Ministry of Health
Federal Republic of Somalia

GLOBAL FINANCING FACILITY
SUPPORTED BY WORLD BANK GROUP

Health Sector Resource Mapping and Expenditure Tracking Report

2018 – 2020

June 2021

Contents

I. Introduction

This report presents Somalia's first comprehensive health sector resource mapping and expenditure tracking. It was commissioned as part of the Investment Case (IC) development process[1] and aims to build a detailed landscape of Somalia's donor and government health sector funding. This report disseminates results from the exercise, identifies funding gaps, and provides recommendations to improve future planning and resource allocation decisions.

Country Context

Somalia is amongst the poorest countries with a per capita Gross Domestic Product (GDP) of US$500 in 2017.[2] After years of political turmoil, it is transitioning towards increased stability through institutional and political progress, which began with the adoption of a provisional constitution and a Federal Government in 2012. Health service data from the recently released 2019 Somalia Health and Demographic Survey (SHDS) indicate weak health systems. For example, only 11% of children are fully immunized.[3] According to 2017 WHO estimates, the 2009 Essential Package of Health Services (EPHS) reaches only 47/89 districts or 5.7 M people (41% of the population).

Availability of limited funding for health underpins these service delivery challenges. Government spending on health is constrained by very limited fiscal space. Most health spending – approximately 45% form each source – is incurred directly by households (out-of-pocket) or funded by donors. Given Somalia's humanitarian context, health sector resources come from both humanitarian actors and more traditional development aid channels. Further, most donor funding is off-budget. These factors – large donor share, presence of multiple actors, and off-budget spending – lead to very little information being available on Somalia's health sector funding, creating fragmentation.

Objectives

The objective of this resource mapping is to develop a comprehensive picture of Somalia's health sector funding and expenditure landscape. This includes developing a detailed understanding of funding sources (who funds?), priorities and activities funded (what is funded?), and the sub-national distribution (where?). This detailed landscape will help ensure that government plans are prioritized based on available resources and to track their implementation. It also aims to reduce donor fragmentation by improving alignment and coordination. The medium-term goal of resource mapping and expenditure tracking is to improve the overall quality of health sector planning and budgeting processes.

The remainder of the report progresses as follows. Section 2 briefly outlines the methodology and the data available for the analyses. Section 3 discusses the resource mapping and expenditure tracking results, and the funding gaps. Sections 4 provides recommendations and discusses limitations of the exercise.

[1] Somalia joined the Global Financing Facility (GFF) in 2019. As part of the joining process, Somalia is developing an Investment Case which prioritizes high impact areas in health and nutrition for investment.

[2] Somalia World Bank Country Partnership Framework (CPF), 2018

[3] Somalia Health and Demographic Survey (SHDS), 2019

II. Methodology and Data

This resource mapping and expenditure tracking (RMET) exercise maps donor and government resources for health to Somalia's 2nd Health Sector Strategic Plan (HSSP II) 2017-21, and the essential package of health services (EPHS) 2009.[4] 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). It has 9 costed strategic priorities with specific objectives and actions within each, and has a performance framework with indicators and targets for each priority. The 9 priority areas are:

1. Health service delivery;
2. Human resources for health;
3. Leadership and governance;
4. Essential medicines and supply;
5. Health information;
6. Health financing;
7. Health infrastructure;
8. Health Emergency Preparedness Response; and
9. Social determinants of health

The EPHS, as the name suggests is a package of key health services -- it has 6 core and 4 additional programs.[5] The additional programs have largely not been implemented. Implementation of the 6 core programs is partial, both in terms of their population coverage *(see section 1)*, and the comprehensive of the package (i.e. not all sub-programs with the 6 core programs were implemented).

This exercise maps resources from 2018 – 22 and expenditure for 2018 – 19. Resources from both traditional development donors and humanitarian actors in health are mapped, an important step to engage humanitarian actors in overall health sector coordination. Further resources are dis-aggregated by geography or administrative unit into the 6 federal member states (FMS), Somaliland, and at the central level (i.e. Federal Government of Somalia or FGS). Health resources are also mapped by funding mode, health program area, cost category, and health system level.

NOTE: The RMET reflects pre-COVID budget allocations for 2020 since majority of the data was collected in the 1st quarter of 2020. Though there has been re-programming of committed funds, and additional funds for the health sector have been made available since, we don't anticipate results to change drastically. Additionally, the analysis on 2018 and 2019 budget and expenditure data remain unchanged. Hence, this RMET remains valid in the post-COVID scenario. At a later stage, data from COVID specific RMET for Somalia can be combined with existing data to update the results from this exercise.

