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Evidence on Pro-Poor Healthcare Finance Approaches in Resource-Constrained Settings

Private Sector Partnerships in Health (PSPH) Somalia

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Abbreviations

BPHS	Basic Package of Health Services
CBHI	Community Based Health Insurance
DEA	Data envelopment analysis
DID	Difference-in-difference
DRC	The Democratic Republic of Congo
EPHS	Essential Package of Hospital Services
EU	European Union
FCAS	Fragile and Conflict Affected States
HEF	Health Equity Funds
IDP	Internally Displaced Person
KfW	Kreditanstalt für Wiederaufbau
LMICs	Low- and middle-income countries
MHI	Mutual health insurance
MSD	Market Systems Development
NGO	Non-governmental Organisations
NHI	National health insurance
NHIF	**National Health Insurance Fund (Kenya)**
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
PSPH	The Private Sector Partnerships in Health (Somalia) programme
RH	Reproductive Health
SM	Strengthening Mechanisms
THE	Total health expenditure
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

Glossary of Key Terminologies

Health Financing	Health financing refers to the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system... the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO definition).
Revenue Raising	Revenue collection is what most people associate with health financing: the way money is raised to pay health system costs. Money is typically received from households, organizations, or companies, and sometimes from contributors outside the country (called "external sources"). Resources can be collected through general or specific taxation; compulsory or voluntary health insurance contributions; direct out-of-pocket payments, such as user fees; and donations. (WHO definition)
Pooling	Pooling is the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not by the individuals who fall ill. The main purpose of pooling is to spread the financial risk associated with the need to use health services. If funds are to be pooled, they have to be prepaid, before the illness occurs – through taxes and/or insurance, for example. Most health financing systems include an element of pooling funded by prepayment, combined with direct payments from individuals to service providers, sometimes called cost-sharing. (WHO definition)
Purchasing	Purchasing is the process of paying for health services. There are three main ways to do this. One is for government to provide budgets directly to its own health service providers (integration of purchasing and provision) using general government revenues and, sometimes, insurance contributions. The second is for an institutionally separate purchasing agency (e.g., a health insurance fund or government authority) to purchase services on behalf of a population (a purchaser-provider split). The third is for individuals to pay a provider directly for services. Many countries use a combination. (WHO definition)
Contracting Out	Contracting out typically refers to purchase of healthcare services from private healthcare organisations. This is common in many middle-income countries and is becoming more common in low-income countries especially when government-run services (Contracting-In) are understaffed or are not easily accessible, while private healthcare organisations, on the other hand, often are more widespread and sometimes even well-funded (including by external sources, e.g., international donors). By contracting out healthcare services to private organisations, governments try to make healthcare services accessible to more people, for example, those in rural, remote and unserved areas.

Cross-subsidization	Cross subsidization is the practice of charging higher prices to one group of consumers to artificially lower prices for another group. In the healthcare financing context this approach is applied to ensure individuals with a higher ability to pay contribute more in order to reduce (or eliminate) the burden for individuals who have a lesser ability to pay. This helps promote equity in a healthcare system (pay according need to irrespective of ability) while ensuring cost of care is adequately covered.
User Fees	User fees refer to a financing mechanism that has two main characteristics: payment is made at the point of service use and there is no risk sharing. User fees can entail any combination of drug costs, supply and medical material costs, entrance fees or consultation fees. They are typically paid for each visit to a health service provider, although in some cases follow-up visits for the same episode of illness can be covered by the initial payment.

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Foreword

Healthcare finance in resource-constrained settings is challenging, particularly when it comes to the revenue raising function, which typically is externally funded especially for the poor.

This brief reviews donor-funded healthcare finance approaches in fragile and conflict-affected states (FCAS), identifying elements that work and those that are less successful, with a view towards informing the Private Sector Partnerships in Health Somalia (PSPH) programme which follows a market systems development (MSD) approach. When put in the "who does/who pays" framework of MSD, donor funded programmes in FCAS typically focus on the "who does", and "who pays" is not an issue – the donor pays.

There is no single model extant that can be considered fully successful from both a healthcare financing perspective (i.e., serving revenue raising, pooling, and purchasing functions) and an MSD perspective (notoriously, the sustainability aspect where revenue raising is heavily dependent on external donor aid). Therefore, it is important to consider specific elements of the healthcare financing approaches that might be applicable to the Somali context as well as those that might be considered a bad risk, in order to recognize and facilitate development of market-based solutions. Overall, evidence is scant, and although MSD is a well-used approach in private sector development globally, predecessor MSD-in-health programmes are rare.

Somalia differs from most other FCAS in that it has a vibrant and resilient private sector; the hidden informal sector is the largest part of the economy, but its scale is unknown. As the 2020-2024 National Development Plan states, "Informal businesses — those operating outside formal licensing and registration procedures — dominate Somalia's economy."[1] In addition, remittances are significant: although remittances are forecast to be 31.4 percent of GDP in 2020 (down only marginally from 31.9 percent in 2019), without remittances in 2020, households and the entire economy would have come close to collapse.[2] The opportunities to mobilize funds from this informal private sector for healthcare finance hence merit further exploration, to reduce dependency on external resources and build a sustainable market where there is essentially no tax base at present.

Finally, it must be recognized that there is a fundamental difference between humanitarian assistance and development cooperation.[3] The MSD approach clearly falls under development cooperation where promoting sustainability is paramount.

Table of Contents

1 Background and Objectives

The Private Sector Partnerships in Health (PSPH) programme in Somalia follows a Market Systems Development (MSD) approach with the general objective of providing Somali citizens, including the most disadvantaged groups, with better access to quality and affordable health services, based on two targeted outcomes:

1. Poor Somalis are able to access better quality and affordable healthcare through the provision of innovative financing mechanisms and safety nets; and
2. Organized private service providers deliver quality and inclusive health services across the country, including areas of difficult access.

Programme Lot 1, linked directly to outcome 1 above, focuses on health financing mechanisms that will benefit the poor.

