry of Planning, Puntland Ministry of Planning.

Figure 8: Higher oil prices and medical costs are driving increases in prices



Source: Somalia National Bureau of Statistics

The triple crisis pushed more people into poverty

The COVID-19 crisis placed further pressure on joblessness and poverty. It is estimated that 21 percent of Somalis had to stop their work activity following the outbreak of COVID-19, in a country where only 55 percent of the population is actively engaged in the labor market. In addition, 78 percent of households reported some reduction in their income from wages.[12] In particular, work activities in the agricultural, energy, and professional services sectors were mostly disrupted. With limited formal job opportunities, more than a third of Somalis were engaged in self-employment, which had been particularly hard hit, with almost one in three household enterprises not operating in July 2020, and revenue generation estimated to have almost halved. With the added shocks of locust's infestation and floods, 25 percent of households involved in farming or livestock activities had not been able to carry out their normal farming activities

Even though, the disruption from COVID-19 affected household incomes from all sources, low income households both experienced crop losses and low income from agricultural employment. 78 percent of households reported some reduction in their income from wages. Households also reported a decline in remittances in July 2020, although there has been some improvement in the receipt of remittance flows through official channel following accelerated financial sector reforms. Low-income households both experienced crop losses and low income from agricultural employment. With few alternative food and income sources, poor households with limited saleable animals faced moderate to large food consumption gaps in 2020 and this is expected to persist through mid-2021. Erratic and poor rainfall, desert locusts and stalk borer infestations, and conflict led to crop losses and low income from agricultural employment. In riverine livelihood zones along the Shabelle and Juba rivers, recurrent floods destroyed farmland and crops and displaced local populations, leading to significant crop and income losses. Rural livelihood activities have also been affected with increased food insecurity among the rural population and internally displaced persons (IDPs), while the urban poor faced limited livelihood assets, few income-earning opportunities, and high reliance on external humanitarian assistance. In addition, some of the urban poor across Somalia also continued to face moderate to large food consumption gaps partly due to the continued decline in external remittances and a slowdown in economic activities in urban areas related to the impacts of the COVID-19 pandemic.

COVID-19 has exacerbated food insecurity while school closures affected human capital: 32 percent of households reported having an adult not having eaten for an entire day. The hunger was even more prevalent among nomads (42 percent) and rural households (37 percent). Food insecurity is expected to remain high through May 2021 due to localized floods, below average rainfall and a worsening desert locust infestation. Human capital has been affected especially by school closures. On March 18, 2020, the Government of Somalia announced the closure of all primary and secondary schools to curb the spread of the COVID-19 virus. During school closures, only 36 percent had students engaged in alternative learning activities.

At the household level, the COVID-19 outbreak adversely affected remittance flows, reducing income for Somali households. Between March and July 2020, the frequency of remittances and amount received decreased for 49 percent and 36 percent of the population, respectively (see Figure 9). Remittance flows decreased further between July 2020 and January 2021 as the frequency and the amount of remittances declined for 69 percent and 67 percent of the population, respectively. The 31 percent decrease in the amount of remittances received from abroad between Wave 1 and Wave 2 reflects the adverse effect of the COVID-19 outbreak on many economies around the world and the financial capabilities of the Somali

[12] Somali High Frequency Phone Survey (SHFPS), January 2021

diaspora. The largest proportion of Somali households reported a decline in income from all listed key sources in both waves of the survey with the income reduction being more prominent in Wave 2 (84 percent) than in Wave 1 (80 percent). The reduction in income is most pronounced in moneys received in the form of pension (99 percent vs. 31 percent), government assistance (82 percent vs. 38percent), NGO assistance (85 percent vs. 56 percent), and family assistance (76 percent vs. 58 percent) in Wave 2 than in Wave 1.

Figure 9a: Share of Somalis reporting change in frequency and amounts of remittances received

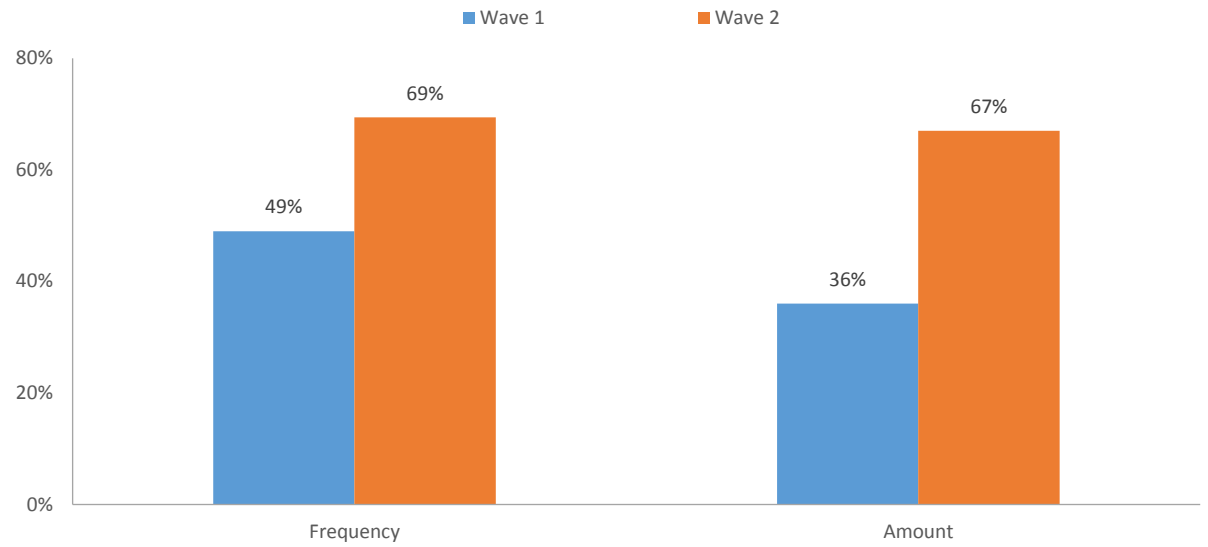
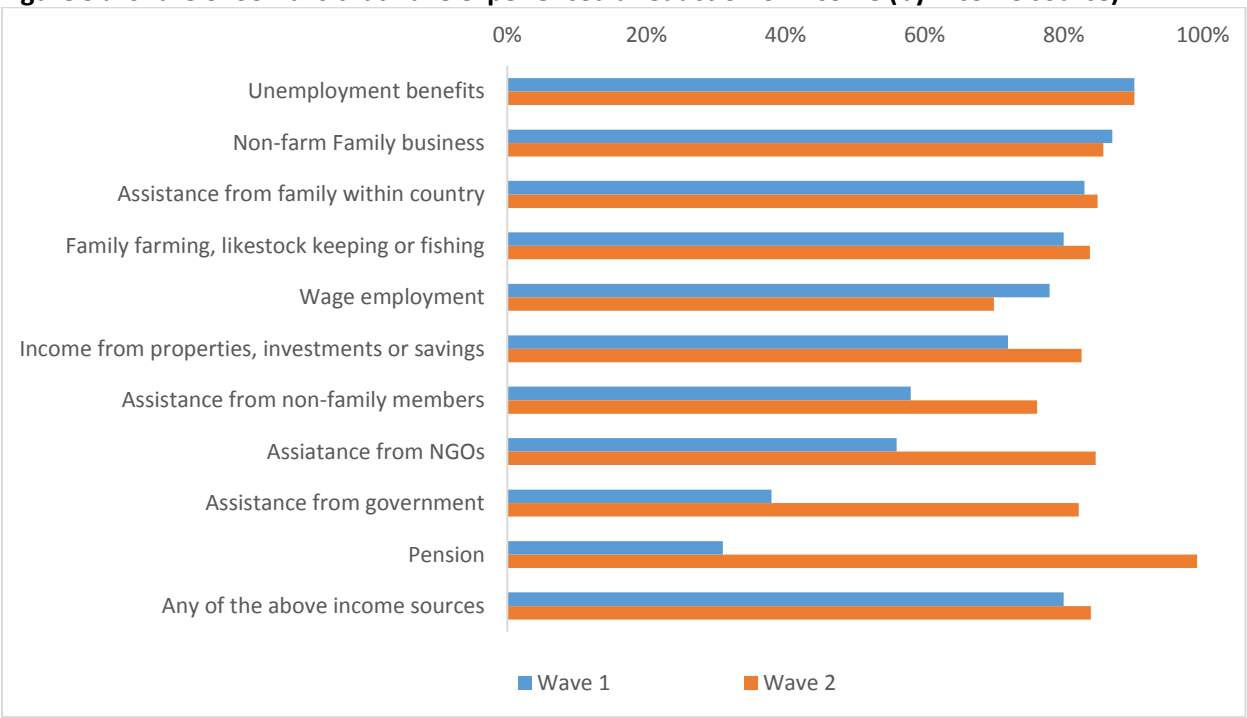


Figure 9b: Share of Somalis that have experienced a reduction of income (by income source)



Source: Somali High Frequency Phone Survey (SHFPS), January 2021
Notes: Wave 1 was conducted in June - July 2020 while Wave 2 was conducted in January – February 2021

Reforms in the financial sector are yielding results

Somalia continues to develop core institutions to support the economy's nascent financial sector. The Central Bank of Somalia (CBS) has made progress in licensing financial institutions. As of April 2021, 13 banks, 10 money transfer businesses (MTBs), and one mobile network operator (MNO) have been licensed under the Central Bank of Somalia Act (2012). CBS introduced modern payment system platforms were deployed in September 2020 to drive the national payment system.[13] CBS is also making progress in building greater international confidence in the domestic financial sector to support stronger links with the global financial community. However, Somalia missed its own internal deadline to deliver the National Risk Assessment (NRA) of December 2020. The NRA exercise is a whole of government self-assessment of money laundering (ML) and financing of terrorism (FT) risks. This is important for Somalia for greater integration of the Somali financial system to the global banking system which requires robust understanding of ML and FT risks. Having been admitted as a member of MENAFATF, it committed for an assessed by regional body in 2024 for compliance to international standards enhancing the fight against ML/FT. As such concerted efforts are being exerted by the authorities to ensure the NRA is completed as soon as possible and ensure that gaps and correction actions are implemented well ahead of the mutual evaluation exercise by MENAFAFT.

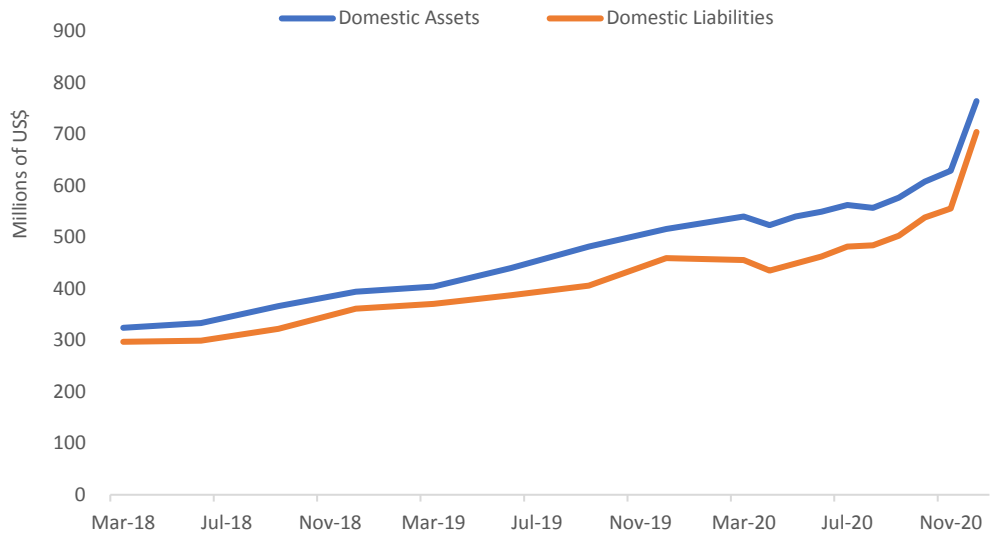
CBS is preparing to introduce a new legal national currency to replace counterfeit Somali shillings currently circulating in the economy. Even though the new currency will provide Somalia with a monetary policy lever, the operation is seen as paving way for financial inclusion of the poor and strengthening CBS supervision role of the financial sector. The lack of a legitimate local currency undermines the prospects for building household wealth and formal financial inclusion for a substantial proportion of the population as the absence of legitimate banknotes are high and disproportionately affect the poor and the vulnerable population. Key to the success of this initiative is political buy-in at the highest levels within FGS and Federal Member States (FMSs). The setting up of a national high-level steering committee for the currency exchange, which is planned to include FMS minsters of finance, is pending but preparation is underway. Speeding up committee setup is critical.

Domestic public confidence in financial institutions is being restored. Bank deposits continue to grow, by 53 percent in 2020, to US$659 million in December 2020 from US$430 million in December 2019 (Figure 10). This indicates increased confidence in the formal banking institutions by the public. There is more financing in the system than before, with bank credit to the private sector increasing by 6.5 percent, to US$219 million in December 2020 (from US$205 million in 2019). Nevertheless, commercial banks were more cautious of lending to the private sector during the pandemic and preferred to enter into joint ventures and partnerships with the private sector. Loans to firms and households (*'murabaha'* and *'qarad-hasan'*) declined in 2020, continuing a trend since early 2019. Meanwhile, the share of financing through bank partnerships and joint ventures (*'musharakah'* and *'mudadarabah'*) has grown steadily over the past several years—in March 2018 this was 11 percent; it reached 33 percent in December 2020. It increased by 47 percent, from US$50 million in 2019 to US$73 million in 2020. Despite recent progress, the CBS estimates that the banking sector meets only a small share of demand for credit and the levels of intermediation are modest relative Somalia's potential.

[13] The Somalia Transaction and Reporting System (STARS) and Somalia Payment Switch (SPS) systems were installed, tested and accepted using cloud hosting computing platforms.

The banking sector continues to be profitable. Total bank assets increased by 48 percent to US$821 million from 556 million in 2019. The growth was driven by cash in hand which more than doubled from US$117 million in December 2019 to US$285 million in 2020. The commercial banks portfolio of cash in hand increased its share from 21 percent in 2019 to 35 percent in 2020. Table 4 provides detailed banking sector performance in 2019-20. Domestic bank assets and liabilities dipped at the start of the pandemic (in April 2020) but recovered sharply (in May 2020), and significantly increased in December 2020 (Figure 10).

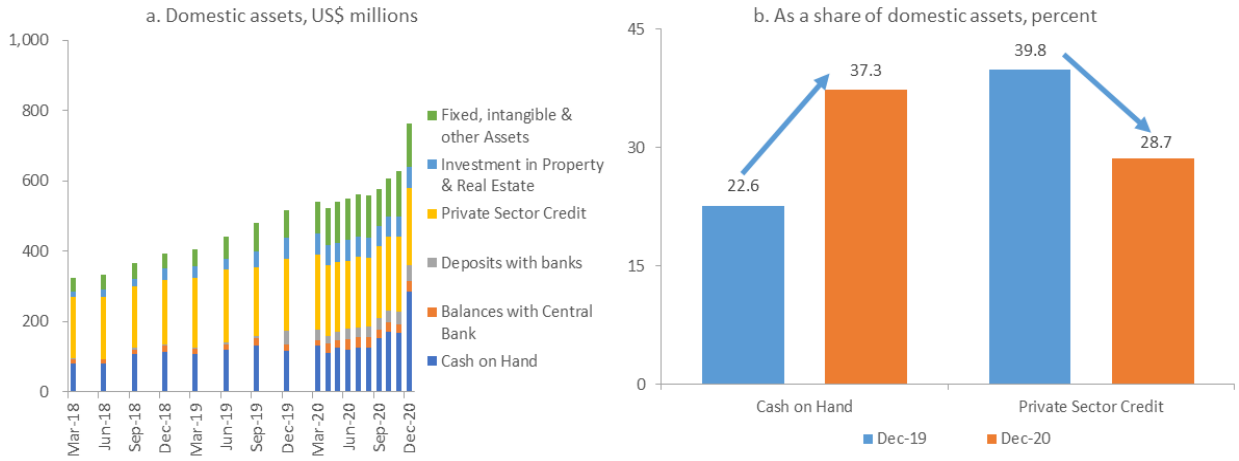
Figure 10: The banking system domestic assets and liabilities have grown significantly



Source: Central Bank of Somalia

The composition of domestic assets shows the banking system is risk averse. Somalia banking system is becoming more liquid as CBS reforms instill confidence in the banking system. However, the pandemic environment is associated with uncertainty and increased risks on economic performance and commercial banks became risk-averse preferring to hold liquid cash rather than lend to the private sector in 2020. The year 2020 depicts a worrying trend that begun in 2019 when the share loans to the private sector dropped from 47 percent in 2018 to 40 percent in 2019. This trend continued in 2020 when the share of loans to the private sector dropped further to 29 percent (Figure 11b). Cash in hand as portfolio in domestic assets increased from 23 percent in 2019 to 37 percent 2020 (see Figure 11a). This could be seen as a good stance based on the banking system's stability and profitability.

Figure 11: The changing composition of banking system assets, 2018–20



Source: Central Bank of Somalia database

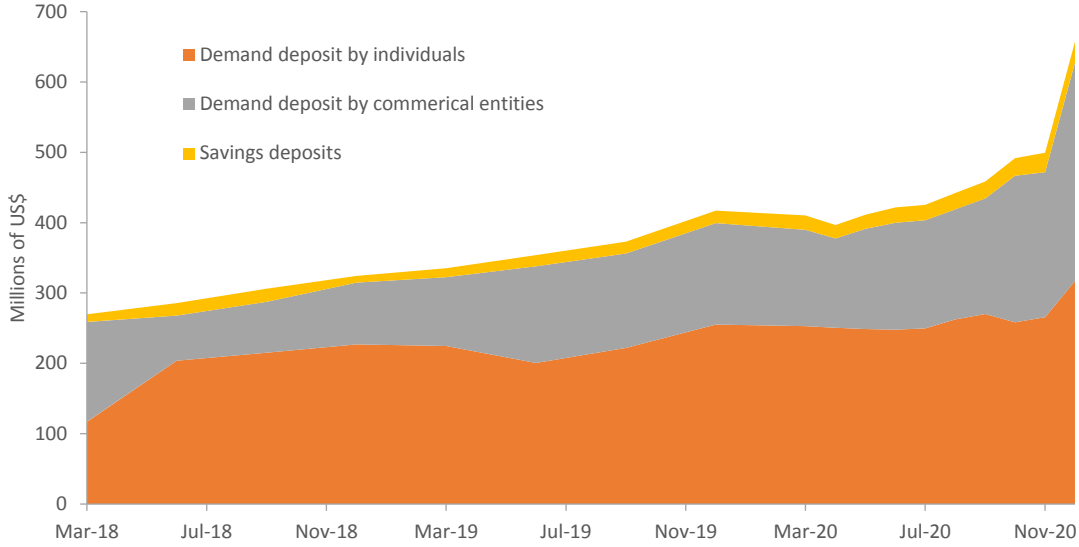
Table 4: Banking Sector Performance in Somalia, 2019–20

	Dec-19	Dec -20	Percentage change (year-on-year)
Balance sheet Items (US$ millions)			
Cash on hand	116.6	285.2	144.5
Credit to the private sector	205.6	219.0	6.5
Of which			
Financing assets	155.6	145.8	-6.3
Investment in equities (partnerships, joint ventures)	40.0	73.3	46.6
Investment in property and real Estate	59.69	60.83	1.9
Total assets	556.22	821.41	47.7
Customer deposits	430.12	659.34	53.3
Total shareholder's equity	96.97	117.12	20.8
Net profit after tax	1.21	(2.31)	-290.9
Non-performing financial assets	8.24	5.88	-28.6
Total capital (CBS/BS/REG/02)	86.31	100.54	16.5
Total net assets (CBS/BS/REG/02)	544.23	806.50	48.2
Ratios (percent)			
Nonperforming assets/gross loans	4.0	2.7	
Profit/equity	1.2	(2.0)	
Capital/assets	15.5	12.2	
Loans/deposits	47.8	33.2	

Source: Central Bank of Somalia

Customers deposits grew strongly despite the pandemic. Customer deposits grew by 53 percent to US$659 million in December 2020 compared to US$430 million in December 2019 (Figure 12). The reaction of customers when the pandemic started in March was to reduce their demand deposits. Demand deposits fell during the months of March to July 2020 and returned to pre-COVID levels in August 2020, implying that anxiety related to COVID-19 pandemic and lockdowns/mobility restrictions may have pushed customers' to prefer to have cash in hand. Conversely, saving deposits remained resilient despite the COVID-19 pandemic as customers increased their precautionary balances. After the relaxing of initial restrictions, households have increased their demand and savings deposits, because of lack of investment opportunities (wait and see attitude), while others they have become more cautious about their health and finances (forced and precautionary savings).