Data Collected

Data was collected from key donors, partners, and government (FGS and Government of Somaliland), constituting the largest share of health sector funding or financial flows (for partners). Contacting implementing partners – such as UNICEF and Save the Children – helped capture additional health resources of donors who could not be directly contacted for data. The analysis in this report includes data from most (but not all) key sources of health sector funding in Somalia.

Details on data availability and completeness, methodology and assumptions are in appendices 1-2.

[4] Resources are mapped to the ongoing EPHS initially conceptualized in 2009; EPHS is currently undergoing revisions

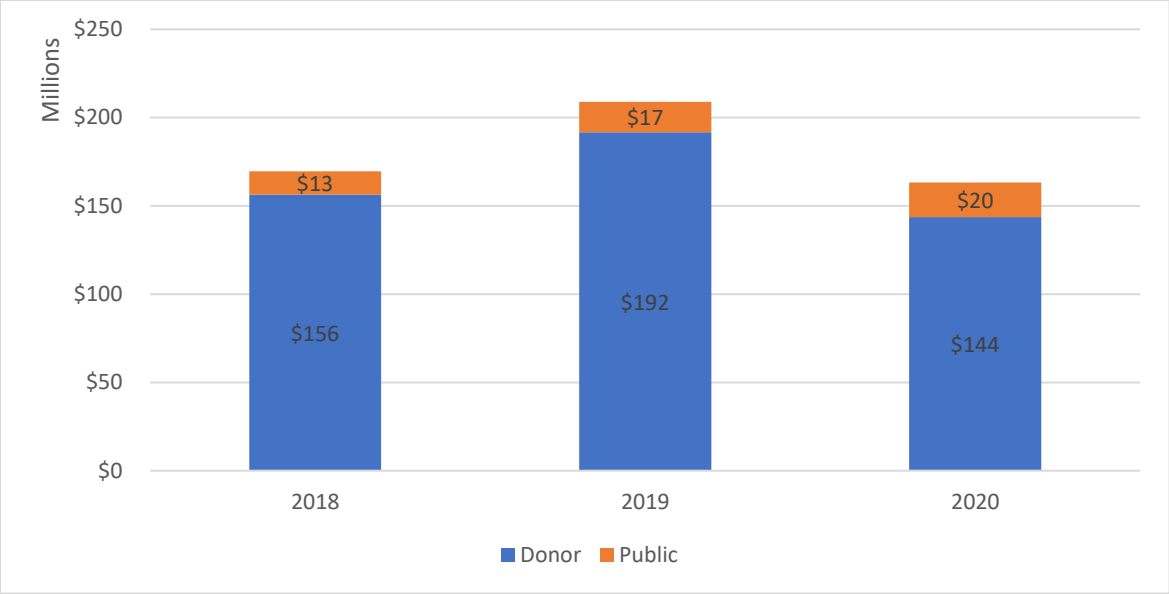
[5] The 6 core programs are: (1) Maternal, Reproductive and Neonatal Health; (2) Child health; (3) Communicable disease surveillance & control, including watsan promotion; (4) First aid and care of critically ill and injured; (5) Treatment of common illness; and (6) HIV, STIs and TB. The 4 additional programs are: (1) Management of chronic disease and other diseases, care of the elderly and palliative care; (2) Mental health and mental disability; (3) Dental health; and (4) Eye health

