

# A Decade of Aid to the Health Sector in Somalia 2000–2009

Emanuele Capobianco

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THE WORLD BANK



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# Foreword

This study reviews trends in aid provided to the health sector in Somalia over 2000–09. It is a testimony to the commitment of donors and implementers who have relentlessly tried to improve the dire health situation of millions of Somalis. At the same time, this study is a wake-up call for all donors and implementers. Have donors been generous enough? Have millions of dollars been invested in the most efficient way to maximize results? Did donors choose the right priorities? Did they stay the course? Did they learn from their own mistakes?

The answers are mixed. Donors stepped up their contributions over the decade: some new financiers came, some others left, but overall, financial support has been constantly increasing. Emergencies took up 30 percent of the overall funding, thus demonstrating the impact on the health sector of man-made and natural disasters. Only 20 percent was allocated for horizontal programs, with increasing funds over the last part of the decade. Vertical programs dominated aid financing for health: in the case of AIDS, TB, and malaria, the generous funding of the last years of the decade does not appear justifiable. Malnutrition, EPI (expanded program on immunization), and reproductive health programs never got the attention they deserved.

The key conclusion of this study is that donors' funding for public health in Somalia over the past decade could have been used more strategically. Better coordination among donors, local authorities, and implementers is now needed to avoid the mistakes of the past and to ensure that priority setting for future interventions is more evidence based and more results oriented.

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# Acronyms and Abbreviations

BCG	Bacillus Calmette-Guérin
CAP	Consolidated Appeals Process
CISS	Coordination of International Support to Somalia
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control and Prevention
CHD	Child Health Days Initiative
DAC	Development Assistance Committee
DAH	Development Assistance for Health
DFID	UK Department for International Development
DPT	Diphtheria, Pertussis, and Tetanus
EC	European Commission
ECHO	European Commission Humanitarian Office
EPI	Expanded Program on Immunization
EC	European Commission
EU	European Union
FGM	Female Genital Mutilation
FAO	Food and Agriculture Organization of the United Nations
FSAU	Food Security Analysis Unit
FTS	Financial Tracking System
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
HIV	Human Immunodeficiency Virus
HSC	Health Sector Committee
IC	Italian Corporation
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IEC	Information-Education-Communication
IFRC	International Federation of the Red Cross
INGO	International Nongovernmental Organization
JNA	Joint Needs Assessment
MCH	Mother and Child Health
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR-TB	Multi Drug Resistant Tuberculosis
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NGO	Nongovernmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
ODA	Official Development Assistance
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
OFDA	Office of Foreign Disaster Assistance

OVC	Orphans and Other Vulnerable Children
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
Polio	Poliomyelitis
RDP	Reconstruction Development Plan
SACB	Somalia Aid Coordination Body
SSS	Somalia Support Secretariat
SWAp	Sector Wide Approach
TB	Tuberculosis
TFG	Transitional Federal Government
UN	United Nations
UNAIDS	The Joint United Nations Program on HIV and AIDS
UNCAS	United Nations Common Air Space
UNCT	United Nations Country Team
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNOSOM	United Nations Operation in Somalia
USAID	United States Agency for International Development
WB	The World Bank Group
WHO	World Health Organization

# Executive Summary

## Background

This study reviews (1) how levels of donor financing of the health sector in Somalia varied over the decade 2000–09, (2) which health interventions were prioritized by donors, and (3) how evenly health sector aid was distributed to the different zones of Somalia. The overall aim of the study was to create evidence for donors, implementers, and health specialists involved in allocation of financial resources to the Somalia health sector.

The results of the study are based on quantitative data collected from 38 Development Assistance Committee (DAC) donors and implementing agencies active in Somalia. Quantitative data were collected between March and May 2007 and in March 2010, with response rates of 96 and 95 percent, respectively.

## Key Findings

*In absolute terms there has been a fivefold increase in funding for the health sector in Somalia over the past decade.* Financing from conventional donors increased from US\$23 million in 2000 to US\$103 million in 2009, with a peak of US\$125 in 2008. Although a trend of increasing development assistance for public health was noted globally in the past decade, the increase in funding for Somalia far exceeds the global rate of increase.

*Aid financing greatly exceeded governments' contributions to the health sector.* While an average of US\$100 million was provided annually to Somalia over the period 2007–09, Somaliland's budget contribution to public health on the same triennium was on average US\$1 million a year. Puntland's budget contribution to health for 2007–2009 was on average US\$300,000 a year.

*Per capita aid for health grew from US\$3–4 in 2000–03 to US\$11–14 in 2007–09, a considerable amount for health in a fragile state. However, poor results point to inefficient use of existing resources.* Total official development assistance (ODA) per capita in Somalia was US\$84, of which US\$14 (17 percent) was channeled to the health sector. When comparing per capita aid for health in Somalia to other fragile states, the increase in recent years brings Somalia on par with Afghanistan. However, high levels of financing does not seem to translate into better results, as experienced in Afghanistan during the past few years. There is clear scope for efficiency gains in Somalia.

*Vertical programs had the lion's share of financing over the decade and the prioritization of vertical programs in the country seems to have been directed more by global priorities and opportunities (such as the polio eradication program and the emergence of GFATM), rather than by public health considerations.* Programs such as those addressing polio, HIV, TB, and malaria received substantial amounts of funding, while programs with greater public health importance in the country (nutrition, reproductive health, and EPI) were comparatively neglected.

*Funding for horizontal programs and for emergencies represented respectively 30 and 21 percent of overall financing to the sector over 2000–09. Funding for both categories increased for 2007–09.*

## **Recommendations**

*Somalia continues to need long-term financial support for the health sector to address the needs of its population. Somalia's financial needs remain high given the challenges posed by its health indicators and the high operational costs linked both to the logistics of the country and to the reliance on international actors located outside Somalia.*

*However, with US\$11–14 per capita of aid for health, the improvement of efficiency in the use of available resources is of paramount importance. To make the best use of a funding level that does not allow room for waste, the health system should focus on evidence-based activities that can maximize results, equity, and efficiency.*

*Contributions to the health sector should be more strategic: funding gaps in key areas (nutrition, reproductive health, and EPI) should be addressed as a matter of priority. At the same time, funding requirements for HIV, TB, and malaria programs should be carefully revised based on real needs. To this end, investments on monitoring and evaluation would be critical, as many programs do not seem to have reliable data on which policies could be based.*

*Partners' coordination mechanisms should be further strengthened. The aid structure in Somalia remains highly fragmented and inefficient. Innovative systems to better link local authorities to national and international partners need to be identified (such as creation of a Health System Analysis Team, as advocated by UNICEF in 2009<sup>1</sup>). It would also be essential to involve critical partners that have not been part of the HSC for many years, such as Médecins Sans Frontières (MSF).*

*Financial tracking of donor resources to the health sector should become an integral part of the health information system. The tool developed for the study could be adopted and improved by interested parties. Financial tracking should be matched with burden of disease and program outcome data.*

*Operational research is needed to integrate the findings of this study and to allow a better understanding of health financing in Somalia. Topics to be studied include health financing by (i) the private sector, (ii) the Somali diaspora through remittances, and (iii) nonconventional donors. Studies on household spending on health would complete the picture by providing information on private expenditures.*

## **Organization of the Chapters**

The report is organized in five chapters. Chapter 1 provides the background to the study, along with its aims and objectives, and contextualizes the study area, Somalia. Chapter 2 provides the conceptual framework for the research by looking at aid financing trends in developing countries, in the health sector, in fragile states, and in Somalia. Chapter 3 describes the methodology, the data collection process, types of data collected, and methodological limitations. Chapter 4 presents the quantitative findings in terms of total

health sector aid financing, and expenditure by disease and by zone. Chapter 5 offers conclusions linked to the four primary study objectives and provides recommendations for future funding.

## Notes

1. UNICEF 2009: “Steps towards harmonizing external support for health care provision for the Somali people.”



## CHAPTER 1

# Background, Aim, and Objectives

### Study's Aim and Objectives

This study is a follow up of the 2007 review of health sector aid financing to Somalia, which covered aid flows to the public health sector between 2000 and 2006. In 2010, the Health Sector Committee (HSC) of the Coordination of International Support to Somalia (CISS) requested a second analysis to cover the period 2007–09, and to provide a 10-year view of aid flows to the health sector in Somalia.

The overall aim of the study is to create evidence for donors, implementers, and health specialists involved in allocation of financial resources to the Somalia health sector. The primary objectives are to assess: (i) how levels of donor financing varied over the years, (ii) which health interventions were prioritized by donors, (iii) how evenly health sector aid was distributed to the different zones of Somalia, and (iv) whether notable changes in aid patterns had occurred after the release of the 2007 study.

With respect to the primary objectives, the benefits of the study are:

- To highlight imbalances in aid support to the health sector. More specifically, to provide key information on the prioritization of health interventions based on availability of external aid and on regional differences. The results of the study may help stakeholders to redefine criteria and address imbalances for the allocation of resources to the Somali health sector. The study results could be used both in the scenario of continued conflict and in the event of transition to peace.
- To provide a solid baseline for future research work on health aid financing in the country. An in-depth knowledge of the current resource envelope will facilitate the preparation of resource forecasts, which are central to the development of meaningful strategies in post conflict countries.
- To provide health policy planners with evidence-based conclusions to address the main priorities identified by the High Level Forum on the Health Millennium Development Goal (MDGs): ensuring longer term predictability of aid flows, reducing shorter term aid volatility, and promoting coordination, harmonization, and alignment.
- To assess the impact of global initiatives on the overall health budget.
- To increase the scarce literature on the Somalia health sector and the literature on health financing in fragile states and in Africa.

### Somalia Health Context in Brief

Since 1991, Somalia has been without a functioning central government and has experienced a prolonged humanitarian crisis due to a civil war that still affects large parts of

the country. The civil war destroyed most of the infrastructure, displaced large populations, and took a heavy human and financial toll on the Somali population (World Bank 2006). In 1991, the Northwest declared the independent state of Somaliland. In 1998, the Northeast declared itself as the independent state of Puntland. The South/Central Zone remains locked in intermittent political conflict and violence (Sorbye and Leigh 2009). In addition to man-made emergencies, Somalia regularly experiences natural disasters: droughts and floods are the two dominant hazards affecting the majority of the country. In 2008, the most severe drought in two decades affected approximately 3.3 million Somalis (EM-DAT), triggering a major humanitarian response.

The people of Somalia are Muslim, largely rural (66 percent), and young: 57 percent of the population is under the age of 20, and 20 percent is under 5 (World Bank, UNDP 2002). Forty-three percent of the population lives in extreme poverty, that is, on less than US\$1 a day; and 73 percent survives on less than US\$2 a day (World Bank 2007). An estimated 80 percent of Somalis have no access to basic health care (Mazzilli and Davis 2009), and Somali health status (Table 1.1) remains among the worst in the world. With an under-five mortality rate (deaths per 1,000 births) of 200, Somalia ranks fourth from the bottom of the global ranking. The under-five mortality rate has not changed over the past 20 years (UNICEF 2010) and remains far above the average for Sub-Saharan Africa countries (144). Similarly, the total fertility rate has barely declined from the 1970 rate of 7.2 children per woman to 6.4 in 2008.

Maternal mortality rate remains among the highest in the world, due to limited access to maternal and reproductive health services—and in particular, to safe caesarean section. Immunization rates are extremely low: DPT3 coverage in 2008 was 31 percent compared with 72 percent in Mozambique and 62 percent in Zimbabwe (UNICEF 2010). Other health concerns include poor nutritional status (42 percent of children are reported as moderately or severely stunted and 13 percent as moderately or severely wasted), and high prevalence of communicable diseases, such as TB and malaria, are endemic in several parts of the country. HIV infection remains below 1 percent, and the number of people living with HIV is estimated at approximately 24,000. Noncommunicable diseases, such as mental illness, also place a heavy burden on the Somali population. Civil war and trauma have led to a high risk, among Somali youth, of developing emotional and psychological disturbances, as found in a Canadian study on Somali immigrants (Reitsma 2001).

There are two additional health problems specific to Somalia. First, about 98 percent of women (UN, World Bank 2006) are estimated to have undergone some form of female genital mutilation (FGM). This practice carries immediate and long-term health risks, including tetanus, hemorrhage, urinary tract infections, and obstructed labor. Second, chewing of khat<sup>1</sup> is also a common practice in Somalia with serious economic, social, and mental health consequences.

