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REBUILDING A HEALTH SYSTEM – EXPERIENCES FROM SOMALIA

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Chapter 13. Rebuilding a health system – experiences from Somalia

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Rebuilding a health system – experiences from Somalia

- Somalia is a country marked by conflict, poverty, chronic and repeated emergencies and some of the worst health indicators in the world.
- The constitution was adopted in 2012, and the federal government reinstalled. Since then, practically all the state-level institutions have had to be rebuilt, as well as institutions and authorities at member state level.
- Somalia's health sector was destroyed by decades of civil war and was practically unregulated and informal.
- With that in mind, and even though the country is again facing severe drought, the Federal Ministry of Health has achieved a lot in terms of reconstructing some of the main functions of a national health system.

Introduction

In March 2017, I was appointed to serve at the Ministry of Health and Social Services (here referred to as the "Ministry", "Ministry of Health" or FMoH) and remained in office until our government's mandate came to an end in August 2022. This makes me the longest-serving health minister in Somali history. Sweden has been a long-standing collaborating partner to Somalia, so when the Swedish Expert Group for Aid Studies (EBA) invited me to write about my experiences of rebuilding a health system for an anthology on global health, I took on the challenge. In this chapter, I describe some of the efforts that were made during my time in office in order to rebuild the health system of Somalia, and some of the challenges along the way. I also try to address the role of international development assistance in this work.

In 2012, Somalia witnessed a peaceful and legal transfer of power from the transitional government to a federal government in Mogadishu, with a four-year term under a provisional constitution approved by the parliament. The Federal Government of Somalia took office with international backing. On November 5, 2012, the new Prime Minister had appointed a ten-member Cabinet of Ministers, including a woman who would serve as Minister for Foreign Affairs

and Deputy Prime Minister. This indeed was a historic move for the country and for Somali women.

Since 2012, the government has experienced a reshuffle on three occasions and has had five health ministers between 2012 and 2016, with an average time in office of approximately 13 months. As I took office as the Minister of Health in 2017, there were ongoing outbreaks of disease, cholera and measles in different parts of the country, severely affected by droughts. Having previously worked as a consultant supporting the health sector through policy and legislation reviews, I was familiar with the immense challenges the health sector and the country faced. The priorities were many, while resources were always limited. It was a huge responsibility to lead the Federal Ministry of Health. It was in these challenging times that I started my mandate as the Minister of Health. The devolution of the federal system and constitution was a design of the system of governance, but also a reflection of the very fractured system of self-government that existed before the civil unrest, that was resolved in favour of a transitional government and finally the current federal government.

In a time when a central government did not exist, local authorities such as cities, regions and states had de facto created rule of law. It was the government's extremely challenging role to start to harmonise and standardise these to create a functioning health system in Somalia. Setting up a functioning system, despite all the operational challenges and many competing priorities in Somalia, was a huge challenge but one that I and the Ministry embarked on straight away.

Context

The situation of Somalia is one marked by chronic and repeated emergencies, decades of war and conflict and attempts to alleviate suffering and reverse the damage done to individuals and communities. Drought and famine are unfortunately part and parcel of the humanitarian needs of millions of people in Somalia and part of the yearly planning. The government's ability to address these needs depends to a large extent on the availability and sustainability of funds, both internal and external. There are numerous other challenges related to security, political instability and weak capacity of institutions etc.

Somalia adopted federalism in 2004 and established federalism in its provisional constitution in August 2012. It is a federal state composed of two levels of government: the federal government and the federal member states (FMS), so it includes both state and local governments. Federal member states also have their own constitutions. The member states are: Puntland, Galmudug, Hirshaabelle, Southwest, Jubaland and Banadir Regional Administration. In addition, there is Somaliland (which is seeking recognition as an independent state, but for the Somali government is part of Somalia). Each member state has a Ministry of

Health and respective directorates which directly collaborate and coordinate with the FMoH departments.

The total population is approximately 19 million. According to the January 2024 report of the IPC Population Tracking Tool[1], 21 percent of the country's population is in IPC 3+ (3 – Crisis, 4 – Emergency, 5 – Catastrophe/Famine). This means that approximately four million people in Somalia – many of whom women and children – are food insecure and faced with the risk of malnutrition and death.

Chronic insecurity and conflict in Somalia has resulted in the displacement of almost four million people across the country over the past three decades, a number that is expected to increase with the government offensives in recent months aimed at curtailing the control of non-state actors (IOM, 2024). Displaced populations, particularly in IDP camps, are often faced with overcrowded living conditions, limited access to clean water and poor sanitation which risk the spread of communicable diseases. Addressing the COVID-19 pandemic was especially challenging when considering this very vulnerable population.