III. Results

1. Resource Mapping

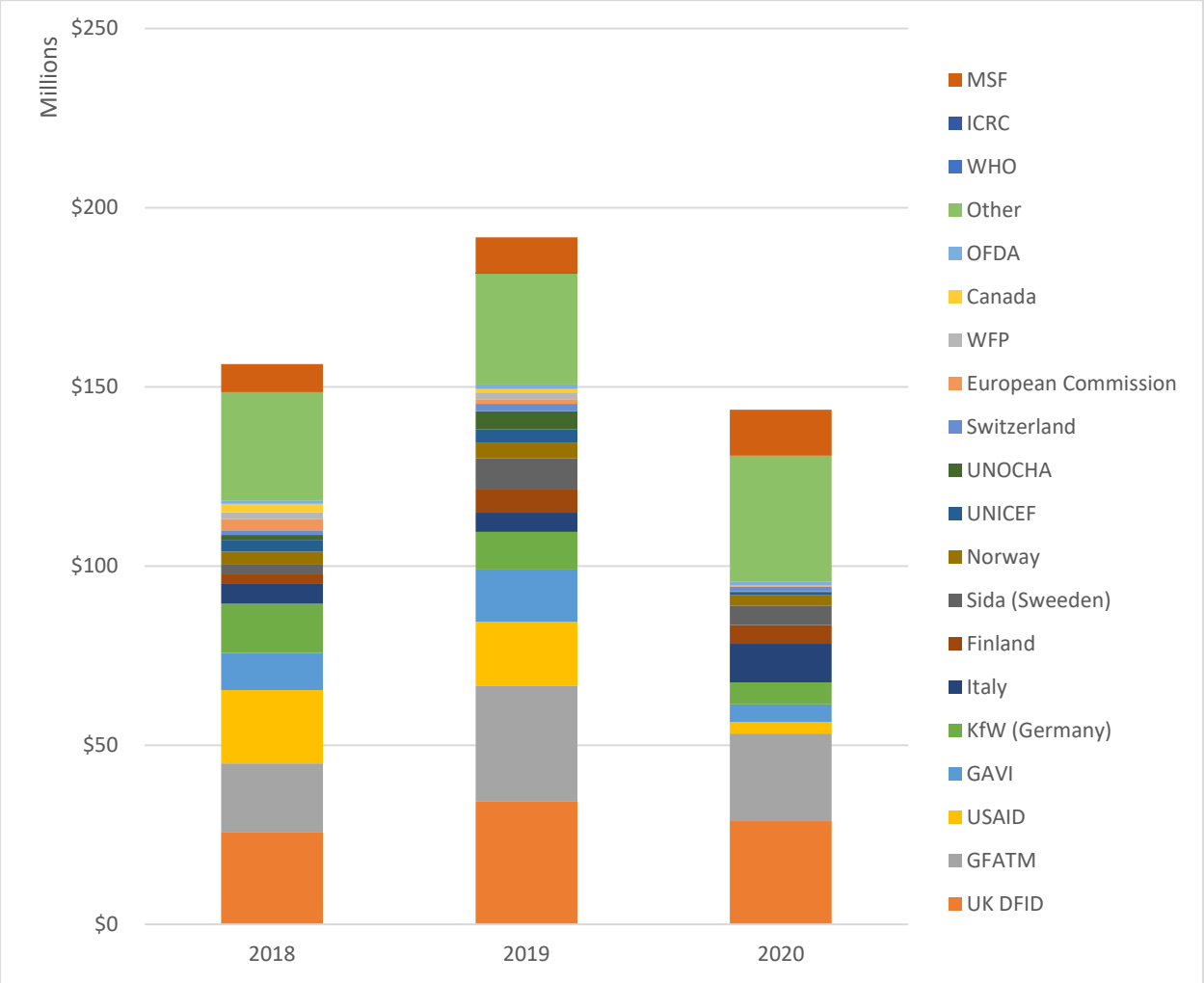
Budget commitments towards Somalia's health sector were estimated at approximately US$ 542 million between 2018 – 20 *(figure 1)*. Donors constitute majority of total funding, at over 90 percent of total for the three years. The public funds shown comprise the budgets provided by the Federal Government of Somalia and the Government of Somaliland.

Figure 1 - Total Funding Available (Budget), 2018 - 20 (USD)