The delivery system for health services in Somalia is highly fragmented. The public health care network is small and severely underutilized: the estimated utilization rate is 0.13 consultations per person a year, or one visit to an MCH facility every eight years (UNICEF Somalia 2007). Public provision relies mostly on national and international NGOs that tend to be concentrated in towns and in secure areas. Direct provision by Ministries of Health is marginal. Private health care outlets proliferate throughout the country and are now estimated to be in the thousands, with large variations in size,

**Table 1.1. Health and nutrition-related MDG indicators, most recent estimates**

	Somalia	Sub-Saharan Africa
<b>MDG 1: Poverty and Hunger</b>		
% under-5 children malnourished (underweight)	32	27
% under-5 children chronically malnourished (stunting)	42	41
% under-5 children acutely malnourished (wasting)	13	10
<b>MDG 4: Child Mortality</b>		
Under-5 mortality rate (per 1,000 live births)	200	144
Infant mortality rate (per 1,000 live births)	119	86
Measles immunization (% children 12–23 months)	24	72
<b>MDG 5: Maternal Mortality</b>		
Maternal mortality ratio (per 100,000 live births)	1,400	900
% births attended by skilled health staff	33	46
<b>MDG 6: HIV/AIDS, Malaria, and Other Diseases</b>		
Prevalence of HIV (% adults aged 15–24)	0.5	5
Contraceptive prevalence rate (% of women ages 15–49)	15	23
Number of children orphaned by HIV/AIDS	9,000	10.2 M
% under-5 children sleeping under insecticide-treated bednets	11	20
% under-5 children with fever treated with anti-malarials	8	34
Incidence of tuberculosis (per 100,000 per year)	249	350
Tuberculosis cases detection rate (all new cases) (%)	73	46
<b>MDG 7: Environment</b>		
Access to an improved water source (% of population)	35	60
Access to improved sanitation (% of population)	50	31
<b>General Indicators</b>		
Population	9 M	772 M
Total fertility rate (births per woman ages 15–49)	6.4	5.2
Life expectancy at birth (years)	50	49.6

Sources: UNICEF Somalia Statistics (2010); [http://www.unicef.org/infobycountry/somalia\\_statistics.html](http://www.unicef.org/infobycountry/somalia_statistics.html); World Bank Millennium Development Goals Global Data Monitoring (2010); United Nations, The Millennium Development Goals Report (2010).

services offered, staff qualifications, and performance. Private facilities offering clinical care are clustered in large cities and tend to be financially inaccessible to the majority of the population. On the other hand, private pharmacies are ubiquitous; they are present not only in urban centers but also in nomadic and settled rural areas. Beyond the sale of medicines, pharmacies offer health services such as injections, blood tests, and diagnoses, as demonstrated by a recent survey in Somaliland (UNICEF Somalia 2009).

## Notes

1. Khat is an intoxicating plant classified as an illegal drug in some countries.



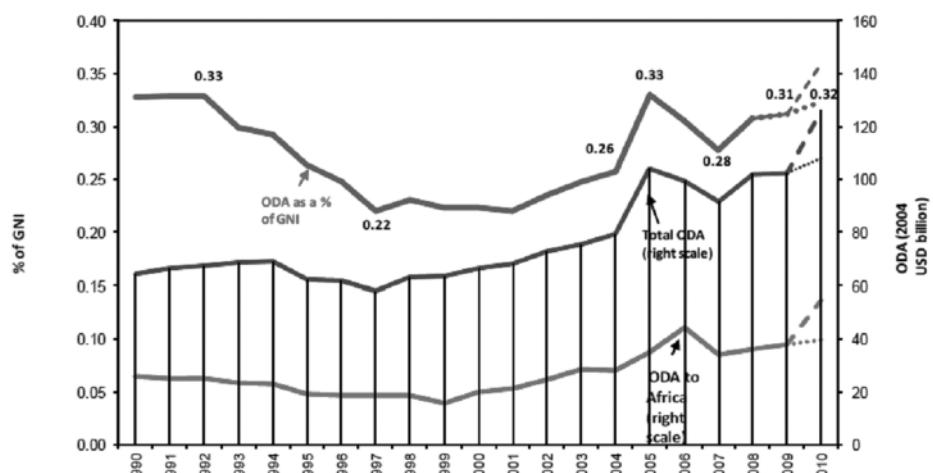
## CHAPTER 2

# Conceptual Framework

### Trends in Overall Aid to Developing Countries

In the past two decades, net disbursements of Official Development Assistance (ODA) have increased overall. While ODA decreased in the early 1990s, it grew steadily between 1997 and 2005 and reached a peak of US\$107 billion in 2005. The increase between 1997 and 2005 was primarily due to debt relief and, to a lesser extent, to emergency assistance and administrative costs. Of the total nominal increase of ODA between 2001 and 2003, for instance, 66 percent went to debt relief and technical cooperation (Gottret and Schieber 2006). During the period 2005–09, net ODA reached a new plateau, though a major dip was observed in 2007 due to a decline in debt relief (Figure 2.1). Interestingly, development aid grew in 2009 despite the financial crisis that started in late 2008. Unlike

**Figure 2.1. DAC members net ODA 1990–2009 and DAC Secretariat simulations of net ODA to 2010**



Note: — dashed line indicates the growth-adjusted trajectory envisaged at Gleneagles.  
.....dotted line indicates estimates based on reported intentions or current 2010 budget plans made by DAC members.  
.....dotted line for Africa indicates a Secretariat estimate of likely actual spending.

Source: DAC/OECD (2010).

other financial flows to developing countries, which have fallen sharply since the onset of the global financial crisis, ODA is expected to continue to rise in 2010. OECD projects ODA at US\$126 billion in 2010, an increase of nearly US\$6 billion over 2009. In Sub-Saharan Africa, ODA declined during the 1990s, doubled between 1999 and 2006, and then declined in 2007 to stabilize around US\$40 billion in recent years. OECD expects a major increase in ODA for Africa in 2010.<sup>1</sup>

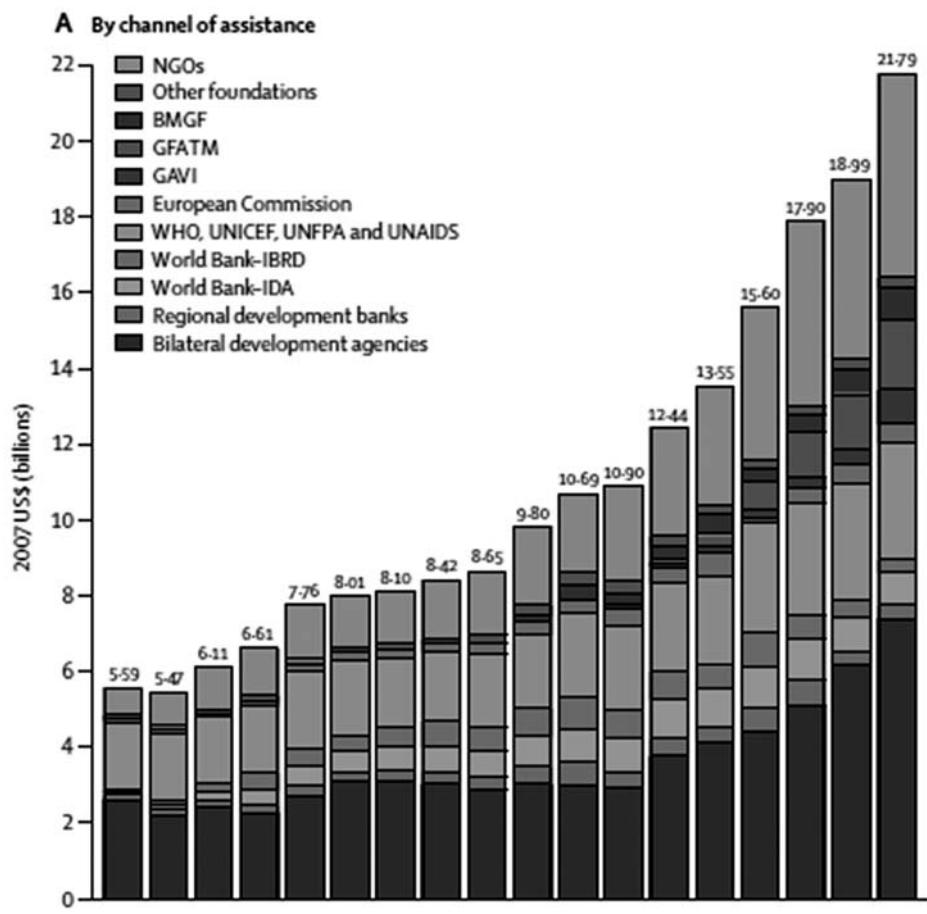
Although ODA increased over time, aid channels proliferated, ODA became more fragmented, and earmarking more frequent. With respect to proliferation, the average number of donors per country rose from about 3 in 1960 to 30 in 2006 (World Bank 2008). Similarly, countries with less than 10 donors fell from almost 40 percent in the 1960s to less than 10 percent in recent years (Bourguignon 2007). The number of international organizations, funds, and programs is now higher than the number of developing countries that they were created to assist (World Bank 2008). With respect to fragmentation, in recent years the number of donor-funded activities has continued to increase, but the average financial size of aid interventions and activities remains small. Aid is dispersed in a myriad of technical assistance activities that tend to be poorly coordinated. Aid transaction costs, for donors and recipients alike, are reportedly very high, though they have not been systematically quantified. In recent years the global aid architecture has become more complex. It has been said that aid has an architecture, but it appears not to have a single architect (Burall and Maxwell 2006): enforcing the principles of the Paris Declaration on Aid Effectiveness<sup>1</sup> is now of paramount importance in order to address aid fragmentation and reduce the inefficiencies created by too many architects.

### Trends in Aid to the Health Sector

Development assistance for health (DAH) in low- and middle-income countries has steadily risen in the past two decades. The total amount of DAH quadrupled from US\$5.6 billion in 1990 to US\$21.8 billion in 2007. DAH doubled between 1990 and 2001, and it doubled again in only six years, between 2001 and 2007. The expansion of resources for global health has accompanied a major shift in the institutional landscape: traditional institutions (UN agencies and development banks) became comparatively less relevant over time, while new institutions—particularly the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation, GAVI)—and NGOs increased their share in the global health panorama. The proportion of DAH channeled through UN agencies decreased from 32 percent in 1990 to 14 percent in 2007. Similarly, the World Bank and regional banks, which accounted for 22 percent at their relative peak in 2000, contributed to only 7 percent of DAH in 2007. Bilateral agencies' share of DAH decreased from 47 percent in 1990 to 27 percent in 2001 and then increased in subsequent years to 34 percent in 2007. In the 2000s two new and large channels of resource flows, the GFATM and GAVI, scaled up rapidly from less than 1 percent of DAH each in 2002 to 8 percent and 4 percent, respectively, in 2007. Last, the share of resources flowing through NGOs increased from 13 percent of DAH in 1990 to 25 percent in 2006 (Ravishankar et al. 2009) (Figure 2.2).

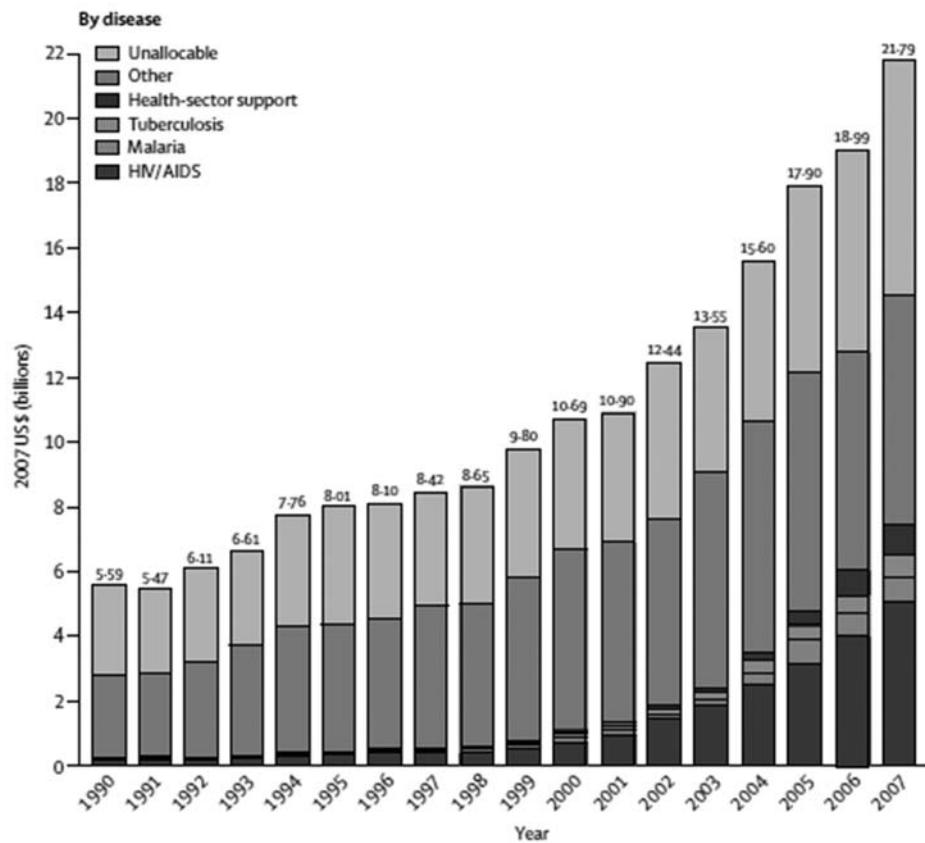
Ravishankar's analysis of DAH from 1990 to 2007 by disease (Figure 2.3) shows a large increase in disbursement for HIV and AIDS: from US\$0.2 billion (3 percent of DAH) in 1990 to US\$0.8 billion (7 percent) in 2000 and US\$5.1 billion (23 percent) in 2007. Comparatively, the funds for tuberculosis and malaria remained small at US\$0.7 billion (3.2 percent) and US\$0.8 billion (3.5 percent), respectively, in 2007. The same analysis shows that the volume of funds devoted to health system remained small despite donors' emphasis to support more horizontal approaches.

**Figure 2.2. DAH from 1990 to 2007 by channel of assistance**



Source: Ravishankar et al. (2009).