Table 1. SDG2 and SDG3 with related indicators in 2020

Goal	Indicator		Male	Female	Total
2 ZERO HUNGER	**Zero hunger**				
	2.2.1	Prevalence of stunting among children under 5 years of age	27.7	28	27.8
	2.2.2	Prevalence of malnutrition among children under 5 years of age	22.7	22.8	22.7
		a) Prevalence of wasting among children under 5 years of age	11.4	12.4	11.6
3 GOOD HEALTH AND WELL-BEING	**Good health and well-being**				
	3.1.1	Maternal mortality ratio (maternal deaths per 100,000 live births)	n/a	692	n/a
	3.1.2	Proportion of births attended by skilled health personnel	n/a	n/a	31.9
	3.7.1	Proportion of women of reproductive age (aged 15-49 years) who have their need for birth spacing satisfied with modern methods	n/a	2.1	n/a
	3.7.2	Adolescent birth rates per 1,000 women			
		a) Women aged 15-19 years	n/a	140	n/a
	3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older	11.3	1.1	5.9
	3.b.1	Proportion of the target population covered by all vaccines included in their national programme	9.9	11.6	10.7

Source: Somali Health and Demographic Survey 2020 (SHDS, 2020)

Around 69 percent of the population live on less than USD1.90 per day, and many more live just above this poverty line (Government of Somalia, 2023). Somalia's population is growing rapidly with an annual growth rate of almost

[1] www.ipcinfo.org/ipc-country-analysis/population-tracking-tool/en/ [Accessed July 11, 2024]

three percent while the annual urban population growth in 2023 was 4.3 percent (World Bank Group, 2018).

Somalia is among the top five countries in the world with the highest child mortality rate. The under-5 mortality rate stands at 106 deaths per 1,000 live births, which is over 50 times higher than countries with the lowest mortality rate. The newborn mortality rate is estimated at 35 deaths per 1,000 live births, among the top three counties in the East and South African regions (SHDS, 2020).

The country is also among the world's top three countries with the highest number of unvaccinated children, with 1.5 million children under the age of five never having received any vaccinations. Somalia's maternal mortality ratio (MMR) is still one of the highest in the East Africa region, although it continues to decline slowly. MMR has reduced from 1,210 per 100,000 live births in the 1990s to 692 per 100,000 live births in 2019 (ibid).

Despite the high rates of communicable diseases and maternal and child illnesses, Somalia is also on the verge of an epidemiological transition, with non-communicable disease and injuries claiming many lives. The top ten leading causes of death in 2019 for both sexes and all ages were:

1. tuberculosis (TB)
2. stroke
3. lower-respiratory infection
4. diarrhoeal diseases
5. ischemic heart disease
6. neonatal disorders
7. malnutrition
8. meningitis
9. measles
10. congenital birth defects

(IHME, 2024).

This illustrates the double burden of disease that challenges the population and the health system and makes it clear that a vertical disease specific approach is not sustainable. Looking at risk factors for both mortality and disability, it is also striking that there is a double disease burden. Among the top ten risk factors are both malnutrition (due to food shortage) and dietary risks (fatty, high sugar diets) (ibid).

Mental health is a neglected health problem with very little resources and limited capacity (Ibrahim, Rizwan, Afzal, & Malik, 2022). People with disabilities have also been identified as a particularly marginalised and vulnerable group in Somalia (WHO, 2021a).

Somalia's health sector was destroyed by decades of civil war which collapsed the entire health system and resulted in some of the worst health and nutrition indicators regionally and globally. Somalia has one of the lowest universal health coverage (UHC) index in the world. In 2019, only 27 percent of the population had access to affordable essential health services (WHO, 2021a). The Harmonized Health Services Survey 2023 (unpublished) revealed concerning statistics about healthcare facilities. Only 42 percent of health facilities provide immunisation services, less than 45 percent offer outpatient services for childhood illnesses, and 39 percent offer diagnosis or treatment for malnutrition. Regarding maternal and newborn health, the survey indicated that only 45 percent of facilities offer delivery services and only 57 percent provide postnatal care. Additionally, just 13 percent of facilities offer the seven signal functions for Basic Emergency Obstetric and Newborn Care (BEmONC[2]), and 9 percent provide the nine signal functions for Comprehensive Emergency Obstetric and Newborn Care (CEmONc[3]). The limited availability of health services has resulted in failure to significantly reduce the morbidity and mortality of women and children in Somalia.