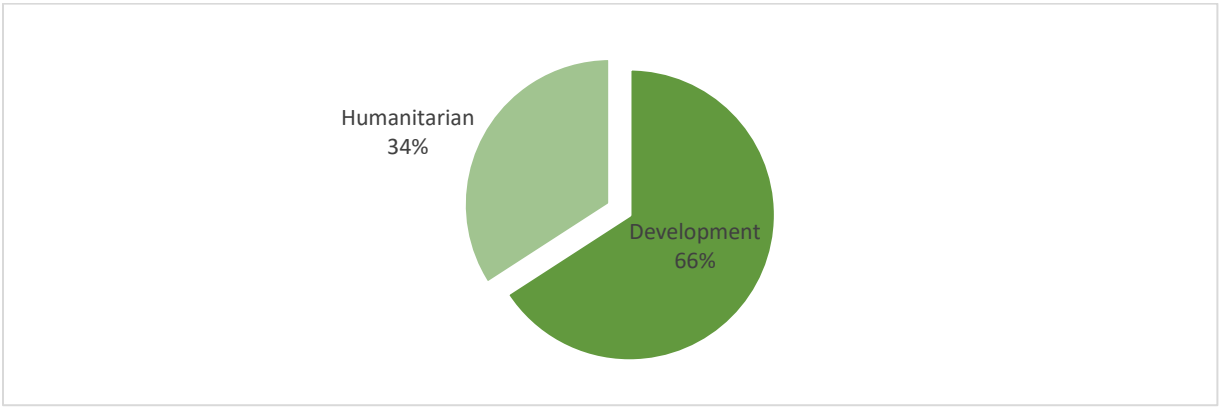
The funding breakdown by donor is shown in Figure 2 below. UK's DFID (formerly DFID, currently FCDO) had the highest share of donor spending, at about 18 percent of the total across the three years. The next largest funders were Global Fund (15 percent), USAID (8 percent), GAVI (6 percent), MSF (6 percent) and Germany's KfW (6 percent). The "Other" category primarily comprised humanitarian funding and included a range of sources such as pharmaceutical companies like Gilead Sciences and Merck, to specialized vehicles to pool money, such as the Peacebuilding Fund.

Figure 2 - Total Funding Available by Donor (Budget), 2018 - 20 (USD)



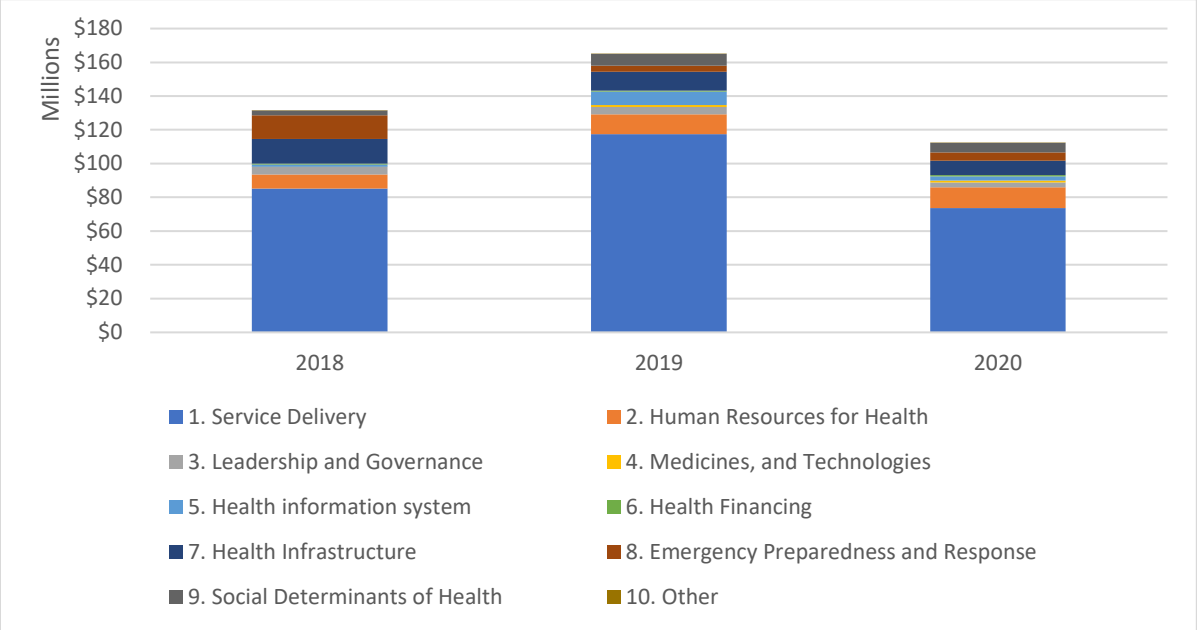
While humanitarian funding remains a critical source of financing for Somalia's health sector, most of the funding included in this resource mapping exercise came from the development sector, at 66% of total resources compared to 34% of humanitarian funding for 2018-2020.

Figure 3 – Humanitarian vs Development Funding Budget, combined 2018-2020



Funding commitments were tracked across the nine HSSP II Priority areas, as shown in Figure 4 below. Overall, the large majority of funding was committed towards service delivery (68% of total funds across the years), followed by HRH (8% of total) and health infrastructure (8% of total).

