An Analysis of the Role of Public-Private Partnerships in Healthcare Service Delivery in Somalia

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Abstract

Background: Public-private partnerships (PPPs) have been a common approach to health care problems worldwide for the last three decades. In 2018's general assembly of the United Nations, ministers from across Africa united in support of the public-private partnerships with the purpose of promoting equitable access to preventive, curative and rehabilitative health services that are affordable, effective, of good quality, and responsive to clients' healthcare needs. Owing to historical political and economic stability in Somalia, the country has not been able to deliver adequate healthcare to its population. Somalia has one of the *worst health indicators in the world*, with life expectancy of 55.4 years, infant mortality of 68.59 per 1,000 live births, under-five mortality of 121.5 per 1,000 live births and maternal mortality of 732 per 100,000 live births. Thus, public-private partnership remains one of the important approaches adopted by Somalia to address this situation.

Objective: This study analyses the role of public-private partnerships in healthcare service delivery in Somalia.

Through cross-sectional study design, the study interviewed 400 respondents from the ministry of health (public sector), private entities involved in the public partnership and beneficiaries who benefitted the services delivered by the public-private partnership projects implemented in the capital city. The study used simple random, convenience and purposive sampling techniques to select the healthcare workers, beneficiaries and public health officials managing the PPP centers, respectively. Quantitative and qualitative data were collected using pre-tested interviewer administered questionnaire and key informant interview guides. The quantitative data was coded and entered to SPSS version 22 for analysis, while NVIVO was used for the analysis of qualitative data. Chi square tests and content analysis were used to determine the role of PPP for health service delivery.

***Result*:** The study demonstrated that Somalia's public-private partnerships for health have the potential to create synergy that can help spur economic growth, create employment and generate income to the local people, achieving universal health coverage and bringing a new meaning to the life of an ordinary person. The role of the public-private partnerships for health can be

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determined by the capacity of the centre and client's level of satisfaction. These are proxy indicators of the health care quality of the healthcare providers. The country's largest medical-surgical tertiary hospital is under public-private partnership agreement, with employee and patient satisfaction rates of 98% and 91%, respectively. Patient satisfaction is influenced by age, [X^2 (3, N = 255) = 24.69, p = .00001], education, [X^2 (4, N = 255) = 13.32, p = .00978], occupation, [X^2 (3, N = 255) = 15.84, P = .00325] and income [X^2 (3, N = 255) = 21.77, p = .00007. In addition, the Ministry of Health of Somalia emphasized the role of PPP in strengthening the health system and providing health services. However, it faces a number of challenges that hinder its proper implementation. The major challenges identified include lack of PPP policy framework, weak government institutions, lack of transparency and corruptions and poor implementation of the agreements.

Conclusion: With political commitment, public-private partnerships for health can play a significant role in the strengthening and development of effective health system in Somalia.

Key words: Public-private partnership, Healthcare Service Delivery, Patient Care

Introduction

Public-private partnerships (PPPs) have been a common approach to health care problems worldwide for the last three decades [1]. The latter half of the 1990s witnessed a burgeoning number of initiatives involving collaboration between the corporate and public sectors with the purpose of overcoming market and public failures of international public health, using global public– private partnerships for health development [2].

Despite the fact that public-private partnership is not a new concept, yet there remains to this day no one single agreed-upon definition of public-private partnership [3]. The concept of public private partnership covers a wide range of situations and is subject to various interpretations. Generally speaking, a public-private partnership can be defined as a partnership between the public sector and the private sector for the purpose of delivering a project or a service traditionally provided by the public sector. According to the World Bank, public-private partnership is *a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance* [4]. Similarly, the International Monetary Fund opines that *public-private partnership is arrangements where the private sector supplies infrastructure assets and services that traditionally have been provided by the government* [5].

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In view of its role, public-private partnerships play a crucial role in increasing the access of quality services to the public by ensuring the necessary investments into public sector and more effective public resources management. Moreover, one of the main potential benefits of PPPs in infrastructure development is the optimization of life cycle costs through innovation, adapted design and improved commercial management [4].