Somalia poses a particular challenge in terms of health financing reforms where a struggling health care system has poor health outcomes and general weakness across its key health systems building blocks[4]. The Somali health care system, as in similar Fragile and Conflict Affected States (FCAS), is typically characterised by[5]

- **Inability to provide health services** to a large proportion of the population;
- Lack of **equity** in who receives the available health services;
- Ineffective or non-existent **referral systems** for the critically ill;
- A **lack of infrastructure** (including facilities, human resources, equipment and supplies, and medicines) for delivering health services;
- Non-operational **health information systems** for planning, management, and disease surveillance;
- Lack of **policy mechanisms** for developing, establishing and implementing national health policies;
- Insufficient **coordination, oversight and monitoring** of health services by the emerging government, which may not have the capacity to manage; and
- Inadequate **management capacity** and systems (such as budgeting, accounting and human resource management systems) for raising and controlling resources.

In such context the purpose of this brief is to provide the PSPH and SDC Horn of Africa team with a summary of what works in pro-poor health care finance in resource-constrained environments, in order to better inform models that may be applicable in Somalia without repeating missteps form the past. Such contexts are characterized typically by weak, conflict affected states with governments having legitimacy gaps (Figure 1)[6]; or as categorized by OECD[7] across five dimensions: violence, access to justice, accountable and inclusive institutions, economic inclusion and stability, and resilience (i.e., capacities to prevent and adapt to

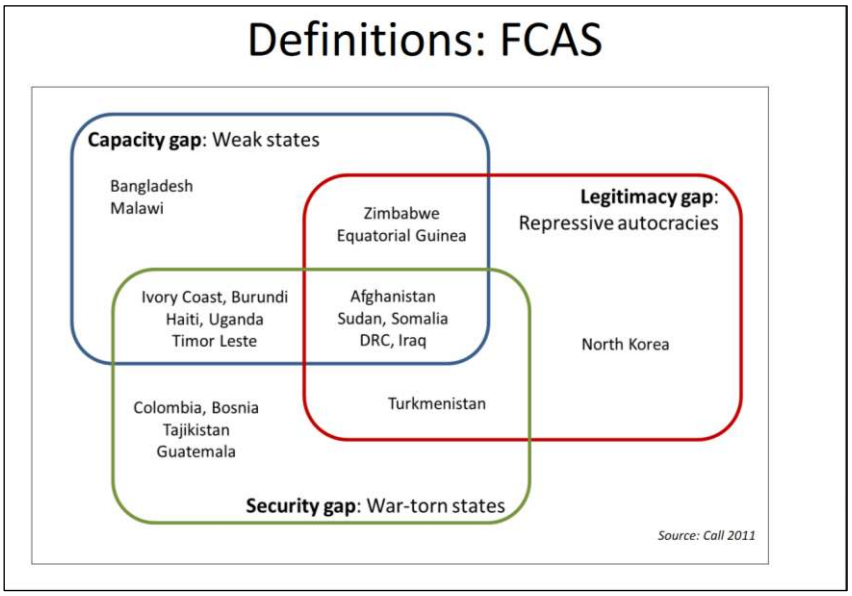

Figure 1: Definition of Fragile and Conflict Afflicted States

social, economic, and environmental shocks and disasters). The evidence collated in this brief focusses mainly on such countries and includes examples from Afghanistan, South Sudan, Democratic Republic of Congo, Iraq, Yemen, Pakistan, Mali, Uganda, Bangladesh, Malawi, Tajikistan, Rwanda (post conflict times), Togo, Syria, Cameroon and Cambodia.

Improving health financing systems is critical to enable countries to raise more resources for health and find the best way to make use of these resources. However, the evidence of what works and what does not in these contexts is limited, primarily based on smaller assessments of common health financing approaches with their respective limitations which we try to bring together in this brief. Even within the limited available evidence on health financing approaches in fragile contexts, ***limitations in respective studies range from poor quality of collected data, research undertaken by designers of the studied health financing reforms and hence with its own bias and interests, to limited focus based on commissioned agencies interest***. Therefore, the evidence discussed in this brief should be taken in this light.

As there is little evidence, it is also clear that there seems to be no concrete guidance on how to translate the existing lessons and principles on health financing approaches (or a recommendation of a particular model) for Universal Health Coverage (UHC) in fragile contexts. This brief is primarily based around efforts of the World Health Organization (WHO) to bring together/collate evidence (specifically in FCAS) through literature reviews of available articles[8] [9]. Positive as well negative aspects of commonly applied health financing approaches in FCAS are presented here that show effects from a UHC perspective (lower OOP, improvement in population coverage and access to care as per needs). Consideration across the key health financing functions of **Revenue Raising**, **Pooling** and **Purchasing** are crucial in the design of a model/models to be piloted by PSPH, the brief hence intends to shed light on evidence across these functions. Please see the Glossary of Key Terminologies on page iii for definitions.

While there appear to be private sector examples (especially in context of innovative revenue raising approaches), literature on assessments of such approaches is limited to non-existent. It is as well clear that Market Systems Development (MSD) approaches in health financing contexts in FCAS are as well quite limited. The brief is hence structured in a way to show existing evidence on aspects of different health financing approaches that work and those which do not/have challenges in FCAS contexts and how they might apply within an MSD context involving private sector funding. As there are limited examples of MSD approaches in health financing and lack of publicly available evidence, this brief does not provide any evidence on MSD approaches but only provides examples as stocktaking of some private sector approaches that might be relevant for PSPH.

2 Successful Models/What Works

In terms of health financing functions especially revenue raising, there seems to be a lack of empirical analyses of trends in aid and internal financing (government allocations) for health at country-level in such FCAS contexts compared to non-FCAS contexts. The typical expectation in non-FCAS contexts of progressivity of domestic revenue raising (general taxation), social health insurance, or other options, coupled with decreasing external aid over a longer period of time is expected to be unrealistic in FCAS. Conflict tends to reduce revenue mobilization because of reduced economic activity and tax base. While there have been examples in post conflict states[10] of positive 'revenue peace dividend' following conflict, in most cases it is only a modest recovery compared to pre-conflict levels. There seemed to be some evidence around the case of Sierra Leone[11], pointing to space to expand domestic resource mobilization, but examples from other contexts are limited. A conventional aspect to look at in FCAS is how to maximize external aid and make it more predictable and stable, while ensuring effective use. An example of this has been in Cambodia and Rwanda where healthcare financing reforms post-conflict which depended heavily on external aid led to significant progress in expanding health care coverage to respective populations. The fact that external aid can produce significant impact is not in doubt, but the long-term sustainability of such efforts is uncertain.