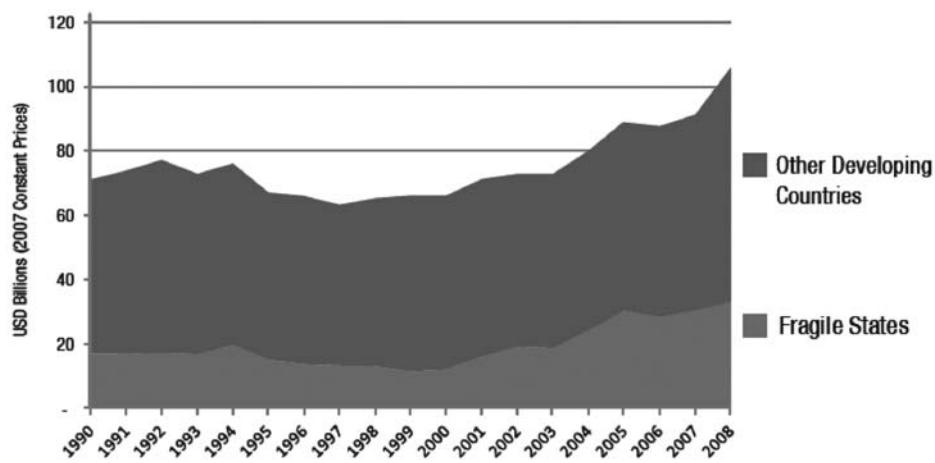
**Figure 2.3. DAH from 1990 to 2007 by disease**



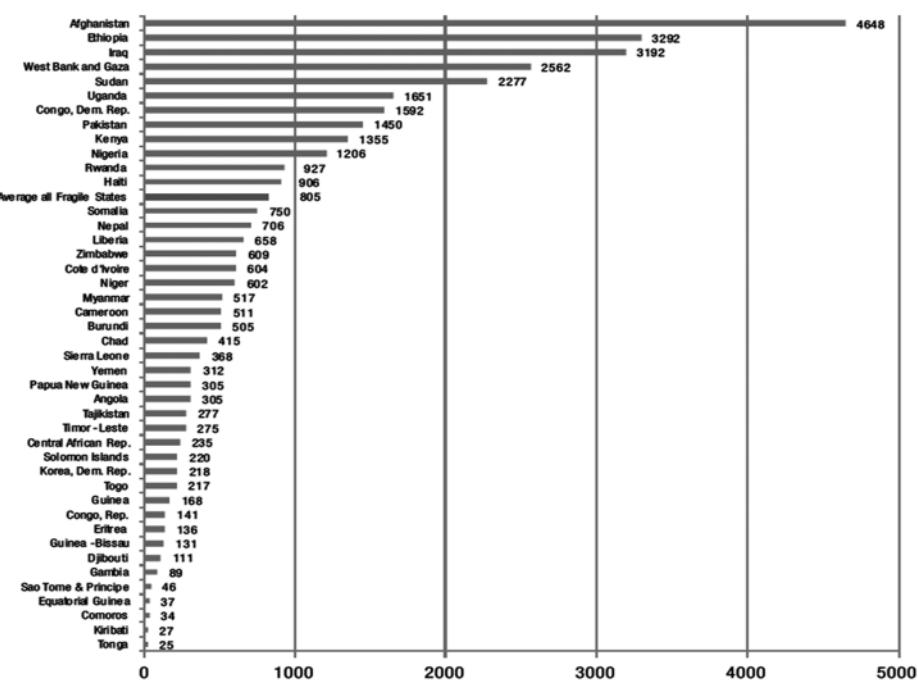
Source: Ravishankar et al. (2009).

### Trends in Aid to Fragile States

ODA to fragile states has been steadily growing over the past 10 years to a total of US\$34.6 billion in 2008 (Figure 2.4). This represents 31 percent of ODA flows to developing countries. However, ODA to fragile states has been increasingly concentrated: in 2008, 51 percent of ODA for the 43 fragile states, benefited just six countries (Afghanistan, Ethiopia, Iraq, the West Bank and Gaza, Sudan, and Uganda), which account for only 23 percent of the population of the total fragile states group (Figure 2.5). Since 2000, Afghanistan and Iraq account for 34 percent of all increases in ODA; 10 fragile states have seen lower ODA levels in 2008 in real terms compared with 2000 (Angola, Equatorial Guinea, Eritrea, Guinea, Guinea-Bissau, Papua New Guinea, São Tomé and Príncipe, Timor-Leste, Tonga, and Yemen) (OECD 2010).

**Figure 2.4. Net DAC ODA to fragile states excluding debt relief (1990–2008)**

Source: OECD/DAC online database.

**Figure 2.5. Net ODA to fragile states excluding debt (2008)**

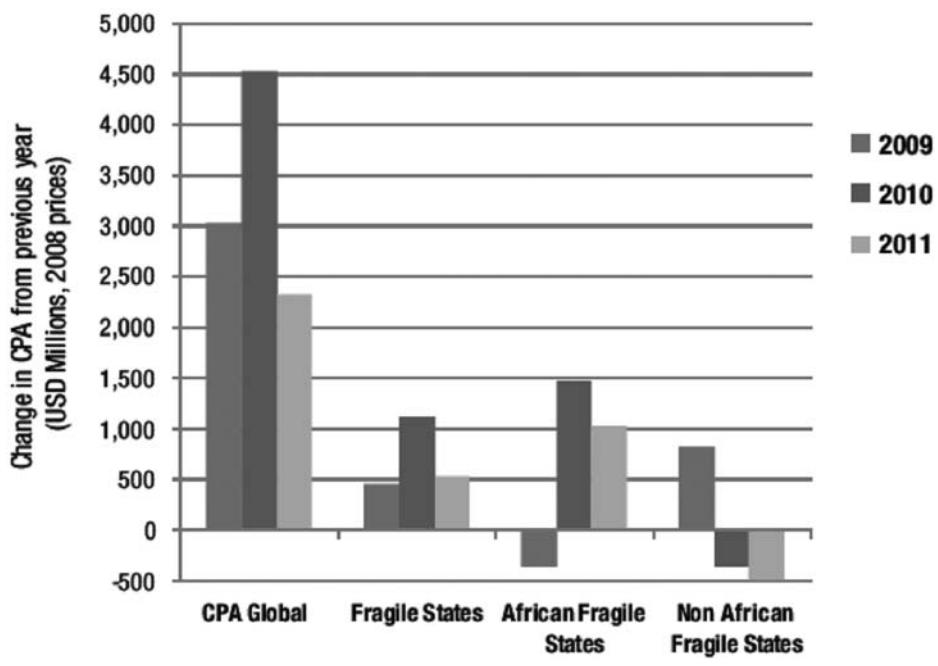
Source: OECD/DAC online database.

Two of the most reported problems in aid in fragile states are volatility and country's accessibility to a limited number of donors. As this study will demonstrate, both problems do not seem to relate to the Somalia health context, as numbers of donors remained large during the past decade and no drops in financing could be observed. Despite the global recession, OECD expects further growth in volumes of aid to fragile states in 2010 (Figure 2.6).

Available data on aid to the health sector in fragile states show that many countries are relatively neglected by the international community, thus falling into the category of "aid orphans." Data also imply that aid allocations may be swayed by geopolitical and media concerns rather than population needs (Table 2.1). Afghanistan is probably the notable exception: despite high geopolitical interests in the country, financial aid for the health sector remains modest, though aid appears to be more strategically targeted and hence more effective (Loevinsohn and Sayed 2008).

Moreover, global knowledge on aid financing to the health sector in fragile states remains limited. This is mostly due to the inherent difficulties of tracking financial flows in contexts characterized by high insecurity, frequent natural and man-made catastrophes, and political changes. Collecting financial data is also made difficult by fragmentation and ambiguities of roles within the donor community, incompleteness of information available, and variety of planning cycles and budget formats, as well as resistance to share financial information (Pavignani and Colombo 2006).

**Figure 2.6. Country programmable aid for fragile states (2009–11)**



Source: OECD.

**Table 2.1. External aid allocated to health care in fragile states**

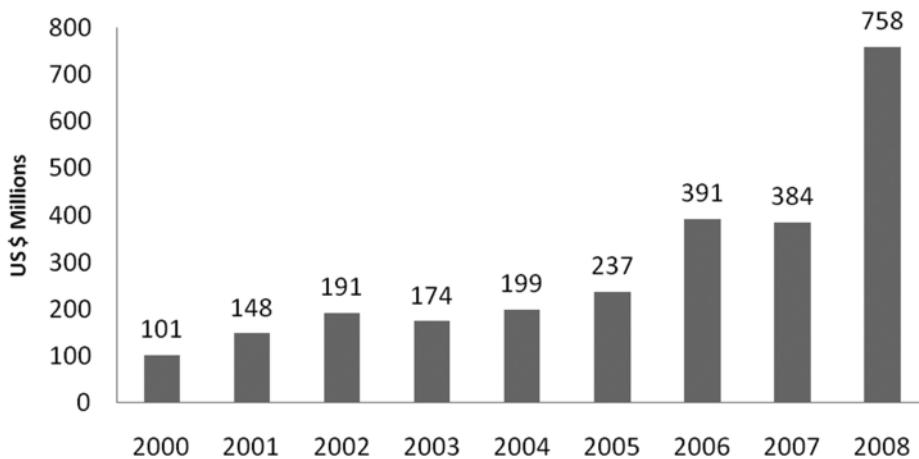
Country	Year	Amount per head	Source
Afghanistan	2009	\$11	World Bank 2010
Congo, Dem. Rep.	2004–06	\$6	WHO 2009
East Timor	2000	\$36	Tulloch et al. 2003
Iraq	2004–06	\$67	WHO 2009
Kosovo	2001	\$60	Pavignani 2005
Somalia	2006	\$7	Capobianco, Naidu 2007
Southern Sudan	2003	\$7	Health Secretariat of the new Sudan 2004
West Bank and Gaza	2005	\$54	WHO 2009

Source: Loevinsohn and Sayed 2008.

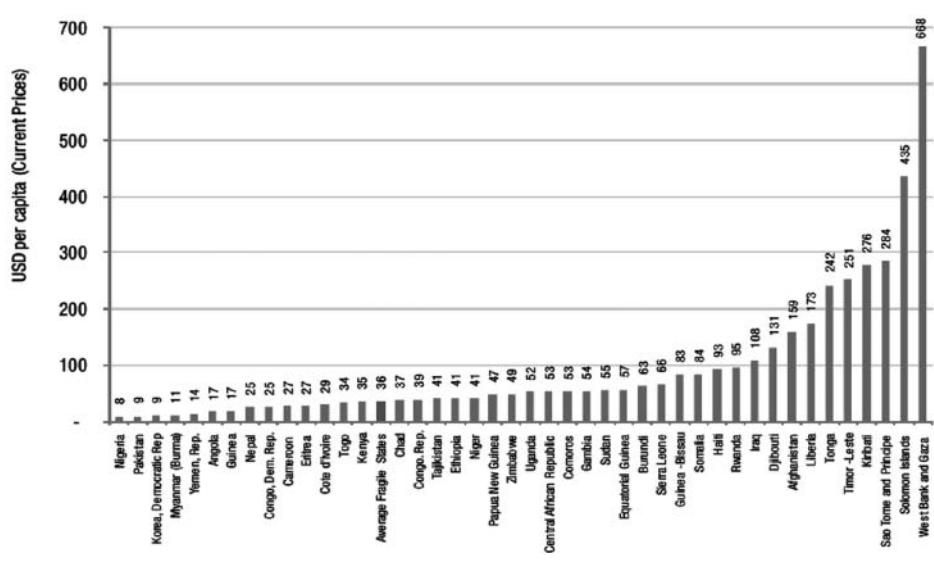
### Trends in Aid to Somalia

ODA to Somalia from 2000 to 2008 totaled US\$2.6 billion (Figure 2.7), with a peak of US\$758 million in 2008. The almost twofold increase in aid from 2007 to 2008 is likely a consequence of the grave humanitarian situation experienced by Somalia during the 2008 drought.

As indicated in Figure 2.8, the 2008 amount puts Somalia just below the average for net ODA to fragile states. However, when net ODA per capita is considered (US\$84 per capita), Somalia appears to receive much more than the average fragile state (US\$36 per capita).

**Figure 2.7. ODA to Somalia (2000–08)**

Source: OECD/DAC online database.

**Figure 2.8. ODA to fragile states**

Source: OECD/DAC online database.

## Notes

1. Ownership, alignment, harmonization, managing for results, and mutual accountability.

## CHAPTER 3

# Methodology

### Approaches

The following approaches were used in both studies, conducted in 2007 and 2010 (the former covering 2000–06, the latter covering 2007–09):

- *Consultations with the Health Sector Committee (HSC) of the Coordination of International Support to Somalia (CISS), formerly known as SACB.*<sup>1</sup> The research protocol for the original study from 2000 to 2006 was presented in February 2007 and endorsed, in March 2007, by the HSC, which represents all donors, UN agencies, NGOs, and Somali authorities involved in the health sector. A follow-up study was requested by the HSC in 2010 to cover 2007–09. In both studies, HSC members played an important role in facilitating the data collection process at their agencies and provided critical input during the data analysis phase.
- *Literature review.* Secondary data were collected through a literature search on global aid flows and more specifically on Somalia and the health sector. Desk reviews of relevant literature on Somalia were carried out.
- *Quantitative questionnaires.* Primary quantitative data collection on financial and in-kind contributions was undertaken via the use of a financial tool developed and pilot-tested by the researchers in March 2007. In 2007, a total of 26 bilateral, multilateral, and other donor organizations and NGOs were sampled. The number increased to 38 in 2010 (Appendices 1 and 2). In 2007, the response rate was 96 percent, and in 2010, 95 percent. Quantitative data were collected between March and May 2007 and again in March 2010.
- *Inclusion of NGOs.* The first study did not include NGOs in the sample, thus missing out on important sources of funding. The follow-up study corrected this problem and involved the largest international NGOs (Annex 2). Whenever available, the NGOs' data for the entire study period (2000–09) were incorporated into the present analysis (for example, MSF financial flows from 2004 to 2006 were not included in the original study but appear in the key findings of this report; earlier contributions by MSF could not be obtained).
- *Consultative workshops.* Preliminary findings were presented to HSC members at a meeting held on 29 March 2010. In-depth discussions were held with key individuals of the HSC during analysis in Nairobi.