The Federal Government of Somalia has limited means to mobilise tax revenue due to political instabilities, violence, large informal sector and a weak tax collection system. Government expenditure on health as a percentage of GDP was estimated to be about 1.3 percent in 2020 (WHO, 2021a)[4].

The work to address the essential needs of the people of Somalia is made consistently harder by the recurring threat of droughts and famine that the Ministry must address. Competing priorities are also challenged by recurrent emergencies that require redirection of funding and human resources.

Setting up the Ministry of Health

How do you start to rebuild a health system, including a Ministry and essential health authorities? The first immediate challenge after I had been appointed was a logistical one. The Ministry of Health was hosted by the Ministry for Foreign Affairs when I first took over and was sharing offices with two other ministries. There were few available buildings, in safe areas, that could function as government offices. The city was severely damaged by the years of violence. Thanks to funding from the Government of Sweden, a new building was constructed and ready for the Ministry in late 2017.

[2] https://iawg.net/resources/basic-emergency-obstetric-and-newborn-care-bemonc-in-crisis-settings-select-signal-functions

[3] https://tnhsp.org/tnhsp/CEmONC-services.php

[4] In Sweden it was about 10.67 percent in 2022
https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=SE

Just as health facilities are faced with challenges related to capacity, staffing and retention of staff, so was the Ministry when I first joined in 2017. Seeking and hiring the best available candidates to the Ministry was a challenge. In the early days of the new government in 2012, there was a reluctance of many to be associated with or identified as government staff due to the fear of retaliation from non-state actors. Part of addressing this was building confidence in the daily work of the Ministry, not only for the people of Somalia but also for the Ministry's own staff.

Despite having a pool of young, extremely knowledgeable and hard-working professionals, the Ministry was at times faced with having unsuitable individuals with limited capacity in certain positions due to prior political appointments. Change is not an easy thing, but I made it my priority to better understand and evaluate the core staff's performance and ability and made a lot of necessary changes over time. Staff recruitment was not previously conducted through a competitive and impartial process but was subject to nepotism. Even during the peak of COVID-19, there were unfortunately some cases of mismanagement of funds that were uncovered at the Ministry, which were promptly addressed, investigated and adjudicated. After that unfortunate episode, the Ministry engaged UNICEF, WHO and World Bank experts to help set up a new public financial management system, a cloud-based procurement system with a fully integrated finance system for the Ministry. In 2021, we recruited staff and established a new administrative and finance office through a fair and a competitive process performed by the National Civil Servant Commission.

Another important pool of talent that we drew from to staff and capacitate the Ministry was the diaspora, consisting of Somali experts who play a crucial role in building and strengthening institutions of Somalia. Many professionals returned after several years of living and working abroad, leaving their families behind to contribute to the rebuilding of their motherland. Their contribution is and has been essential to build the capacities of the young and dynamic staff at the Ministry of Health at both national and member state level. During my time as minister, medical doctors from the diaspora were invaluable in the management of COVID-19 cases, for example, and providing various essential services across the country. Additionally, they provided their expertise as writers of policies and advisors within the Ministry which has been very important to the Ministry in strengthening its capacity. One concrete example is the young Somali-Swedish professionals who developed digital dashboards for both drought and COVID-19 pro bono[5].

At the end of my ministerial mandate, I oversaw the handover of 132 permanent staff who received a salary from the government, and 360 temporary staff who primarily received incentives and reimbursements from various implementing

[5] https://www.nomadilab.org/about-us

partners. Some of them also pursued fellowships and higher education programmes in prestigious universities abroad.

Because of the very special circumstances related to building a Ministry and at the same time trying to achieve improvements in health and health care in a highly fragile setting, the Ministry was very operative, especially in the early days. There were no institutions or government agencies that could be commissioned to carry out tasks or to implement assignments put forward by the Ministry.

FMoH initially had five departments, namely:

- Policy and Planning
- Public Health
- Medical Services
- Administration
- Finance and Human Resources

Since then, the Ministry has undertaken reforms in the health sector to institute the necessary structures that can enable it to address existing healthcare challenges. Accordingly, restructuring the Ministry was a necessary step in conjunction with the reform process, serving as the base to enable the Ministry to realise the targets set out in the national priorities. In January 2021, the HR department was split into the (a) Human Resources for Health which is more of a technical programme on health staff and (b) FMoH Staff/Human Resource Administration and Management.

The department 'Human Resources for Health' dealt with all the normative work such as workforce planning and production by working closely with medical, nursing and midwifery schools, development of training materials and guidelines, continuous education of the current health workforce/in-service training and the functioning of the National Health Professional Council (NHPC).