Having said this, an aspect from an MSD perspective in Somalia would be to explore possibilities of generating domestic revenues from the resources that exist within the private sector. As mentioned in the foreword, private resources in Somalia largely exist within the informal sector and are not well quantified; however, they are agreed to be a significant share of the economy. A number of innovative approaches in raising additional revenues for health for the poor have been documented (some taken from development experience beyond FCAS), ranging from sin taxes (Tobacco and Alcohol excise taxes), additional Value Added Tax, excise on unhealthy food items, levy on currency transactions, financial tax transactions, diaspora bonds, tourism and travel related levies, luxury taxes, levies on mobile phone use, to selling franchise products[12]. As an example, Gabon (not a FCAS) has funded its social health insurance fund for the poor through a compulsory tax on turnover of mobile phone operators, taking advantage of widespread mobile phone use, as well as a tax on external money transfers.[13] Innovative private sector approaches to raising revenues and pooling funds for healthcare using mobile platforms are incipient in Kenya, which borders Somalia and has a significant ethnic Somali population. In Somalia, with years of weak government structures, a healthy informal economy has maintained[14] and is largely based on livestock trade, money transfer/remittances and telecommunication, areas where innovative approaches to generate revenues for financing health care mandate further investigation.

Evidence on ***Health Insurance*** approaches in FCAS is found to be even less than for other health financing approaches. Rwanda has had relative success with Community Based Health Insurance (CBHI); CBHI was officially introduced in 1999/2000 and through 2011/2012 Rwanda was not far from effective UHC. However, since then, CBHI faced chronic financial deficit.[15] There have also been issues with renewals. The scheme has four premium bands based on assessment of a family's economic status by community leaders. The lowest band (1) is fully subsidized while the highest band (4) has the most disposable income. Mukangendo et al. (2018) showed that enrollment rates declined from a high of 91 percent in 2011 to 74 percent in 2013/2014, particularly among the middle-income groups (2 and 3). The primary reason mentioned for non-renewal was that the premium was not affordable. A deeper look shows that rigidities in payment modality contribute to low adherence to the CBHI scheme. For instance, a single payment can be problematic as incomes of workers in the informal or agricultural sectors vary and the premium may be due at a time when their financial situation is poor, and there may be difficulties in raising sufficient funds to pay premiums for all members before enrolment.[16]

A pilot[17] in Afghanistan seem to show no evidence on reduction in out-of-pocket expenditure and limited improvement in enrolment and cost recovery. However, the same pilot showed evidence of higher utilization of health services. Some studies[18] in Afghanistan and Iran with refugees and internally displaced persons (IDPs) also point to a possible strategy where purchasing insurance cover in established programmes for vulnerable, displaced and refugees seemed to be positive. This approach, though, was heavily dependent on external development aid. As with non-FCAS contexts, trust as well lack of capacity is an issue as well for health insurance programs in FCAS contexts which particularly effect the aspect of collection of contributions

(especially in voluntary approaches) and hence building on existing programmes which already have the trust of the community, seems to be the encouraged approach[19].

Health insurance in Rwanda

Rwanda has over the last few years, since its troubling times in the 1990s, made significant progress in the delivery of healthcare. This is in the backdrop of an increase in total health expenditure (THE) per capita from USD 9 in 2000 to USD 34 in 2006, with external sources accounting for the majority of THE while households contribution falling to 26% through OOP payments. These numbers have continued to improve over the years with OOP payments at an all-time low of approximately 10% of total health expenditures in 2018. A key initiative that the government supported was the establishment of over 100 mutual health insurance (MHI) schemes between 2000 and 2003, which were subsequently scaled up in 2005 with the support of external funding. The insurance coverage in-country stood at around 84% at the end of the decade.

Saksena et al. (2010) showed that MHI is not only associated with higher utilization, but also with better financial risk protection. Indeed, the individuals that were covered by the MHI scheme were more likely to use services irrespective of wealth and were less likely to face catastrophic OOP payments. However, the authors also reported some limitations and room for improvement of MHI schemes in terms of benefit packages offered, co-payment policies, and even health insurance literacy amongst the population. While MHI was associated with higher utilization, even among the insured population more than 40% were not using health services when they were sick and, moreover, one-fifth of covered households with MHI who did seek care were still faced with a financial burden exceeding 10%.

Health Equity Funds, an approach where third party organizations (primarily NGOs) are tasked with identification of poor and funding their access to care (paying facilities through donor/government provided funds), seem to show positive results from Cambodia. Similar evidence is not available yet from slightly modified replications of such models in Laos, DRC, Rwanda, Mali, Togo, Syria and Cameroon. Sustainability is a primary issue with this approach as to date the schemes have been externally funded.

Health equity funds in Cambodia

Cambodia is one of the poorest Southeast Asian countries. It has low per capita health expenditure of USD 122 (in 2009), yet as a percentage of GPD (6%) it is relatively higher compared to other countries in the region. Health equity funds (HEF) are a key feature of the Cambodian health system and have been operating in Cambodia since the early 2000s. They were based on the logic of giving healthcare providers the incentive to stick to prescribed payment exemptions of poor and vulnerable populations by compensating them for the lost fee revenue paid by a third party. HEF were financed by international donors and operated by local NGOs, who had the responsibility to select patients to be covered by the fund and as well reimbursed for secondary costs such as transport and food costs.

The existing literature on HEFs points to the positive effects of the schemes; however, the evidence is generally based on small-scale studies and there is no country-wide evaluation. Flores et al. (2013), exploiting the geographic spread of HEFs in Cambodia over the last few decades, compared changes in outcomes related to utilization and healthcare payments. Most significant finding in their study is that HEFs are indeed successful at targeting the poorest section of the population. The estimated effect of a HEF on health payments (conditional on their being any payment) was much larger in both absolute and relative terms for the poor. OOP payments also fall significantly more for households dependent on public providers. They found, however, no significant effect on the aggregate rate of utilization. There was a negative impact on the utilization of private facilities, which might suggest that HEFs discourage the use of private facilities although this is not clear-cut due to the lack of significant positive effect on public care. They conclude by saying that although HEFs have been beneficial in reducing payments by vulnerable populations, there is still the question of how sustainable they are due to the reliance on external donors.

Vouchers are demand side approaches where targeted incentives are provided directly to clients (generally through a third-party administrator/NGO), and at times directly to providers, to stimulate behavior change and increase utilization of care. Pilots in Yemen and Pakistan have shown some positive effects in terms of increasing access to family planning for poor households[20] but overall evidence on voucher programmes is still limited in FCAS contexts.