## **Data Collection Process**

### *Data Collection*

Two types of quantitative data were collected: (i) contributions by donor agencies and (ii) expenditure by agencies that implemented donor and own funds on health sector activities (henceforth referred as recipient/implementing agencies). As a first step, all donors (bilateral, multilateral, and other donors) were requested to supply total contributions and disbursements<sup>2</sup> for calendar years 2000 to 2009 in support of the health sector<sup>3</sup> in Somalia. Commitments or pledges were not considered. As a second step, recipients and implementing agencies were requested to provide actual expenditures on health sector programs for the same period. Data were mainly extracted from computer print-outs provided by the major recipients and implementing agencies, self-completed spreadsheets by some implementing agencies, or published annual financial reports (in the case of MSF).

### *Data Verification*

The majority (88 percent in 2009) of donor contributions were accounted for at the donor agency level. In case of omissions from donor agencies or donor uncertainty of the total amount contributed, data were checked at the level of the implementing agencies. To avoid double counting, approximately 80 percent of all funds contributed were cross-checked with recipients and implementing agencies or against contracts or documentation issued by the donor agency.

### *Rate of Exchange*

In total, 80 percent of the donor contribution was recorded in U.S. dollars. Funds obtained in foreign currency were converted into U.S. dollars by using the average annual rate of exchange for that particular year from the Oanda website.<sup>4</sup>

### *Confidentiality*

The data at the level of individual donors or recipients were disclosed only to the research team. All financial records will be destroyed three months after the publication of this report.

## **Types of Quantitative Data Collected**

Four main types of retrospective quantitative data were collected: [A] total aid financing, [B] health sector expenditures by disease, [C] by zone, and [D] by activity (for horizontal programs only). Although A was obtained primarily from the financial data of donor agencies (88 percent of funds in 2009), B, C, and D were obtained from financial data of recipient and implementing agencies (91 percent of funds in the last three years) or from a review of partner contracts at the donor level (9 percent of funds in the last three years) especially in cases where the implementing agency was not based in Nairobi.

- A. *Total donor health sector aid financing* refers to contributions (financial and non financial) made by donors for health sector activities.

- B. The category *Health expenditures by disease and program* refers to expenditures by recipient/implementing agencies on various disease programs ranging from vertical programs such as polio, nutrition, EPI, TB, malaria, or HIV (see Figure 2.7 for the number of diseases reported) to horizontal programs, such as primary health care, hospital care, and health systems support.
- C. The category *Health expenditures by zone* refers to expenditures by recipients and implementing agencies incurred for the benefit of beneficiaries in the three zones (Somaliland, Puntland, and South/Central zone). A fourth category, *Countrywide*, includes expenditures not targeted at any specific zone but benefiting the entire country. The fourth category also includes program support costs such as salaries.
- D. The category *Health expenditures by activity* refers to expenditures by recipients and implementing agencies for all major costs, such as supplies, monitoring and evaluation, staff costs, and so forth. For the last three years, this information was collected only for expenditures on horizontal programs.

As expected, the study found differences between the disbursements reported by the donors and the expenditures reported by recipients and implementing agencies (Table 3.1). The average difference for all years was 9 percent.

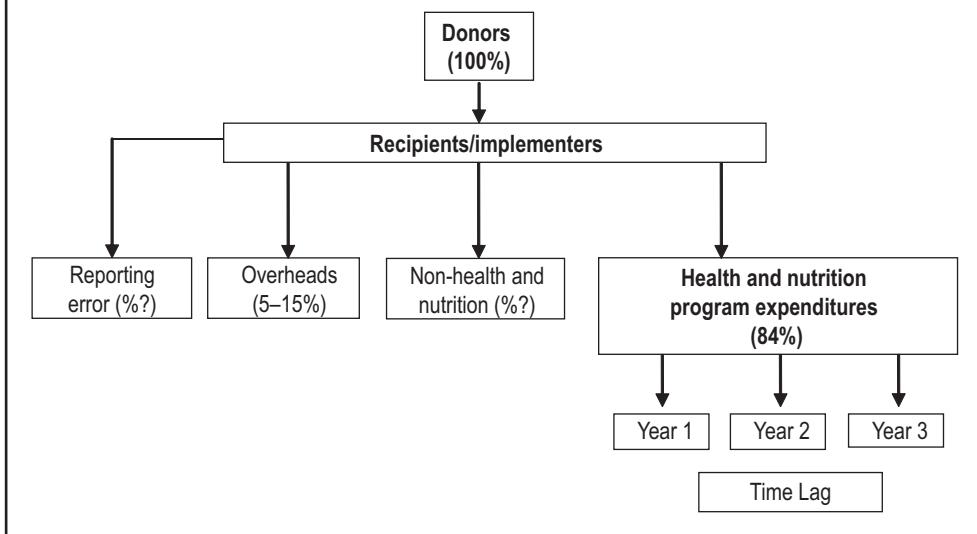
**Table 3.1. Percentage difference between data collected from donors and recipients and implementing agencies**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	All years
A. Donor Contribution	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
B. Expenditures by Recipients/ Implementers	86%	91%	76%	94%	75%	87%	87%	88%	86%	109%	91%
Implements % Difference	-14	-9	-24	-6	-25	-13	-13	-12	-14	+9	-9

Source: Authors.

Four factors explain the difference (Figure 3.1). First, there is a time lag between contribution of funds by donor agencies and the implementation by recipients and implementing agencies. In other words, funds disbursed by donors in one fiscal year are often spent by the recipients and implementing agency in another fiscal year. Analysis of the data revealed that in 2002 and 2005, two donor organizations were found to be providing larger than usual funding, which was used in the following years. From 2004 to 2005, disbursements by the GFATM accounted for the majority of the difference, as start-up activities delayed recipients and implementing agencies from spending the grants. In 2006, the difference was due to disbursement by the Italian Cooperation of US\$6.5 million for health systems development activities that would be implemented by the recipients and implementing agencies in subsequent years. In 2009, fewer contributions were received and implementing agencies spent money received in 2008 during the humanitarian emergency. Hence, a positive difference of 9 percent is observed.

**Figure 3.1. Explanations for the difference between donor disbursement and recipients' and implementing agencies' expenditures**



Source: Authors.

Second, when funds are transferred from a donor to a recipient or implementing agency, the recipient or implementing agency may take a portion of the funds (generally between 7 and 15 percent) as overhead, which generally occurs at the headquarters level. In this study, the overhead could not be accounted for, as some recipients and implementing agencies did not have specific data on overhead for Somalia.

Third, some donors provide unearmarked funds that are categorized as health sector disbursements by the donor agency. However, at the recipient and implementing agency level the same funds could be spent for initiatives not strictly linked to the health sector, such as food aid or water and sanitation.

Fourth, reporting errors cannot be ruled out.

### Methodological Limitations and Challenges

The study has the following limitations:

- *Scope of the study.* The study focuses on health sector aid financing by DAC donors. Due to its design, the study does not include remittances from the Somali diaspora, out-of-pocket health care spending by individuals, funds from non-DAC donors, private funding of local and international NGOs (apart from the major NGOs based in Nairobi), and expenditures from the three Ministries of Health.
- *Missing data.* Data were not obtained from UK Department for International Development (DFID) and Norway for 2006 and from International Committee of the Red Cross (ICRC) and MSF for 2000–03. For 2007–09, data were missing from Norway and Finland.

- *Agency overheads.*<sup>5</sup> Overhead that is not part of direct disease program costs for donor and recipients and implementing agencies could not be obtained. For instance, costs related to UNCAS and European Commission Humanitarian Office (ECHO) flights for transport of personnel and supplies to Somalia were not captured. The cost of security or money transfer was also missed.
- *Coding of expenditures by donor or implementing agencies.* Activities may be coded differently by different implementing agencies. Researchers tried to obtain detailed information about funding across programs, but in a few cases they could not disentangle funding for different categories—or were not allowed to. For example, all activities implemented by MSF have been included in the emergency category, though part of MSF interventions could be included in other categories (such as primary health care or nutrition programs). This may result in over- or underestimation of funding in certain categories in the analysis of aid by disease or program.
- *The inclusion of all HIV expenditures as health expenditures.* Although not all HIV expenditures are strictly health sector-related, it was impossible to separate health from other multisectoral HIV interventions, as most donors categorize HIV expenditures under health.
- *Differing financial reporting systems provided challenges in disaggregating expenditures by zone.* Expenditures by zone were either obtained from organizations' financial reporting systems (2000–09) or in some instances disaggregated by program managers (2000–06). In the first study, bias was introduced to the data for the allocation by zone due to two major programs, HIV and polio. For 2000–06, as advised by program managers, HIV expenditures were equally divided by each zone. Polio expenditures were apportioned according to the number of children vaccinated in each zone. In 2007–09, only programs disaggregated by organizations' financial systems (52 percent of total funds) were considered in the analysis by zone.
- *Differing financial reporting systems provided challenges in disaggregating expenditures by activity.* Costs were allocated differently in different agencies. For example, travel for training might be allocated to capacity building by one agency and to travel by another. In addition, some agencies financial systems did not disaggregate expenditure by specific activities. In a few instances costs had to be reallocated per activity at the discretion of the researcher and the program or finance managers.

Data collection provided the following methodological challenges:

- *The process was lengthy and labor intensive.* Data collection and verification of quantitative data took on average five contacts per agency during the first study and three contacts per agency during the second study. Follow-up contacts were made via telephone, email, or personal visits.
- *Retrieving financial data from agencies not based in Nairobi was particularly difficult.* Agencies relied on the Nairobi office to make contact with their respective headquarters to supply information.
- *The institutional memory of donors and recipients and implementing agencies was not always strong.* Collecting data from 2000 proved challenging since in a few agen-

cies archived data were difficult to retrieve. For two agencies, annual reports were used to extract data for the initial study.

- *Obtaining actual expenditures from recipients and implementing agencies was more difficult than expected.* Some agencies required more time to access actual expenditures while information on budgets were easier to access.

## **Usefulness of the Data**

Despite the limitations and methodological challenges experienced, the study offers some useful insights, as illustrated in the findings over the decade and in the conclusions and recommendations sections. The use of the same methodology in 2007 and 2010 allows a reliable review of trends of aid to the sector. The study provides important baseline data, raises levels of awareness, and generates questions about past and future aid financing to the health sector. Finally, it highlights gaps in knowledge that may be filled by future studies.

## **Notes**

1. Somalia Aid Coordinating Body.
2. Disbursements and contributions are financial (monetary) and nonfinancial (in-kind) made by donors to recipient/implementing agencies. In this study a donor had disbursed funds when the contributions had left the agency's bank account.
3. In this study, financing for the health sector refers to aid for health only; food aid or support for water and sanitation interventions were not included.
4. Average annual exchange rates are available at: <http://www.oanda.com/convert/fxhistory>.
5. Overhead is generally described as the ongoing administrative expenses of a business that cannot be attributed to any specific business activity but are still necessary for the business to function. Examples include rent, utilities, insurance, and so on ([www.investorwords.com/3547/overhead.html](http://www.investorwords.com/3547/overhead.html), accessed May 23, 2007).

## CHAPTER 4

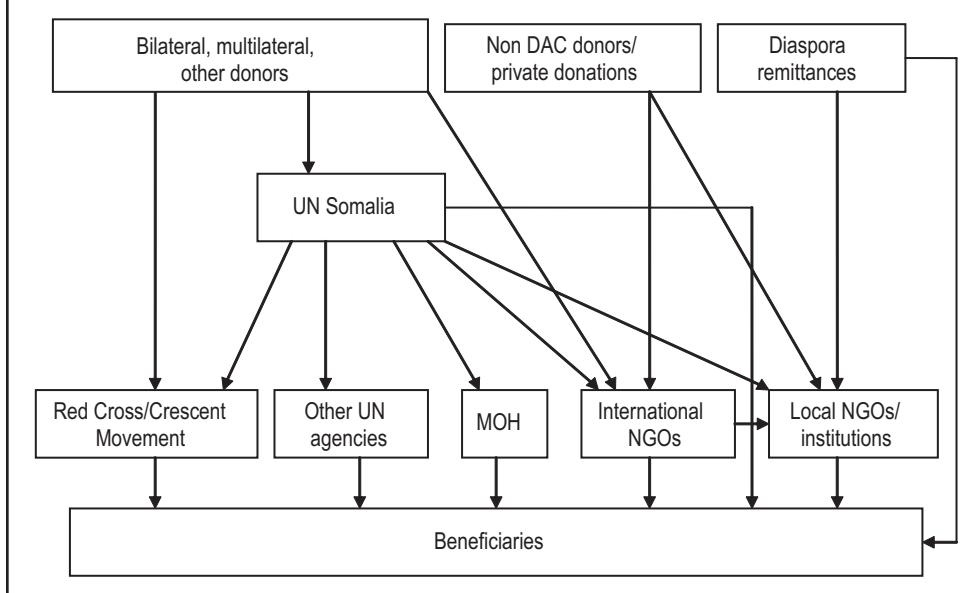
# Key Findings

### Financial Aid Flows

In Somalia, aid to the health sector flows through an intricate network characterized by three groups of financiers and many intermediaries (Figure 4.1).