Although, the concept of public-private partnerships had originally been confined to the traditional infrastructure sectors of transport, water, and energy, over the past few years, the use of public-private partnerships has become increasingly popular in the health care sector. Because when compared to the services solely provided by the public sector, forming PPP can reduce the disease burden of the public sector by involving the private sector in health projects, and can be beneficial to the citizens, governments and even to the private sector itself. There is also potential in increasing the efficiency and competition in the provision of services and in lowering the delivery costs while, at the same time, expanding the healthcare service coverage [6].

Furthermore, the stumbling blocks in contemporary health care are, to use Mason and Mitroff's (1981) term, wicked problems that are too complicated for governments to solve individually. Hence, both the public and the private sector recognize their individual inabilities to address the emerging public health issues that continue to be tabled on the international and within-country policy agendas [7]. These considerations led to the evolution of a range of interface arrangements that brought together organizations with the mandate to offer public good on one hand, and those that could facilitate this goal though the provision of resources, technical expertise or outreach, on the other.

Therefore, WHO recognized public-private partnership as a collaboration between the public and private sectors to enhance the performance of healthcare systems by promoting equitable access to preventive and curative health services that are affordable, effective, of good quality and responsive to clients. Consequently, WHO recommends the governments to adopt such partnerships as a means to ‘‘bring together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles" [8].

After gaining independence in 1960, Somalia enjoyed nine years of parliamentary democracy, arguably producing the first peaceful, democratic transfer of power in Africa. However, the military led by Mohamed Siyad Barre overthrew the incipient civilian government in a bloodless coup in 1969 adopting scientific socialism in which the government owns and controls the factors

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and mains of production including health systems. Anyway, after twenty-one years of dictatorial rule, the military government was finally violently ousted from power by a conglomeration of various clan-based rebel groups in 1991 [9].

Before the collapse of its state, Somalia had an effective social service – though rudimentary but reasonable by African standards – which had painstakingly been built over the previous 30 years by both civilian and military administrations. However, the eruption of civil war and the subsequent collapse of the central state in 1991 severely disrupted all public social services in Somalia [10].

Currently, Somalia, a third world country in the horn of Africa, suffers from a marked political, social and economic instability, drought and that have plagued the country's fragile democracy and thus has impeded the development. Somalia is a complex political, security and development environment, and much of its recent past has been marked by poverty, famine and recurring violence. However, in 2012, with the establishment of permanent political institutions and important military offensives, Somalia entered into a new period; a period where longer term peace seems possible. After decades of conflict and instability, a federal government was established, built through national dialogue and consensus [11]. Furthermore, according to UNDP (2013), Somalia's private sector has demonstrated impressive resilience in many areas including telecommunication, financial services, construction, livestock, and fisheries. This led that the country's economy is dominated by the private sector.

Access to essential quality healthcare services is an important aspect of every country's development [12]. Substantially improved health outcomes are a pre-requisite if developing countries are to break out of the cycle of poverty. Owing to historical political and economic stability in Somalia, the country has not been able to deliver adequate healthcare to its population. This is reflected in the various international indicators such as life expectancy, poverty index, mortality rates which all stand at the worst level of the global indicators.

According to WHO, Somalia has one of the worst health indicators in the world [13], with life expectancy of 55.4 years, infant mortality of 68.59 per 1,000 live births, under-five mortality of 121.5 per 1,000 live births and maternal mortality of 732 per 100,000 live births. Consequently, public-private partnership remains one of the important approaches adopted by Somalia to address this situation.

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Using the public-private partnership agreements on healthcare service delivery signed by Somali government, the study examines the role of sustainable public-private partnerships for healthcare service delivery in Somalia.

Materials and Methods

Ethical consideration

Ethical clearance for the study was obtained from the Ethics Committee of the Ministry of Health & Social Service. (Protocol reference number: MOH&HS/DGO/0032/Jan/2020). Written or verbal informed consent was obtained from all participants before the study. Participant names were used in the data collection process and all the voice recorded were transcribed using coded names and numbers to represent participants.