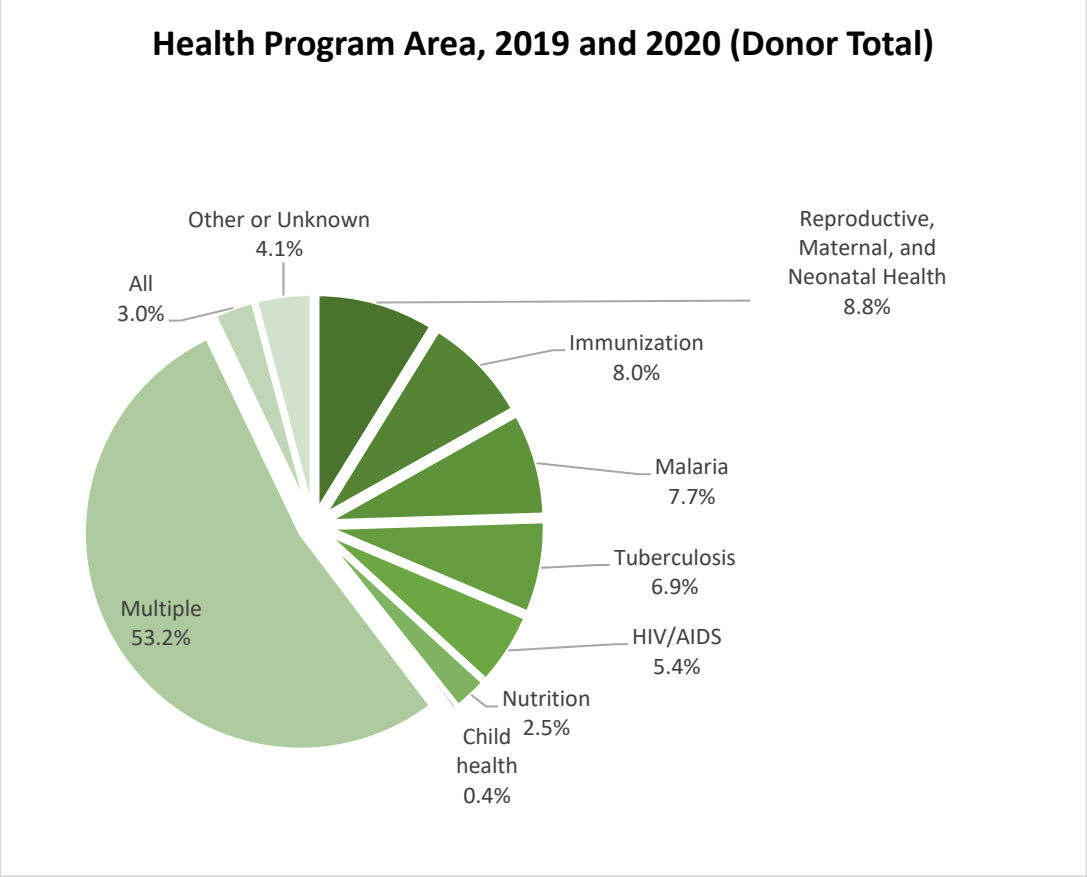
Figure 4 – Budget commitments by HSSP II Priority Area, 2018 – 2020 (USD)



The resource mapping tracker donor funding by health program area (this data was not available for public funds), showing that most donor funds covered multiple program areas (Figure 5). This would be expected as donors largely fund the delivery of the EPHS, which is comprehensive across the health program areas. RMNCH was the

next largest program area covered (8.8% of total donor funding), followed by immunization (8%), malaria (7.7%), TB (6.9%), and HIV/AIDS (5.4%).

Figure 5 – Donor Funding by Health program area, 2018-2020 (USD)



2. Funding Gap

We compared the costs of HSSP II to the funding commitments to calculate the funding gap from 2018 to 2020. There was a gap across all three years, ranging from US$32 million to over US$63 million (Figure 6).

Figure 7 shows the funding gap over the three-year period, broken down by HSSP II priority area. Whereas the service delivery component was almost entirely funded, at 97% of total across the three years, other priority areas were significantly under-funded, such as Health Financing (9%), Medicines and Technologies (10%), and Health Information Systems (18%). Using this breakdown can be a useful way to assess the distribution of resources across different elements of the health sector plan.