The FMoH Staff/HR Administration and Management dealt with HR recruitment, administration, and deployment at the Ministry, under the Department of Admin and Finance.

We also created a new department called "Family Health". This department had the mandate to lead efforts related to reproductive, maternal, newborn and child health (RMNCH), immunisation and nutrition. This would enable the Ministry to consolidate important interventions aimed at addressing the high morbidity and mortality rates as well as communicable diseases which cause the majority of preventable deaths in the country.

The Department of Medical Services is responsible for the hospitals, pharmaceuticals and supply chain management, medical infrastructure and quality assurance initiatives.

A priority I set myself during my time as minister was to leave behind a stronger and more capable Ministry with improved performance and service delivery. This involved ensuring that the people of Somalia had improved access to affordable and quality secondary health care services through the country's national hospitals. Health care in Somalia is expensive. The private sector is strong and virtually unregulated (Gele et al., 2017; Warsame, 2020). Malpractice is common and cases of malpractice with negative consequences are met with impunity from regulatory bodies.

Therefore, part of the government's work was to take over the care and responsibility of institutions that perform essential functions for the health sector of Somalia. Hospitals previously managed by the public sector before the civil war were occupied during the war, and later on managed by private individuals. Banadir Hospital and Demartino Hospital are the main referral hospitals in the capital city of Mogadishu. The hospitals are situated in strategic areas and serve a wide population including a large number of IDPs located within the city and outskirts. Banadir Hospital is a mother and child hospital, a referral hospital for the entire country and a teaching hospital. It was established in 1976 as part of the Chinese government's development projects to support the Somali people. Demartino Public Hospital is the oldest and largest healthcare institution in Mogadishu and has been a cornerstone of Somalia's healthcare system since its establishment in 1922. The hospital has evolved into a comprehensive healthcare provider, and has become synonymous with resilience and dedication, continuing to provide essential healthcare services despite numerous challenges, including extensive damage during the civil war. One of our Ministry's priority areas was to take back control of these hospitals. A large part of the population could not afford the cost of private hospitals, and it was vital to ensure they had access to some quality services at least. There also was a strong symbolic value in demonstrating that the government was taking back responsibility for providing basic services, to slowly regain people's trust for the government. As of February 6, 2019, both hospitals were under the responsibility of the FMoH.

In 2012, the FMoH also regained control of the National Public Health Reference Laboratory building, that had been inhabited by internally displaced people living there since the collapse. It was common for people without shelter to occupy empty government places. Minor renovations were carried out the same year. Later, from 2013 to 2014, a major renovation and expansion were undertaken, and basic equipment was installed in 2015. In August 2017, we inaugurated the renovated lab, with the capacity to conduct molecular biology that was later further developed during the COVID-19 pandemic. A month after the first confirmed case of COVID-19, Somalia began testing in the laboratory and conducted training for lab technicians from the federal member states (sub-national level) (Mohamed, 2023; WHO, 2023b).

These actions described above were not only important because they ensured that hundreds of thousands of Somalis now had improved access to quality healthcare through national public hospitals or because the country had a functioning national reference laboratory that met global standards, but it also built credibility, for both the population and different partners nationally, regionally and globally.

Necessary legal measures and policy framework for health

At a cabinet retreat in May 2017, each ministry was tasked with identifying priority areas that could be addressed in the first 90 days of the new government. We, as the Ministry of Health, prioritised the establishment of important policies and regulations that guide the health sector. Everything, from pharmaceuticals to the training of health professionals and providing treatment and care was practically unregulated. The National Health Professionals Council Bill (NHPC) was presented to the cabinet within the set time frame and was approved by the cabinet and submitted to the national legislature.

The cabinet also endorsed the establishment of the following institutions:

- The National Institute for Health (NIH) was the first government agency to be established under the Ministry in 2019. It functions as the country's International Health Regulations (IHR)[6] focal point.
- Establishment of the National Medicine Regulatory Authority (The decision was still pending in parliament when I handed over the mandate in August 2022).