Figure 12: Customers deposits grew sharply in 2020



Source: Central Bank of Somalia

External sector vulnerability deepened

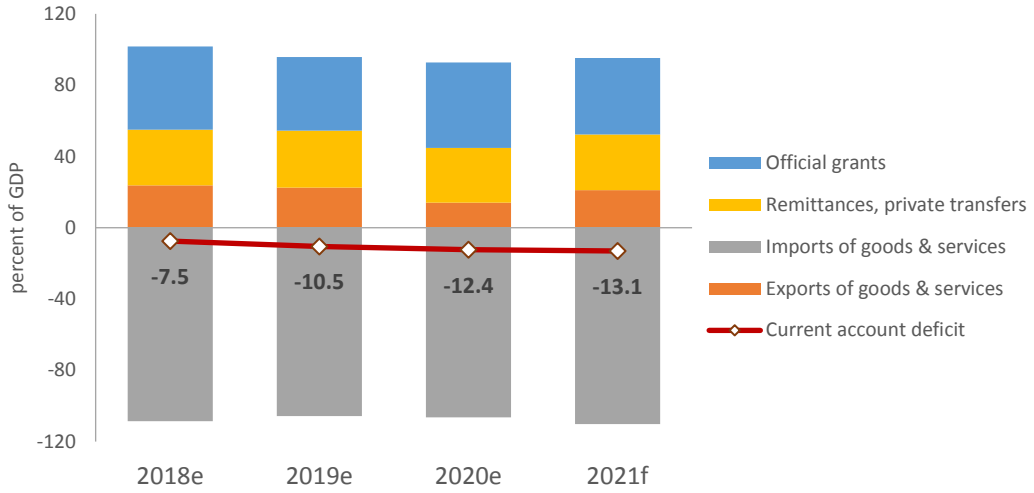
External balances deteriorated in 2020 because of the global pandemic. The current account deficit worsened to 12.4 percent of GDP in 2020 from 10.5 in 2019. A significant fall in exports, from 22.6 percent of GDP in 2019 to 14 percent in 2020 (Figure 12), was a primary cause (merchandise exports fell by 13.9 percent in 2020 according to CBS data). The unprecedented collapse in global travel caused reductions in Somalia's two exports—travel-related services and live animals. Somali livestock exports generally peak during the Hajj season, but this demand dried up in 2020 with Saudi Arabia's cancellation of the annual Hajj pilgrimage.[14] Although at the outset of the global pandemic many (including the World Bank) forecast that mobility restrictions and the global recession would cause a sharp drop in remittances to developing countries, remittances from the Somalia diaspora declining only marginally, falling to 30.8 percent of GDP in 2020 from 31.9 in 2019. Higher official grants helped finance the current account deficit. Reaching the Highly Indebted Poor Countries (HIPC) Decision Point in March 2020 restored Somalia's regular access to concessional grants from multilateral partners. As a result, official grants increased to 47.9 percent of GDP in 2020 from 41.3 percent in 2019. These grants helped the country to respond to the triple crisis.

Merchandise imports increased in 2020. Total imports increased marginally to 106.4 percent of GDP in 2020, from 105.6 percent in 2019. Merchandise imports increased by 3.8 percent in 2020 to US$3.8 billion from US$3.6 billion in 2019 (Figure 14a). Imports of medical products and oil products increased by 46.6 and 39.7 percent respectively in 2020. However, food products declined by 19.6 percent to US$1.2 billion in 2020, from US$1.5 billion in 2019 as supply routes were disrupted by COVID19 restriction and investors drew down the inventory. As a share of total imports, all categories of imports experienced growth except food and construction. The share of food in total imports fell to 31.1 percent from 40.2 percent, while construction share fell marginally from 11.2 to 11.0 percent during this period.

[14] Saudi Arabia severely restricts imports of Somali sheep and goats except during the annual Hajj pilgrimage.

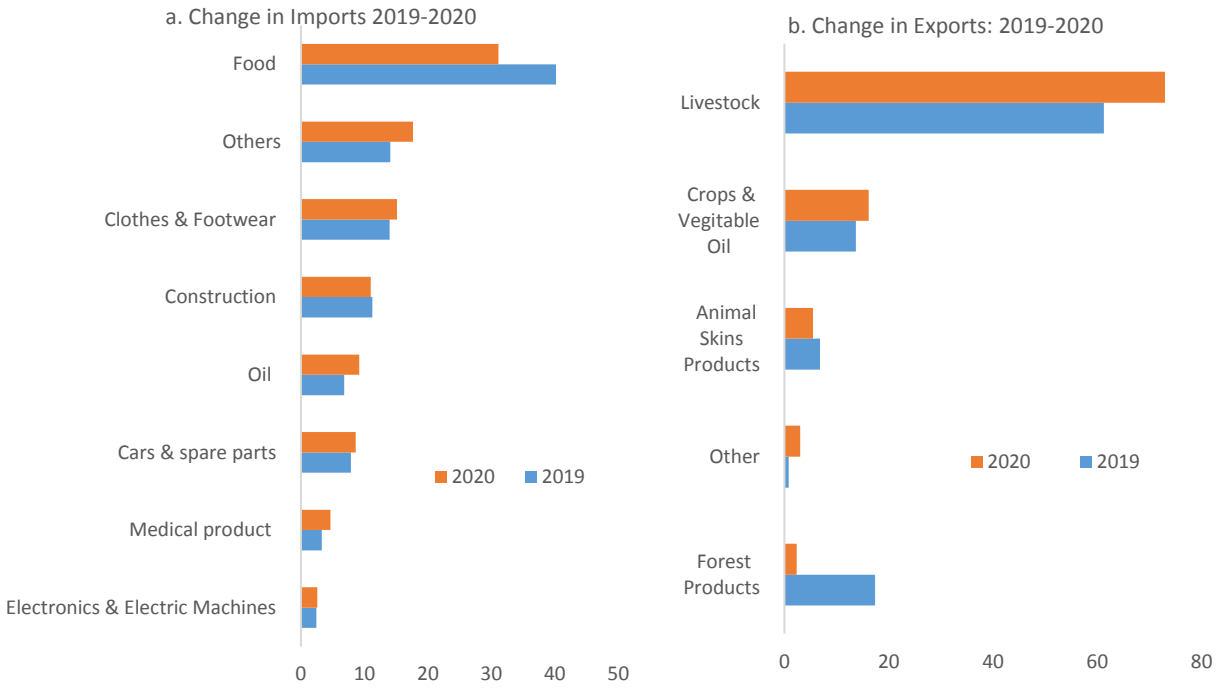
Merchandise export earnings contracted in 2020 as a result of COVID19 restrictions. According to CBS data**,** the value of exports declined by 13.9 percent to US$545 million from US$633 million. The decline in exports was a result significant drop in forest products which fell by 88.1 percent to US$12.7 million in 2020 from US$110million in 2019. The exports of livestock increased marginally by 2.6 percent to US$398million from US$388million. As a share of total exports of goods, livestock increased to 73.0 percent in 2020 from 61.3 percent while forest products declined to 2.3 percent from 17.4 percent in the same period (see Figure 14b).

Figure 13: The external position deteriorated in 2020



Source Central Bank of Somalia, IMF

Figure 14: Composition of exports and imports (share of the total)



Source: Central Bank of Somalia database

Public finances came under stress in 2020, necessitating large adjustments through a revised budget

Somalia's triple crisis increased pressure on public finances. Disruptions stemming from the pandemic reduced revenue collected by federal and state governments at the same time as they faced demands to spend more on health and disaster relief. As a result of reaching the HIPC Decision Point, the FGS mobilized new external grants to finance new social programs, emergency projects to address flooding and locusts invasion, and intergovernmental grants to the FMS and the Banadir Regional Authority. In June, MOF submitted a revised 2020 budget to the parliament to obtain authority for spending adjustments and to revise revenue targets. As will be discussed, estimates of the 2020 outturn show that FGS domestic revenue fell below the levels collected in 2019 and projected in the original 2020 budget, but outperformed the targets in the revised budget (Table 5Table 5). Large increases in external grants enabled the FGS to begin rebalancing public spending towards economic and social services. Revenue was nevertheless insufficient to support full execution of the ambitious revised budget, which required the FGS to cut discretionary spending on procurement of goods and services. This section of the Somalia Economic Update first analyses the 2020 fiscal outturn at the federal government and provides summary outturn at the FMSs. The subsequent section provides highlights of the 2021 FGS budget, including the quarter 1 outturn.

Table 5: FGS Fiscal Operations, 2018–21

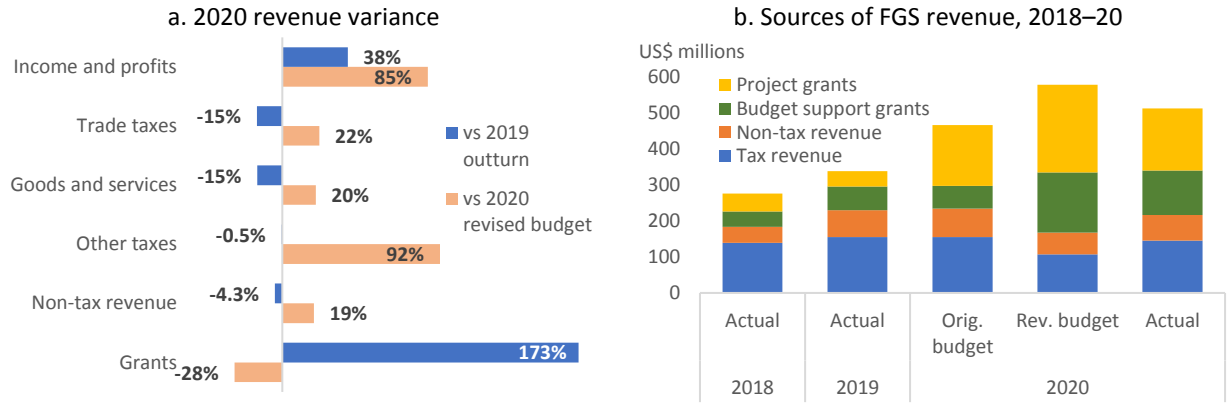
	2018	2019	2020			2021
	Actual	Actual	Orig., budget	Rev. budget	Actual (est.)	Budget
Revenue and grants	**276.2**	**337.8**	**466.2**	**578.1**	**506.8**	**680.5**
Domestic revenue	183.4	229.7	234.4	167.5	211.2	269.7
Tax revenue	138.9	154.7	155.5	107.0	139.5	182.9
Taxes on income, profits, property	8.6	11.7	11.3	8.7	16.2	13.8
Taxes on goods and services	22.1	25.0	27.1	17.8	21.3	30.0
Taxes on international trade	100.3	107.0	106.0	74.8	91.1	128.0
o/w import tax on khat	13.4	16.6	14.0	5.0	5.5	37.0
Other taxes	7.9	11.1	11.1	5.7	11.0	11.0
Non-tax revenue	44.5	74.9	78.9	60.5	71.7	86.8
o/w telecoms spectrum fees	..	8.7	12.6	12.6	1.7	12.6
Grants	92.8	108.1	231.8	410.6	295.6	410.8
Budget support	42.8	65.5	63.0	167.3	123.1	130.0
Project support	50.0	42.6	168.8	243.3	172.5	280.8
Expenditure	**268.5**	**315.7**	**476.2**	**696.6**	**494.7**	**680.5**
Recurrent spending	258.6	300.9	435.5	652.4	476.2	597.5
Compensation of employees	142.8	162.8	220.3	229.9	227.0	252.8
Use of goods and services	80.6	92.7	132.2	152.6	80.3	183.1
Debt service (incl. principal)	0.0	0.0	0.3	14.4	14.4	16.5
Grants (intergovernmental, etc.)	30.8	45.0	42.6	155.0	90.2	70.5
Social benefits	0.3	0.0	25.0	93.4	62.1	60.2
Other expenses	4.1	0.4	15.1	7.0	2.2	14.4
Capital spending	9.9	14.8	40.6	44.3	18.6	83.0

Sources: 2020 outturn data from MOF website (mof.gov.so/fiscal); other data from MOF 2021 budget documents.
Notes: Budget support above excludes disbursements from the World Bank's Recurrent Cost and Reform Financing Investment Project, which are shown as budget support in MOF tables.

Domestic revenue collection contracted but higher grants cushioned fiscal operations

FGS domestic revenue collection surpassed the revised target but was lower than the previous year's outturn. COVID-19 containment measures led to revenue shortfall across all streams except income and profits taxes, which grew by 38 percent albeit from a small base (Figure 15Figure 15a). Tax revenue exceeded the target in the revised budget by 29 percent and non-tax revenue (licenses, fees, and other charges) by 19 percent, but they fell short of actual collection in 2019 by 6 and 4 percent, respectively. The five-month airport closure halted the legal importation of khat from neighboring Kenya and Ethiopia accounted for around 85 percent of the drop in domestic revenue collection in 2020. Revenue from the import tax on khat declined by 67 percent compared to 2019, as there was no revenue collection from importation of khat in both quarter 2 and 3, and quarter 4 recorded only a dismal collection—12 percent of US$5.6 million collected in the same period in 2019. Telecommunications spectrum fees also severely underperformed in 2020. Due to challenges in introducing the new universal communications licensing framework, the FGS collected only $1.7 million in spectrum fees in 2020—only 20 percent of what it collected in 2018 and 14 percent of the 2020 target. Partially offsetting these declines, increased revenue from customs duties on petroleum imports and higher income from the port concession and overflight fees collectively generated US$9.9 million in 2020 than in 2019.

Figure 15: COVID-19 containment measures dampened revenue collection, but grants eased the pressure



Source: FGS MOF, 2020

Increased donor grants supported the country's response to the triple crisis and partially mitigated the drop in domestic revenue (Figure 15b). Total donor disbursements almost tripled, increasing by 3.7 percentage points in 2020 to reach 5.9 percent of GDP in 2020. Total budget support accounted for 42 percent of total donor grants in 2020, increasing by over US$100 million compared 2019, mainly through African Development Bank and World Bank reengagement grants provided when Somalia reached the HIPC Decision Point. As noted earlier, reaching the Decision Point also enabled the country to access much-needed financing for its response to the triple crisis. Disbursements for the Baxnaano program, emergency locusts response, and the crisis response projects accounted for almost all the increase in project grants between 2019 and 2020.

The FGS increased spending to meet crisis needs but underspent on procurement of goods and services

The FGS revised the 2020 budget to respond to the triple crisis. Total expenditure in 2020 rose to 9.9 percent of GDP in 2020 from 6.4 percent in 2019 (**Error! Reference source not found.**). The revised budget almost quadrupled the appropriation for cash transfers delivered to households through the Baxnaano Program. New expenditure on these social benefits accounted for 13 percent of total FGS spending in 2020. This was in addition to other new spending on social and economic services.

The budget allocated more funds to the health sector. The national response to COVID-19 crisis not only saw increase in intergovernmental transfers but also to FGS health sector. Even though health spending remains small, it more than doubled its 2019 level to account for 1.3 percent of the total spending. The COVID-19 crisis has exposed Somalia's weak healthcare system from critical infrastructure, personnel, access, and limited resources to response to any health-related shocks. This has highlighted the urgent need to strengthen the healthcare system and capacity to deliver services to the Somalis and improve existing poor health outcomes (See SEU Special Focus, Part II).

Finally, the FGS increased intergovernmental grants to subnational governments to offset revenue shortfalls due to the impact of the COVID-19 crisis. Total grants (including projects grants) reached 1.8 percent of GDP in 2020, from 0.9 percent in 2019, becoming the second largest expenditure after wage bill. The COVID-19 crisis has exposed the vulnerability of the subnational governments to manage their operations and is likely to create additional pressure as they become increasingly reliant on grants. Therefore, monitoring of subnational fiscal risks remain critical going forward.

Meanwhile, the FGS cut spending on procurement of goods and services in 2020. Actual 2020 spending on goods and services was 47 percent below the revised budget appropriation and 13 percent below actual spending in 2019. Several factors account for this. The decline between 2019 and 2020 actual spending is largely explained by public financial management (PFM) reforms in the security sector. Anchored in the 2017 National Security Architecture (NSArch) and the 2018 Operational Readiness Assessment, the government has implemented key reforms including biometric registration of all Somalia security forces - which allows verification of all payments including direct payments to individual accounts; enhanced human resources management system – which now connects the security sector payroll into the overall Somalia Financial Management Information System (SFMIS); and improved internal controls which includes logistics procedures and central purchasing contracts for major supplies in sector.[15] Similarly, at the beginning of 2020, the government started including security rations to the wages of eligible personnel, previously paid as "other general expenses" under use of goods and services.[16] The pandemic-related lockdown also contributed to the decline in spending: spending on rent and travel fell by 30 and 25 percent, respectively. Finally, spending fell short of the revised 2020 budget because execution of donor-financed and other projects was delayed. Under-spending on consultants, health and hygiene products (for COVID-19 projects), and specialized materials and services (including, for example, those needed for locust control) totaled US$39.3 million (53 percent of the total under-execution of goods and services spending shown in Table 5).

[15] 2020 Somalia Economic Update

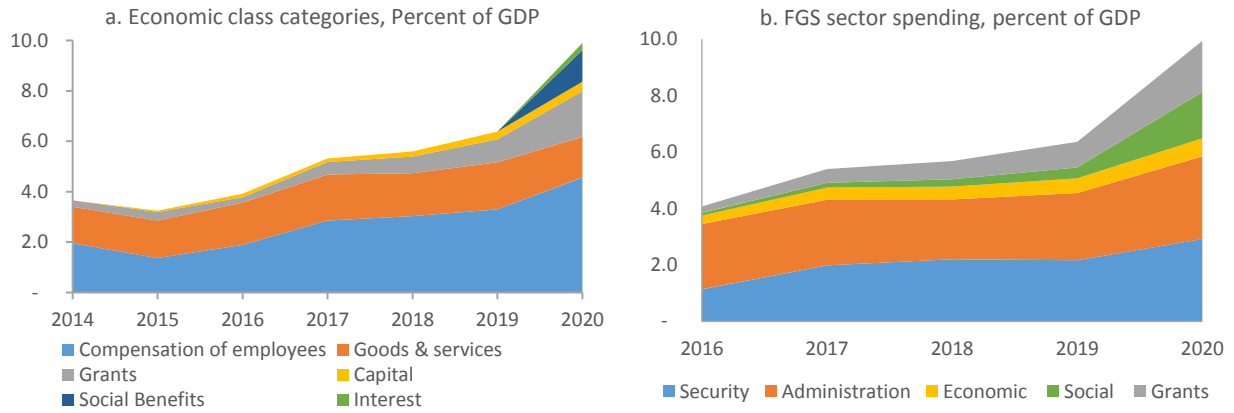
[16] Security sector spending on "other general expenses" alone fell by US$12.6 million in 2020. This exceeds the decline in total FGS goods and services spending of US$11.3 million across all sectors and goods and services.