Figure 6 – HSSPII Funding Gap, 2018 – 2020 (USD)

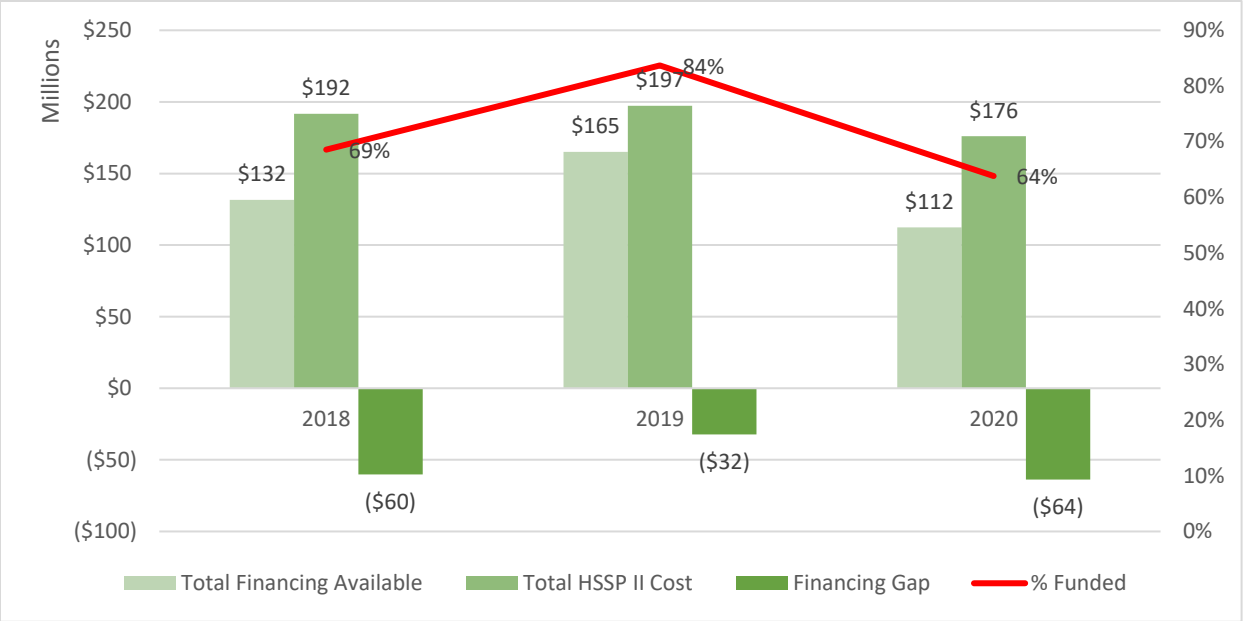
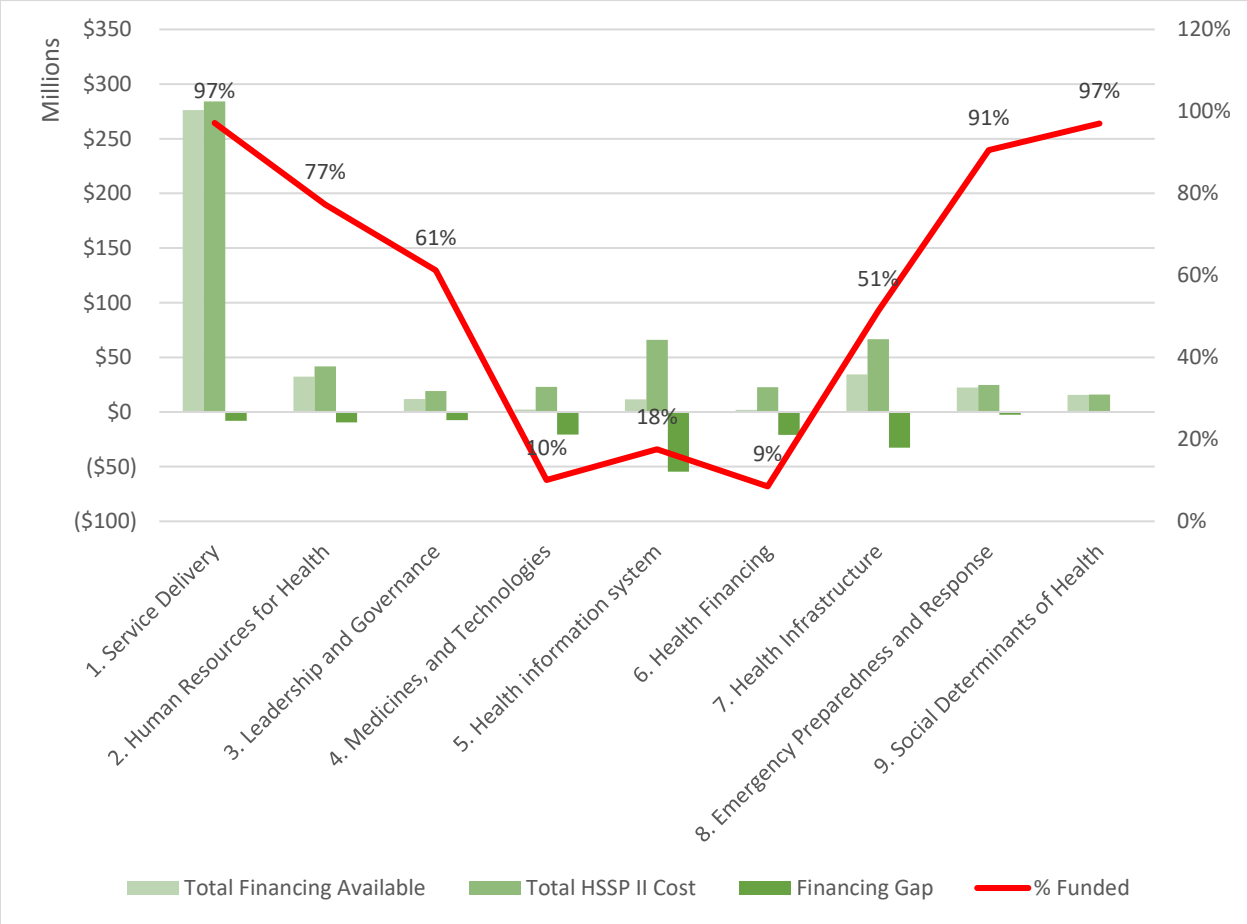