Vouchers in Yemen

Yemen is one of the poorest countries in the Middle East and North Africa region and has for many years been in a state of conflict. It is estimated that about 15 million people lack adequate access to healthcare, which affects women and children in particular. For instance, only about 34% of Yemeni women in rural areas give birth with the help of a skilled birth attendant. Financed by development partners (KfW), the programme was focused in rural areas and run mainly through the public sector and a national NGO, which acted as the voucher management agency. The vouchers were distributed to eligible women at a heavily subsidized rate of 200 Yemeni rials (less than one USD) and around 15% of distributed vouchers were fully subsidized for women who could not afford the fee.

Grainger et al. (2017) looked at the Yemen Reproductive Health (RH) Voucher Programme, that aimed to promote the uptake of safe motherhood services during 2014, when the country's security situation was deteriorating further. They showed that the voucher system did facilitate access to healthcare services for women, as the utilization rate went up significantly. While erupting conflict deteriorated the supply chain as well damaged health facilities, leading to closures that caused lower redemption rates of voucher, they estimated that out of all women who received vouchers, 65% subsequently went on to use them for health services. They also found that on the supply-side, the voucher programme brought about much needed improvement in quality of care and upgrading of health facilities. These results are very impactful given that they were recorded during intense periods of insecurity and civil unrest, during which one would expect to see significant reductions in non-essential service delivery although this was not the case. Longer term financial sustainability was still a question considering the dependence on donor grant.

Conditional cash transfers are increasingly used in humanitarian settings, including across sectors like food security, livelihoods, shelter, water and sanitation, protection, health, nutrition and education. Traditionally in this approach, beneficiaries are required to comply with specific conditions to be eligible for the transfer and in health examples include cash payouts for up-to-date vaccinations or completing a set of regular visits to a health facility (e.g., for pregnant women). Key merits for this approach are said to be that it is cost effective and timely, allows recipients greater choice and dignity, that they have beneficial knock-on effects on local economic activity[21]. There has also been evidence on such a programme in Afghanistan[22] where it was observed the approach could successfully increase utilization of maternal and child health services, especially when both family and health workers were targeted. Again, this externally funded approach has primarily been used in humanitarian contexts and has limited applicability in market-based programs

Performance Based Financing (PBF) approaches seem to be increasingly implemented in low- and middle-income countries including several FCAS. In such approaches, a third-party entity externally verifies services provided by facilities and, based on volume or quality factors/scores, makes payments to the health facilities. Specifically, in FCAS contexts the conditions of fragility leading to a greater role for external actors, openness to institutional reform, lower levels of trust both within the public system and between government and donors seems to favor PBF adoption even though evidence on effectiveness of such approaches is limited. Within the limited evidence from FCAS, it is observed that marginal system improvements occur on aspects like creating more incentives for service delivery and quality for some services, bringing focus to data quality, and enabling national policies focus on improving equity as well improving governance[23].

In FCAS contexts, public health care infrastructure is generally weak and ***Contracting-out*** approaches (see Glossary) to NGOs to provide services on behalf of the government (often with donor funding) has been common (Haiti, Afghanistan, DRC, Liberia, South Sudan, etc.) in order to purchase and provide health care services to the target population. This approach either applies pooled funds to purchase a defined basic benefit package from contracted private health facilities (e.g., in Afghanistan), or from mixed or hybrid models including

public health facilities, with the latter having the expectation of supporting improvement of public health care infrastructure.

Contracting-in and -out in Afghanistan

Following the fall of the Taliban more than a decade ago, Afghanistan was left with a critical need to plan the development of a sustainable health system. Together with international donors such as the United States Agency for International Development (USAID), the European Union (EU), and the World Bank (WB), the Ministry of Public Health (MoPH) identified priorities to improve key population health indicators, which were at an all-time low after decades of conflict. One such initiative was the establishment of a contracting-out model through which NGOs delivered the basic package of health services (BPHS) and the essential package of hospital services (EPHS), as defined by the MoPH. This method was applied in 31 out of 34 Afghan provinces. Contracting-out models were especially popular when health services needed to be made accessible as fast as possible, which is often the case in post-conflict countries. The remaining three provinces applied a different mechanism: a WB-financed model where the MoPH led and managed BPHS service delivery under a contracting-in model named Strengthening Mechanisms (SM).

Blaakman et al. (2013) compared the two approaches and showed through a unit cost analysis, that the average per outpatient BPHS visit was USD 3.41 in the SM provinces versus USD 5.40 in the contracted-out provinces during the same period. This indicated the cost for the same services was 58.5% higher in contracted-out provinces, compared to contracted-in ones. However, they showed that contracted-out facilities incurred, on average, 17% higher technical efficiency relative to contracting-in facilities, when considering aspects such as distance, security, quality of care, staffing, and drugs, as well as outputs in terms of number of ANCs, deliveries, family planning, etc. even when controlling for quality. In this approach as well the dependence on external donor aid was high.

3 Unsuccessful Models/What Does Not Work

While there was evidence from Afghanistan of higher utilization and positive experience of building on existing programmes, challenges have also been observed. In an example from Palestine, a government ***Health Insurance*** programme for the formal sector was expanded to the informal sector on a voluntary basis with reduced/waived[24] premiums for vulnerable groups, but it was unable to improve vertical equity (in terms of higher income groups paying a higher share of income)[25]. Similarly, amongst challenges experienced by health insurance programmes in Afghanistan, evidence[26] shows also that insecurity, low quality of health care, poor awareness among the population, limited willingness to pay and low available technical capacity are barriers to expansion of health insurance. These challenges are expected to also be experienced in the Somali context.