The Ministry has since endorsed several national and thematic strategies and important normative and guiding documents for the improved functioning and smooth running of the health sector:

- Health Sector Strategic Plan II and III
- The Recurrent Cost and Reform Financing (RCRF) – for Female Health Workers
- Every Newborn Action Plan, 2019–2023
- Immunisation policy, 2021
- Roadmap towards Universal Health Coverage, 2021–2026
- Reproductive Maternal Neonatal Child Adolescent Health, 2020–2024
- Somalia's Nutrition Strategy, 2020–2025

[6] International Health Regulations (IHR) – an overarching legal framework that defines countries' rights and obligations in handling public health events and emergencies that have the potential to cross borders. https://www.who.int/health-topics/international-health-regulations#tab=tab_1

Development assistance for health in Somalia

Due to the many challenges and multi-sectoral and multi-faceted needs that evolve in complex humanitarian settings like Somalia, it is essential for all actions to be comprehensive, harmonised and a whole societal effort. Government across all three levels (namely federal, member state and local) as well as non-governmental organisations, the UN system, donors and implementers must be encouraged to work together to avoid fragmentation and duplication of efforts. But how does this work?

Building resilience and sustainability requires coordination by relevant bodies such as FMoH and other government bodies to ensure effective prioritisation of actions. This harmonisation requires a great deal of communication, coordination and joint action which seems almost impossible in a fragile context such as Somalia.

For technical assistance and expertise related to health and health care, WHO is a key partner. WHO also directly implements programmes and several offices in Somalia. The current collaboration strategy is for the period 2021-2025. WHO has supported every aspect of the health system, including strengthening the Health Information System, together with other multilateral organisations like UNICEF (WHO, 2022a). This includes integrated disease surveillance and early detection of disease outbreaks (WHO, 2023b).

Somalia has numerous multilateral and bilateral partners that are involved in development assistance for health, and there has been a large number of programmes implemented. There are both successful and less successful examples that can be learned from. Some are described below and show both the willingness to alleviate the difficult circumstances for the population of Somalia, as well as the challenges with a magnitude of stakeholders and different approaches.

The first example is the Essential Package for Health Services (EPHS) that was introduced in 2009. The EPHS work was conducted during a critical transitional phase in Somalia and, while identifying key needs for the people of Somalia, it also highlighted key challenges for the health sector. A major priority was the limited institutional capacity of the member states' Ministries of Health, limited human resources for health to carry out essential health work and finally, unsustainable and inadequate financing for the work in the long term.

EPHS started as a learning exercise in 2009 and expanded in 2012 into an implementation phase through the Joint Health and Nutrition Programme (JHNP). The JHNP was a five-year programme that ran from 2012–2016 and was led by the Somali health authorities with support from several joint UN partners - UNFPA, UNICEF and WHO. The programme was financed through

donors such as the UK's Department for International Development (DFID), the Finnish Development Cooperation, the Government of Sweden and the United States Agency for International Development (USAID). Building on the EPHS, the JHNP aimed to reduce maternal and child morbidity and mortality, improve the health and nutritional status of the people of Somalia, and provide accessible, quality and affordable reproductive, maternal, new-born and child health and nutrition services across the entire country. This marked a first attempt at harmonisation that is urgently needed to address the needs of the country, while at the same time ensuring institutional development for the health authorities of Somalia. A mid-term evaluation of the JHNP was carried out by the Swedish International Development Cooperation Agency (Sida) in 2015, and a lot of progress as well as challenges were identified, including lack of donor coordination and weak capacity at institutional level (Andersson, Lukmanji, Nor, & Rothman, 2015).

The termination of the JHNP in 2016 unfortunately contributed to the fragmentation of service delivery, with different partners covering different geographical areas and package components. Donors instead entered into bilateral agreements with the government/Ministry of Health. Implementing partners were also scattered. A strong coordination mechanism was unfortunately still missing, contributing to weaknesses and confusion in the delivery of health services.

Examples of bilateral initiatives that followed include a GBP 100 million DFID project; Somalia Health and Nutrition Project (SHINE) between 2016-2021, was extended to 2022 focusing on health and nutrition status, with a particular focus on women and children. SHINE worked closely with the different member states´ Ministries of Health (MoHs) in Somalia.

The Community Health and Social Accountability Project (CHASP) 2017–2021, and 2021–2024 is a programme managed by Save the Children and funded by Sweden (through Sida) and Switzerland (through the Swiss Agency for Development). The programme provides maternal and child health services in selected areas and health facilities. Further, it aims to strengthen the capacity of relevant health authorities (Sida, 2023).

Qualifying for the Global Financing Facility

In 2019, Somalia became a GFF country (Global Financing Facility for Women, Children and Adolescents), which was a milestone and major achievement since a lot of restructuring and improvements were required to be made before being approved. As part of the GFF process, an investment case report was developed, serving as a foundation for the efforts to support reforms (MoH Somalia).

The Global Financing Facility (GFF) is a country-led partnership, hosted at the World Bank, that fights poverty and inequity by advancing the health and rights

of women, children and adolescents. It does this by supporting countries to strengthen health systems and improve access to care through prioritised plans, aligned public and private financing and policy reform (GFF, 2024).