Figure 7. HSSPII Funding Gap by Priority Area, Combined 2018-2020 (USD)



IV. Recommendations

The analysis in the above section shows a large funding gap – over US$156 million across the three-year period analyzed – towards the HSSP II. In 2020, a third of HSSP II remained unfunded. Dissecting the HSSP II gap by priority area also shows a large funding gap for critical components of the health system, such as health information and health infrastructure.

This report has three key recommendations to improve health sector planning:

1. **Need for prioritization given the large funding and limited revenue mobilization potential.** It is unlikely additional resources can be mobilized to fill the large funding gap. Hence, resources will need to be better prioritized. Data and analyses from the RMET will help facilitate that prioritization. For example, this RMET demonstrates that the existing EPHS is not feasible given the resources available. This information will help prioritize activities in the ongoing EPHS revision to ensure that the new EPHS fits the available resource envelope. RMET data and analyses should also be used as inputs to prioritize activities in Somalia's health sector investment case (IC) currently under development.

2. **Improving efficiency of health sector spending.** Related to the above, efficiency of health sector funding can be improved by increasing or re-allocating funding to HSSP II priorities with a large funding gap, such as health information and health infrastructure. While making re-allocation decisions in the absence of additional funding will be difficult, investing in critical but underfunded components of the health system is likely to have a large overall impact on strengthening health systems and improving service delivery.

3. **Improving planning processes and donor alignment.** The RMET compiles a large amount of health funding data in an otherwise data scarce environment. This rich repository of data should be leveraged to improve government planning and budgeting processes. It can also be used to reduce donor fragmentation and identify avenues for donor alignment and coordination. Specific government planning processes and concrete avenues for donor alignment should be identified where this data can be leveraged.

V. Limitations and Lessons Learnt

Somalia's first round of RMET had an ambitious agenda in its scope and coverage. Challenges incurred during the course of the RMET exposed the limitations of the process. This section highlights three key lessons learnt from the limitation of the first round of RMET in Somalia. These should be considered, and addressed to the extent possible, while designing the next round of RMET.

1. **Limited availability of anticipated funding data makes medium-term planning challenging.** Little or no data are available on health sector funding commitments beyond the current year, especially at the granular level required for RMET. Further, by the time resource mapping results are finalized, there is limited scope for re-allocation and alignment since it is already quarter 3 of the current year. Future resource mapping and expenditure tracking should start earlier. For example, the 2021 RM exercise should be complete by early Q1 of 2021. Additionally, more detailed partner discussions should be held prior to the start of the exercise to determine if additional anticipated funding data can be made available.