In the LMIC context, neighbouring Kenya's experience with the National Health Insurance Fund (NHIF) mirrors international experiences which show that few countries have made substantial progress toward UHC on a voluntary basis. Kenya, like most LMICs, has a large proportion of informal sector workers. The challenge with scaling up voluntary health insurance among the informal sector in Kenya is evident. Most of the reforms implemented by the NHIF since 2010 have been aimed at expanding membership coverage with a specific focus on the informal sector. It is not surprising that at 19 percent, health insurance coverage in Kenya closely mirrors the proportion of formal sector workers. Though informal sector individuals form 83 percent of total employed individuals in Kenya, they contributed only 24 percent of the total number of individuals enrolled in the NHIF in 2017. Further, in 2017 the proportion of enrolled informal sector individuals who subsequently did not renew their membership was 73 percent, signalling a high attrition rate. The voluntary nature of informal sector individual membership has left the NHIF susceptible to adverse selection.[27]

Conditional cash transfers are said to have risks in terms of increasing insecurity and corruption, exclusion of some groups (such as women), misuse and unsuitability in situations where functioning markets and services do not exist. At times due to non-economic barriers, they can impede access to services.[28] There is evidence that unconditional or multipurpose cash transfer approaches (one grant for multiple needs across sectors) are less effective for health care, as health needs are not distributed equally and out-of-pocket expenditures on health care are not predictable,[29] hence reducing the effectiveness of such approaches.

Abolition of ***User Fees*** is an approach which evidence seems to support in terms of increased access, but the effect on sustainability has not been studied. User fees in weak states and underfunded health systems at times can be an important revenue source but they are found (including in FCAS contexts like Burundi, Sierra Leone, Democratic Republic of Congo, Chad, Haiti, and Mali) to increase inequity and reduce utilization rates. At the same time, abolition of user fees for large populations leads to increase in utilization of health services.[30] Approaches to introduce targeted exemptions from user fees (for poor and vulnerable individuals/groups) or introduction of only "modest fees" as a compromise do not seem to improve coverage. In addition, maintaining exemption approaches in weak health systems over a period of time is challenging. A quasi-experimental study in Afghanistan showed that abolishing user fees for the basic package of health services (BPHS) leads to an improvement of utilization (without affecting quality of care).[31] While there are cost recovery approaches being applied by some donors, there seems to be some consensus with multilateral agencies on not applying user fees for primary care especially during humanitarian situations, as well debates around use of fees in contexts where situation keeps moving between emergency and post/pre-emergency phases. Another challenge especially in provision of care to IDPs and refugees (relevant as well for Somalia) seemed to the fact that parallel and externally funded systems (free for refugees) tend to be created but end up creating a parallel system that increases fragmentation and disparities in accessing care and places further pressure on national health financing.[32] Such fragmentation hence should be avoided as much as possible and integration into the existing health care system (e.g., use of the same facilities) and financing approaches should be encouraged.

Abolition of user-fees in Uganda

Uganda faced a period of unrest and civil war from the mid-1970s to the early 1980s, which left the country in dire need of aid in reconstructing the social system. This led to the development of Uganda's Poverty Eradication Action Plan in 1997, with a special focus on health. A significant step was the abolition of cost-sharing in public facilities, following reports on the detrimental effects of it on health service access of the poor. This meant total removal of cost-sharing in public health facilities at the community level, and retention of a two-tiered fee system in public hospitals: a paying window for those who can afford it and a non-paying one for those who cannot. Those identified as poor according to the Uganda Participatory Poverty Assessment Process (undertaken by the Ministry of Finance, Planning and Economic Development) were eligible for the latter.

Nabyonga et al. (2005) investigated the change in utilization of health services for the first two years of implementation, focusing on the poor and vulnerable groups. They showed that there was a considerable increase in utilization in all population groups. This increase was higher in lower level (primary care) facilities compared to referral facilities and was also higher among the poor compared to other groups. There was also slightly better quality of care observed with fewer drug stock-outs taking place, but no significant effects of indicators such as cleanliness, compound maintenance and staff availability. This clear increase in overall outpatient department utilization suggests that user fees were most likely a barrier to the utilization of public services, particularly for the poor and vulnerable communities.

Performance based financing still has varying evidence[33] around impact on population and improving access to care. One expectation from such an approach was the improvement of strategic purchasing in the health care system, that can induce positive healthcare provider behavior. A review of effects of such an approach in FCAS like Zimbabwe, Uganda and DRC, though, showed no systematic transformation of purchasing[34] in the healthcare sector. Such approaches do not function effectively unless anchored in wider national health financing reforms in the country and adapted to the respective country context.[35]

Performance-based financing in DRC

The Democratic Republic of Congo (DRC) presents the typical features of a fragile state and even a post-conflict setting in certain areas. Foreign aid played a significant role in service delivery, especially during the conflict years. However, during this time, the NGO activity was mainly focused on humanitarian response. This has led to an extremely complex and fragmented post-conflict environment. This of course had consequences on the health system. Flow of funds are very complex and volatile and public investment in health is extremely low, with a mere 4% of governmental spending going to the health sector (between 2006-10). Moreover, the allocation of resources between central and administrative spending, and between provincial ministries is very unequal and unpredictable, which leads to regional disparities. Donor expenditures, on the other hand, represent the equivalent of approximately 290% of total public spending (for 2009). This helps in the short term, but as this was mainly project-based, it increased the health system's dependency on foreign aid. One intervention implemented to strengthen the health system was performance-based financing (PBF), specifically for healthcare staff. The World Bank implemented a P4P approach as part of its HSRSP programme to support service delivery in two districts of Katanga Province in DRC. The project design involved paying all workers in primary healthcare facilities, referral hospitals & health centres and health zone teams according to a cash bonus system: 70% paid monthly as a fixed amount depending on the grade of the worker and 30% performance-related and paid quarterly based on facility performance and grade of the worker.

Fox, et al. (2014) assessed the World Bank P4P project, drawing on quantitative and qualitative data at different levels of the health system. They found that there was actually no evidence of benefits for any of the service inputs, processes or outputs measured including availability of equipment, services provided, average waiting time, unapproved absences or friendliness of staff. This suggests that it is not necessarily a given that a pay-for-performance approach has the desired effect on workers' motivation. This is especially true when staff often are required to increase their workload to achieve performance goals and simultaneously, the income from user fees gets reduced due to fall in prices of services. In the context of Katanga, health workers were already almost entirely dependent on user fees for their remuneration before the World Bank project started due to irregular pay of (low) monthly salaries. Overall, the authors concluded that it is important to carefully consider the wider human resource policy reforms and priorities in order to get appropriate design and implementation in place, an even bigger challenge for fragile and post-conflict settings.