- The so-called traditional donors (bilateral,<sup>1</sup> multilateral,<sup>2</sup> and others<sup>3</sup>) are the object of this study. These donors provide direct and indirect funding to several agencies and institutions operating in Somalia. Funding is directly channeled to international NGOs, the Red Cross/Red Crescent Movement, or more frequently, to the UN Somalia Family. The UN plays a crucial role in further channeling funds to a series of implementers that include local NGOs and institutions, international NGOs, ministries of health, and the Red Cross/Red Crescent Move-

**Figure 4.1. Financial aid flows in the Somalia health sector**



Source: Authors.

Note: Non-DAC donors are donors from countries not represented in the OECD Development Assistance Committee (DAC).

ment. UN agencies that receive funds from traditional donors may also directly implement or channel funds to other UN agencies;

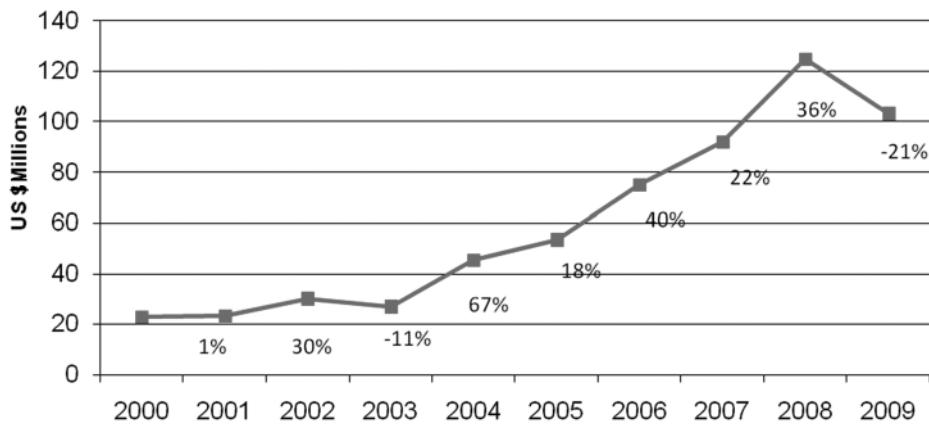
- Non-DAC donors<sup>4</sup> and private financiers<sup>5</sup> usually sponsor international NGOs or national NGOs/institutions. Non-DAC donors, mostly Arab countries supporting Islamic charities, and private donors are not included in this study. However, their contributions to the health sector are relevant.
- Somalis living abroad are reported to contribute significantly to the economy of the country. Funding for health reaches the beneficiaries to meet the financial needs of medical treatment. In other cases remittances are used to support local institutions or NGOs. The analysis of Somali remittances to the health sector is not part of this study.

### Total Health Sector Aid Financing

Total health sector aid financing to Somalia grew from US\$23 million in 2000 to US\$103 million in 2009 (Table 4.1), almost a fivefold increase in 10 years. Data show an increasing trend throughout the decade with a peak of US\$124 million in 2008 during the humanitarian emergency created by a severe drought in the country. The 2009 reduction in financing is likely due both to a reduction of emergency funding following the resolution of the drought, and to lower OFDA contributions due to the USAID decision to reduce overall funding to Somalia to avoid the diversion of aid to groups linked to Al Qaeda.

The totals reported (Figure 4.2) are conservative estimates of the total aid provided to the health sector in Somalia. DFID contributions for 2006, and ICRC and MSF disbursements for 2000–03 could not be obtained and are therefore not included. Furthermore, the total disbursements exclude remittances from the Somali diaspora, funds from non-DAC donors, and private funding for local and international NGOs.

**Figure 4.2. Total health sector aid financing (2000–09)**



Source: Authors' calculations.

In real terms, keeping the rate of exchange constant using 2000 as the base year, aid financing between 2000 and 2009 increased by three and a half times (Table 4.1).

**Table 4.1. Total health sector aid financing using current and constant rate of exchange and adjusting for U.S. dollar inflation (2000–09)**

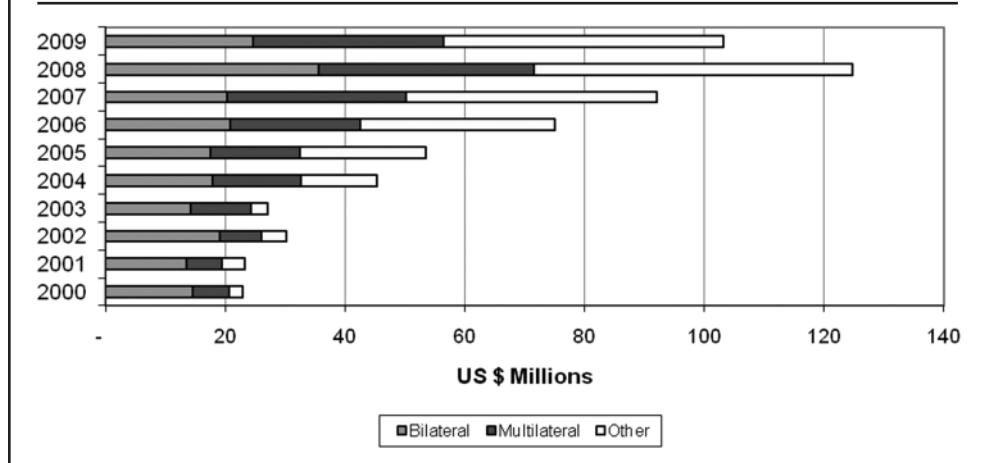
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Reported Disbursements US\$ (Millions)	23.0	23.3	30.3	27.1	45.3	53.6	75.1	91.8	124.8	103.3
Annual increase current		1%	30%	-11%	67%	18%	40%	23%	36%	-21%
Reported Disbursements US\$ (Millions) constant	23.0	22.9	28.5	24.4	37.0	44.1	61.8	70.4	91.8	74.9
Annual increase constant		1%	24%	-17%	52%	19%	40%	14%	30%	-22%

Source: Authors' calculations.

The increase in financing to Somalia over 2000–08 is predominantly due to an increase in financing from multilateral sources and others (see Figure 4.3). The emergence of the GFATM as a major player in the health sector in Somalia and the financing from MSF explain the surge observed in the “others” category from 2004 onwards. The increase of multilateral funding is responsible for larger funds available from 2006 onward, mostly thanks to ECHO and the UN. On the other hand, the level of bilateral support has remained constant over the years, with the major exception of 2008, possibly due to the drought emergency.

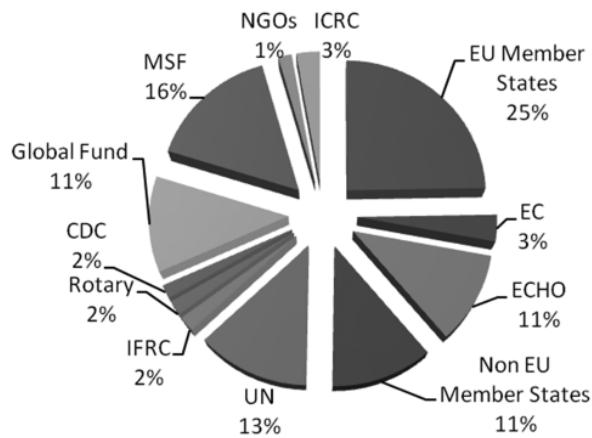
In light of the aggregate data from 2000 to 2009 (Figure 4.4), the European Union (EU)—through its member states, the European Commission (EC), and the EC Humanitarian Office—provided almost 40 percent of the total funding for the health sector. Non-EU member states accounted for 11 percent while the UN accounted for 13 percent. The GFATM and MSF were large contributors to the sector (11 percent and 16 percent, respectively) during the past decade, though their contributions started from 2004 on (see Chapter 3 for explanations of MSF contributions).

**Figure 4.3. Total health sector aid financing by donor category (2000–09)**



Source: Authors' calculations.

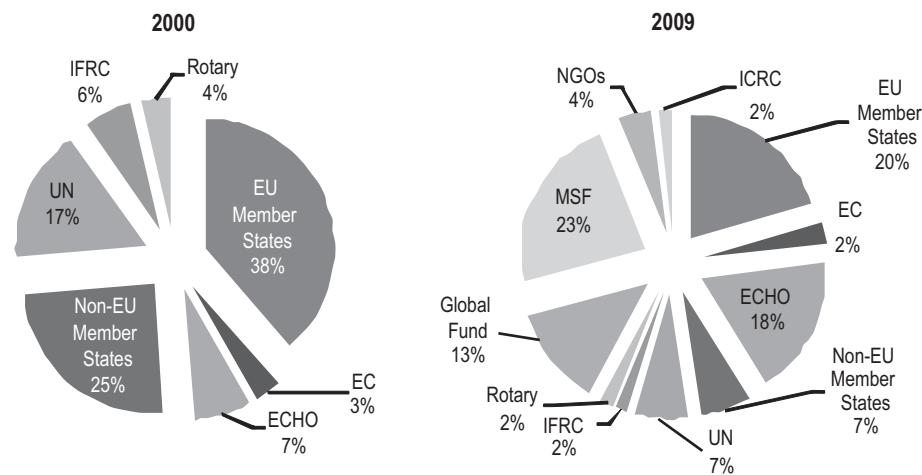
**Figure 4.4. Percentage contribution of health sector aid financing by donor category (2000–09)**



Source: Authors' calculations.

A comparison of the relative contributions for health in 2000 and 2009 shows important changes in the panorama of donors to the health sector (Figure 4.5). First, the number of players has increased over the years. In 2009, NGOs (including MSF) represented a large share—27 percent—of financing to the sector, and the GFATM accounted for 13 percent of the total financing. MSF became the largest financier to the sector in 2009, providing more financing than all the UN agencies together or all EU member states. Second, the relative weight of “old” players changed overtime. While ECHO’s weight increased from 7 to 18 percent between 2000 and 2009, the UN’s relative contribution shrank from 17 to 7 percent, and the EU member states’ relative contribution declined from 38 to 20 percent.

**Figure 4.5. Percentage contribution of health sector aid financing (2000 and 2009)**



Source: Authors' calculations.

Aid per capita for the health sector almost quadrupled in the last decade, rising to US\$11.2 in 2009 from US\$3.2 in 2000 (Table 4.2). In the last three years (2007–09) aid per capita ranged between US\$11 and US\$14. As indicated above, the figures are conservative, as they capture only DAC donors' contributions. However, the population figures used in the calculation remain highly contentious in Somalia. The population estimates used for the analysis were obtained from the Human Development Report 2006 published by UNDP.

**Table 4.2. Per capita health sector aid financing (US\$)**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Total US\$ million	23.0	23.3	30.3	27.1	45.3	53.6	75.1	91.8	124.8	103.3
Population million	7.1	7.3	7.5	7.8	8.0	8.2	8.5	8.7	9.0	9.2
Per capita US\$	3.23	3.18	4.01	3.49	5.67	6.51	8.87	10.55	13.93	11.21

*Source:* Authors' calculations.

*Note:* According to the Human Development Report 2006, the population of Somalia was estimated at eight million people in 2004, with a growth rate of 2.9 percent. The population for 2000–03 was adjusted using the 2.9 percent figure for the years prior to 2004. The Human Development Report 2009 estimated the 2007 population to be 8.7 million, with a growth rate of 2.8 percent.

### Health Sector Aid by Disease and Program

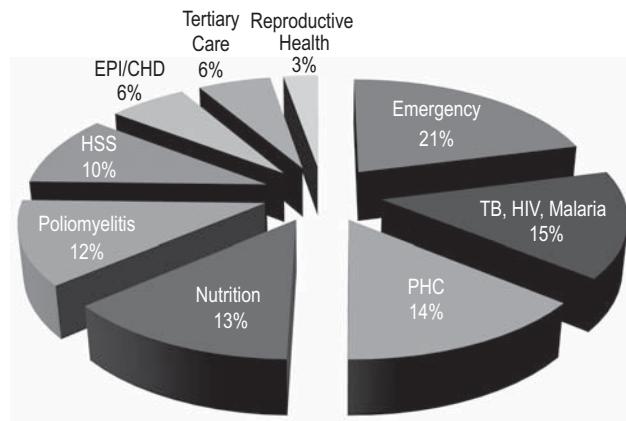
Recall that the analysis of aid by diseases, by zone, and by activity is based on the expenditures by recipients and implementing agencies. These expenditures are lower than the total donor contributions (with the exception of 2009), which are used in the analysis for the total health sector aid financing to Somalia (Table 4.3). The reasons for this difference were explained in section 3.