2. **Budget execution analysis missing due to difficulty in distinguishing historical budget from expenditure data.** Since this was the first round of RM in Somalia, 2018 and 2019 budget data were retrospectively collected to establish a trend. Most donor and partner reporting systems were unable to distinguish between the two. This is often because reporting systems are designed to modify budgets throughout the year such that they map to end of year expenditure. A consequence of this is the absence of budget execution analysis in this RMET despite the collection of expenditure data (budget execution mechanically becomes ~100% for most donors). However, this should not be an issue in future rounds since retrospective budget data will not be collected going forward.

3. **There is a practical limit to the level of data granularity and a trade-off between which dimensions can be captured.** Donors, implementing partners and governments either don't have the reporting systems or the bandwidth to share data at the level of granularity initially envisaged. At the same time, this RMET demonstrated that information can still be shared at a fairly granular activity level – almost 2500 separate activities were recorded in this round of RMET – each with its 2018-20 budget allocation and 2018-19 expenditure, and tagged to a HSSP II priority area, EPHS program, funding mode, etc. This indicates the need to be more prudent in the initial design of the RMET data collection template in the next round. Further, there is a trade-off between the dimensions each activity can be tagged to. For example, this round focused on mapping resources to HSSP II priority areas and EPHS instead of mapping them to health program area, cost category and health system level. While the latter dimensions were collected, most activities were organized such that they were classified as 'multiple', limiting the use of that information. Making these trade-offs explicit in the initial design of future RMET data collection templates will make the data collection process more efficient.

Appendix

Appendix 1: Methodology

The below steps outline the methodology and the timeline of the RMET exercise.

1. A standardized excel-based data collection template was sent to 17 entities – government, donors, and partners – to map resources to HSSP II and EPHS in December 2019. Please refer to appendix 2: data availability and completeness for the list of entities.

2. The template sought to collect health sector budget (2018 – 22) and expenditure (2018 – 19) data from donors, implementing partners, and government. Data was collected at the granular level of activity; for each activity information on funding source, assistance type (development or humanitarian), funding mode (on- or off-budget), HSSP II priority area, EPHS status and program area, health program area, cost category, health system level, and sub-national distribution was sought in addition to the budget (2018-22) and expenditure (2018-19) amount. The data collection period, initially scheduled from January – March 2020, was extended to May 2020 due to limited partner availability with a COVID-19 surge. Meetings were held, in person in Nairobi or virtually, to explain the template and guide the data collection process.

3. The data shared by donors and partners was cleaned and validated between February – May 2020 before finalizing. This entailed follow-up conversations to ensure consistent categorization of activities within each entity's data and across various entities who shared their data.

4. The finalized data from each entity was compiled in a master database in May 2020. Any duplicates, i.e. activities which were inputted twice due to data being provided by both donor and implementing partner were removed. The entry with higher level of granularity was retained.

5. This master dataset without duplicates was transferred to a 'Resource Mapping and Expenditure Tracking' tool developed by the GFF and analyzed in June 2020.

Appendix 2: Assumptions

Below are the assumptions made in the RMET exercise:

1. **Sub-national funding**: Sub-national funding data for most activities was available. In cases where that data was not available for some activities, the sub-national funding share was assumed to be equal to the share for that donor or implementing partner's other activities. If more relevant samples could be used to assume missing sub-national data, such as by priority by donor, that average sub-national share was applied to activities missing sub-national data.

2. **Sub-national population**: The sub-national population was calculated by multiplying 2018 total Somali population by population share of each FMS and Somaliland. The sub-national population shared was obtained from the UNFPA Population Estimation Survey, 2014**.** The population growth for each region assumed to be same as Somali population growth rate

3. **EPHS Costing:** The 2014 EPHS costing was extrapolated to 2018-20 to calculate the EPHS funding gap. The following three steps were followed:

    i. The per capita median regional cost - $5.51 per capita (2012) - from the 2014 EPHS Cost Analysis Report was used as the baseline per capita cost.

    ii. The 2012 per capita cost number was adjusted for health price inflation to arrive at the 2018-20 per capita EPHS cost. The health price inflation of ~3% per annum from the Somali Consumer Price Index (Feb 2020) published by the Directorate of National Statistics, Ministry of Planning, Investment & Economic Development was used.[6] The per capita cost adjusted for health sector inflation increased to $6.97 per capita in 2020.

    iii. The per capita cost was multiplied by the 2020 population to arrive at the total EPHS cost, amounting to $110.7 M in 2020.

[6] Obtained from https://www.afdb.org/en/documents/somalia-consumer-price-index-february-2020