Change and continuity in the FGS budget

Adjustments made through the revised 2020 budget introduced important changes to the composition of FGS spending. For reasons discussed above, the FGS initiated or expanded projects to address the triple crisis. Figure 16Figure 16b illustrates that these sharply increased the social sector's share of the budget, as well as spending on social benefits (which was nonexistent prior to 2020). Figure 16 also shows the steady increase in FGS spending on grants to subnational governments.

Nevertheless, security and administration continue to be the FGS's top spending priorities. Even if one excludes intergovernmental grants from the administration sector, total spending by these two sectors increased in nominal terms by 26 percent and the share of spending by these two sectors fell only to 48 percent in 2020 from 52 percent in 2019.

Figure 16: Composition of FGS spending, 2016–20



Source: Staff calculations based on IMF, MOF and World Bank data

The wage bill continues to absorb the lion's share of total expenditure (Figure 16a). It increased by 39 percent in 2020 to 4.6 percent of GDP from 3.3 percent in 2019; accounting for almost half of total spending. This is attributed mainly to the new and harmonized salary scales for both the Somalia National Army and the police force.[17] Administration sector wages increased by 14 percent, economic services by 25 percent, and social services by 13 percent. Both administration and security sectors account for over 80 percent of the total FGS wage bill.

Public investment spending remains low. Despite increasing by 25 percent in nominal terms in 2020, capital spending's share of spending fell slightly to 3.7 percent of total FGS spending in 2020 from 4.7 percent in 2019. Under-execution is also a problem, in addition to low budget allocations. Projects spent only 44 percent of the funds appropriated in the revised budget for capital investments.

Diversifying sources of revenue continues to be an urgent priority. Since its establishment in 2012, the FGS has made great strides towards rebuilding the legal and institutional framework for inland revenue administration.[18] The government is heavily dependent on revenue derived from international trade, transport, and travel—which, as the current global crisis underscores, are extremely vulnerable to shocks. These revenue streams accounted for 72 percent of domestic revenue in 2020 (only a modest decline

[17] The FGS also took over SNA stipend payments

[18] See Gaël Raballand and Justine Knebelmann, "Domestic Resource Mobilization in Somalia," (Washington: World Bank, February 2021).

from 76 percent in 2018).[19] Meanwhile, the FGS's reliance on external grants increased sharply in 2020 as a result of both reengagement with IFIs and the onset of the triple crisis, rising to 58 percent of total revenue and grants from 33 percent in 2019. Such heavy reliance poses a risk to fiscal operations and undermine budget credibility when these funds are not realized and/or disbursements are low.

Intergovernmental grants eased fiscal stress at subnational level especially among states with no ports

Domestic revenue performance was muted in almost all the FMSs in 2020. Tax revenue in Puntland increased by 15 percent over 2020, driven by taxes on goods and services and a strong rebound on trade taxes (

Figure 17a). However, grants offset underperformance in other revenue streams. In contrast, Jubbaland experienced 22 percent tax revenue shortfall with taxes of goods and services dragging performance by 50 percent compared to 2019 outturn. However, strong collection in trade taxes (17 percent higher than 2019) and grants eased the contraction. The newer states (SWS, GSS and HSS) benefited from increased grant financing as domestic revenue in these states remains very small.

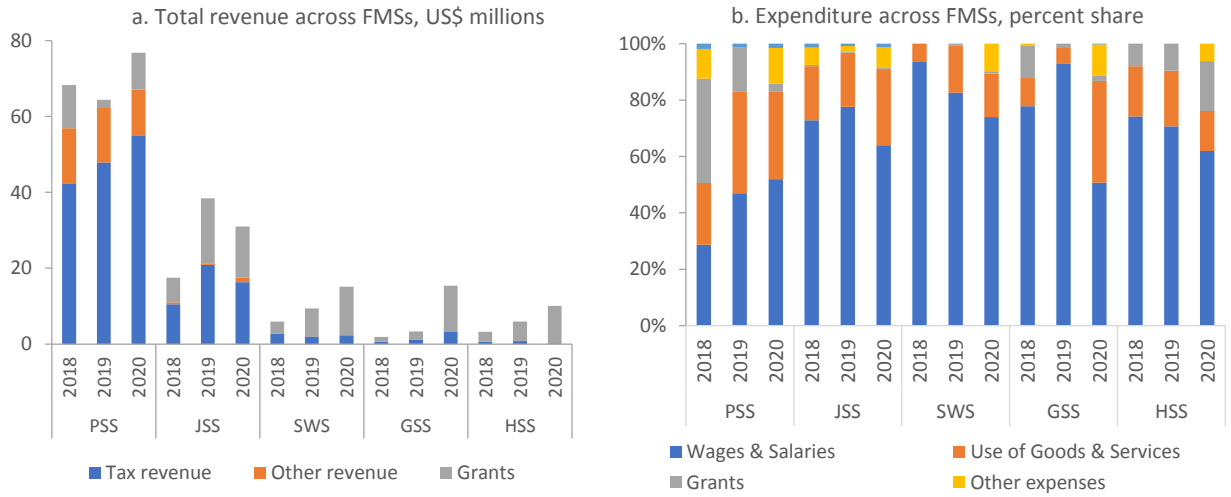
Expenditure pressure across all the FMSs increased in 2020 as COVID-19 global pandemic ravaged the country (

Figure 17b). Like the FGS, budgets in the FMSs are largely allocated the spending compensation of employees and use of goods and services, leaving no fiscal space for investments or service delivery.

[19] In addition to customs duties and other taxes on international trade, this figure includes harbor fees, overflight fees, stamp duty on customs, airport fees, and visa charges and passports.

The COVID-19 crisis has enhanced intergovernmental cooperation. Federal and subnational governments engaged in a coordinated national response at the onset of the COVID-19 pandemic in Somalia which saw increased mobilization of external assistance easing fiscal stress across jurisdictions. This continued coordinated effort is also evident in areas of budget planning, data sharing, and reporting. Federal and state ministers of finance stepped up their engagement in 2020 to plan a coordinated fiscal response to the crisis. They increased the frequency and improved the quality of data sharing – a much needed basis to support the coordinated response as well as to monitor results. Similarly, the federal ministry of finance has begun publishing a monthly consolidated (FGS and FMS) fiscal operations report on its website. With the country still battling the COVID-19 crisis including new waves, continued cooperation will be instrumental in (i) enhancing support for public health measures around prevention, early detection and treatment of COVID-19 cases, and; (ii) rapid deployment of the COVID-19 vaccine.

Figure 17: Expenditure pressure increased across the FMSs in 2020



Source: Staff calculations based on data reported by FMS finance ministries.

FGS 2021 budget: Rising fiscal challenges as the country faces multiple shocks and political uncertainty

The FGS 2021 budget was approved by parliament on December 29, 2020. It envisaged continued efforts to increase domestic revenue mobilization with the assumption that the COVID-19 crisis abates starting the fourth quarter of 2020 and the economy begins to rebound as well. While this assumption may hold

to some extent, Somalia, like other countries continue to battle the COVID-19 crisis, resurgence of new a wave in March 2021. This is worsened by projected weather-related shocks (continued locust infestation and suppressed GU rain season) and lingering political uncertainty related to the next general elections which could combine to slowdown recovery momentum.

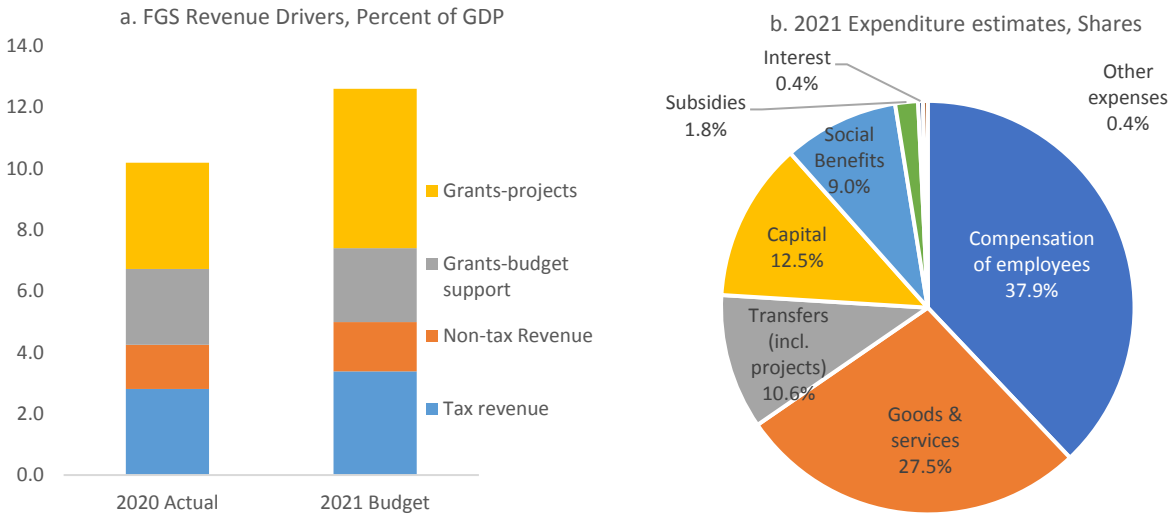
Increased expenditure needs amid slow revenue recovery

Domestic revenue is projected to increase by 28 percent to US$270 million, equivalent to 5 percent of GDP (Table 5). This is predicated on the outlook that revenue collection across all streams will rebound to 2019 levels with easing of COVID-19 containment measures and new proposed tax measures will boost collection by a projected US$30 million (Box 1). Trade taxes are expected to grow by 41 percent in 2021with anticipated rise in imports as economic activities pick-up in the post-COVID-19 recovery period. Similarly, importation of khat will resume as suspension of international flights has been lifted. However, supply chain constraints mainly with Kenya remain unsolved and threatens rebound in revenue collection under this stream. Taxes on goods and services is estimated to grow at the same rate, 41 percent as hotels, telecommunication, and electricity companies resume tax payments after previous suspension due COVID-19 crisis. Tax revenue on imported goods is expected to remain strong hence sustaining overall performance under this revenue stream. Furthermore, nontax revenue will grow by 21 percent pegged on sustained growth in harbor fees, resumption of airports and overflight fees collection, and rebound in telecommunication spectrum fees and administrative charges.

Box 1: FGS proposed tax measures are expected to yield about US$30 million in 2021

- Increase khat tax rate per bundle from US$2.5 to US$4
- Additional charge on petroleum products (yielding additional US$1.9M)
- Temporary COVID-19 tax relief measures (lower rates on rice, dates & flour) to be removed
- COVID-19 increased rates on tobacco, plastic bags & cosmetics to continue
- Resumption of full rate collection on electricity sales tax as at Jan. 1, 2021
- Rental collection expected to increase due to automation

Figure 18: FGS domestic resources are expected to recover; expenditure priorities remain the same



Source: FGS 2021 Fiscal Year Budget Act No.00017/2021
Notes: Subsidies consist of financing provided by the Gargaara Facility to MSMEs.

The government proposes to spend US$666 million in 2021, about 12.3 percent of GDP and 35 percent higher than 2020 outturn (Table 5). The expenditure is expected to be driven by year-on-year revenue growth estimated to reach 12.6 percent of GDP, 2.4 percentage points higher than 2019 (Figure 18a). The budget anticipates a 39 percent increase in donor grants, which could finance up to 60 percent of the total expenditure, mainly dominated by projects grants at 41 percent and budget support at 19 percent. Over-reliance on donor grants, particularly budget support, to finance operations could prove risky in 2021 due to the prevailing political environment.[20]

Wage bill and use of goods and services still dominate FGS spending. These two categories will account for 38 percent and 27.5 percent of the total budget respectively in 2021 (Figure 18b). The wage bill is expected to increase by 10 percent compared to 2020 outturn, owed mainly to wage adjustments in the security sector (SNA and police force, among other MDAs). Use of goods and services is estimated to more than double its level in 2020, reflecting anticipated donor projects expenditure under this category. Grants to subnational governments are expected to return to their 2019 levels in 2021—US$41.3 million, representing 6.2 percent of the budget. Project grants, mainly for public works, water, and crisis response programs, account for 4.4 percent of the total budget, bringing total transfers to 10.6 percent of the total budget. Social benefits introduced in 2020 is projected to relatively remain at the same level, 1.1 percent of GDP. Capital spending is expected to quadruple to 1.5 percent of GDP from 0.4 percent in 2020.

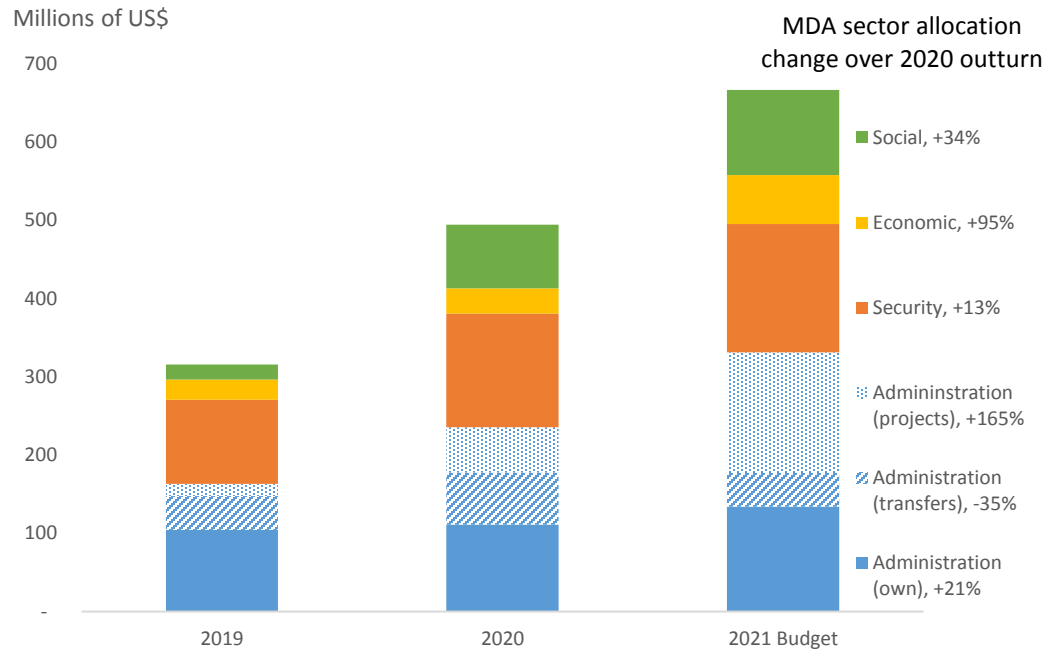
Security and administrative services are the biggest gainers in the 2021 budget and will continue to constitute the largest share of the budget. Spending in administration sector is set to increase by 21 percent and in security by 13 percent (Figure 19). Economic sector spending will more than double its level in 2020, an increase of 95 percent. This will be driven by increased spending spread across water, energy, urban development, and road infrastructure. Donor projects are increasingly playing a critical role

[20] The country is experiencing growing political tension over the delayed elections scheduled to have taken place in 2021. The current administration term expired on February 8, 2021. The international partners have warned that they would reconsider their bilateral relations with Somalia—including diplomatic engagement and financial assistance—if the election impasse was not resolved quickly.

in enhancing public service delivery and strengthening government institutions. Overall donor projects' commitments now account for 36 percent of the total budget, mainly in administration, economic and social sectors.

The budget proposes to sustain increased pro-poor spending in social protection, health, and education, mainly through donor funded programs (Figure 19). Social sector spending will increase by 34 percent comprising largely of continued support to poor and vulnerable households through (i) the Baxnaano Program, cash transfers in response to the locusts threat, (ii) Somalia Crisis Recovery Project, and (iii) health and education support through the Recurrent Cost and Reform Financing Facility. As the country continues to battle the COVID-19 crisis, health sector spending is estimated to reach 5 percent of FGS total expenditure, increasing over 5 times though from a small share of 1.3 percent in 2020. Resourcing the sector will remain critical in the medium term with uncertainty surrounding the end of the COVID-19 crisis as well as rebuilding and strengthening the weak healthcare system. Education sector expenditure is expected to almost triple to US$40 million (equivalent 6 percent of the total budget) from US$14.3 million in 2020.

Figure 19: FGS expenditure is set to increase across all sectors in 2021



Source: Staff calculations using data from the FGS Appropriation Act, 2021

Challenging times ahead: Quarter one performance is characterized by domestic revenue shortfall unlike previous years as donor environment becomes unpredictable

Implementation of the 2021 FGS budget is facing pressures associated with lingering political uncertainty and the second wave of COVID-19 infections. Domestic revenue collection has declined substantially in the first quarter, 13 percent compared to similar period in 2020 (Table 5). Nontax revenue contributed to the major decline, by 45 percent during this period, driven by dismal to virtually no collection in overflight, passport, and telecommunication spectrum fees depicting slow-pick up in activities in the aviation sector, continued COVID-19 surge, and protracted political climate . Rebound across all other revenue streams cushioned the shortfall. In particular, trade taxes have picked up to

record a positive growth of 2 percent compared to the same period in 2020. This is attributed to rising demand for imports with gradual rebound of economic activities. However, tax revenue from importation of Khat remained subdued as supply chain constraints persist. Overall, the preliminary data shows that if monthly collection is sustained, annual outturn will reach the 2020 level, just over US$200 million hence, the projected growth of 28 percent unlikely to be achieved. The challenging fiscal situation is exacerbated by lower donor grants, particularly expected multilateral budget support which did not materialize in quarter one, leaving only earmarked projects grants and small share of bilateral assistance to supplement fiscal operations.

Expenditure was higher in quarter1 compared to similar period in 2020, driven by compensation of employees (Table 6**).** Actual expenditure reached 12.8 percent of the total approved budget. Wages and salaries accounted 8.4 percent – 31 percent higher compared to similar period in 2020, good and services 2 percent, and intergovernmental transfers 1.4 percent, but has fallen during this period in line with lower allocated amounts in the overall budget.