4 Key Lessons Learned for the Somali Context

Virtually all the cited approaches applied in FCAS, especially for the poor, rely on external (donor) aid channelled as subsidies through various demand and supply side approaches. In either context their long-term sustainability remains a challenge, especially when states are unable to take over these subsidies when a development partner exits. An MSD approach hence merits consideration, which in contrast to past approaches aims to mobilize the existing private sector to address pro-poor healthcare needs in an economically viable manner by supporting the development of the private market to grow their business while mobilizing revenues to cover the healthcare cost of the poor.

As public health structures are weak and there is a strong dependence on the private sector to cater to healthcare needs in Somalia, there is merit in the approach to organize and utilize private healthcare facilities through networks like Caafinet. While this can address some key supply side questions, from a health financing perspective there is a parallel need to organize the demand side and give clients a voice to be able to balance out market forces, especially when the healthcare sector is heavily dependent on private interests. This generally translates to a ***Purchaser*** role that helps build competition amongst providers, demand better quality, improve provider responsiveness towards clients, negotiate rates/contain costs, and ensure access for vulnerable populations. This is especially important for interventions with a pro-poor focus where Social Health Insurance may be part of the longer-term perspective. As state actors are weak, options for such a role for the private sector (or at least some aspects) need to be explored further. While the private sector is key in PSPH interventions, the public sector also needs to be engaged, particularly in forming the appropriate regulatory framework. As an example, say a private insurer, association, or NGO is taking up the purchaser role where the intention is to apply taxes on mobile transactions or remittances to generate revenues to subsidize the poor. While the approach might primarily have roles for private sector actors (like mobile service providers, banks, remittance service operators, and/or health insurers), regulations from the government side will be needed to enforce such taxation, standardization of transaction rates and other conditions within which the designed system needs to operate in the longer run.

Revenue Raising for healthcare is a challenging aspect in a context like Somalia. Because there is significant external aid involved, better aid coordination as well stabilization over a period of time seems to be one logical conclusion from the literature reviewed, although it begs the question of long-term sustainability where the healthcare system is supported through domestically generated sources. Targeted humanitarian aid (vouchers, cash, or mobile money transfers, etc.) when provided as unconditional or multi-purpose transfers will probably not be very effective when it comes to paying for healthcare, and if used, should be made conditional/restricted to paying for healthcare expenses. These approaches are beyond the realm of MSD.

While the state has been weak, unlike during the pre-civil war period, private investments in commercial activities driven by the Somali diaspora have gradually risen. Complete dependence on domestically raised revenues for health seems challenging in the short run, though one aspect to further explore is innovative ways in which the current private sector can be leveraged to generate or organize existing revenues that can be earmarked for healthcare. As an example, a remittance company World Remit owned by an entrepreneur originally from Somaliland has set up, based on the success of his business, a foundation that is making large investments in Somaliland including in the healthcare sector. Similarly exploring options with private sector remittance services to develop products to transfer or pool funds specifically for healthcare are possibilities to explore. Innovative approaches in non-FCAS contexts have been observed; areas like telecommunication and remittances have steadily grown in Somalia, even in times of uncertainty, with the latter in 2019[36] accounting for 20 percent of the nation's GDP and providing livelihood for 40 percent of the Somali population. These sectors in particular could be explored to find innovative ways to organize revenues to pay healthcare costs for the poor.

Contributory mechanisms, especially user fees at point of care, are found to be hurdles in increasing access to care for the poor, and for patients below a certain level of disposable income accessing private sector providers will be impossible to financially sustain without external subsidies. This is a limitation of a purely private-sector driven MSD approach, and a constraint in Somalia where the public sector has little to contribute other than channelling unstable external donor-provided funds. Those without disposable income will be served through humanitarian assistance. However, at present the private sector can likely play a significant and largely unexplored role in raising and pooling funds for healthcare on the demand side (especially from

those working in the informal sector) as well as providing better value for money from the (primarily private) supply side. This would serve to expand the reach of the private healthcare sector deeper into lower-income population groups. In the absence of publicly funded social health insurance, the contribution of the population ideally should be in some prepaid form (health savings or insurance) and not at the point of care when need arises (out-of-pocket expenditure). Targeting in such a context becomes important and here the definition of the target group for PSPH is important, differentiating those who can pay from those who cannot. To our knowledge no such targeting mechanism exists at present in Somalia. There is also the possibility of exploring cross-subsidy payment models within the private sector businesses themselves (see Glossary).

While raising additional money (or better organizing existing money) to pay for healthcare for more of the vulnerable population is crucial, it is of course important to ensure good value for money. A mechanism needs to be developed to ensure that the limited resources to pay for the poor are optimally used and ensure that poor do not end up paying the Poverty Penalty, and also get better efficiency from the money that is spent. This translates into the pooling and purchasing functions in a health financing intervention.

Pooling revenues can lead to better redistributive effects especially when prepaid and not at the point of care. Efforts should be made to identify how PSPH interventions can increase the pooling aspect which will also help reduce the fragmentation and duplication of effort that often occurs in such contexts, with multiple development partners and INGOs supporting various population subsets. This can be in form of a coordination function established under a purchasing entity as mentioned above, an aggregator of the population (e.g., types of social structures already trusted by the community), or in form of an insurer undertaking such a role. A voucher or insurance entity or a HEF operator in this regard including in the private sector could be a possibility but should ideally be able undertake a coordinating role across other efforts currently underway.

Purchasing of services as observed in literature, seems to have some efficiency gains when contracting out to private providers and as well looking at the Somali context this seems quite clear. While the service provider aggregators like Caafinet are useful in this regard, a definition of a standard benefit package (established list of basic or specific targeted health care services) across the facilities provided at acceptable quality and negotiated rates would be important in a PSPH intervention. Here again an active purchasing entity to undertake such contracting will go a long way and improve efficiencies as well ensure intended effects are observed from provider side. Healthcare has a cost which cannot be removed completely (e.g., waiving user fees without off setting loss in revenue) but a balance must be met where health facilities are appropriately remunerated and able to cover their costs, while at the same time private healthcare providers are not able to unreasonably drive up costs, which ultimately would lead to barriers to access for the poor.