**Table 4.3. Health sector aid by disease and program (2000–09) (US\$ million)**

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	All years
A. Donor Contribution	23.0	23.3	30.3	27.1	45.3	53.6	75.1	91.8	124.8	103.3	597.6
B. Expenditure by Recipient/Implementers	20.1	21.3	24.4	25.5	36.3	47.4	66.5	82.1	110.0	112.7	546.3
% Difference	14%	9%	24%	6%	25%	13%	13%	12%	14%	+9%	9%

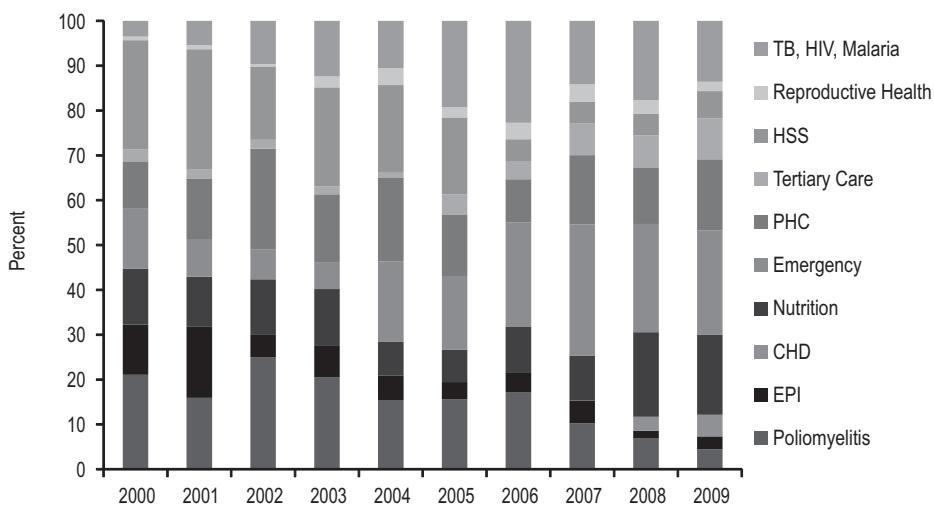
*Source:* Authors' calculations.

Over the decade (Figure 4.6), the majority of funding went to emergency programs (21 percent), TB, HIV, and malaria (15 percent), primary health care (14 percent), nutrition (13 percent), the polio program (12 percent), and health system strengthening activities (10 percent).

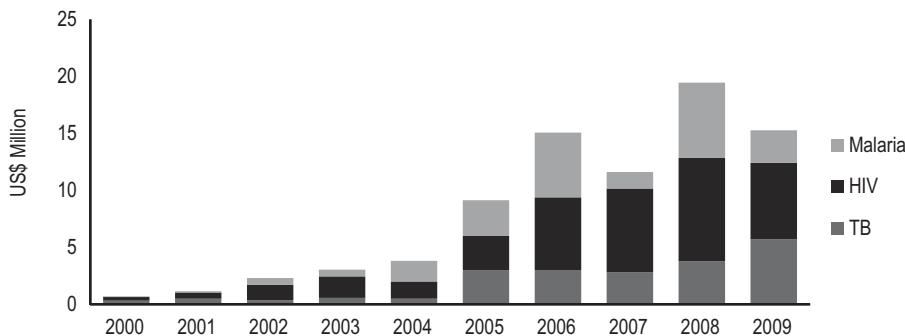
**Figure 4.6. Percentage contribution by program (2000–09)**

Source: Authors' calculations.

During 2000–09, however, major changes occurred in the distribution of aid by programs (Figure 4.7). The polio program benefited from large financing throughout the decade. Between 2000 and 2006, the polio program used to account for approximately 20 percent of overall financing, but polio's weight decreased to less than 10 percent annually in 2007–09. The HIV, TB, and malaria programs, fairly small at the beginning of the decade (<5 percent), became very relevant after the start of GFATM financing in 2005 and accounted for more than 20 percent of overall financing in the peak of 2006. The three programs slightly decreased in relevance between 2006 and 2009, but they remained

**Figure 4.7. Percentage contribution by program (2000–09)**

Source: Authors' calculations.

**Figure 4.8. Health expenditure: TB, malaria, and HIV (2000–09)**

Source: Authors' calculations.

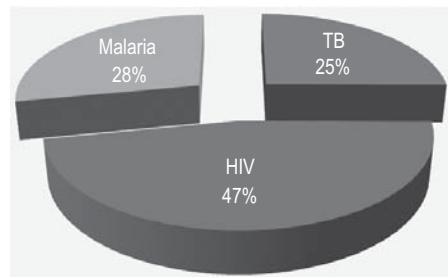
heavily funded compared with other vertical and horizontal programs. Although absolute contributions for horizontal programs increased over time, the relative weight decreased from 37 percent in 2000 to 33 percent in 2009. Emergency programs' relevance increased over time, as they accounted for approximately 25 percent of the overall annual funding between 2006 and 2009.

**HIV, TB, and Malaria Programs:** The shift toward financing of vertical programs became more noticeable from 2005 on due to the presence of funding from GFATM (Figure 4.8). In the eight rounds of proposals issued between 2000 and 2009, the GFATM approved six proposals (two for each disease) for a total amount of US\$154 million. GFATM funds for HIV and malaria are managed by UNICEF while World Vision International manages the funds for TB. Implementers include NGOs, UN agencies, and civil society organizations. By 2009, practically all funding for the malaria and TB programs in Somalia was from GFATM. Interestingly, however, in 2009 a third of the funding for HIV still came from sources other than GFATM.

The generous funding for the three programs must be considered in light of the epidemiological burden of each disease, as well as of the programs' results. Somalia remains a country of low HIV prevalence (0.5 percent in 2007), with 24,000 people living with HIV (UNAIDS 2008). With an incidence of 249 per 100,000 population, TB is responsible for approximately 23,000 new pulmonary cases a year; the estimated prevalence for all forms of TB is approximately 30,000 and 5,500 people are expected to die annually due to TB (WHO 2009). For malaria, WHO reports approximately 37,000 cases, while the estimated number of deaths is approximately 3,500 a year (WHO 2008).

Given the above burden of disease, one may expect an approximately equal distribution of financial resources for the three diseases, with higher investments in TB and malaria. Instead, the approximately US\$80 million distributed for the three programs over the past decades have disproportionately benefited the HIV program: 47 percent of the total, against 28 percent for malaria and 25 percent for TB (Figure 4.9). More important, the burden of the three diseases should be compared with estimates from other public health programs in Somalia. Malnutrition in Somalia, for instance, affects a much larger proportion of the population affected by TB, HIV, and malaria: approximately 800,000 children under five suffer from moderate to severe stunting, and approximately

**Figure 4.9. Health expenditures: TB, malaria, and HIV (2000–09)**



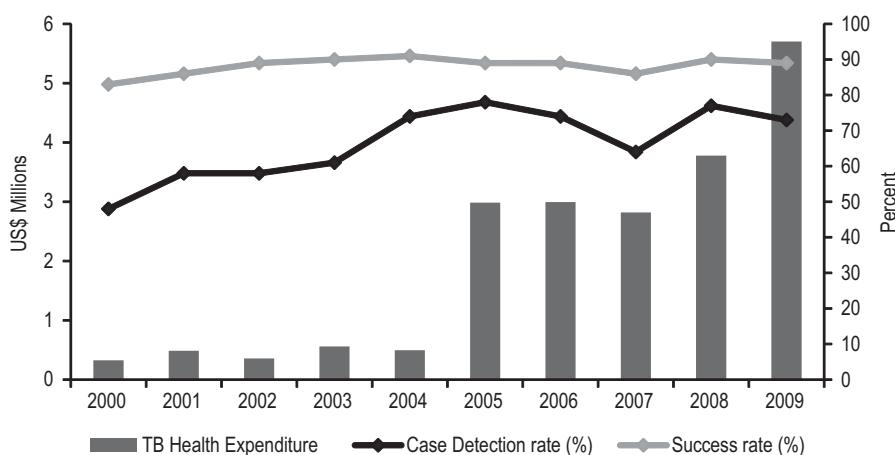
Source: Authors' calculations.

250,000 children suffer from moderate to severe wasting (UNICEF 2010). Despite the staggering numbers, the TB, HIV, and malaria programs received approximately the same amount of funding as malnutrition during 2006–09 (US\$15 million a year).

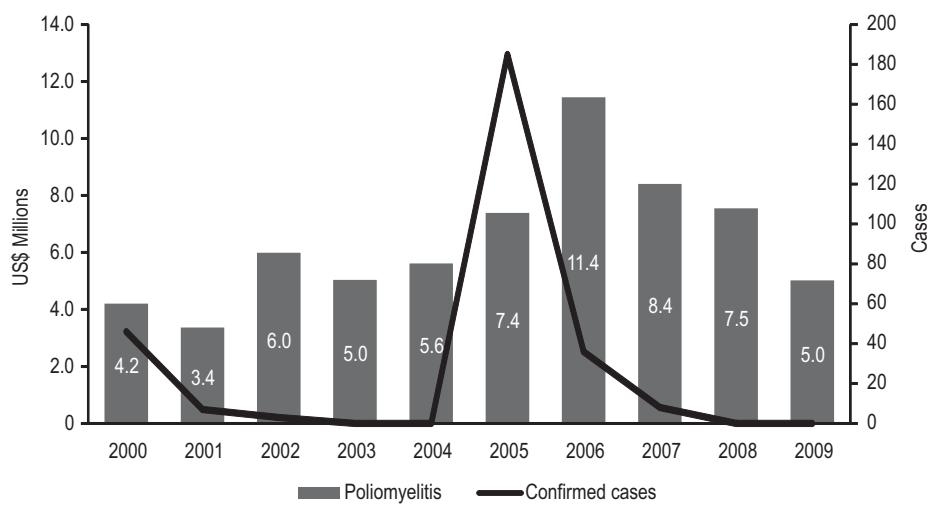
An analysis of program results for the three programs is difficult due to lack of reliable data. However, the TB program has been long established in the country and provides high quality statistics. The program performed well in the first half of the past decade, reaching

the global targets for case detection and treatment outcomes in 2005. However, program performance does not appear to have improved after 2005 (Figure 4.10), despite a remarkable increase in funding (almost a tenfold increase between 2004 and 2009). Assessing progress is difficult for the HIV program, as the majority of activities tend to be preventive in nature. As of 2010, prevalence data indicate that the epidemic is not generalizing, while on the curative side, less than 500 people currently are reported to receive anti-retroviral therapy (WHO 2009). Prevention activities among young people appear to reach only a minority, as only 4 percent of young people have comprehensive knowledge of HIV (UNICEF 2010). On the malaria front, progress has been made in the provision of insecticide-treated nets (ITNs), though the percentage of households owning at least one ITN remains low (12 percent). The percentage of children under five sleeping under ITNs is equally low (11 percent). On the treatment side, the percentage of children under five with fever receiving anti-malarial drugs is at 8 percent (UNICEF 2010).

**Figure 4.10. Health expenditures: Tuberculosis financing versus TB case detection and TB success rate (2000–09)**



Source: Authors' calculations.

**Figure 4.11. Health expenditures: Poliomyelitis (2000–09)**

Source: Authors' calculations.

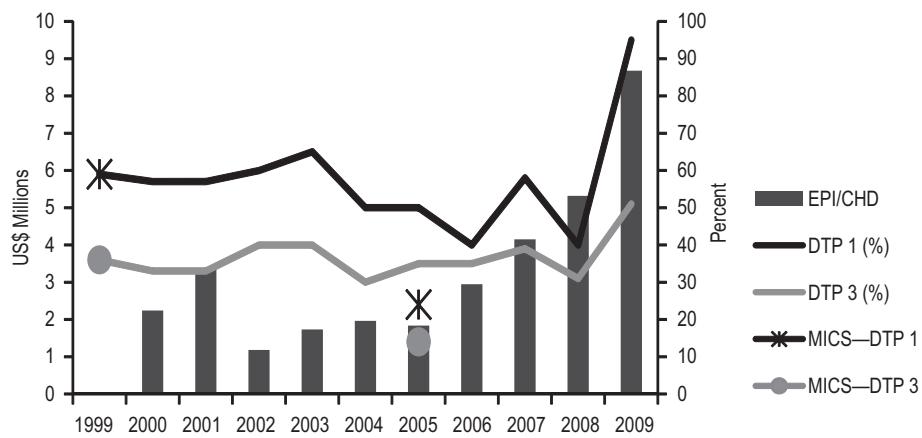
**Poliomyelitis Program:** The polio eradication program received US\$64 million in the past decade (Figure 4.11) and was the largest funded vertical program up to 2006. Sponsored by several international donors, the program is jointly coordinated and implemented by WHO and UNICEF.

The number of confirmed cases was brought down to zero in 2002, thanks to biannual national immunization campaigns. However, in 2005 a major outbreak involved 185 children and required a massive increase in activities to reduce cases to 35 in 2006 and 8 in 2007. Since 2008, no polio cases have been reported in Somalia (WHO 2010). An analysis of funding during the decade attests to the program's significant expense and the fact that increased financing at the moment of crisis resulted in sharp decline of cases. The decrease in expenditures in 2008–09 largely due to withdrawal of campaigns in the South/Central zone due to political unrest.

**Expanded Program on Immunization (EPI):** Funding for EPI was stable during the first part of the decade, with approximately US\$2 million provided to Somalia every year. However, a steady increase in financing was reported from 2006 on (Figure 4.12) with a peak of US\$8.7 million in 2009. The sharp increase in 2008 and 2009 is due to the implementation of child health days campaigns across Somalia by UNICEF and WHO in partnership with local authorities and NGO partners. The child health days package includes immunizing every child under five against measles, polio, diphtheria, whooping cough, and tetanus, in addition to providing Vitamin A, deworming tablets, and nutritional screening for referral of malnourished children to feeding programs. Women of childbearing age are immunized against neonatal tetanus.