"Damal Caafimaad" (EPHS 2020) is the flagship health care programme supported by the GFF, aiming to improve health and healthcare services in Somalia and executed by the Federal Government of Somalia (WB, 2021). It aims to improve the coverage of essential health and nutrition services in five member states.

Collaboration with Africa CDC (Centres for Disease Control and Prevention)

Technical support and capacity building is needed just as much as financial resources. Africa CDC plays an important role in capacity building and leadership for the establishment of strong public health institutes in Africa. The National Institute of Health (NIH) is a Somali agency that has benefitted from the expertise and experience of Africa CDC since its inception. Before the establishment of NIH Somalia, Africa CDC funded a consultant to provide technical advice on the design of the institute. Both the headquarters in Addis Ababa and regional ACDC office for East African countries, based in Nairobi, has had close collaboration with NIH. Africa CDC is essential for the African public health leadership, for countries to gain knowledge from each other and to facilitate established collaboration between countries on the continent, as well as border control for early detection of disease etc. Laboratory collaboration between countries is another area that could be significantly developed in the future.

Challenging coordination

Coordination of authorities at different levels within the country is a huge challenge, as well as donor coordination because of the extremely fragmented health sector. Coordination is a necessity for several reasons. The responsible health authorities need to be in control of health service delivery and be able to collect critical health information, among other things. With the JHNP, Somali Health Authorities (at that time divided into three zones – Somaliland, Puntland and South-Central Zones) together with health sector partners established health sector coordination across three levels, namely zonal health, nutrition and WASH sector coordination. A National Health Sector Committee and Health Advisory board was effective until 2016.

At the time when the programme was ending, new federal member states had emerged, and the Health Sector Coordination Committee met a lot of challenges.

Some coordination meetings had to take place outside the country to accommodate Somaliland, and due to political pressure.

In line with the National Development Plan (NPD 8), the Federal Government of Somalia then established a coordination architecture, in which a social development working group became functional, with two sub-working groups; i) Health, Nutrition and WASH sub-working group chaired by the Ministry of Health and ii) Education, Youth and Employment sub-working group chaired by the Ministry of Education, Culture and Higher Education.

A workshop in Addis Ababa, Ethiopia, in late 2019 was organised and the FMoH, together with the Federal Ministry of Finance, the Ministries of Health in the federal member states, representation from UN organisations and several development partners, civil society organisations and the private sector agreed to re-establish an in-country coordination platform for health, nutrition and WASH sectors (FMoH Somalia, 2022).

Coordination is challenging on several levels. Many partners and donors are located outside the country due to security reasons and a lot of meetings have to take place outside the country, which also adds another burden on policymakers and civil servants. Since 2018, the Somali government has advised partners to relocate inside the country. This step has facilitated working relationships between national and international partners.

Training and research

Among all the things needed, quality and capacity in health training, education and research, including One Health and innovation in Somalia is crucial (Bile, Warsame, & Ahmed, 2022). As with health care providers, most universities in Somalia are private, and there is need for stronger regulation, control and capacity building. At the same time, there is limited capacity and limited resources at both the federal and sub-national government level for data collection and investigating and monitoring health statistics. Therefore, there is a need for health authorities to have close collaboration with teaching and research institutes. The FMoH has worked together with WHO to develop research priorities for health for Somalia (Ssendagire, Mohamoud, et al., 2023). Among many other partners, Sweden has also supported capacity building in health research through its support in building research capacity at the National Institute of Health, as well as other initiatives from Swedish universities such as Umeå University[7] and Dalarna University (Erlandsson et al., 2021), and by the Somali-Swedish Research Association (SSRA) (Dalmar et al., 2017).

[7] www.umu.se/en/department-of-epidemiology-and-global-health/collaborate-with-us/somali-swedish-research-cooperation/

In 2022, the National Institute of Health (NIH) and the Federal Ministry of Health and Human Services convened the first Somali Health Research Conference in Garowe (January 30 - February 1, 2022), hosted by the Puntland State Ministry of Health, and with participation and financial contribution from Sweden.

The NIH and FMoH have carried out several initiatives to enhance training and research. Health research prioritisation workshops between NIH and Somali universities have been conducted. The Department for Research at NIH established a mechanism to collaborate with Somali universities through the Somali Universities Association and a Memorandum of Understanding was signed.