Table 6: FGS Revenue and Expenditure Outturn, first quarter 2020 and 2021

Item	2020 Q1 (millions of US$)	2021 Q1 millions of US$)	Percentage change (year-on-year)
Total revenue and grants	**122.4**	**76.9**	**-37**
Domestic revenue	59.5	52.0	-13
Tax revenue	36.1	39.1	8
Taxes on incomes and profits	2.4	3.0	26
Taxes on goods and services	5.0	5.8	16
Taxes on international trade	26.1	26.5	2
Other taxes	2.6	3.8	45
Nontax revenue	23.4	12.8	-45
Grants	62.9	25.0	-60
Total expenditure	**67.4**	**85.5**	**27**
Recurrent	65.9	83.7	27
Compensation of employees	42.7	56.1	31
Use of goods and services	8.8	13.7	55
Interest and other charges	1.5	4.2	181
Grants (intergovernmental, etc.)	12.9	9.6	-25
Social benefits	-		
Other expenses	-	0.1	
Capital	1.5	1.8	18

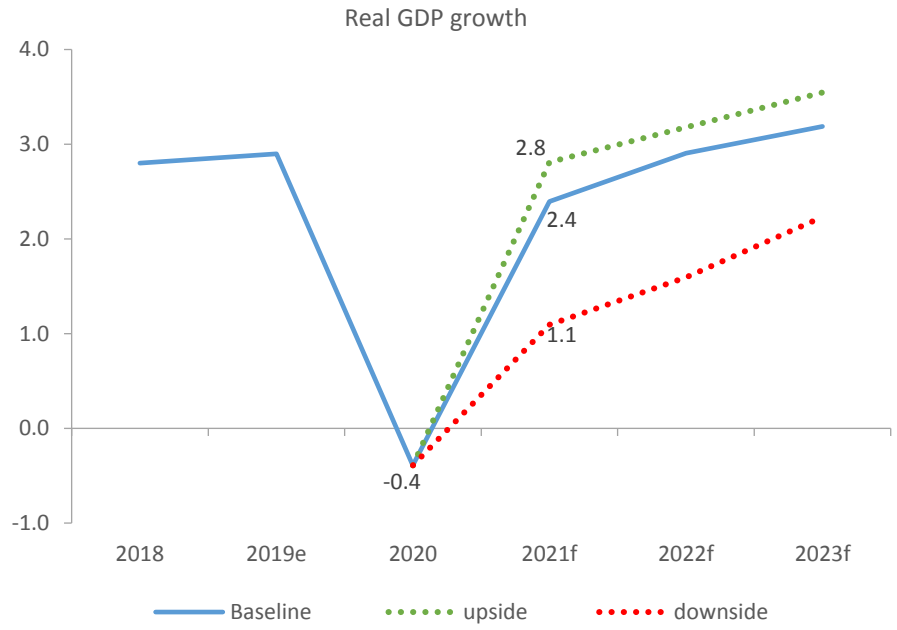
Source: FGS MoF

Medium-Term Outlook, Risks and Challenges

Somalia is emerging from the triple shocks of 2020

The economy is expected to enjoy a moderate recovery over the medium term. Real GDP is forecast to grow by 2.4 percent in 2021 in the baseline scenario, accelerating slightly in 2022–23 (Figure 20). As economic activities gain momentum, growth will reach pre-COVID-19 levels of 3.2 percent in 2023. The baseline scenario assumes Somalia will weather the pandemic without the need to reimpose the stringent lockdowns and serious travel restriction that were lifted in August 2020. It assumes a slow update of vaccinations due to hesitancy (even though vaccines are available under COVAX facility).[21] It assumes a gradual pick-up in economic activities and businesses and firms gradually return to their normal levels of sales—enabling steady recovery. It also assumes that there is continued support to firms and vulnerable households through the Gargaara lending facility and Baxnaano programs. Recovery in remittances will help firms' recovery and boost households' incomes and export demand will rebound. It also assumes no further climatic shocks affecting mainly the agricultural sector during this period.

Figure 20: Economic recovery will be moderate in 2021 and in the medium-term



Source: World Bank Staff Estimates, 2021

The baseline scenario projects a rebound in household, domestic investment, and export demand. Gradual pick up of economic activities began with the easing of the COVID-19 lockdown restrictions in August 2020, private consumption improving, exports demand increased, and businesses began to stabilize. Private consumption, the main driver of Somalia's GDP, is projected to grow at 2.8 percent in 2021 and 3.3 and 3.5 in 2022 and 2023 respectively. With the modest recovery, per capita private consumption is projected to stagnate in 2021; this trend is expected to continue in the medium term. Government consumption is anticipated to increase albeit marginally as political uncertainty lingers, in line with expected recovery in domestic revenue collection, and external grants assumed to continue

[21] It is assumed 500,000 vaccination in 2021 and 700,000 in 2022

unhindered. Private investment is expected to pick-up in 2021 with planned investments in sectors such as energy, ports, and the financial sector, promising to gradually reinvigorate the economy as the COVID-19 crisis abates. Recovery of agricultural productivity will improve households' incomes and food security as well as increase exports supply. Easing of the COVID-19 containment measures will continue to boost export demand and higher growth in remittances will improve household incomes and investments.

Inflation is assumed to remain low. Inflation decline to about 2.5 percent in 2021, from 3 percent in 2020. De facto dollarization continues to provide relative price stability, particularly given Somalia's dependence on imports. In the baseline scenario it is assumed that growth of the agriculture sector is moderate, reducing domestic inflationary pressure.

The external sector will remain vulnerable in the medium-term, however. The current account deficit is forecast at 13.1 percent of GDP in 2021 and projected to steadily narrow over the medium term, at about 12.7 and 13.0 percent of GDP in 2022 and 2023. This will be driven by Somalia's high import needs, higher oil prices, and reflecting the high level of grants and remittances. Moreover, the import basket will gradually include a greater share of investment goods as recovery picks up. Nonetheless, stronger exports demand amid improved economic activity and global environment, can ease external vulnerability.

Risks to the outlook are mainly on the downside

The medium-term outlook remains highly uncertain and will continue to be subject to risks from political uncertainty related to the upcoming elections, possible deterioration of the security situation, lingering impacts of COVID-19 crisis, and climate-related shocks. These risks can impede economic activity and reverse the growth recovery in the baseline scenario.

Somalia political environment remains uncertain. The general elections were to be held early 2021 (before the expiry of the current administration's term on February 8, 2021) in accordance with the Provisional Federal Constitution. However, the disagreements among political actors have delayed the elections and raised political divisions across Somalia with increasing tensions and insurgence activities. Hence, the current political climate could reverse the steady progress and reform momentum that the country has achieved since 2012. If agreements on electoral modalities are further protracted, there may be waning support from the international community to provide official development assistance at levels comparable to 2019 and 2020. Growth in 2021 may be weaker if external financing conditions tighten and political tensions escalate.

The ongoing insurgency in Somalia is delaying and dampening growth prospects. Although Somalia's economy remains stable, simmering conflict continues to pose risk to economic activity. Terrorism attacks by Al Shabaab continue to threaten security situation in Somalia and may be heighten by the current political environment. Terrorist activities have scared away both domestic and foreign potential investors and tilted FGS priority spending towards security.

Weather-related shocks add more risks to the outlook. Weather and climatic shocks could lower agricultural output (both crops and livestock), exacerbate water stress, and increase Somalia's humanitarian needs. Higher oil prices could hurt Somalia's economic prospects by increasing its import bill and worsening its already vulnerable external sector.

Resurgence of COVID-19 crisis would hurt the growth outlook. The pace of recovery in 2021 is expected to be subdued, reflecting the lingering disruptions to activity from an earlier second wave of COVID-19 and the emergence of more contagious variants of the virus. The success of the vaccine rollout in Somalia

depends crucially on the distribution infrastructure that the authorities and international community manage to put in place and citizens' willingness to be vaccinated. If supply and distribution issues continue, Somalia will struggle to reach herd immunity before the end of 2023, leaving the country exposed to new, more virulent strains of the disease, and raising the prospect that COVID-19 crisis will become a permanent, endemic problem in the country. Notwithstanding, growth in 2021 may be weaker if the pandemic is prolonged.

Reflecting these risks and the uncertain environment, this Somalia Economic Update presents two scenarios for the medium-term growth outlook:

In the downside scenario, the economy would grow at 1.1 percent in 2021, increasing to only 2.2 percent in 2023. This is premised on an upsurge in COVID-19 cases, suppressed rainfall and prolonged locusts' threat, and deterioration of the political climate. The mutation of COVID-19 variants and new waves are likely to force the government to revert to lockdown and mobility restrictions to tame the virus thereby constraining recovery of economic activities. Secondly, early warning systems point to a possibility of below average rainfall including worse drought conditions and continued threat of locusts' invasion. This will affect crop and livestock production, agricultural labour demand, and likely increase in food imports. Delays in lifting restrictions exacerbate the slowdown in consumption expenditures, and weather-related shocks will be more severe than in the baseline scenario. Lastly, the delaying elections beyond 2021 as constitutionally mandated is likely to create political tensions leading to increased insecurity and insurgence activities. This will affect economic activities and erode business confidence. External assistance is assumed to decline in this scenario.

In the upside scenario, growth will be more robust, at 2.8 percent in 2021. This is anchored on improved weather conditions, no further COVID-19 restrictions, and the election impasse is resolved. Economic recovery be robust in 2021 if rainfall is adequate with less floods, no lockdowns and mobility restrictions, and the current social protection programs are expanded to include vulnerable households in urban areas. The scenario also assumes the current election impasse is resolved and elections is held in 2021. As a result, the economy will grow at 3.2 percent and 3.5 percent in 2022 and 2023 respectively.

Policy Options for Economic Recovery

The COVID-19 global pandemic exposed the costs of not investing in a public health system. The near-term economic prospects for the Somalia depend on the pandemic's path. Added spending to contain the pandemic will necessarily come at the expense of other budget priorities, including vital spending on other key health areas and much-needed capital investment. The need for additional public spending on health, not only to scale up the resilience of local health systems and public infrastructure is key in supporting the testing and tracing, but also to ensure that the logistical, administrative, and financial requirements of mass vaccination are in place. The slower the pace of vaccination and larger the unvaccinated population, the greater the possibility that new variants of the virus will develop, adding to the prospect of a more protracted pandemic in the country.

Building a sustainable, resilient, and inclusive economy. With limited fiscal space, Somalia needs to prioritize reforms that boost resilience to future shocks, and that emphasize sectors with the greater return on growth and employment. Accelerating the pace of poverty reduction will require policy interventions to raise productivity, create jobs, and expand pro-poor programs. Such interventions could include increased remittances, expansion of social protection programs, increased agricultural productivity and increases in public investments. Creating a better investment climate is key. Reform

initiatives to improve the country's business climate and attract more private investment should now be urgent for the post-election government. These reforms could include reducing the cost and improving the reliable of electricity, leveling the playing field among the private firms (new and old entrants into the market), aligning the treatment of firms in the formal and informal sectors, reducing red tape, and broadening financial inclusion. As Somalia embark on the road to recovery from the triple shocks, these structural reforms will enable jobs to be at the center of policy action and private sector response.

Supporting vulnerable population. The Baxnaano Programme has highlighted the importance of being able to channel support quickly and efficiently to those most in need during the COVID-19 crisis and after the locusts infestation. Extending the reach and responsiveness of such social protection programs through the innovative and cost-effective use of mobile money, electronic cash transfers, and virtual engagement is key in supporting Somalia's vulnerable population. Building on the Baxnaano Programme to further enhance the safety nets in Somalia is key. This could be done by adopting national social safety net strategy, which clearly sets out target populations and delivery mechanisms, and is capable of being scaled up rapidly in response to economic shocks or reforms.

Increasing exports of current products. In the short to medium term, Somalia's trade strategy should focus on increasing exports of products in which Somalia currently has a comparative advantage. Although most of these exports are primary products (like live animals and vegetables), other manufactured products (like fish oil and processed fish) on the lower end of the complexity spectrum seem feasible given Somalia's capability stock. These products are within Somalia's current reach; fostering them would increase manufacturing skills that are a prerequisite for accelerated diversification into more sophisticated products. This strategy can lay the foundation for acquiring the more sophisticated technical skills necessary for large-scale manufacturing. (see World Bank 2021).

Part II: Resilient Health Systems for Somalia's Economic Growth

The Case for Investing in Health

This issue of the SEU focuses on Somalia's health sector as an essential component of resilient and inclusive development, while further strengthening the country's nascent federal system and institutions. There is severe underinvestment in Somalia's health sector relative to other sectors of the economy. Health spending accounts for just 1.3 percent of total government spending compared to the security sector which accounts for 29 percent of total government spending, education which accounts for 3 percent and civil aviation which accounts for 2 percent of total government spending. Health spending in Somalia also trails the Abuja target of at least 15 percent of the total government budget.[22] This section will highlight the need for increased investment in health as a significant economic priority.

The COVID-19 pandemic has highlighted the urgent need to strengthen Somalia's health system as a national economic and security priority. As of February 2021, Somalia reported 4,814 confirmed coronavirus cases and 132 deaths. With less than 27,000 tests conducted and only 15 ICU beds for a population of 15 million people, the government's capacity to adequately test, trace, and report cases of COVID-19 infections and deaths is limited, suggesting that the COVID-19 fatality rates are higher than reported. The Government's response to the COVID-19 pandemic also suggests that Somalia is among the least prepared countries to detect, manage, and report disease outbreaks to prevent their global spread. The ability to manage epidemics is often linked to civil unrest, political instability and ultimately a weakened economy,[23] demonstrating that investing in the Somali health system is not only an urgent political and economic consideration, but also foundational to reducing fragility and enhancing economic development.

Investments in health are inextricably tied to Somalia's long-term economic growth and development. Healthier workers are more innovative and productive. Improvements in life expectancy tend to make people more forward-looking, which incentivizes saving for retirement and physical capital accumulation, contributing to improved labor productivity and economic growth. In low-income countries, it is estimated that an increase in life expectancy from 50 to 70 years will increase GDP per capita by 1.4 percent.[24] In Sub-Saharan Africa (SSA), it is estimated that improvements in labor productivity resulting from better childbirth practices and treatment and prevention of high-burden infectious disease would result in regional GDP increases of 0.2 percent annually.2 As communicable diseases, reproductive, maternal and neonatal disorders are responsible for most of the premature deaths in Somalia, highly cost-effective investments in reducing DALYs caused by communicable, reproductive, maternal and child heath disorders will be key to Somalia's long-term economic growth.[25]

Investments in quality and reliable health service provision will enhance the visibility of the government, demonstrate the state's governance capacity, and reinforce its legitimacy. The provision of public goods and services offers a fundamental pathway to stabilization, reconstruction and nation-building in fragile post-conflict environments. Service provision contributes to stabilization and nation-

[22] In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15 percent of their annual budget to improve the health sector. Source: World Health Organization (2011). The Abuja Declaration: Ten Years On.

[23] Price-Smith A., (2002). The health of nations: infectious disease, environmental change, and their effects on national security and development. Cambridge, MA: MIT Press; 2002.

[24] Barro (1996). Determinants of economic growth: a cross-country empirical study.

[25] The World Health Organization defines an intervention as cost-effective if it costs less than the country's gross national income (GNI) per capita.

building by legitimizing the role of Governments. Enhanced legitimacy will then lead to a self-enforcing cycle of increased sociopolitical stability and improved service provision, facilitated by the government's bolstered role.[26]

Investing in the health sector will increase economic opportunities, especially for women whose labor force participation has far-reaching implications for Somalia's human capital growth.[27] Around the world, the health and social services sector employs more women than any other sector. In SSA, 65 percent of all nurses are women. Investing in the health sector provides an opportunity to increase female labor force participation in Somalia where just about 7.4 percent of all women aged 15–49 have some form of employment.[28] Investments in health can catalyze women's economic empowerment with several downstream effects on human capital accumulation, especially during childhood, and help promote equitable, inclusive and sustainable economic growth.[29][30]

Taken together, investments in health will set Somalia on a path to reaping substantial demographic dividends from improvements in the life expectancy and reductions in the fertility rate. Persistently high fertility contributes to maternal mortality, household poverty, childhood malnutrition and lower workforce participation among women. There are substantial benefits to having smaller family sizes both at the micro and macro levels. At the household level, families will face continuing challenges to ensure that their children are educated, nourished, and healthy, in an environment where several generations are deprived of access to basic services. At the national level, Somali authorities will continue to face enormous pressure to educate additional cohorts of schoolchildren, and the rise in demand for health and social services will further outstrip the capacity of the fragile systems in the country. Somalia's high dependency ratio (97 percent) indicates a low working share of the population.**Error! Bookmark not defined.** A recent study finds that a one percentage point reduction in the child dependency ratio is associated with a roughly 0.4 percentage point drop in the poverty headcount rate.[31] This underlines the economic importance of investments targeted at reducing fertility rates and improving female labor force participation.

The Special Focus of this issue provides an overview of the Somali health sector, with special emphasis on: i) health outcomes in Somalia; and ii) the major system bottlenecks faced by the health sector and how they affect the efficiency of the health system, service utilization, and outcomes. Chapter 3 provides a set of recommendations on how the Somali health sector can be strengthened to better respond to the country's health needs over the short to medium term.

The Current Situation with the Somali Health Sector

Building a responsive, fair, and efficient health system through coordination

Following Somalia's independence in 1960, the country had a rudimentary but functioning health system, which achieved several important milestones. By 1970, two nursing schools had been established - one in Hargeisa, and another in Mogadishu. A faculty of medicine and surgery was established in Mogadishu in 1973 to boost human resources for health. By the mid-1970s, primary health

[26] Brinkerhoff et al., (2012). Service delivery and legitimacy in fragile and conflict-affected states: Evidence from water services in Iraq. Public Management Review, 14(2), 273-293.

[27] World Health Organization (2016). Women's contribution to sustainable development through work in health: Using a gender lens to advance a transformative 2030 agenda

[28] World Development Indicators

[29] International Monetary Fund (2017) Invest in women and prosper. *Finance and Development. Vol (54)*

[30] World Bank (2018) To build human capital, prioritize women's empowerment. *In Africa Can End Poverty*

[31] Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change, World Bank Group, 2016.

care had been introduced with the help of the Finnish International Development Agency (FINIDA). As of 1977, Somalia eradicated the smallpox disease, becoming the final country to report a naturally occurring smallpox case. These achievements resulted in further inflow of foreign assistance, which helped to establish medical training institutions with emphasis on respiratory diseases.[32]

Decades of political instability and prolonged conflict destroyed health infrastructure, leading to a deterioration in health outcomes of the Somali people, particularly among women and children. Prior to the military regime of Siad Barre in 1969, private medical practice existed concurrently with public healthcare. However, the socialist government ended private medical practices in 1972, which reduced the quality of care as health workers grew increasingly dissatisfied with government wages. [33] Sustained conflict between 1991 and 2012 destroyed the health system, sanitation, and safe drinking water systems, creating fertile grounds for a rise in infectious disease. Women and children are most affected, as Somalia has one of the highest fertility rates in the world, while maternal and child health services barely exist. The high burden of communicable, reproductive, maternal, newborn, child and adolescent disorders highlights the need for immediate investments in health to focus on reproductive, maternal and child health services as well as enhancing surveillance, prevention and treatment of preventable infectious diseases.[34]

Out of the conflict, a vibrant private sector emerged, but significant health needs remain unmet. At least 60 percent of health services and 70 percent of Somalia's medicines are estimated to be delivered by the private sector, concentrated in urban areas.[35] However, Somalia's private sector is informal and unregulated due to constraints on the government's regulatory capacity.35 As a result, there are no quality and safety standards in place for health services or pharmaceutical products in Somalia. In such an environment, the full potential of the private sector is not realized as the supply of unsafe health services undermines efforts to improve health outcomes. While the private sector has no formal organization, several private sector networks have emerged to coordinate private sector health providers in the country.

Alongside Somalia's large private sector, a multiplicity of non-Governmental organizations emerged providing humanitarian health services. Numerous international and national non-Governmental organizations provided health services, with funding sources ranging from donor organizations, the diaspora, and other private sources. Exact numbers of NGOs providing humanitarian health services are not available and the sector is fluid, with organizations leaving and new actors emerging. While there is limited coordination of the humanitarian health sector, the UN health cluster system provides some coordination.

Government health service delivery is limited in Somalia. Puntland and Somaliland manage some health services on a limited basis. The FGS delivers some hospital services in Mogadishu. The overwhelming majority of health services are delivered by NGO.

In 2013, the Joint Health and Nutrition Program (JHNP) and the Health Consortium for Somali People began implementing an essential package of health services (EPHS), coordinating donors and NGOs to

[32] Qayad, M. G. (2008). Health care services in transitional Somalia: challenges and recommendations.

[33]Barre, M. S. (1973). My Country and My People: The Collected Speeches of Major-General Mohamed Siad Barre, President, the Supreme Revolutionary Council, Somali Democratic Republic (Vol. 3): Ministry of Information and National Guidance.