MICS data for 1999 and 2005, as well as WHO/UNICEF Joint Reporting data obtained from HMIS, indicate a stagnating performance of the EPI for the majority of the decade (DPT1 was 59 percent in 2000 and 40 percent in 2008, while DPT3 was 36 percent in 2000 and 31 percent in 2008). Surprisingly, in light of the cost-effectiveness of immunization programs, only a limited amount of money was invested in EPI, which received

**Figure 4.12. Health expenditure: EPI funding versus DTP1 and DTP3 coverage (2000–09)**

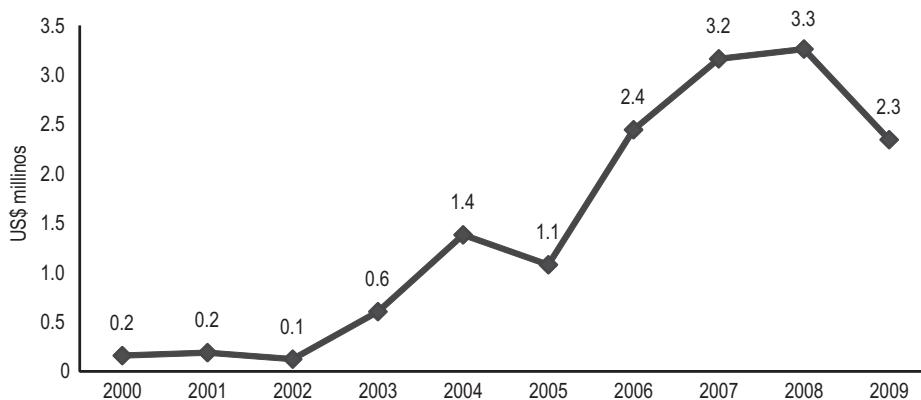


Source: Authors' calculations.

only US\$33 during the decade, almost half of the total amount of polio funding (US\$64 million). However, the introduction of child health days in 2008 is a welcome strategic move with the potential to increase the unacceptably low EPI coverage. Preliminary immunization statistics for 2009 seem to confirm that child health days are indeed bringing vaccines to many more children, though data should be validated through the next MICS or ad hoc household surveys. Last, as EPI heavily relies on the existing health network, the program's performance may benefit from increased financing to the overall health system and specifically from investments in primary health care.

**Reproductive Health:** Overall investments in reproductive health remain low (Figure 4.13) given very high mortality (1,400 per 100,000 women), high total fertility rate (6.4), low institutional deliveries (nine percent), and low prevalence of modern contra-

**Figure 4.13. Health expenditures: Reproductive health (2000–09)**

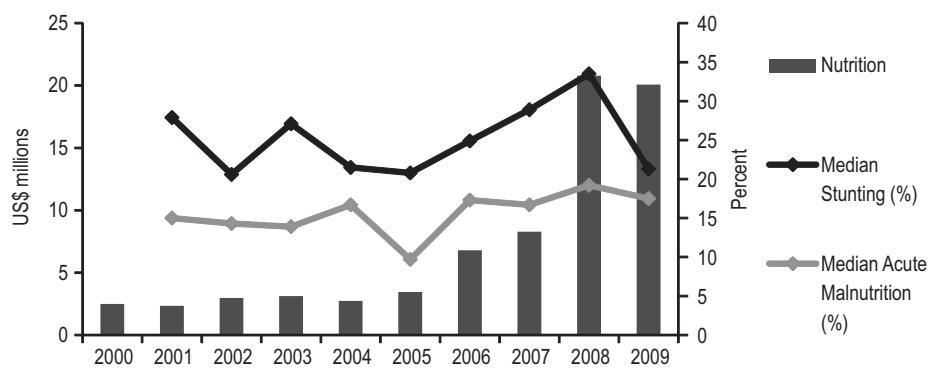


Source: Authors' calculations.

ceptives (one percent) (UNICEF 2010). Despite notable increases in funding observed from 2006 on, resources appear insufficient to target the enormous challenges in the reproductive health area. In this regard, the finalization of the national strategy and action plan for reproductive health (2010–15) represents a golden opportunity to focus partners' attention on this critical area and to mobilize additional resources.

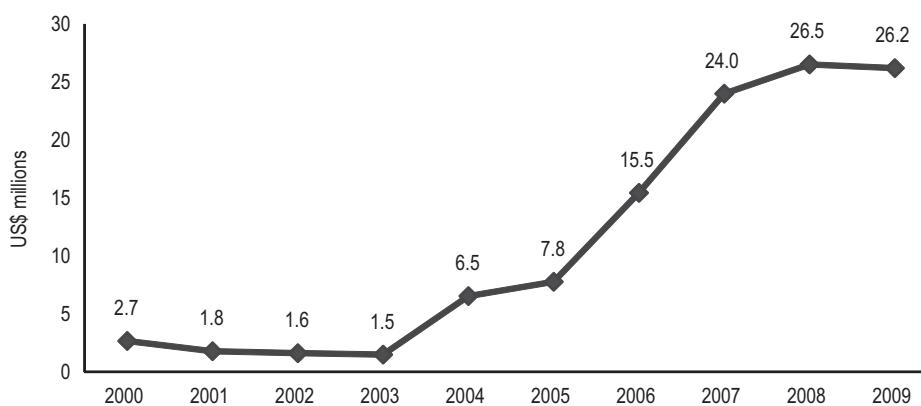
**Nutrition program:** Malnutrition is a major public health problem in Somalia, affecting hundreds of thousands of children and severely undermining future productivity, long-term economic development, and poverty reduction in the country (Figure 4.14). Malnutrition rates in Somalia rank among the highest in the world and call for a massive response, as funds allocated over the past decade (13 percent of total aid financing to Somalia) do not seem to have produced tangible results. It is encouraging to see an increase in funding in 2008 and 2009, though the increase may be linked to interventions to tackle acute malnutrition cases resulting from the severe 2008 drought. A new strategy to address this public health emergency is absolutely needed, and increased funding should be provided to support its implementation.

**Figure 4.14. Health expenditures: Nutrition financing versus malnutrition indicators (2000–09)**



Source: Authors' calculations.

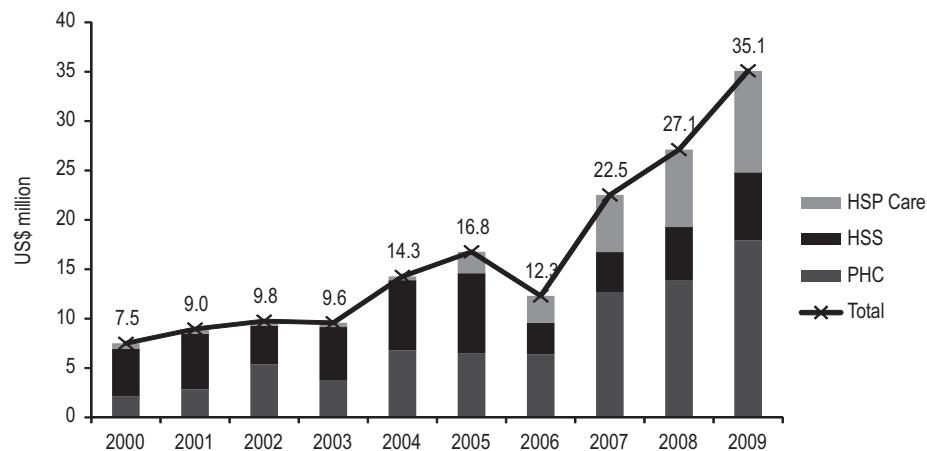
**Emergency programs:** Emergencies accounted for 21 percent of all financing in the decade 2000–09 and thus were the number one financing category in the health sector (Figure 4.15). Recall that the analysis of emergency expenditure includes, among others, all expenditures incurred by MSF from 2004 on (Chapter 3). Between 2000 and 2006, emergency funding accounted for 15 percent of total aid financing to the sector, but between 2007 and 2009, it accounted for 26 percent, with a peak of US\$26.5 million in 2008. These figures are stark testimony to the emergency nature of much of the health work in the country. While many actors in the sector rightly try to focus on strengthening the system for delivery of health services under normal circumstances, many activities in the sector are conducted in emergency mode to confront the consequences of either natural or man-made disasters. Droughts, floods, fighting, and mass displacements have been the norm in the past decade, and they have particularly worsened in the second half.

**Figure 4.15. Health expenditures: Emergency (2000–09)**

Source: Authors' calculations.

**Horizontal Programs:** The horizontal programs category combines financing for hospitals, primary health care, and health system strengthening. Health system strengthening is a code provided by numerous agencies (such as EU, ECHO, DFID, Italian Co-operation, and the GFATM) to support a varied array of areas including infrastructure, human resources, equipment, treatment protocols, and manuals, as well as training and development.

Financing for horizontal programs averaged US\$9 million in the period 2000–03, grew to an average of US\$14 million between 2004 and 2006 and then doubled to an average of US\$28 million in the triennium 2007–09. Notably, financing for horizontal programs reached US\$35 million in 2009 (Figure 4.16). This increase in absolute terms, however, did not translate into an increase in relative weight versus other programs. Within

**Figure 4.16. Health expenditures: Horizontal programs—hospital care, health systems strengthening, and primary health care**

Source: Authors' calculations.

the annual overall aid envelope, financing for horizontal programs actually decreased from 37 percent in 2000 to 33 percent in 2009.

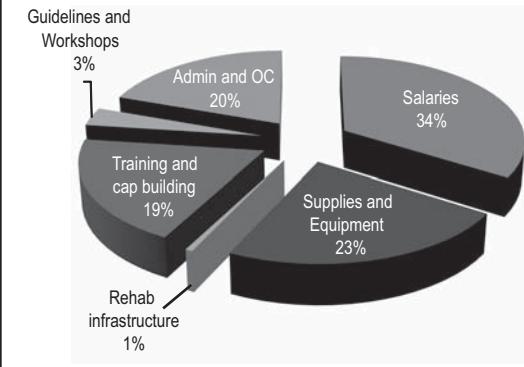
Analysis of the three areas included under the horizontal programs category shows that the increase in financing in recent years was driven predominantly by an expansion of funding to primary health care and to hospital care. Support for health-system strengthening activities has not varied much over the years. When the entire decade is considered, 47 percent of all financing for horizontal programs went to primary health care, 33 percent to health system strengthening, and 20 percent to hospitals.

To better understand the components of the horizontal programs category, a breakdown was attempted wherever data allowed (which is for only 51 percent of all horizontal program expenditure for the last three years) (Figure 4.17). The largest proportion went to salaries (34 percent), followed by supplies and equipment (23 percent), operating costs (20 percent), training and capacity building (19 percent), and a smaller portion to guidelines and workshops (3 percent). The smallest portion went to infrastructure (1 percent).

### Health Sector Aid by Zone

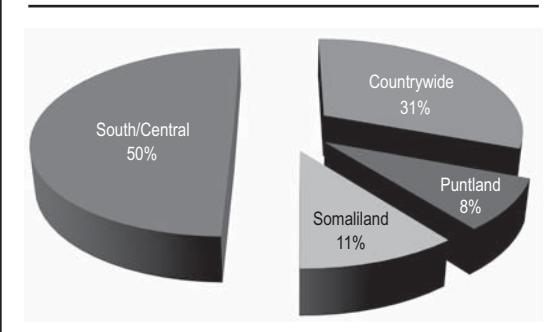
Not all health expenditures are reported by zone. Indeed, the study found that only 52 percent of the expenditures of last three years were reported by zone. The distribution of health expenditures by zone over the period 2000–09 shows that the South/Central zone received 50 percent of the overall funding, while Somaliland received 11 percent and Puntland 8 percent (Figure 4.18). In addition, 31 percent were allocated to activities in support of all zones.

**Figure 4.17. Expenditure by activity for 2007 to 2009—horizontal programs**



Source: Authors' calculations.

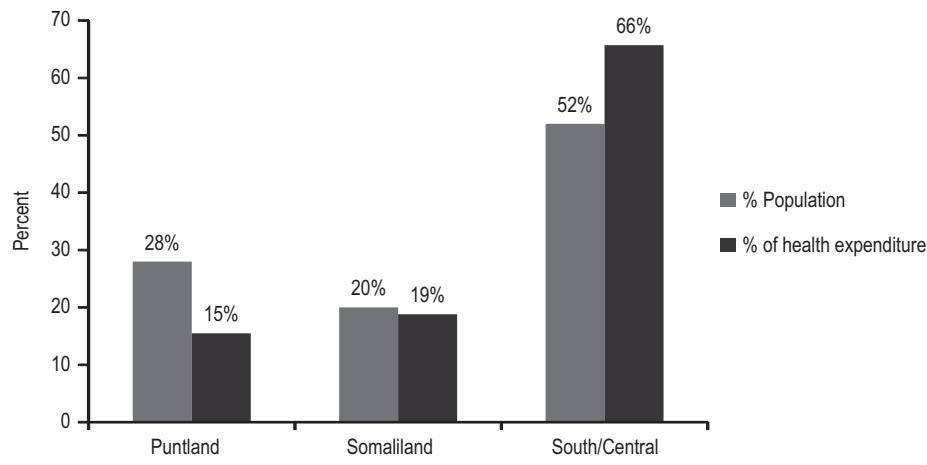
**Figure 4.18. Distribution of health expenditures by zone (2000–09)**



Source: Authors' calculations.

There appears to be a close relationship between health expenditures and population size. If countrywide expenditures are omitted, the allocations for the decade show that South/Central received a slightly larger portion of the share of expenditures (66 per-

**Figure 4.19. Distribution of population and health expenditures by zone (2000–09)**



Source: Authors' calculations.

cent for 52 percent of the population), possibly due to the severe humanitarian emergencies in the zone (Figure 4.19). Puntland received proportionately less aid (15 percent for 28 percent of the population), while the Somaliland allocation almost precisely matched its population size.