The Somali Federal Ministry of Health and Human Services and the National Institute of Health, with the support of the Africa Field Epidemiology Training Program (AFENET), has also established a strong field epidemiology training programme (SOMFETP) since August 2021, with five subsequent cohorts of students and 123 health workers graduating from the training. These health workers are essential for disease outbreak preparedness and response, including early warning systems for new outbreaks and for the health information system.

As with many fragile health systems, Somalia faces a critical health workforce shortage and limited capacity and skills. Private universities produce a large number of trained young professionals each year. Adequate training and capacity enhancement is fundamental for their professional development. Training and research in health are basic requirements for the success of health system development and both advance efficiency for stronger health systems and better health outcomes.

COVID-19 as an example of working together nationally and globally

Despite the many challenges it brought, COVID-19 gave the world a tangible example of how working together can benefit us all (Ssendagire, Karanja, et al., 2023). Somalia's health sector was not ready for the pandemic. It did not have the human resources to ensure that essential services were maintained. It did not have the laboratories needed to test and diagnose. Social distancing and contact tracing were almost impossible in crowded settings in urban centres and IDP camps. However, despite all this, the resilience of the Somali health sector took centre stage in one of the most difficult times in recent history.

Somalia launched its national contingency plan for COVID-19 on March 5, 2020, and reported its first case 11 days later. The COVID-19 contingency plan was designed to improve coordination and leadership, enhance national capacity

for case detection, care and support, create capacity for infection prevention and control and strengthen risk communication mechanisms.

On March 13, 2020, the Ministry of Health and Social Services recognised Demartino General Hospital as the country's medical and COVID-19 quarantine centre in the capital Mogadishu. The hospital adapted their routines to accommodate patients with COVID-19.

As of May 5, 2021, the total number of confirmed COVID-19 cases nationwide was 14,121, with confirmed number of deaths at 721. These figures are grossly under-reported as most cases were not tested or hospitalised due to limited capacity for testing and intensive care services. During some of the early peaks, information on the number of weekly burials was collected in some locations, as well as verbal autopsies from family members to try and get a rapid assessment of the magnitude of the spread.

In addition, prevalent disinformation and misinformation regarding COVID-19 in popular social media contributed to low confidence of the general population towards government-led COVID-19 response measures, particularly face mask use and social distancing. One way to effectively address this and instil some confidence was through daily briefings which provided credible information, shared verifiable data and worked to address the misinformation spreading via media.

Various donors and partners provided their financial and technical support to the Federal Ministry of Health and ensured that Somalia's efforts to tackle the pandemic also had positive outcomes for other areas such as laboratory capacity, oxygen plants and integrated health surveillance. Sida was instrumental in supporting the Ministry of Health in ensuring essential services continued during COVID-19 while at the same time supporting the vaccination campaign.

The work of Sida has consistently been aligned with the priorities of the Ministry of Health and the needs of Somali people. For example, the high-level policy dialogue between the Government of Sweden and the Ministry of Health in 2020, during the peak of the pandemic, highlighted the strategic priority of ensuring that the country has a modern and responsive health information management system. The launch of the National Institute of Health and its strengthening over the years was supported by Sida and WHO in collaboration and was invaluable, not only in COVID-19 time but also in strengthening a core need of the Somali health sector (WHO, 2022).

Solar-powered oxygen delivery systems

Another great result achieved despite and because of the pandemic was the development of solar-powered oxygen delivery systems through our work with donors and WHO (WHO, 2021b). Demartino hospital was assigned as the

referral hospital for COVID cases through its intensive care unit (ICU) with patients arriving from all over the country. Because of the high demand for ICU beds at Demartino, the hospital could not provide services to all who needed them and the waiting lists became long. When COVID patients' clinical status worsened to the point of hospitalisation, oxygen was being sourced through private providers. There were only two private providers that had oxygen available in the city of Mogadishu. When the situation worsened in the country, the availability of oxygen through those private providers became a challenge with great competition between public and private facilities. In one instance, one of the two oxygen concentrators broke down during the night leaving only one available for the entire city.

The business community and partners including WHO sourced oxygen for the hospital during COVID but there was a global shortage that meant delays were expected. There was an urgent need for a sustainable and long-term solution that would benefit the hospital and its patients long term. The solar-powered oxygen systems that were introduced were innovative and sustainable in ensuring access to oxygen during a critical time in Somalia (WHO, 2021b, 2023a). The collaboration and partnership between the Ministry of Health, WHO, the World Bank, IOM, UNICEF and donors ensured that this life-saving technology was utilised in Somalia. Though it was borne out of a need to support COVID-19 patients, it can and has been used to support other patients including paediatric patients with pneumonia. Innovation and collaborations helped save countless lives in Somalia.