[34] Communicable, maternal and neonatal disorders constitute 63 percent of all DALYs (Source: Global Burden of Diseases, 2019)

[35] Internal World Bank Study, 2020

provide services. Somalia's 2009 EPHS included six core programs (maternal, reproductive and newborn health; child health; communicable disease surveillance and control, first aid and critical care; treatment of common illnesses, and HIV, STIs & TB) as well as four additional programs (Chronic disease management; mental health & mental disability; dental health; and eye health). Due to limited resources, JHNP did not cover the nationwide or the full components of the EPHS. However, JHNP improved coordination between health service delivery partners.

After the closure of the JHNP in 2016, largely due to the end UK Foreign Commonwealth and Development Office (FCDO) financial support, partner fragmentation resumed, with partial geographic coverage and varying package components supported by different partners. According to 2017 WHO figures, following JHNP's closure approximately 47 out of 89 districts (5.7 million people) had access to part of the EPHS, representing 41 percent of the population. Numerous humanitarian health service providers operate in the country with limited information on who covers which services in which locations. Several larger donors, including Germany, Sweden, and FCDO support larger geographic swaths of the country, coordinating with the Government, although the financing they provide is not on the Government's budget.

The Federal Government of Somalia (FGS) is making efforts to coordinate development partners as an urgent and necessary step to address the leading causes of mortality and morbidity. The Government holds regular health sector coordination meetings to bring together health sector development partners. In 2020, the government revised the EPHS, developing a comprehensive package of health and nutrition services with the aim to align fragmented donor financing around the implementation of the revised EPHS. The upcoming Damal Caafimaad Project, currently in preparation to be supported by the World Bank and Global Financing Facility (GFF), will help the government quickly expand access to high-impact, essential health and nutrition services to address the leading causes of mortality in Somalia. It will also further strengthen the health systems and the institutional capacities of federal and state health ministries to more efficiently coordinate, pool and utilize health resources for improving health outcomes of the Somali people.

Somalia's Health Outcomes

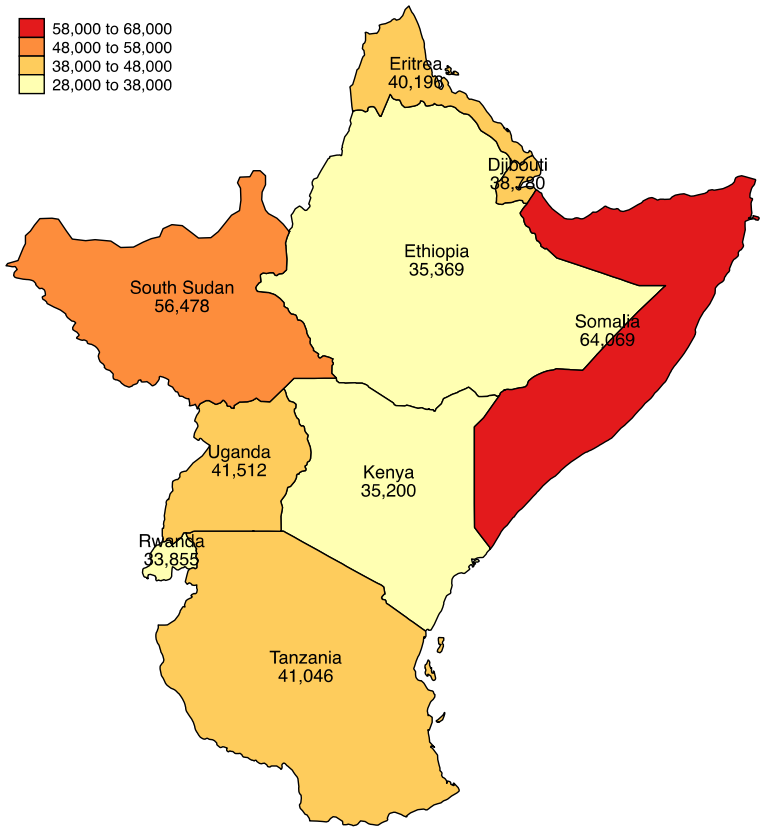
This section provide an analysis of the current health outcomes in Somalia through the lens of i) Somalia's fertility rate, which is currently one of the highest in the world and its implications for maternal and child health outcomes; and ii) the substantial communicable disease burden amidst a rising incidence of non-communicable and mental health disorders. The section concludes by highlighting the socioeconomic disparities in health-seeking behavior and health outcomes, and their implications for inclusive growth and sustainable development in Somalia.

Life expectancy and fertility

Although life expectancy has improved over the last three decades, Somalia's life expectancy is lower than the SSA average. At present, the average child born in Somalia can expect to live up to 57.1 years, up from 50.4 years in 2000 and 45.3 years in 1990. This compares to 66.3 years in neighboring Kenya and the SSA average of 61.3 years. Similarly, the Disability Adjusted Life Years (DALY) rate which measures the overall disease burden is 64,069 per 100,000 population in Somalia, compared to the SSA average of 47,359 per 100,000 population (see Figure 21).[36] This means that critical labor needed for development is lost to death and disability at a very high rate.

[36] Global Burden of Diseases 2019, Results Tool

Figure 21: Disability Adjusted Life Years (DALY) per 100,000 population

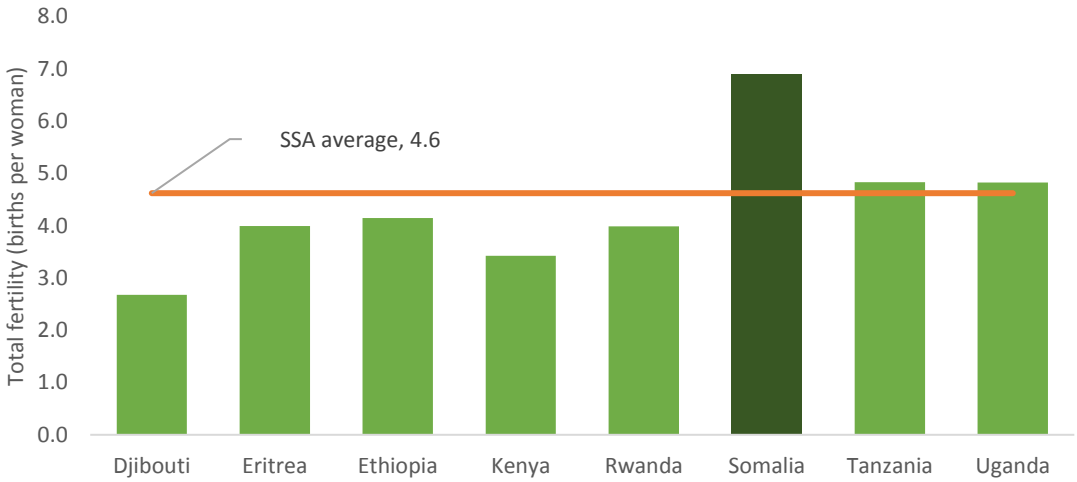


Data source: Global Burden of Disease (GBD) 2019. Map production: World Bank Health Team.

The inability of the economy to create jobs for the country's fast-growing youth population, spurred by high fertility rates, has contributed to rising unemployment in Somalia. As seen in Figure 3, the average number of children per woman in Somalia as of 2020 was 6.9 compared to the SSA average of 4.6 children per woman (Figure 22).[37] Somalia has an estimated annual population growth rate of 2.9 percent and an annual GDP growth rate of about 2.8 percent, resulting in the doubling of the population every 24 years. This implies that the economy is barely able to generate enough economic opportunities to meet the needs of a rising population. Consequently, Somalia has a high unemployment rate of 13.4 percent compared to the SSA average of 6.6 percent.[38] The high level of unemployment can increase the vulnerability of unemployed youth to armed groups, making them more likely to participate in systemic violence and exacerbating insecurity.[39]

[37] Somalia Health and Demographic Surveys, 2020 & World Development Indicators, 2020.
[38] World Development Indicators 2020.
[39] Cramer (2011). Unemployment and participation in violence. The World Bank.

Figure 22: Total fertility rates for selected countries



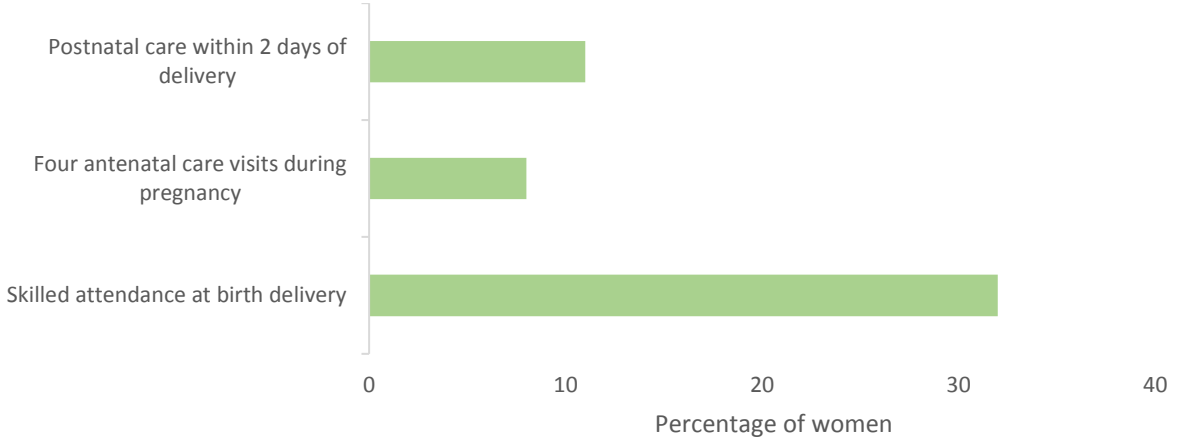
Note: Each column represents the average number of children to women aged 15–49. Data sources: Somalia Health and Demographic Survey (2020), World Development Indicators (estimates for 2019).

Maternal, child and reproductive health outcomes

Access to birth spacing services in Somalia is severely limited. According to the 2020 SHDS, 32 percent of all births to women aged 15–49 between 2015 and 2020 were unwanted at the time of conception, and 37 percent of currently married women reported having unmet birth spacing and limiting needs (i.e., short and long-acting contraceptive methods) that can help couples space out children.

The high fertility rate and inadequate availability of birth spacing services are compounded by the absence of maternal and child health services. During pregnancy, antenatal care (ANC), which refers to the prenatal health services that a pregnant woman receives from a trained provider can play a vital role in reducing the risk of morbidity and mortality of both the expectant mother and the newborn child. In Somalia, only eight percent of women receive the WHO-recommended four ANC visits with a trained provider during pregnancy, while only 32 percent of all births are delivered with the assistance of a skilled provider (Figure 23). In addition, only 11 percent of all mothers had a postnatal check within the first two days after delivery according to the 2020 SHDS. Vaccination coverage is also low among children with just 11 percent of all children aged one to two years in Somalia receiving all basic childhood vaccinations.

Figure 23: Coverage of maternal health services in Somalia

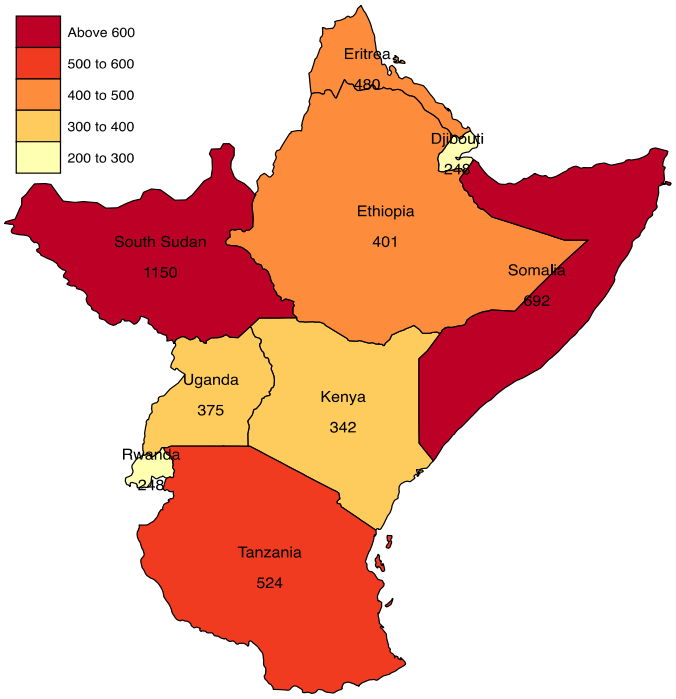


Note: Each column represents the percentage of all women aged 15-49 who had a live birth between 2015 and 2020 who received the specified health service. Data source: The Somalia Health and Demographic Survey 2020.

Consequently, maternal and child mortality rates in Somalia are among the highest in the world. Due to the high fertility rate, Somali women are frequently pregnant, resulting in increased exposure to pregnancy's associated risks in a context with gaps in service delivery availability and quality. Frequent and close births also make women more susceptible to disease, disability and malnutrition. Though declining over time, Somalia's maternal mortality ratio remains high at 692 per 100,000 births compared to the SSA average of 534 per 100,000 live births (Figure 24).[40] The under-five mortality rate, a measure of the probability of a child before reaching the age of five, is 117 per 1,000 live births— higher than the SSA average of 76 deaths per 1,000 live births.[41]

[40] UN Maternal Mortality Inter-Agency Group (UN MMIEG) in 2020.
[41] UN Inter-agency Group for Child Mortality Estimation (UN IGME) in 2020.

Figure 24: Maternal mortality ratio in selected East African countries (maternal deaths per 100,000 live births)



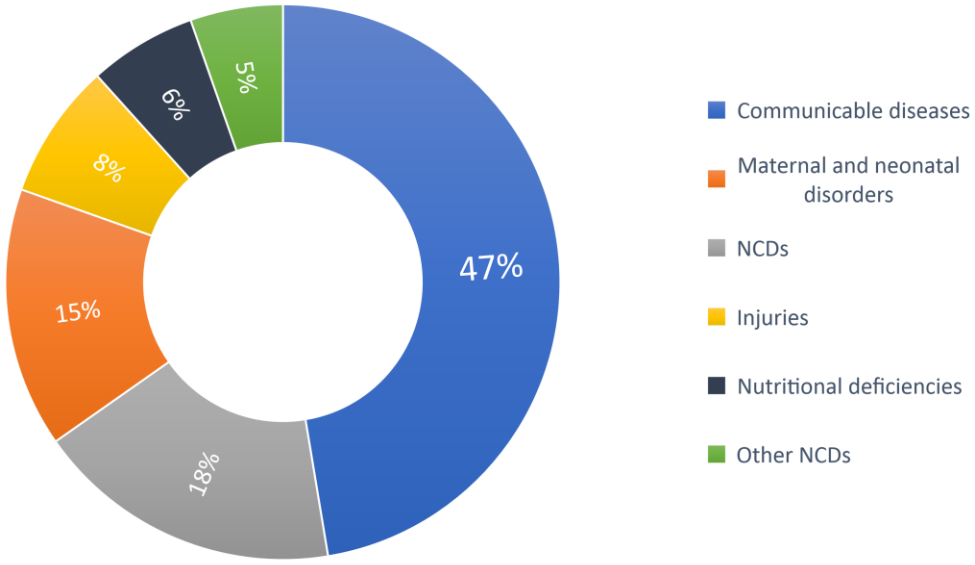
Although the communicable disease burden has declined from the 2009 levels of 52 percent (as a share of all DALYs), Somalia's communicable disease burden is still relatively high at 47 percent in 2019, compared to the East-African subregional average of 40 percent.[42] Tuberculosis, meningitis, acute hepatitis, measles, and other respiratory and infectious diseases account for the majority (37 percent) of the entire communicable disease burden.[43] The prevalence of vaccine-preventable diseases such as measle is a result of Somalia's low vaccination rate ; according to the 2020 SHDS, only 11 percent of all Somali children aged one to two years have received all basic childhood vaccinations.

Data source: The Somalia Health and Demographic Survey, 2020 & United Nations Maternal Mortality Estimation Inter-Agency Group, 2017.

Simultaneously, there has been an upward trend in the burden of non-communicable diseases, which has increased from 19 percent in 2009 to 23 percent in 2019. Cardiovascular diseases, diabetes, congenital birth defects, urinary and gynecological diseases, and mental disorders account for more than half of all non-communicable diseases related DALYs in Somalia.[44] The most commonly diagnosed chronic health problems in Somalia are hypertension and diabetes. Approximately 33 percent of all individuals have high blood pressure, while 20 percent have diabetes diagnosed by a physician according to the SHDS 2020. While regular checks for blood pressure can help with their management, these services are not always available at health facilities in Somalia.[45] Figure 25 and Figure **26** show the distribution of the disease burden in Somalia.

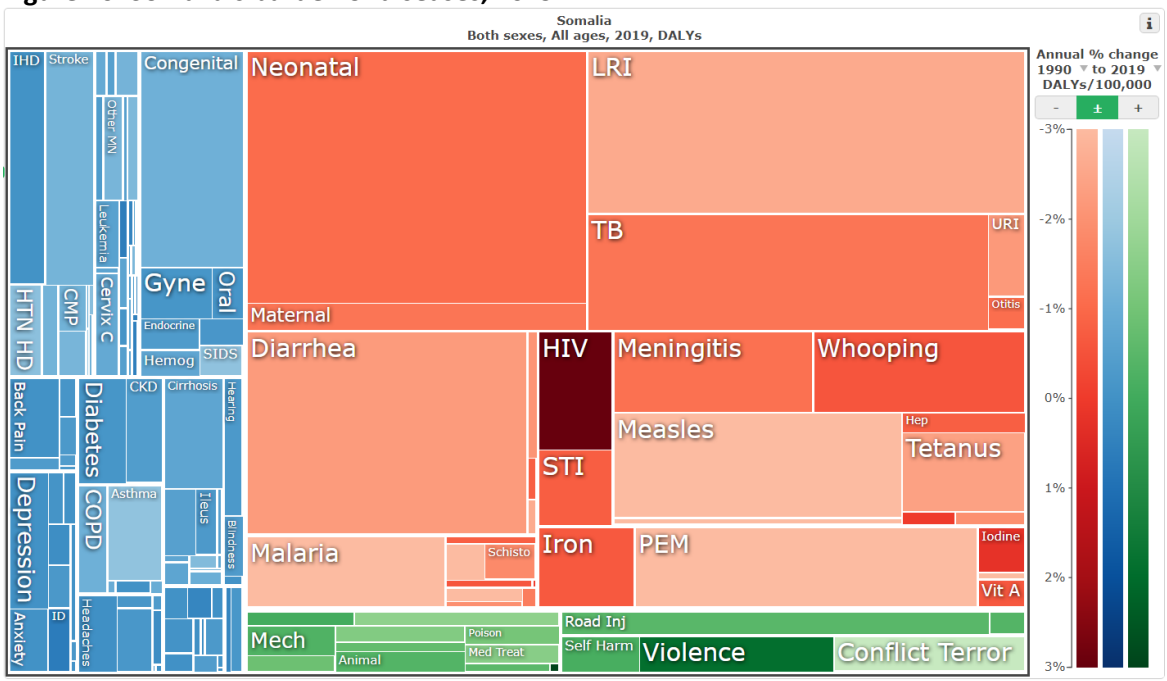
[42] Global Burden of Diseases, 2019
[43] Global Burden of Diseases, 2019
[44] Global Burden of Diseases, 2019
[45] The Somalia Service Availability and Readiness Assessment (SARA) Survey, 2016

Figure 25: Distribution of total DALYs in Somalia by type of disease



Note: Each sector of the circle represents the percentage of DALYs caused by the particular group of diseases. Data source: Global Burden of Diseases, 2019.

Figure 26: Somalia's burden of diseases, 2019



Data source: IHME GBD Compare. Data for Somalia retrieved on April 16, 2021 from https://vizhub.healthdata.org/gbd-compare/. Note: The orange shaded region represents the communicable, maternal, neonatal, child health and nutritional disease burden. The blue shaded region represents the non-communicable disease burden while the green shaded areas represent injuries. For each region, darker shades represent an increase in the disease burden from 1990 to 2019.