5 Stocktaking of Private Sector Innovations Relevant to PSPH

There have been a number of solutions that have been applied in the health financing domain for payment for healthcare, mobile money-based savings, and insurance products. Mobile technology has been the basis for many health financing interventions. Such solutions primarily open the door to alternative ways to raise additional revenues from clients, while examples applying insurance solutions offer interventions that go beyond revenue raising and as well touch on the pooling and purchasing aspects. Below are short descriptions of some examples of innovations from neighbouring Kenya that may hold lessons for Somalia. Unfortunately, none of the referenced commercial models have been independently reviewed, and most of the data on health outcomes as well as financial outcomes (i.e., sustainability), if available, is proprietary and not available through public sources – particularly for models that have not survived in the marketplace.

Avenue Healthcare – Prepaid financing scheme within a provider network

Avenue Healthcare is a private provider in Kenya established in 1995 that owns and manages four hospitals (Nairobi, Kisumu, Mombasa, and Thika) and 14 outpatient clinics (9 in Nairobi and 1 each in Kisumu, Mombasa, Nakuru, Eldoret, and Ongata Rongai). Avenue Healthcare offers a provider-based managed healthcare system where enrolled individuals pay a fixed annual fee for access to health services within the Avenue network. This form of risk pooling eliminates the need for intermediaries such as insurance companies by making the medical provider the repository for the pooled funds. Avenue Healthcare itself takes on the risk though this leads to a mixing of roles of a purchaser (of services like an insurer) and (healthcare) provider.

Avenue Healthcare offers a range of prepaid family (Jamii) medical schemes that offer network coverage - outpatient coverage at Avenue clinics and inpatient coverage at Avenue Hospital - with degree of coverage varying depending on the service package chosen and premium amount paid. Individual OOP exposure is greatly reduced or entirely eliminated depending on the package chosen. Because services are prepaid, theoretically the provider has incentive to reduce costs, to keep members healthy, and in a competitive environment, to give high quality, effective care. However, the reduction in cost for is not guaranteed if the one who sets the prices and collects the fee is the same (in this case, the facility/network), and it can also be that the annual fee is hiked to match the higher cost of services provided by the facility.

Avenue Healthcare's current target market is the formally employed through corporate clients; however, the basic business model of prepaid financing schemes through a provider network is adaptable to other contexts with different network structures, target markets, and service packages. Ideally, there should be a separation of the network management role (representing the interests of the service provider) and the purchaser role (representing the interests of clients).

M-TIBA – Mobile health savings wallet and healthcare payment mechanism

M-TIBA is a “health wallet” on the mobile phone that allows patients to set funds aside for healthcare. INGO PharmAccess collaborated with Safaricom (Kenya's largest company and dominant mobile provider) and developer CarePay to jointly develop M-TIBA to facilitate healthcare payment in Kenya. Launched in July 2016, M-TIBA is a three-way platform connecting patients, healthcare providers and healthcare payers (e.g., governments, insurers, donors). The platform exchanges money and data between these three groups, allowing for the financing of users and payment of providers. M-TIBA provides a mobile health wallet that allows patients to save, borrow, and share money for healthcare costs using a basic mobile phone, and is free for users (although Safaricom charges a commission on payments through M-Pesa). Money stored in M-TIBA can only be used to pay for out-of-pocket treatment and medication at partner clinics and hospitals, to pay for contributions to the National Health Insurance Fund (NHIF), or to purchase private insurance packages. M-TIBA has enrolled over four million people since its launch and has over 3000 health providers on the platform.

M-TIBA is not an insurance and hence not the risk carrier but only a collection wallet which allows saving money or collection of money at an individual level (from various sources), earmarked for health care expenses including health insurance that might be offered by an external insurer like NHIF.

Despite heavy enrolment and funding, M-TIBA has challenges, such as users not always making regular payments, mostly because a huge share of the Kenyan population does not have sufficient or regular income

to be able to contribute frequently to health savings. Individuals face the difficult choice of basic spending needs or saving for health expenditures. Unfortunately, while enrolment in M-TIBA has been high, savings rates have been low. Most users have never saved in their health wallets. Many accounts are dormant because low-income consumers have limited funds to save. M-TIBA developed tailored incentives, such as bonus top-ups to encourage people to save, but these have been dependent on donor funding.

Afya Poa **–** Mobile-enabled health insurance and health savings plan for informal workers

Afya Poa is a low-cost health insurance product targeted to the informally employed (known as the "jua kali" sector), who constitute 83 percent of Kenya's workforce but are largely uninsured. The product is managed and distributed by Insurance for All (IFA) Insurance Agency Ltd. and underwritten by Sanlam Insurance Company Ltd. The product combines three benefits, namely health insurance, health savings, and health loans on a mobile-enabled platform. The development of Afya Poa was supported with technical assistance from DFID's PSP4H MSD programme from 2013 to 2018. After programme support ended, in 2019 IFA/Afya Poa received private equity investment from a Dubai-based firm and has focused more on partnerships with organizations to build volume instead of only targeting individual informal workers. Some of their current partnerships include digital taxi service companies; logistics operators that use motorbike riders to deliver products; jewellery exporting companies who work with local artisans; and SACCOs (Savings and Credit Cooperative Organisations). Afya Poa competes with the government sponsored NHIF, membership in which is voluntary for informal workers.

Afya Poa's biggest challenge has been sale of policies and enrolment of members from the informal sector, who typically earn daily wages, have little disposable income, have no or small savings, and have no habit of purchasing health insurance. Changing that behaviour has been difficult, even with a tested, targeted product that uses mobile technology and addresses members' difficulty in raising sufficient cash to pay an annual lump-sum premium by offering mobile premium loans that are deducted from mobile phone credit in small, frequent increments. The daily premium payment matches informal worker's earning patterns, and the mobile platform matches the day worker who does not have time to see an agent to service the policy. However, after six years of operation, Afya Poa covers only some 5,000 lives.

Linda Jamii – Low-cost mobile-enabled health insurance

Changamka Micro-Insurance Limited, a Nairobi-based company, developed the low-cost health insurance product Linda Jamii in 2014, in conjunction with British American Insurance Kenya Limited (Britam) and Safaricom, Kenya's dominant mobile operator and largest company. Changamka developed the technology; Britam served as the risk underwriter, contracted health providers and paid out claims; and Safaricom provided the subscriber base and large-scale product marketing. Linda Jamii targeted the 'uninsured' market, charging what they considered an affordable annual premium of KES 12,000 (approximately CHF 100). Individuals could pay the premium in lump sum, or make small premium payments using their mobile phones through Safaricom's M-Pesa, gaining partial benefits for a lower amount and full benefits after completing the amount set per family per year. The list of benefits that Britam offered for their low premium (outpatient, inpatient, eye care, dental, emergency care, and cash payments during hospitalization) was similar to commercial covers on offer for many times the cost. The main difference was in the limits, much lower for Linda Jamii due to the lower premiums.