Study design and setting

This study has been conducted through cross-sectional study design. The target population of the study consisted of 400 respondents from the ministry of health (public sector), private entities involved in the public partnership and beneficiaries who benefit the services delivered by the public-private partnership projects. The study employed a simple random and convenient sampling techniques to select representative sample from the facility employees and beneficiaries while purposive sampling techniques were used to obtain appropriate key informants interview respondents from the ministry of health and the concerned private sectors.

***Table 1*: Sampling techniques used for the study**

Sample	Number	Sampling Approach
KII with Ministry of health officials	5	Purposive sampling
KII with private sector officials in the PPP arrangement	10	Purposive sampling
PPP health centre employee survey	130	Random sampling
PPP health centre beneficiaries' survey	255	Convenience sampling
Total	**400**	

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A researcher-made questionnaires and interview guide were drawn out based on the researcher's readings, previous studies, professional literature, published and unpublished thesis relevant to the study. Moreover, observation was also be used to obtain first-hand information about the infrastructure and services offered in the public-private partnership centre. Both oral and visual data were recorded to see the real-time situation and to know the behavior of the clients/patients in the actual place. In this study, a triangulation approach has been adopted in data processing, analysis and interpretation of research results. The qualitative data were analysed using NVIVO (version 12) and flow chart matrix to establish convergence and divergence of themes while the quantitative data analysis was carried out using SPSS (version 23) and graphics have been generated using Microsoft Office-Excel 2013. Each variable was analysed separately except in cases where correlations are required.

Results

Demographic information

A total of 400 (210 men and 190 women) individuals were interviewed in the study. The mean (standard deviation) age was 32.3 (11.5) years, 17.8% were 15-24 years, 57.5% were 25-34 years old, 11.5% were 35-44 years old and 13.2% were above 44 years old. More than half (56%) of the participants were married, 51% of the service clients were illiterate while 78.6% of the healthcare providers had bachelor's degree in medical-related fields.

The partnership models that shape Somalia's PPP agreements

The study reveals that 97% of the public-private agreements signed by the federal government of Somalia with private parties were based on build-operate model where it tenders to a third party the provision of all goods and materials including consumables and medical inventory stock, medical and non-medical services, health staff and other staff for a definite period of time. The study has also revealed that the newly adopted public private partnership nexus has directly or indirectly strengthened the Somalia's health system infrastructures. More than 95% of the respondents agreed that PPPs have accelerated the faster implementation of healthcare reforms using flexible and innovative processes available for the private organizations.

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Regarding the role that Somalia's public-private partnership has played, the majority of the clients (89.8%) emphasized that it contributed to the provision of quality and timely health services, while most of the care providers stated that it ensures more effective public health resource management. Similarly, key informants of the study argued that public private partnerships ensure the necessary investment into public health sector, reduce the risk management expenditure and renovate health facilities.

Concerning the infrastructure of public-private partnership facilities, 76% of the participants reported that the PPP-based health facilities have sufficient premises, ward spaces and cleanable wall surfaces.

Patient satisfaction is one proxy indicator of the health care quality; however, enhancing patient satisfaction in low-income settings is very challenging due to the inadequacy of resources as well as low health literacy among patients. Patient satisfaction affects clinical processes and patient outcomes. Various studies have shown that positive patient outcomes are associated with increased patient satisfaction. According to the study, most beneficiaries (93.2%) of the PPP health facilities came for services including general medicine, orthopaedic and traumatology, pediatrics, obstetrics, gynecology, ENT, ophthalmology, diagnostics, dentistry, surgical intervention and critical care services. The study also revealed that about 21% of the clients were from referred from primary and secondary care centers. Furthermore, the average time taken to receive full medical services and average user charges was 5.3 hours and 112 USD, respectively.