### Notes

1. These include the DAC donors.
2. These include EC, ECHO, Development Banks, and the UN.
3. These include the GFATM, ICRC and IFRC, and international NGOs.
4. These include, for example, Arab countries.
5. These include private donations that are made to charities and local or international NGOs.

## CHAPTER 5

# Conclusions and Recommendations

In this chapter, the conclusions of the study are presented according to the four primary objectives of the study (Chapter 1). In light of these conclusions, a number of recommendations are provided.

### Conclusions

*QUESTION 1: How did levels of donor financing to the health sector vary throughout the years?*

- *In 2000–2009, funding for the health sector in Somalia increased by almost five times in absolute terms (or by three and a half times in real terms).* Although a trend of increasing development assistance for health was noted globally in the past decade (Figures 2.2 and 2.3, Chapter 2), the increase in funding for Somalia exceeds the global rate of increase. The total aid provided by bilateral DAC donors, as well as by multilateral (UN, EC/ECHO, and World Bank) and other donors (GFATM, International Federation of the Red Cross (IFRC)/ICRC, GAVI, and NGOs), has steadily increased from US\$23 million (2000) to US\$103 million (2009) with a peak of US\$125 million in 2008. The figures above do not include funds provided by non-DAC donors (such as Arab countries), domestic funding on health, and remittances. The US\$103 million is therefore a conservative estimate. The total envelope of aid to the health sector is expected to be significantly higher if all other contributors to the health sector are included.
- *Aid financing greatly exceeded governments' contributions to the health sector.* While an average of US\$100 million was provided annually to Somalia over 2007–09, Somaliland's budget contribution to health on the same triennium was on average US\$1 million a year. Puntland's budget contribution to health for 2007–09 on average was US\$300,000 a year (European Commission 2010). No data could be obtained for the Central and Southern Zone.
- *Per capita aid for health grew from US\$3–4 in 2000–03 to US\$11–14 in 2007–09, a considerable amount for health in a fragile state. However, poor results point to inefficient use of existing resources.* Total ODA per capita in Somalia was US\$84, of which US\$14 (17 percent) was channeled to the health sector. A comparison of per capita aid to that of other fragile states (Table 2.1, Chapter 2) shows that the increase in recent years puts Somalia on par with Afghanistan (Table 2.1, Chapter 2). However, a high level of financing does not seem to translate into better results, as experienced in Afghanistan during the past few years. There is clear scope for efficiency gains that can be achieved only by redefining priorities for the sector and by “consolidating and rationalizing the existing health care delivery system” (UN and the World Bank 2006).

- *Between 2000 and 2009, aid financing to the health sector was not volatile in absolute terms, contrary to findings in other fragile states.* However, the mix of health donors in Somalia dramatically changed over the years. While UN and EU member states' relative contributions decreased over time, the influence of new players such as the GFATM and NGOs substantially increased in line with global trends observed in the sector (Chapter 2).

**QUESTION 2: Which health interventions were prioritized by policy planners through financial aid allocations?**

*Vertical programs received the lion's share of financing over the decade, and the prioritization of vertical programs in the country seems to have resulted more from global priorities and opportunities (such as the polio eradication program and the emergence of GFATM), rather than by public health considerations.*

- With US\$64 million of external funding in 10 years, the polio program absorbed 12 percent of all aid financing for health in the country. The program, which was run effectively, carried out regular national campaigns in a very difficult environment and responded well to outbreaks. As of 2008, it achieved the target of zero polio cases, which has been maintained to date at a cost of approximately US\$10 million a year. Given the global nature of the program, Somalia will continue to require generous funding for polio eradication until the last case of polio in the world is identified. Unfortunately, the global polio eradication program failed to reach its eradication targets by the year 2000 and subsequently by the year 2005. As of 2010, outbreaks continue to be reported in several countries in Africa and elsewhere, and polio remains a threat to Somalia and to the world. The burden placed by this vertical program on the health system in Somalia has been considerable, though recently some efforts were made to integrate polio activities with other programs (such as child immunization days). Overall, the opportunity costs of the program in Somalia have been very high. Even though polio eradication is a public good, the authors believe that other programs should have been and should be prioritized, both in terms of financial and technical support.
- With an average of US\$3.8 million a year for the last decade and a peak of US\$9.1 million in 2008, the HIV program has been an "aid darling" in Somalia. For the last five years the GFATM alone contributed an average of US\$4 million a year. Despite generous financing for HIV/AIDS by the GFATM, other partners continue to pour additional money into the program. In light of the paucity of epidemiological data and limited monitoring to track outcomes, showing that resources for HIV have been used efficiently is difficult. Stronger epidemiological evidence, more targeted approaches, and better monitoring systems are urgently required in order to guide the program and maximize cost efficiency of interventions.
- The TB and malaria programs also benefited from generous funding from the GFATM. The study shows that despite an almost fivefold increase in funding for TB from 2005 to 2009, no significant variations in program outcomes have occurred. Similarly, for malaria, it is not yet evident how extra funding translates into improved outcomes for the population living in endemic areas.

- Malnutrition is possibly the biggest public health problem in Somalia, given the number of people affected; the severity of the disease, as observed through ad hoc surveys; and the long-term consequences of malnutrition for individuals and the society at large. Funding for nutrition programs has been limited throughout the majority of the decade, though in 2008 and 2009 funding for malnutrition more than doubled from the 2007 baseline. This study did not cover food aid; therefore, the financial picture provided is partial. However, in light of the dramatic data on malnutrition, it is fair to call for an increase in the response and the funding for this area.
- Similarly to malnutrition, other important vertical programs were neglected during the past decade. EPI, a very cost-effective program, appears to have been severely underfunded over the years (less than US\$3 million a year up to 2006), though recent investments in child health days seem to be bringing positive results. With an average of US\$1.4 million a year over the decade, reproductive health also appears underfunded despite a very heavy disease burden indicated by all available statistics. The 2010–15 reproductive health strategy and action plan should become the platform to raise visibility for this area and to obtain the required financing to implement the strategy. Last, it is important to note that basically no financing could be traced for noncommunicable diseases. While this may be understandable because of the prevalence of communicable diseases in Somalia, it is hard to ignore mental health and disability problems in a country that has been affected by almost two decades of conflict.

*Funding for horizontal programs represented approximately 30 percent of overall financing to the sector in 2000–09. Funding for horizontal programs largely increased over 2007–09.*

- A large increase in financing for primary health care and hospital care was responsible for the increase in funding for horizontal programs in 2007–09.
- Funding for the health system strengthening component remained stable over the decade (approximately US\$5 million a year), but activities in this area became more focused in recent years and have laid the foundations for a stronger public health system. The Joint Needs Assessment conducted in 2005, the creation of a health system working group in the HSC, and heavy investments by the European Union in recent years (under the so-called “Lot 3 project” managed by UNICEF) supported the production of valuable studies, reports and strategies. These analytical pieces—such as the definition and costing of an essential package of health services, the analysis of the private sector in Somaliland, and the 2010–15 reproductive health strategy—represent the building blocks for more evidence-based priority setting in the health sector.

*High levels of funding for emergencies underline the tension between provision of humanitarian assistance and long-term development goals.*

- Emergencies received 21 percent of overall funding to the health sector in Somalia over the decade. Although expenditures were lower from 2000 to 2004 (an average of US\$2.8 million a year), from 2005 to 2009, funding increased to an average of US\$20 million a year. The majority of the funding came from MSF, which, as of 2009, was the largest financier for health services in the country

(larger than all UN agencies combined and than all EU members combined). Expenditures reported under primary and tertiary health care are also likely to support response to health emergencies caused by conflict and natural disasters. So it is likely that 40–50 percent of the overall financing for health services in Somalia may *de facto* support humanitarian rather than developmental activities.

***QUESTION 3: How evenly was health sector aid distributed to the different regions of Somalia?***

The answer to this question is not straightforward, since a third of all aid financing for health was allocated by donors and implementers centrally rather than at the zonal level. However, from available data, there appears to be a close relationship between population size and level of expenditures. The majority of resources (66 percent) went to the South/Central zone (accounting for 52 percent of the population), 19 percent went to Somaliland (accounting for 20 percent of the population), and 15 percent to Puntland (accounting for 28 percent of the population).

An underlying question is how much of the funding “in the name of Somalia” reached the intended beneficiaries living in the country over the 10-year period analyzed. Although this study did not plan to answer this question, several reviewers of the study pointed to the fact that high administrative and operational costs of agencies located outside Somalia could severely diminish the effective amount of aid reaching the Somalis. Also, the reported fragmentation of aid into numerous discrete projects may give rise to further diseconomies of scale.

***QUESTION 4: Have notable changes in aid patterns occurred since the release of the 2007 study on aid financing in Somalia?***

The analysis of recent trends in aid financing (2007–09) shows some encouraging data. First, aid for the health sector continued to flow to Somalia and per capita aid increased to relatively good levels for a fragile state. Second, funding for some neglected programs such as EPI sharply increased to support new delivery strategies (such as child health days). Third, financing for horizontal programs increased in absolute terms, and enormous progress was made in strengthening the knowledge base about health systems in Somalia and in devising new evidence-based strategies. Fourth, the mix of relief aid and development assistance was sustained, thus simultaneously supporting the response to humanitarian emergencies and the efforts to build a stronger health system in the country. Last, the HSC request to repeat the 2007 study supported the 2007 recommendation to make financial tracking of donor resources a more regular activity.

However, some of the problems highlighted in the 2007 study persist. In particular, the priority setting still appears to be primarily driven by funding opportunities and agencies’ priorities, rather than by public health considerations. Hence, important programs (nutrition and reproductive health, especially) remain grossly underfunded.

## **Recommendations**

- *Somalia continues to need long-term financial support for the health sector to address the needs of its population.* Somalia’s financial needs remain high given the challenges posed by its health indicators, the high operational costs linked to both the logistics of the country, and the reliance on international actors located outside Somalia.

- *However, with only US\$11–14 per capita in aid for health, improving efficiency in the use of available resources is of paramount importance.* To make the best use of a funding level that does not allow room for waste, the health system should focus on evidence-based activities that can maximize results, equity, and efficiency. The authors believe that the successful experience in Afghanistan of contracting of NGOs for the delivery of a basic package of health care services could easily be adapted to the Somali context, as a way to increase the overall efficiency of aid.
- *Contributions to the health sector should be made more strategic: funding gaps in key areas—nutrition, reproductive health and EPI—should be addressed as a matter of priority.* At the same time, funding requirements for HIV, TB, and malaria programs should be carefully revised based on real needs. To this end, investments in monitoring and evaluation would be critical, as many programs do not seem to have reliable data on which policies could be based.
- *Partners' coordination mechanisms should be further strengthened.* In this regard the authors support the conclusions of the 2009 UNICEF report “Steps towards harmonizing external support for health care provision for the Somali people.” In particular, Somalia could greatly benefit from the creation of a Health Systems Analysis Team (HSAT) of senior public health experts that could work with local authorities and national and international partners to set priorities for the sector and harmonize funding decisions.

It would also be essential to involve critical partners that have not been part of the HSC for many years, such as MSF.

- *Financial tracking of donor resources to the health sector should become an integral part of the health information system.* The tool developed for the study could be adopted, and improved by interested parties. Financial tracking should be matched with burden of disease and program outcome data. Information could include future funding levels that would allow partners to better plan their programs. By doing so, aid financing analysis could become an extremely useful tool for policy planners both at government and donor level.
- *Operational research is needed to integrate the findings of this study and to allow a better understanding of health financing in Somalia.* Topics to be studied include health financing by (i) the private sector, (ii) the diaspora through remittances, and (iii) nontraditional donors. Studies on household spending on health would complete the picture by providing information on private expenditures.



# Appendices



## Appendix 1. Study Sample in 2007 Study (n = 26)

Bilateral	Multilateral	Other
EU: • Denmark • Finland • France • Germany • Italy • Netherlands • Sweden • DFID Non-EU: • USAID • Japan • Norway	EC ECHO World Bank Islamic Development Bank United Nations: • WHO • UNICEF • UNAIDS • UNDP • UNFPA • UNHCR • UNIFEM • FAO/FSAU	GFATM ICRC IFRC

## Appendix 2. Study Sample in 2010 Study (n = 38)

Bilateral	Multilateral	Other
EU: • Denmark • Finland • France • Germany • Italy • Netherlands • Sweden • DFID Non-EU: • USAID • OFDA • Japan • Norway	EC ECHO World Bank African Development Bank United Nations: • WHO • UNICEF • UNAIDS • UNDP • UNFPA • UNHCR • UNIFEM • UNOPS • FSNAU	GFATM ICRC IFRC GAVI NGOs: • MSF • COOPI • COSV • TROCAIRE • CCM • CISP • INTERSOS • World Vision • PSI



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*A Decade of Aid to the Health Sector in Somalia 2000–2009* is part of the World Bank Working Paper series. These papers are published to communicate the results of the Bank's ongoing research and to stimulate public discussion.

This paper reviews trends in aid provided to the health sector in Somalia over 2000–2009. The paper is primarily concerned with how donors' money was used in Somalia's health sector. This research is intended to help donor agencies, nongovernmental organizations, and health workers in Somalia improve financing allocations to the health sector toward better results. The research shows that donors' funds increased over time; however, investments were not always strategic and key priorities for the health sector, like fighting malnutrition or immunizing children, were seriously neglected. The paper concludes that better coordination among donors, local authorities, and implementers is now needed to avoid the mistakes of the past.

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