Although much hyped and with major corporate backing, low-cost medical cover Linda Jamii folded after less than two years, signalling failure to gain traction in the market. Linda Jamii was discontinued from September 30, 2015, after reaching about 80,000 users. Reasons were not disclosed by the partners; however, it is reasonable to assume that costs of underwriting, administration, and marketing exceeded revenues and investment targets were not met.

One lesson learned is that despite initial take-up it is difficult to sustain saving behaviours. Many clients paid the premium in lump sum. Those who saved often contributed only twice or three times instead of regularly saving small amounts. Most of the partially insured members did not manage to keep saving to get the full cover; hence their policies lapsed after 6 months.

Airtel Insurance – "Freemium" hospitalization insurance from mobile provider

MicroEnsure is a for-profit microinsurance company operating in 17 countries throughout Asia and Africa. MicroEnsure partnered with Airtel and PanAfrica Life Assurance Limited to develop the Airtel Insurance health insurance product in Kenya, with coverage based on monthly airtime usage. MicroEnsure provided the

technology, mobile network operator Airtel provided the customer base, and PanAfrica Life underwrote the risk and paid out the insurance claims. The health insurance offered a simple benefit: qualifying customers received lump-sum hospital cash paid to them via mobile money if they spent three nights or more in any hospital across the nation, for any medical reason, with no exclusions.

The insurance product was a loyalty programme in which a predetermined amount of Airtel monthly airtime earns users insurance the following month. To gain more benefits, users must increase their airtime usage. Because the MicroEnsure-Airtel product was expected to increase brand loyalty as well as revenue for the telecom, Airtel paid the premiums to MicroEnsure and its partner insurance company. The product does not require consumers to make payments towards the insurance coverage, and no premiums are collected through airtime deductions; MicoEnsure calls this a "freemium." Insurance payments were distributed through mobile money accounts: once expenses are incurred at hospitals, clients submit claims for reimbursement using their hospital admission and discharge forms.

Airtel Kenya launched in August 2015, reaching 173,000 by March 2016. Its current fate is unknown although it appears that the product is no longer on the market in 2021 (a search of the Airtel consumer website in May 2021 showed no evidence of the insurance product). There are no assessments of health outcomes.

Mamakiba – Mobile health savings plan for maternal care

Jacaranda Health is a for-profit social enterprise providing maternal health services to low-income people in Kenya's peri-urban areas. Jacaranda's Mamakiba was a health savings plan that targeted low-income, pregnant women with mobile phones linked to Safaricom M-Pesa accounts. It provided women with a means to save and pre-pay for anticipated maternal health needs such as antenatal care, delivery and postnatal care. By allowing for flexible savings regimens, users could decide the amount and frequency of payments, and the ultimate savings target. Payments were not compulsory and could be skipped without any penalty. At the outset, the women received support in financial planning. Second, users received text messages reminding them to save, confirm deposits and provide updates on their savings. Finally, savings were tied to specific health needs and could not be misappropriated once deposited.

Unfortunately, Mamakiba was discontinued because of low uptake following a decline in users, with customers expressing preferences for alternative models such as point of-sale (i.e., OOP) mobile payments using M-Pesa. Jacaranda Health also attributes this decline to competing household financial priorities and late decision making. Other reasons behind the low uptake of the product include the absence of a saving culture among the target market and the high cost of marketing the product.

Sema Doc (Hello Doctor) - Prepaid telemedicine consultation

Sema Doc was a service that enabled users to get prepaid access to a doctor for medical consultations via their mobile phones, as well as save and borrow money for medical expenses. It was a collaboration between Hello Doctor (established in 2010 in South Africa) for doctor access, NCBA for health accounts and health loans. and Cannon Assurance for the hospital cash benefit. Sema Doc was supported by Kenya's Ministry of Health as well as Safaricom, Kenya's dominant mobile provider and largest company. Sema Doc targeted to reach more than 11 million mobile subscribers.

The use of technology enables healthcare to be delivered in rural areas that previously had limited access, while mobile payment solutions facilitate collection of premiums. The high penetration of mobile payment solutions in Kenya differentiates it from other countries in the region, and the depth of penetration and the maturity of the mobile money market in Kenya enabled development of m-health solutions such as Sema Doc.

Clients could enrol in the service through their mobile phones, by dialling *220# on their Safaricom line. After registration, a monthly subscription cost KES 300 (approximately CHF 2.50), paid through M-Pesa. Benefits were continuous access to medical doctors via mobile phone, health tips via SMS, access to instant health loans, a dedicated health savings account, and a hospital cash benefit (the only pure insurance component). Members had access to 30 affiliated doctors 24 hours a day, 7 days a week and could choose to either text a doctor with a question or request a call back to discuss health problems. Doctors were given medical regulatory approval to diagnose and treat 22 conditions over the phone. Where necessary, the member would be referred to a GP, clinic, or pharmacy with instructions as to what to expect and what to request. A call with a doctor cost a member KES 60 (approximately CHF 0.50) and a member paid KES 20 to text a doctor with a question.

Sema Doc launched with much fanfare in August 2015, including endorsement by Kenya's First Lady, and by the end of its first month had approximately 2350 members. As of April 2016, it had approximately 12,000 members, only 0.1 percent of Kenya's mobile subscribers. Despite government and major corporate backing, Sema Doc was subsequently withdrawn from the Kenyan market and there is no evidence of activity as of May 2021.

A significant challenge for Sema Doc was member retention. Getting individuals to stay with the product was challenging in the low-income environment where daily circumstances greatly affect members' financial situations. There was also the challenge of adverse selection, members joining the product when their health needs were most acute and withdrawing from the product when they no longer had a short-term need for care. Overall challenges facing Sema Doc were largely behavioural (and relevant to all mobile telemedicine consultation services):

- Changing consumer behaviour, i.e., the belief that when one is unwell, they can be assisted on the phone rather than face to face with a doctor;
- Ensuring that the education reaching the customer translates to behavioural change; and
- Changing consumer health-seeking behaviour from curative to preventive.

6 End Notes

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