Mental disorders are estimated to cause 13 percent of all Years Lived with Disability (YLD)[46] in Somalia, but there is a lack of mental health services. As of 2020, only 4.3 percent of all individuals were diagnosed with mental illness by a physician (SHDS 2020), although the actual prevalence is estimated to be higher at 14 percent.[47] However, care and support for individuals with disability, including mental illness, is lacking with an estimated 42 percent of individuals receiving no form of support at all and only 56 percent receiving medical support.[48]

Nearly all women in Somalia have undergone female genital mutilation/circumcision (FGM/C) and attitudes towards the practice are less favorable among educated women and women in higher income households. The practice has substantial support from women in Somalia: an estimated 72 percent of all women agree that the practice should continue while 19 percent oppose the practice. However, support for female circumcision declines with educational and income status: 78 percent of all women with no formal education support the practice, compared to only 44 percent of those with higher education.[49]

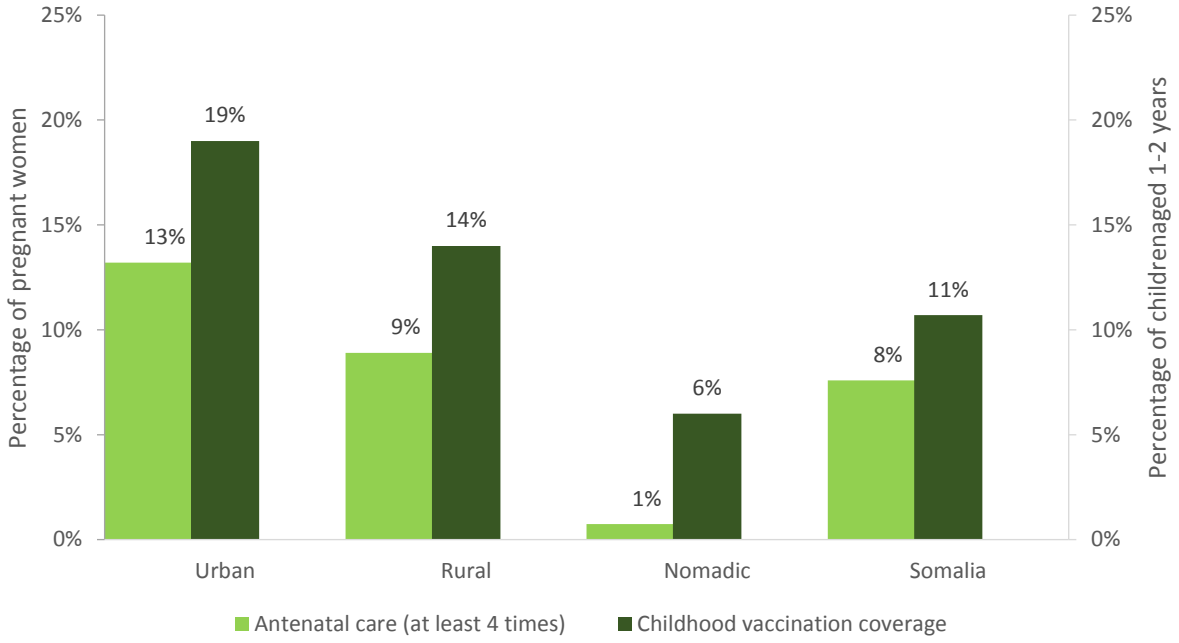
Health disparities

There are notable health disparities in Somalia across geographic areas and socio-economic groups. For example, health outcomes are worse in rural and nomadic areas. Women in nomadic and rural areas tend to have more children on average than women in urban areas, but they are less likely to have access to ANC and PNC services from a trained provider. Only nine percent of mothers in nomadic areas and 35 percent of mothers in rural areas received at least four ANC services from a trained, compared to 49 percent in urban areas. ANC coverage is only 12 percent for women in the lowest income quintile compared to 56 percent of women in the highest income quintile. In nomadic areas, the basic childhood immunization coverage is less than one percent compared to 14 percent in rural areas and 19 percent in urban areas (Figure 27). Similarly, the percentage of women (aged 15–49)[50] who are underweight is 25.5 percent in nomadic areas, 16.1 percent in rural areas and 13.7 percent in urban areas.

Maternal health outcomes are generally better in Somaliland compared to the rest of Somalia. The fertility rate in Somaliland is lower (5.7 children per woman) than the Somali average (6.9 children per woman). Antenatal care coverage and institutional delivery rates are also higher in Somaliland than most of Somalia at 20 and 40 percent respectively, compared to 11 and 21 percent respectively in the rest of Somalia (Figure 28).

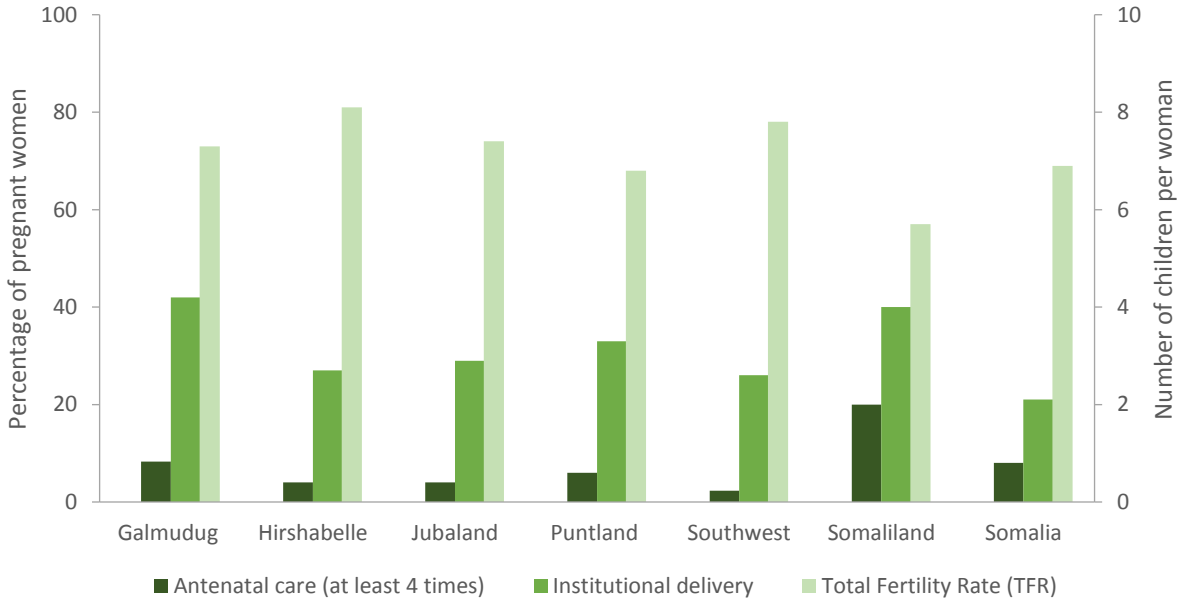
[46] "Years lived with disability" (YLD) is a measure reflecting the impact an illness has on quality of life before it resolves or leads to death.
[47] Global Burden of Diseases, 2019
[48] Somalia Health and Demographic Survey, 2020
[49] Somalia Health and Demographic Survey, 2020
[50] The SHDS 2020 data does not allow for a further disaggregation by age groups.

Figure 27: Disparities in maternal and child health services across geographic areas



Data source: Somalia Health and Demographic Survey, 2020.

Figure 28: Disparities in maternal and child health services across locations

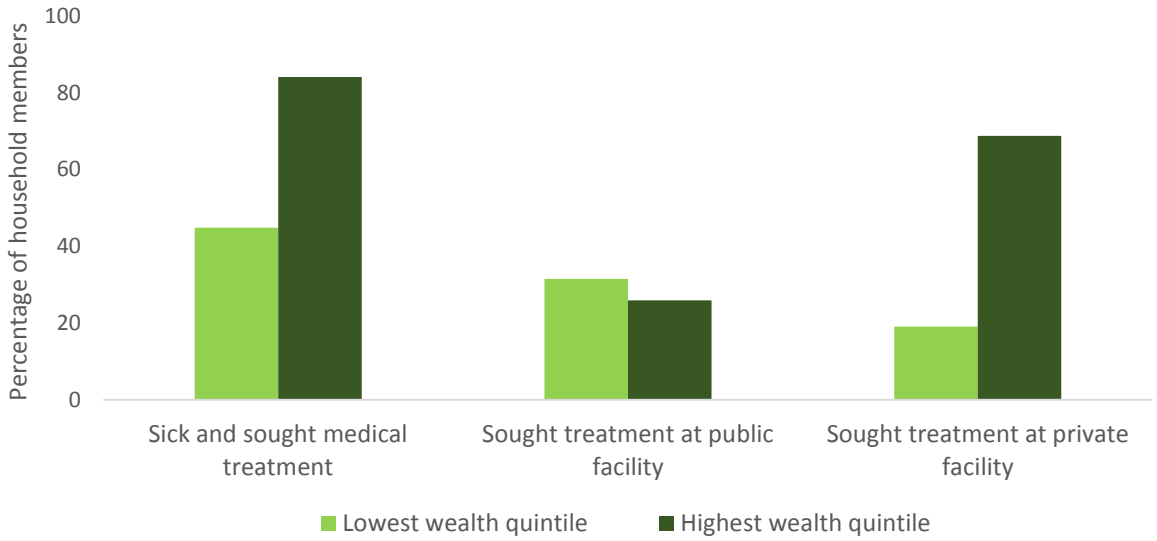


Data Source: Somalia National Bureau of Statistics

Similar disparities are seen across socio-economic groups. For example, there are significant disparities between the heath-seeking behavior of low-income households and high-income households in Somalia. Households in the lowest wealth quintile are 86 percent less likely to seek treatment when sick as compared to households in the highest wealth quintile (Figure 29). Financial constraints faced by low-income households in rural and nomadic areas where majority of the households are in the lowest wealth

quintiles along with an inadequate number of facilities, are likely at the root of these disparities.[51] These disparities are also reflected in health service delivery indicators, for example, the percentage of deliveries by a skilled provider is 9.7 percent in the lowest wealth quintile and 64.1 percent in the highest quintile, with progressive increases in the middle quintiles.

Figure 29: Disparities in health-seeking behavior by income groups



Note: Each column represents the percentage of household members. Data source: Somalia Health and Demographic Survey, 2020.

Disparities in women's health outcomes underline the impact of gender disparities. For example, the death rate among women between 15 and 49 years is 7.6, compared to the death rate among men which is 6.7. Globally and in most countries, death rates between genders are reversed, with higher death rates among men than among women. In the context of ongoing conflict and insecurity, which generally disproportionately increases mortality rates among males, high death rates among women underline the impact of high maternal mortality rates and high fertility rates.

The socioeconomic disparities in health-seeking behavior and outcomes have significant implications for Somalia's sustainable economic growth and development. These disparities underline the need for targeted actions to improve health service delivery equity.

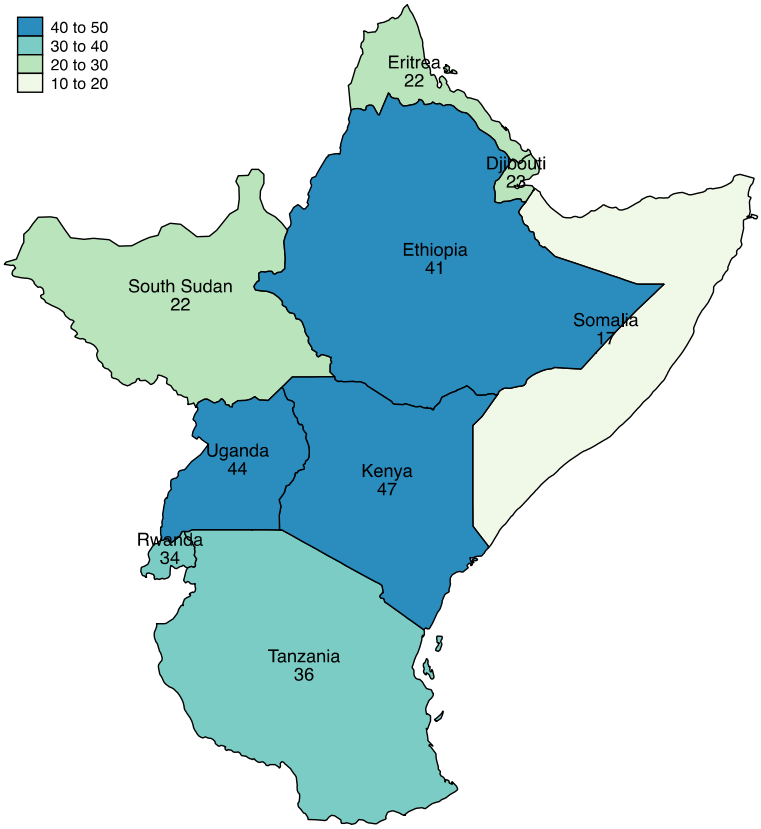
Health System Bottlenecks

The health system in Somalia is relatively fragile, ranking 194th out of 195 countries (behind North Korea and ahead of Equatorial Guinea) on the Global Health Index with a score of 17 out of 100 (Figure 30).[52] Several institutional and systemic challenges account for the fragile and weak nature of Somalia's health system.

[51] Somalia Health and Demographic Survey, 2020

[52] The index measures the health system's capacity in six functional areas: (i) prevention of the emergence or release of pathogens; (ii) early detection and reporting of epidemics; (iii) rapid response to and mitigation of epidemics; (iv) robust health system to treat the sick and protect health workers; (v) compliance with international norms; and (vi) overall risk environment and country vulnerability to biological threats. Source: Global health security index 2019, Bloomberg School of Public Health, John Hopkin University.

Figure 30: Global Health Security Index for selected countries, 2019



Note: The GHS index ranges from 0 to 100. 0 being the least favorable conditions to prevent the spread of disease and 100 being the most favorable conditions to prevent the spread of disease. Data source: Johns Hopkins Center for Health Security. Map production: World Bank Health Team

This section provides an analysis of the current status of the Somali health system and its bottlenecks within the framework of the 2007 WHO health system building blocks: (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/ governance. These building blocks are organized to reflect the focus of the SEU by highlighting financing, service delivery (including health workforce and medicines), and governance (including health information systems).

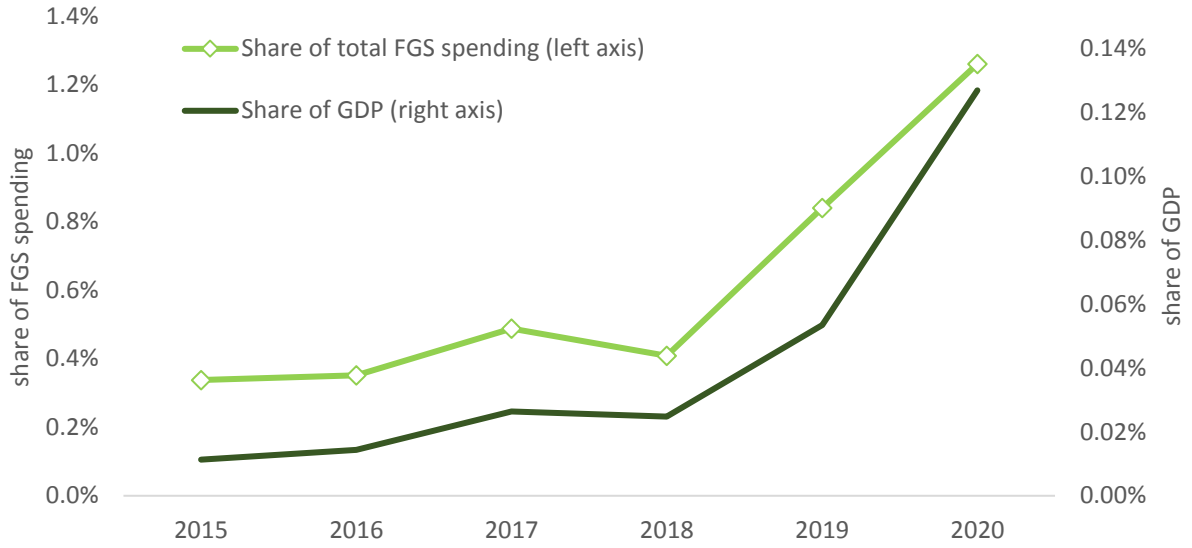
Health Financing

Low government revenue mobilization leaves Somalia dependent on foreign and private sources of health financing. Although the FGS has been strengthening its revenue systems since 2012, it collected only around 3 percent of GDP in tax revenue—far below the SSA regional average of 19 percent.[53] The inability of the Somali government to mobilize sufficient revenues means that the government maintains a relatively small financing envelope for public services and investments, including health. Although health spending by the FGS increased almost 14-fold between 2015 and 2020, this growth was from a small base, and FGS health spending remains minimal as both a share of total FGS spending and as a share of GDP (Figure 31). Donor support and private spending are instead the major sources of health expenditure in

[53] Ministry of Finance data (www.mof.gov/fiscal) and World Development Indicators. Federal Member States collected tax revenue equivalent to 0.14 percent of GDP in 2020.

Somalia, comprising approximately 40 and 43 percent respectively of total health spending, as shown in Figure 32.[54]

Figure 31: Federal Ministry of Health Spending, 2015–20



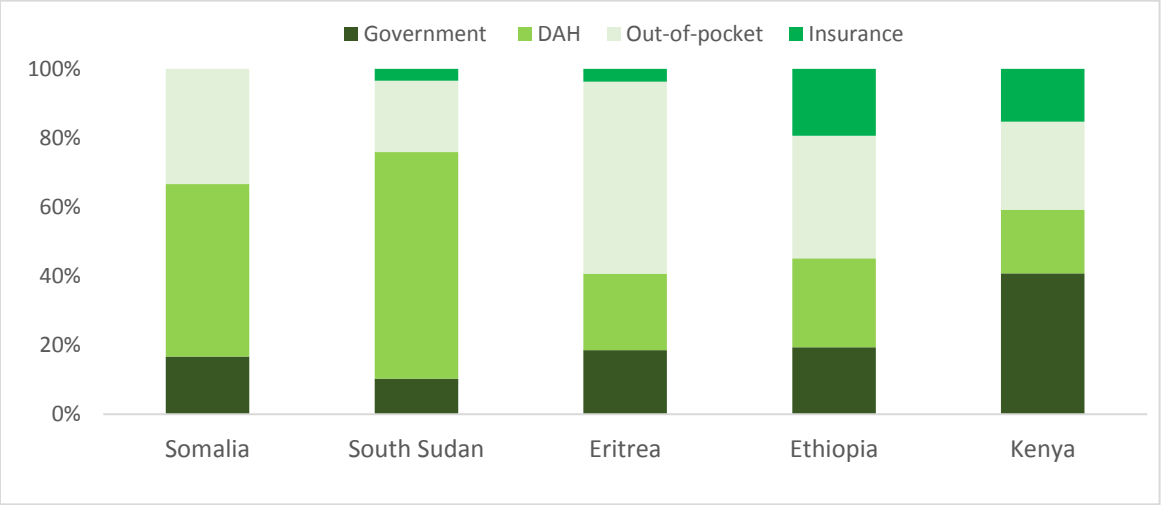
Data source: Ministry of Finance

There are disparities in health spending across the Federal Member States. The federal government spending makes up about 47 percent of total government spending on health. The remaining 53 percent is split among member states with spending by Jubaland making up 20 percent of total government spending on health. Hirshabelle and Galmudug have the lowest shares in total government spending at 7 percent each as of September 2020.[55] In Somaliland, health spending as share of total spending was 4.72 percent (2020).[56]

The low level of government health spending is compounded by challenges pooling funds and purchasing health services. Government and development partner funds are fragmented, which undermines equity and financial risk protection, due to the lack of risk pooling that enables cross-subsidization from healthy to sick and from richer to poorer populations. The health system is not yet fully developed to efficiently determine the type of health services to purchase, how to purchase them and determination of which service providers to purchase the health service package from as well financial management systems for health service providers.