Sustainability and funding

The needs in Somalia are many and close partnerships with donors foster a mutual understanding between health authorities and donors and enhances the understanding that action is not successful in a silo but in tandem with ongoing, parallel actions from various partners (donors, UN agencies, implementing partners, etc.).

At the same time, it is vital to ensure that the Ministry can also find national funds through tax revenue which will need government action beyond the Ministry of Health. Investment in key sectors such as health, education and employment should be a priority and a way to prevent young people engaging in antisocial and violent practices.

When I took over the Ministry in 2017, the health sector budget was USD 1.2 million. Ensuring that the Ministry could have a sizeable budget to prioritise and plan effectively was a priority of mine and by the end of my mandate, in 2022, I was able to secure funding for the Ministry of over USD 50 million, classified as MoH's budget. This was a substantial increase and a first step. Strengthening the health sector and ensuring harmonisation and synergy in the action of partners

would allow the Ministry to address the challenges faced by the people of Somalia in a coherent fashion and open the opportunity for better multi-sectoral planning and action.

In summary

I would like to express my deepest gratitude to the Swedish government and people for their generosity and support to the Somali people and in particular to the health sector. Your contribution has made a significant impact specifically on Somali mothers and children and the health system of the country in general. This would not have been possible without your and other donor's support.

Somalia has come a long way after decades of civil war and the conflict that has resulted in widespread violence, displacement and humanitarian disaster. But there is still a very long way to go. The country still faces some of the worst health indicators in the world, and the health sector is still hugely underfunded. High maternal and child mortality rates, malnutrition and the prevalence of infectious diseases (such as malaria and tuberculosis) are significant public health challenges.

In 2012, and starting with JHNP, donors moved from decades of ad-hoc funding small projects to a long-term health systems approach with sustainable impact. This can enable the transition from predominantly humanitarian aid to a more long-term approach and, through building Somali capacity, will build resilience through a stronger health response to future crises.

Despite several challenges, there are improvements in some key areas, such as access to reproductive, maternal, and newborn health and family planning, child health, and nutrition services, strengthening the health system (e.g. building the capacity and accountability of health institutions) etc.

The health of women and children in Somalia is a top priority for the government and the people of Somalia, as well as for Sweden and other donors, and therefore deserves substantial attention and focus. In order to succeed, and for sustainability and effectiveness, prevention and health services for women and children need to be an integral part of the health system in general. Donors supporting a country should align their contributions with the country's specific needs and priorities to be successful. At times, donors tend to focus on areas that they have prioritised or that they consider a priority or highly important, based on their own mandates and perspectives. This may not always align with the existing gaps or the strategic priorities of the recipient country or with the human resources and capacities present in the country. To maximise effectiveness, minimise fragmentation and build capacity in the country, donors should conduct a thorough gap analysis in collaboration with the government to ensure that their support addresses the country's priority needs. It is my belief that an integrated approach, similar to previous experience such as the Essential

Package of Health Services, could ensure that high priority and critical areas of healthcare can be addressed sustainably and effectively. This would be preferable than focusing narrowly on one area through vertical programming and a more siloed approach.

Additionally, donors should coordinate their efforts further to maximise impact and resource efficiency. Joint planning and developing and strengthening information sharing systems before the distribution of financial resources can help ensure that all resources can be used efficiently so there is comprehensive coverage of specified geographic areas. It should be part and parcel of any joint work that donors commit to supporting the Ministry when strengthening the recipient country's health system, particularly in areas like governance and stewardship. This is an important building block to ensure that future partnerships can be successful and future work like scaling up or addressing new priorities can be more seamless. Through empowering the Ministries to take a leadership role and identify and set priorities as they arise, donors can help build a more sustainable and effective health system.

The health of the population in Somalia, especially of women and children, are dependent on strong support from policymakers and leaders within the country to back universal health coverage as a priority, and continued support from external donors for a foreseeable future.

Despite the many challenges that exist in the context of Somalia, there have been many successes over the years that bode well for the future of the health system in the country. There have been many concerted efforts to strengthen the institution of the MOH both at the federal and state levels and an alignment of efforts and priorities.

It is my greatest wish that the work of providing quality and affordable health care to the people of Somalia and strengthening the health sector remains a priority for national institutions and the international community. The agenda has been set across all levels (globally, regionally and nationally) to ensure that we see improvements in the health status of the people of Somalia. I hope that we will be able to see substantial progress towards maternal and child health and reducing preventable deaths of women and children as well as universal health coverage in Somalia in the near future, but there is still a long way to go.

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