[54] Micah et al. *Health sector spending and spending on HIV/AIDS, tuberculosis, and malaria, and development assistance for health: progress towards Sustainable Development Goal 3 (2020).*
[55] Internal World Bank Report, 2020
[56] Citizen's Budget 2020, Republic of Somaliland. Ministry of Finance Development

Figure 32: Components of total health spending for selected East African countries



Notes: "DAH" refers to [Donor Assistance for Health]. Data source: Health sector spending supplementary data, The Lancet.

Health insurance is almost non-existent in Somalia. In 2020, only two percent of households reported using insurance to cover their health expenses.[57] The absence of insurance means that households without enough savings often resort to liquidating private assets or borrowing to finance health expenses, creating financial risk protection problems and limiting access to care to those who can afford it.40

Donors finance the majority of health sector spending and most donor funding is off the government's budget, limiting coordination and efficiency. A resource mapping and expenditure tracking (RMET) exercise was conducted between 2019 and 2020 jointly by the government and the Global Financing Facility (GFF) to understand the sources of health sector funding, the government's priorities and the activities funded. The study revealed that total 2019 health sector funding (excluding out-of-pocket payments) was US$208 million; of which US$191 million[58] came from development and humanitarian partners and showed a large increase from the previous year's amount of US$156 million in 2018.[59]The UK was the largest donor, followed by the Global Fund. The resource mapping exercise also found that all donor funding was off the government's budget. A mapping of funding available to support the government's priorities in Somalia's Second Health Sector Strategic Plan 2017–21 (HSSP-II) also revealed that between 2018 and 2020, 59 percent of all health sector funding went towards service delivery, followed by emergency preparedness and response, which received 16 percent of the total funding with effectively no allocation for health financing reforms.[60]

Fund flow fragmentation and the associated purchasing issues creates inefficiency and inequity as each flow uses its own provider payment system, which can create mixed or perverse financial incentives at the provider level. Additionally, each fund flow has its own operational procedures and accounting systems, which creates inefficiencies, which is a heavy burden for service providers in a low capacity system. For example, a medium-size primary health care center (PHC) may have ten or more government,

[57] Somalia Health and Demographic Survey, 2020

[58] The FGS also reported a similar amount of US$188 million of donor funding for the health/nutrition sector in 2019. (Ministry of Planning, Investment and Economic Development. Aid Flow in Somalia (2020))

[59] Global Financing Facility. The Somalia Resource Mapping and Expenditure Tracking (RMET) Report (2020).

[60] The HSSP II is a detailed plan to operationalize the first ever Somali National Health Policy (NHP 1) endorsed in 2014, and the health part of the 2017–19 National Development Plan (NDP 1).

development partner or private funds flows all with different financial incentives and accounting systems, contributing to inefficiencies that will hamper extension of service coverage to the population.

Weak public financial management (PFM) systems inhibit efficient use of resources. The FMoH lacks robust internal controls and systems inherent in PFM, as highlighted by an Auditor General's Office report.[61] A paucity of on-treasury health sector resources has severely constrained PFM capacity in the FMoH, resulting in significant governance challenges within the FMoH. As Somalia's government health budget increases the importance of strong PFM systems has been recognized by the government as a means to improve the efficiency, effectiveness, and equity of government spending across the FGS and the FMS, and to build capacity for efficient, effective, transparent, and accountable public expenditures to increase confidence in the state. The current administration has demonstrated a commitment to anti-corruption, as evidenced by the passage of anti-corruption legislation in September 2019, and a new PFM Act passed in December 2019. Despite Somalia's post-conflict context, the country has successfully built a solid foundation for PFM in a short time period. These systems support workflow and authorization controls for government finances, bring discipline to control activities, and strengthen accountability and transparency. The recent "Somalia: Public Expenditure Management Assessment" (June 2020) conducted by the World Bank identified three priority areas to strengthen Somalia's PFM systems: i) strengthen the legal and regulatory framework; ii) improve PFM procedures for effective budget implementation; and iii) promote greater transparency and accountability in PFM systems. While government-wide PFM reforms are ongoing, PFM in the Somali health sector is extremely critical to strengthen efficient resource use and accountability as well as mitigate fiduciary risks. PFM systems are also critical to encourage donors to move resources on Government systems, towards increased efficiency.

Service delivery

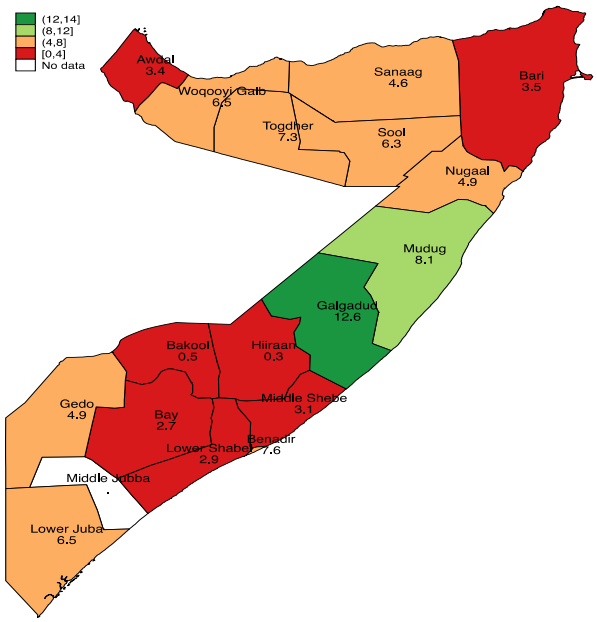


Figure 33: Number of inpatient beds per 10,000 population in Somalia

There are widespread gaps in health infrastructure with significant disparities in facility density across regions. The national inpatient bed density, which measures access to inpatient services, is 5.34 inpatient beds per 10,000 population which is substantially below the WHO target density of 25 beds per 10,000 population and the SSA regional average of 9 beds per 10,000 population.[62] The inpatient bed density is highest in the Galguduud region in central Somalia and lowest in the southwestern parts of Somalia as shown in *Figure 33*. The national maternity bed density stands at 2.55 maternity beds per 1,000 pregnant women, well below the WHO target of 10 maternity beds per 1,000 pregnant women.[63]

Note: Lower values are in red, middle-range values are in orange while higher values are in green. Data source: Service Availability and Readiness (SARA) Survey, Somalia 2016. Map production: World Bank Health Team

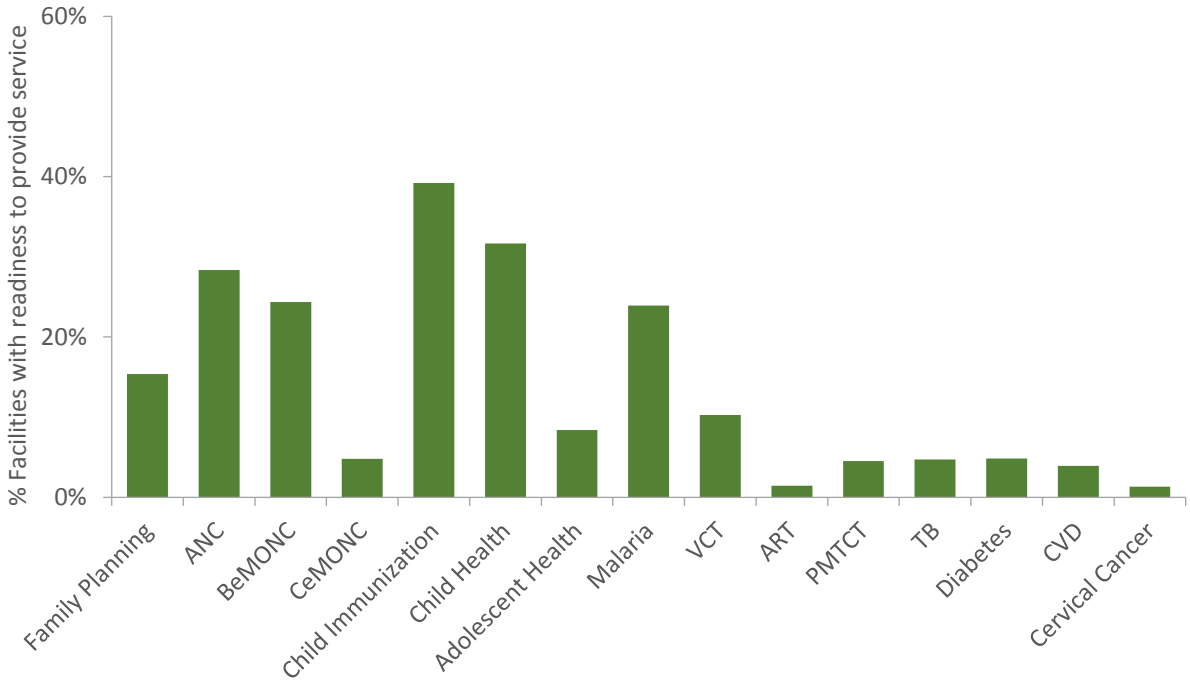
[61] Consolidated Compliance Audit Report of The Federal Government of Somalia for the Year Ended 31 December 2019. Retrieved from https://oag.gov.so/audit-reports

[62] Somalia Service Availability and Readiness Assessment Survey, 2016 & Africa Development Bank, *Health in Africa over the next 50 years* (2013).

[63] Africa Development Bank, *Health in Africa over the next 50 years* (2013).

Existing facilities are not adequately equipped with the basic equipment and supplies needed to deliver health services. Figure 34 shows the percentage of facilities in Somalia with the basic infrastructure and amenities, basic equipment, standard precautions for infection control, laboratory tests, and pharmaceuticals for providing the specified health services. Only 28 percent of all facilities have the required ability to deliver antenatal care services, while only 32 percent of all facilities have capacity to provide child health services. In addition, less than 5 percent of all facilities have the amenities required for tuberculosis, diabetes and cervical cancer screening and treatment.

Figure 34: Service readiness of facilities in Somalia

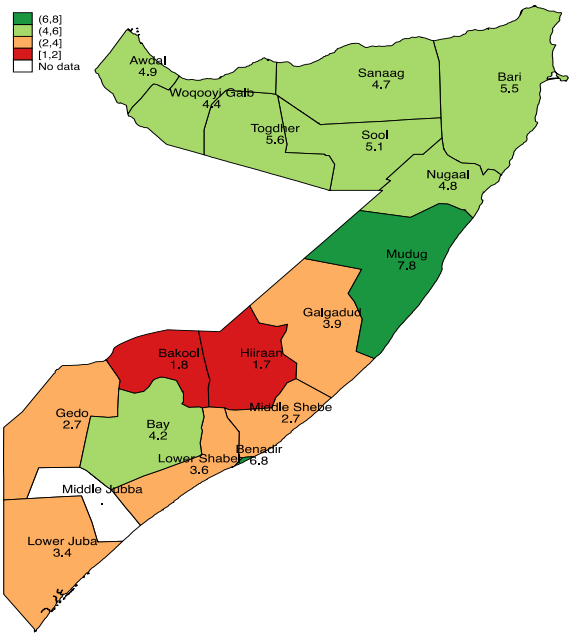


Note: Each column shows the percentage of all facilities (blue fill) with the capacity to deliver the indicated health service. Data source: The Somalia Service Availability and Readiness Assessment Survey, 2016.

There is a severe shortage in the supply of frontline health workers in Somalia, with the few workers inequitably distributed across the country. The number of core health care providers (i.e., generalist medical doctors, specialist medical doctors, non-physician clinicians, nursing professionals, and midwifery professionals) per 10,000 population was estimated to be 4.28 as of 2016, below the SSA average of 13.3 per 10,000 population and WHO recommendation of 23 core health workers per 10,000 population.[64] Puntland and Somaliland have a slightly higher core workforce density than regions in the four emerging states which comprise the former South-Central zone (Figure 35). In the interim, expatriate medical professionals, whose costs of hiring and retention exceed national and regional averages, have been used as part of efforts fill the gap in supply.[65]

[64] For WHO Regions: Global Health Observatory, World Health Organization,
[65] The Danish Immigration Service, *Somalia Health System (2020).*

Figure 35: Core health worker density per 10,000 population in Somalia



Utilization of both outpatient and inpatient services remains low across Somalia. The outpatient service utilization rate, measured as the number of outpatient visits for ambulant care per capita across the country, is 0.23 visits per person per year while the inpatient service utilization rate, measured as the number of hospital discharges per 100 population, is about 0.81.[66] Significant demand side barriers magnify supply side problems, and are responsible for the low service utilization rates across the country. Among women, these barriers include financial constraints with about 65 percent of all women aged 15-49 surveyed in the 2020 SHDS citing this as a major constraint to accessing needed healthcare, and distance to health facility which is identified as major constraint by 62 percent of women. In addition, 42 percent of the women cite the need for permission from the household head to access healthcare as a major barrier.[67]

Note: Lower values are in red, middle-range values are in orange while higher values are in green. Data source: Service Availability and Readiness (SARA) Survey, Somalia 2016. Map production: World Bank Health Team

Sector Stewardship

Somalia's Federal Ministry of Health (FMoH), formed with the FGS in 2012, is nascent and in the process of developing its role as the steward of the health sector. In addition, Somalia's lengthy constitutional review process is yet to be concluded, which is expected to further clarify the roles between the FGS and FMS. While definitions of health sector stewardship vary within the literature and public health organizations, it is broadly defined as "the wide range of functions carried out seeking to achieve national health policy objectives".[68] Elaborating on the WHO's health systems function, Murray and Frenk (2000) identify six core health sector stewardship functions: system design, performance assessment, priority setting, intersectoral advocacy, regulation, and consumer protection. This section will focus specifically on: (i) policy and priority setting, (ii) sector coordination, (iii) regulation, and (iv) health information systems and performance management.

Policy and Priority Setting

The FMoH, in coordination with the FMSs, develops policies to guide health service delivery. The FGS prepared the Second Health Sector Strategic Plan (HSSP-II; 2017–2021), which is in line with the National Development Plan (NDP; 2020–2024). Recently, the Reproductive Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Strategy 2020–2024 was validated. While these policies aim to address relevant issues to Somalia, their implementation faces challenges as the scope of the strategies is beyond available resources and implementation capacity. In 2020, the government revised the EPHS, developing a comprehensive package of health services, based on the most recent burden of disease data and other updated information. Balancing the breadth of coverage and the breadth of services within the EPHS package within a limited available resource envelope was a key challenge in updating the 2020 EPHS. The

[66] Somalia Service Availability and Readiness Assessment Survey, 2016

[67] Somalia Health and Demographic Survey, 2020

[68] World Health Organization, *Stewardship in Health Systems. &* Murray, C. and Frenk, J. *A framework for assessing the performance of health systems*. World Health Organization, Bulletin of the World Health Organization, 2000

government is in the process of coordinating partners to effectively align around the 2020 EPHS, with consideration for available resources as well as implementation capacity.

Sector Coordination

Government health sector coordination capacity is weak, partially as a function of the FMoH's nascent state and partially a result of substantial fragmentation in both country and donor financing and interventions. Health development coordination has been primarily through the NDP coordination structure, with health coordination under the Social and Human Development pillar along with education and water/sanitation. The Human Development Pillar has Government leadership from the health, Water and Sanitation, and Education sectors, with donor co-chairs. The platform does not have participation from all FMSs, and follow-through on actions and specific focus on the health sector are limited. Each development partner and financier has been running separate coordination structures for their programs. The country has an active humanitarian cluster system, which is also fragmented from development coordination in the health sector. The attempt for coordinated financing and service delivery around the common EPHS by the key partners between 2013 and 2016 demonstrated an effective mechanism. However, due to the closure of the program and changes to political structure, the health sector coordination committee has been constrained. The GFF in collaboration with other partners is currently supporting the government's efforts to set up a government-led health sector multi-stakeholder country coordination platform with support from GFF to accelerate efforts to align resources around government priorities for improved health status in the country through identifying and filling gaps in service delivery, institutional capacity, and health system building.

Inter-governmental coordination in the health sector is also limited, reflecting political complexity and the nascent state of federalism. Building on the successful experience of inter-governmental coordination between Ministries of Finance at the FGS and FMS levels, and given the importance of effective inter-governmental policy dialogue for service delivery in federations, ad hoc inter-governmental coordination activities in various sectors, including health, are being formalized.

Regulation

Due to the legacy of state collapse and conflict, the Somali health sector is largely unregulated, including for pharmaceuticals, medical services, supply, and registration and licensing of health workers. Although Somaliland and Puntland have more developed regulatory frameworks in some areas, implementation remains weak. Regulation of the health sector is fundamental to translating health policy goals into outcomes through the use of standards and sanctions to guide service delivery, and ensuring that patients receive safe, quality healthcare. However, the FMoH's limited capacity, along with financial and logistic constraints, have hampered its ability to design and implement a functioning regulatory framework, and there are virtually no functional regulatory mechanisms for pharmaceuticals, health service quality, or health professionals. The only requirement to provide medical services or to import and sell pharmaceuticals in Somalia is the acquisition of a business license.[69] Despite all the limitations, the Somali Federal Parliament unanimously passed the National Health Professionals Council (NHPC) Act in July 2020, which marks an important first step to build a functioning regulatory body for health services and professionals to improve the quality, safety and efficiency of health service delivery for Somali people. However, given limited regulatory capacity, functional regulation of the Somali health sector will take time to develop and is expected in the medium to long term.

[69] Internal World Bank Study, 2020

Health Information Systems and Performance Management

There are substantial gaps in both the availability of reliable, timely health information in Somalia and data use. Somalia's 2020 Health and Demographic Survey (SHDS) was the country's first nationwide survey on health outcomes and service delivery. Previous surveys included the 2016 Service Availability and Readiness Assessment (SARA, 2016, WHO), which detailed health service availability; a 2014 population estimate survey conducted by the government in collaboration with UNFPA; and a 2011 Multi Indicator Cluster Survey (MICS), which was limited to Somaliland and Puntland. The SHDS's execution and publication, while complicated by delays and challenges in the release of disaggregated and raw data, signaled a progression towards increased availability of health service data in Somalia. The lack of available data has made use of information for performance management difficult, engendering a reliance on soft information with little documented evidence base. Since the SHDS's publication, there have increasingly been efforts to use the data as the basis for decision making, including the development and prioritization of the EPHS.

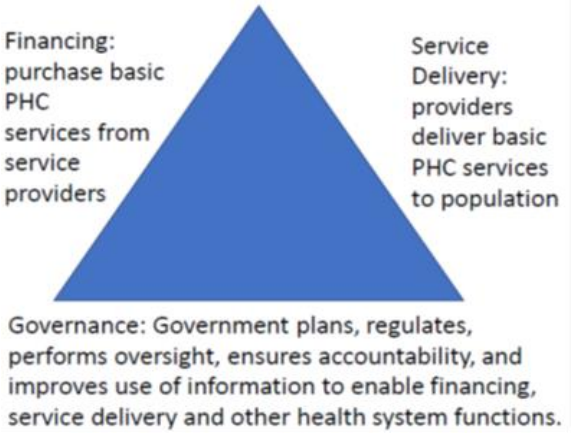
Somalia's Health Management and Information System (HMIS) is nascent. Somali governments at the FGS and the FMS levels have committed to using the District Health Information System (DHIS2), although reporting is not consistent across all regions within the country and quality remains low. Data use is concentrated at higher levels of the system with limited data flowing down to health facilities and little use of data to improve health outcomes, which is the ultimate goal of routine information systems. Fragmentation in partner support for HMIS has constrained the development of strong HMIS supervisory, quality improvement, and data use activities, although efforts are underway to harmonize partner support for HMIS. In addition, the government is currently integrating vertical databases into DHIS2 and updating indicators in the DHIS2 system. In conjunction with increased use of survey data, the government is in the process of increasing use of routine data for decision making.

Taken together, Somalia's health and health system needs are substantial. However, there are currently important opportunities to strengthen health systems for improved health outcomes. Somalia is currently developing an investment case for health, which is a prioritized plan of key reforms that different partners and the government can support. The investment case is a key opportunity for increased coordination among partners. Given the substantial needs in Somalia, there are critical questions on how the government and partners can effectively use current opportunities to improve Somalia's health systems and outcomes, including: i) what is the role of the government in the health system?; ii) how can resource efficiency be improved in light of current fragmentation?; and iii) to rapidly improve health outcomes, where should service delivery initially focus? The next sections will explore these questions in greater detail.

How Can the Somali Health Sector be Strengthened to Better Respond to Health Needs in the Next Three to Five Years?

Building on the health system bottlenecks identified in the previous section, this section will outline proposed strategies which the Somali health sector should focus on in the next three–five years to address health system challenges, while accounting for limited resources and capacity along with substantial health needs. This chapter is organized by the health system functions financing, service delivery, and governance (see Figure 36) and will answer three key questions: i) How can resource efficiency be improved, in light of current fragmentation?; ii) To rapidly improve health outcomes, where should the initial focus of service delivery be?; and iii) What is the role of the government in the health system?

Figure 36: Key health systems functions to purchase and deliver basic PHC services



Health Financing: How to improve health service efficiency?

There are three globally recognized health financing functions: Health purchasing includes "who" to purchase from, "how" to purchase or through which provider payment systems, "what" to purchase or what constitutes the health service package. "How" to purchase and "who" to purchase from are covered within the health financing section; "what" to purchase is covered within the health service delivery section. Revenue collection is the source and amount of funds, pooling is the accumulation of prepaid revenues on behalf of a population, and purchasing is the transfer of pooled funds to providers on behalf of a population.

Who to purchase the set of health services from?

Government contracting of health service providers has been demonstrated to be a means to rapidly expand health service provision in the context of low government service delivery capacity. To support rapid expansion of health services within limited capacity, the Government has decided to use health service contracting as the means for health service delivery in the forthcoming World Bank financed Damal Caafimaad project. In a Government contracting model, roles between the government and contractors are clearly established: the government is the purchaser and regulator of health services, while contractors manage and deliver health services. This clear division of responsibilities will help improve transparency and accountability in Somalia's nascent health systems. Somalia's large number of NGOs are a service delivery asset. Currently, most of these NGOs are financed by development partners or private donors and operate almost entirely outside of government systems. Government contracting of these service providers is a way to effectively harness this existing resource and move towards reduced fragmentation, and increased efficiency and Government leadership. In the short-term, the existing capacity and knowledge of these NGO providers will help facilitate rapid expansion of health services to the population of Somalia. In the medium-term, the government may decide to either continue contracting with non-state actors for a health service package or develop a mixed model of contracting with both public and private providers. Somalia also has a large number of existing, largely for-profit private sector service providers who can be contracted to improve health service quality, equity, and to ensure they are delivering a mix of services that addresses the populations needs. This process will also incorporate broader policy dialogue across levels of government, and with development partners and non-state actors to develop comprehensive policies, strategies and plans for the structure of the Somali health system (health system structure in concert with the service delivery model in the Service Delivery section below).

Efficient and effective health financing and contracting to purchase a health service package requires good financial management at service provider level. The strategy of contracting with service providers to purchase a health service package will be complemented by building financial management competencies at the service provider level. Somali health systems can be strengthened over the next three to five years by creating space and actively encouraging service provider management through good financial management systems and processes. Contract terms, standards, requirements and monitoring indicators could help improve performance in many aspects of service provider management and accountability, including: i) financial management systems and processes to establish basic business management functions and better use information (e.g., plan, budget, procure, internal controls, account, report, internal and external audit, human resource management); and ii) build capacity in the discipline of management, including confidence to respond to incentives and better use of information and analysis to assemble inputs into service outputs and deliver services to clients.

How to purchase a health service package?

Using provider payments to contract service providers requires a mechanism or system to establish the price or payment amount of the health service package. The price or payment amounts can be determined through market dynamics where bidders can individually determine prices for their services and the government can select contractors based on a series of factors including cost. Such a system is likely to put the future Somali health purchaser in a difficult position by driving inequality, fragmentation, cost escalation and an inability to move towards universal health coverage (UHC). Specifically, if one service provider is successful in negotiating higher payment rates than another service provider to deliver the same services to a population with largely the same characteristics, the government will have difficulty convincing this provider to accept lower payment rates in the future. Similar problems will persist within the country if different development partners use different payment formulas. Alternatively, the government can utilize regulatory policy to establish pre-defined parameters which determine total contract price for specific services. A harmonized payment system can be used for both NGOs and government contracting of private, for-profit health service providers to harness Somalia's large private healthcare market and standardize payments to improve efficiency and harmonize fund flows to move towards fund pooling.

Given weaknesses in Somalia's HMIS system and nascent payment systems, bundled output-based payments to purchase a health service package are a means to harmonize payments, reduce fragmentation, and increase efficiency within the Somali context. By design, output-based payments will enable the government and development partners to match limited resources to a prioritized health service package while empowering service providers to determine the optimal mix of inputs to deliver service outputs. While payments could also be made based on inputs of the service being delivered (e.g.: salaries, supplies, drugs, travel, utilities, etc.), without a well-established system and with limited information on health service delivery, as is the case in Somalia, input-based payments are unlikely to match the covered benefits or services being purchased. Further, exactly what is being purchased would not be transparent to either the health purchaser or service provider. Input-based payment systems also allow minimal flexibility for service providers to adapt to local needs and conditions on the ground. Evidence in fragile settings have found these systems to be ineffective in improving health service delivery and health outcomes, while output based systems (e.g.: payments on services provided or delivery

outcomes) have been found to improve health outcomes through a focus on results.[70] Similarly, unbundled payments (e.g., consultation, diagnostic test, surgical procedure) increase the risk to the purchaser of exceeding the available budget if providers submit greater than expected claims. Unbundled payments also require fully functional, established data and payment operating systems are required to effectively track services provided and make timely payments. Although bundled service payments may contribute to underserving patients and increases the risk to the service provider of service costs exceeding payments (often due to factors beyond their control), given weaknesses in data and financial management systems these make the most sense for Somalia's context.

Given that service delivery needs are different for different populations, adjustors can be included in the formulas to ensure that sufficient funds are available for populations whose services may have additional delivery costs and to incorporate policy objectives such as need, equity, and performance. For example, women of reproductive health age and infants tend to need and use more PHC services than young men; specific population groups such as the urban and rural poor may have higher service delivery costs and may be a priority group within government policy, necessitating additional funds. Output-based payment formulas can be set at realistic intervals (i.e., annually) and do not necessitate real-time data. As such, they are more feasible as they can use existing national data, more efficient with lower administrative costs, will reduce the risk of overspending available budget, and will enable establishment of government health purchaser role in setting up provider payment rates. In addition, bundled output-based payments can incentivize the provision of services across the entire package, facilitating holistic and patient-oriented care, and focus on prevention, health promotion and disease management without prioritizing specific services. Further, such a method could be used in conjunction with other performance-based payment systems on top of base payments (bonuses) to incentivize specific needed improvements, such as health service quality.

Ensuring contracted service providers have autonomy to determine the best mix of inputs, is a way to support service providers to improve health service outcomes. With autonomy, health service providers can use locally available information to determine how to best improve health service and produce results, based on established indicators**.** This allows them the flexibility to manage service delivery and adapt to changing environments.

The second phase of health financing can focus on increasing health sector allocations, pooling funds, refining and deepening health purchasing and financial management, and further addressing health system inefficiencies. Revenue collection activities include dialogue between health and finance authorities on the appropriate level and types of revenue for the health sector, and steps to ensure certain and predictable general revenue for service provision. Pooling government and development partner funds to purchase a health service package from both public and private providers will be difficult before government structures and capacity are built. However, a key government role is to increase efficiency by reducing fund flow fragmentation and administrative costs while increasing equity and financial risk protection on the road to universal health coverage. To improve health purchasing and financial management in the second phase, the impact of financial incentives on provider service delivery will be assessed and improved data used to gradually refine provider payment, provider financial management, and PFM systems to adapt to both evolving health policy and service provider responses. In addition, more complex purchasing of outpatient specialty and rehabilitative or other forms of long-term care could be

[70] Loevinsohn, Benjamin, and April Harding. 2005. "Buying Results? Contracting for Health Service Delivery in Developing Countries." *The Lancet* 366 (9486): 676–681.

incorporated into a second phase of a health service package purchasing. Further, identifying the most effective interventions to reduce unnecessary care, improving the quality of care, and ensuring the right services are delivered by providers who are well-trained, and placed can reduce inefficiencies and increase value for money.

Service Delivery: to rapidly improve health outcomes, where should service delivery initially focus?

There is a pressing need to improve health outcomes in Somalia, as argued in Sections 1 and 2 above. Somalia's high mortality and morbidity rates and low life expectancy are driven by high rates of neonatal mortality, maternal mortality, injury, and communicable diseases, which are the major causes of morbidity and mortality in the country (see Figure 6). Based on global evidence, focusing on the major causes of morbidity and mortality using high-impact, cost-effective interventions is a means to rapidly improve health outcomes within limited health service resources and capacity. Given limited resources and current capacity, an extensive package including areas with less of an impact on mortality and morbidity will divert resources and capacity from the major causes of morbidity and mortality, impacting the ability to reduce the top causes of morbidity and mortality. For example, in Afghanistan, using a prioritized package of high-impact health services, the country reduced child mortality from 254 out of every 1,000 live births in 2003 to 161 in 2008 and 55 in 206. Similarly, antenatal care visits in Afghanistan increased from less than 10 percent of pregnancies in 2003 to over 50 percent of pregnancies in 2010 and over 60 percent of pregnancies in 2015. To identify high-impact health services which have proven to be cost effective and focus on Somalia's major causes of morbidity and mortality, Somalia used global data available in the Global Health Cost Effectiveness Analysis and the third edition of the Disease Control Priorities (DCP3). The result is a health service package with high-impact interventions focusing on reproductive, maternal, child, and neonatal health as well as communicable disease and injury.

In addition to improving health outcomes, a health service package focusing on high impact interventions to address the major causes of morbidity and mortality is also feasible within available capacity and can help improve health equity. Along with focusing on the major causes of disease, these interventions can be delivered with consideration of Somalia's currently limited-service delivery capacity. While improvements in staffing and physical infrastructure will be needed, these are largely enhancements to existing service capacity to improve health service quality and coverage. A package focusing on high-impact interventions addressing the major causes of disease can also be scaled up to increase population coverage and improve health service equity. Over time, as available resources increase and service capacity improves, additional interventions can be added to the package of health services.

Expanding coverage of a health service package with high impact, cost-effective interventions will also increase life expectancy and promote a healthier and a more productive workforce within the current capacity and resource constraints in Somalia. An increase in the life expectancy and health of the Somali labor force will provide a much-needed basis for the government to expand revenue mobilization through taxation and other pooling mechanisms to fund the long-term goal of achieving self-sustaining universal health coverage.

Governance: what is the role of the government in the health system?

In the health service contracting model, the government has a regulatory, oversight and monitoring role. These are roles which can only be filled by the government and require developing oversight, accountability and monitoring capacities. Oversight of contracts purchasing a health service package requires establishing procurement, financial management systems, and accountability systems including internal and external audit as well as mechanisms for community engagement. Two regulatory priorities include regulating medicine supply (including essential medicines list, import process and taxation, and ensuring high quality medicines), and developing a legal and regulatory framework for health service providers, including ensuring a level public-private provider playing field.

Health information systems and use of data for analysis and decision-making are key to both system level strengthening and provider level service delivery. Ultimately, output-based payment systems rely on accurate, reliable data, and while the payments can be initiated using existing data, refinement of the systems will require high-quality, real-time data. Further, integrated or interoperable systems will help avoid the fragmentation, inefficiency, and lack of reliable data that has occurred in other developing countries. Linking health and financial information systems has a variety of benefits, including that health information directly related to payments tends to generate higher quality data due to penalties for inaccurate reporting. Harmonized or interoperable information systems can also enable better analysis and use of data for decision-making at both service provider and system levels. In the medium to long term digital health information systems can be used to improve interoperability of data as well as availability and reliability.

Organizational and individual capacity building, as well as on-the-job training will contribute to implementation of health system strengthening interventions and help realize the envisioned role of the government in the health sector. Organizational and individual development will help ensure the "right organization or person does the right thing." Individual capacity building should include both theory and practice, with a focus on on-the-job training to take advantage of strategies and systems put in place to strengthen all health functions, particularly health financing and management of service delivery. Capacity building will also focus on confidence building, as many individuals are positioned to play their roles but need the inspiration and confidence. Government and development partner capacity building will encompass training, mentoring, and other mechanisms to enable staff to perform at both system and provider levels. The initial focus will be on the practical, feasible and sustainable first step functions and systems described throughout this paper, while in parallel, laying the groundwork for subsequent implementation phases.

Strengthened accountability systems are critical to improve transparency and the Government's responsiveness to citizens' needs. Accountability systems can be improved through health facility level feedback. In addition, routine household surveys collecting information on both citizen and beneficiary perspectives on health services can be used to help improve the health system's responsiveness to citizens. Additionally, digital means of citizens feedback, such as mobile phone-based platforms, can help to improve collection of feedback on health services from citizens, taking advantage of Somalia's relatively extensive mobile phone coverage. Strengthened government-led coordination platforms, incorporating robust data use, with engagement of civil society, donors, and the private sector and also critical to improving accountability. In addition, strengthened financial transparency through PFM systems, with engagement of civil society, FMS, and the FGS, is important to improve use of financial resources.

Development of institutional roles, rights, responsibilities, and relationships is another critical governance task which is critical for contracting. The process of defining and strengthening the role of the government in the health sector should take into account: i) roles across levels of government,

including assignment of functions and ownership of public providers; ii) roles across national level government structures, including for key multi-sectoral programs such as health, nutrition, and social welfare; iii) the division of responsibilities between the FGS and FMSs under a contract management arrangement; and iv) structure and roles within FMoH, including health purchaser contracting for delivering a health service package and organization of service delivery departments.

Somalia is a new federal country and like many other federations in the world, including Brazil, Ethiopia, India, Nigeria, Pakistan, and Uganda, Somalia's federal structure has developed in response to its unique history, culture, and socio-economic needs.[71] Federalism presents a number of benefits for the health sector, in particular the proximity of decentralized levels to local needs provides opportunity for decision-making planning, and budgeting based on local context and evidence and can increase the timeliness of decision making. However, many federal systems face revenue generation challenges and inadequate planning and implementation capacity at the decentralized levels.

Health functions in Somalia's federal system have yet to be delineated between the FGS and the FMS. Delineation of health system functions is part of broader constitutional development efforts underway for the country. Currently, the country is at a critical juncture for identifying roles in the federal system. Core considerations in identifying roles within the federal system include how to ensure equity, effectively operationalizing health system functions, and tailoring health services to local needs. In addition, capacity is a key consideration in determining the responsibilities of the federal versus state levels of the health system. In addition, capacity at both the FMS and FGS levels is nascent and being developed. As a result, current roles in the federal system may differ from longer-term roles, as capacity increases.

Given the likelihood that short term functions in the Federal system will likely differ from long-term functions, to ensure effective divisions of responsibility, there is a need to proactively identify short and long-term options for decentralization. In the long-term, lessons and experience from other federal countries indicate that to ensure high-quality, equitable health services sub-national governments are best placed to manage health service delivery while the federal government is best placed to be responsible for intra-state coordination, setting quality standards, and regulation. However, ensuring consistent, equitable delivery of basic health services is a priority. To address capacity gaps and inconsistencies at the FMS level and ensure equity and consistency across the country, in the short term it may be most effective for service delivery to be coordinated by FGS. Simultaneously, regulatory functions, such as regulation of health workers and health facilities, pharmaceuticals, and health service quality can be established at the federal level, with execution at both the federal and sub-national levels. For example, the federal level may set regulatory standards for pharmaceuticals, while the state level may carry out quality checks on pharmaceuticals to ensure that pharmaceuticals meet standards set at the federal level. In terms of health service delivery, day to day oversight of health service delivery as well as determining service locations and the facility mix may benefit from local, contextual knowledge and oversight inherent to decentralization at the state level, while the FGS may identify the health service delivery package to be delivered throughout the country, to ensure equity and align with global targets. Initially, health service purchasing (contracting) may be through the Federal level with a gradual transition of contracting to the FMS level as FMS capacity increases.

[71] *Somalia: Moving the Federalism Agenda Forward.* The World Bank. 2020

Conclusion

While Somalia has a long road ahead to strengthen the health system and improve health outcomes, at present there are important opportunities to have a tangible impact on Somalia's health sector. The recommendations for the health sector based on the findings in the SEU are as follows and further summarized in Table 7:

i. **Health Financing:** Use of a harmonized, output-based provider payment formula will help to establish the government's role in setting health service prices towards equitable service delivery. These harmonized, output-based payments will also establish a basis through which pooling can be further established. Further, government contracting of NGOs to deliver health services is an optimal way to expand health service delivery in the context of limited government capacity. Contracting is also a way to define roles between the health service purchaser (the government) and providers (NGOs). Health service contracting can also be used to harness Somalia's large, existing, and primarily for-profit private sector which can be more effectively deployed to deliver health services.

ii. **Health Service Delivery:** Incoming donor funding into Somalia through the World Bank and other partners offers the opportunity to focus on cost-effective, high impact interventions which target the primary burdens of disease to improve health outcomes in Somalia. Improvements in quality of services can have a dramatic impact on value-for-money. Health outcome improvements will have substantial economic impacts for the country, improving economic participation and increasing livelihood generation capacity.

iii. **Stewardship:** Complementary to improving health outcomes, developing government stewardship capacity is a means to strengthening the health sector response to the population's health needs by enabling sound and sustainable regulatory, monitoring, and oversight systems. Further, health service contracting will not only rapidly expand health service delivery in the context of limited government capacity but will also clearly delineate roles and responsibilities between the health service purchaser and provider, strengthening PFM. In the short term, the FGS can contract health service providers, while capacity of FMS is further strengthened. FMS can be responsible for day-to-day monitoring of health service contracts. Contingent on the direction of ongoing discussions on constitutional arrangements between the FGS and FMS, the FMS can gradually take on responsibility for service delivery.

Table 7: Summary of Recommended Actions in the Short and Medium Term

Area	Short Term Recommendations	Medium-Term Recommendations
Health Financing	• Use of a harmonized, output-based provider payment formula • Contracting of NGOs to deliver health services	• Harmonized, output based provider payment formula used by financers as a step towards pooling • Government contracting of for-profit, private sector health service providers using harmonized payment formula
Health Service Delivery	• Finance high-impact, cost-effective interventions to rapidly improve health outcomes • Strengthen HMIS System through a focus on improved data use and quality	• Finance additional interventions as additional resources become available and health outcomes improve

		• Introduce digital data options to improve timeliness of data
Stewardship	• Capacity development of FGS and FMS • Delineation of service delivery roles and responsibilities • Contracting of health service providers by FGS with day to day monitoring from FMS	• Continued FGS and FMS capacity development • Increasing service delivery role for FMS, dependent on direction of constitutional discussions