The country's largest medical-surgical tertiary hospital is under public-private partnership agreement, with employee and patient satisfaction rates of 98% and 91%, respectively. A chi-square test was performed to examine the relation between demographic characteristics and the satisfaction of the clients. Regarding the gender, the study showed that there was a significant association between gender and client satisfaction, X^2 (1, N = 255) = 4.11, p = .0426. Similarly, the study revealed that client satisfaction is influenced by age, [X^2 (3, N = 255) = 24.69, p = .00001], education, [X^2 (4, N = 255) = 13.32, p = .00978], occupation, [X^2 (3, N = 255) = 15.84, P = .00325] and income [X^2 (3, N = 255) = 21.77, p = .00007.

On the other hand, the chi-square test also showed that there was no significant association between satisfaction of the client on the services provided and marital status, X^2 (3, N = 255) = 1.74, p = .62721 (see table 2).

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Table 2: Association between demographic characteristics and client satisfaction

Demographic characteristics	N	Clients Satisfaction on the services provided		X^2	P value
		Yes N= 218	No N= 37		
Gender					
Male	99 (38.8)	91(37.4)	8(66.7)	4.11	.0426
Female	156 (61.2)	152(62.6)	4(33.3)		
Client's age					
15-24 years	73(28.6)	67(30.7)	6(16.2)	24.69	.00001
25-34 years	137(53.7)	123(56.5)	14(37.9)		
35-44 years	34(13.3)	22(10.1)	12(32.4)		
45 and above	11(4.3)	6(2.7)	5(13.5)		
Marital status					
Single	61(23.9)	52(23.9)	9(24.3)	1.74	.62721
Married	157(61.6)	132(60.5)	25(67.6)		
Divorced	30(11.8)	28(12.8)	2(5.4)		
Widowed	7(2.7)	6(2.8)	1(2.7)		
Client's level of education					
Illiterate	130(51.0)	101(46.3)	29(78.4)	13.32	.00978
Primary	46(18.0)	42(19.3)	4(10.8)		
Secondary	39(15.3)	37(17.0)	2(5.4)		
Post-secondary	17(6.7)	16(7.3)	1(2.7)		
University Degree	23(9.0)	22(10.1)	1(2.7)		
Client's occupation					
Unemployed	125(49.0)	96(44.0)	29(78.4)	15.84	.00325
Farmer	26(10.2)	24(11.0)	2(5.4)		
Wage employee	27(10.6)	24(11.0)	3(8.1)		
Business	48(18.8)	46(21.)	2(5.4)		
Civil servant	29(11.4)	28(12.9)	1(2.7)		
Client's monthly income					
1.0-99.0 $	19(7.5)	12(5.5)	7(18.9)	21.77	.00007
100-299 $	111(43.5)	87(39.9)	24(64.9)		
300-499 $	70(27.5)	66(30.3)	4(10.8)		
500 and above	55(21.5)	53(24.3)	2(5.4)		

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It is worth noting that majority (94%) of the hospital staff were fulltime staff with average working hours of 8.8 hours per day for 6 days per week. Similarly, with regard to staff work experience, the study has depicted that majority (81.5%) of the respondents had a working experience of 5 years or less.

Challenges facing the public private partnerships for health in Somalia

In the aftermath of the collapse of the Somali central government, the country has been mostly unstable and insecure for over two decades. The situation has seen the country torn apart in almost all aspects of life including the health system. To date, despite considerable investment by the international community aimed at enhancing stability and livelihood, Somalia still experiences challenges in security, governance, rule of law and health infrastructure.

A number of challenges were raised by the respondents during the interview. The most frequent challenges mentioned include: lack of PPP policy framework, weak government institutions, lack of transparency and corruptions and poor implementation of the agreements.

Firstly, as mentioned repeatedly, one of the biggest challenges that PPPs for health have faced in Somalia is the lack of a policy framework to guide the implementation process.

"As far PPP for health is concerned, lack of policy framework governing the partnership agreements has always been the major obstacle we had encountered in Somalia because policies clearly state the objectives, the model of contract, roles and responsibilities, legal and regulatory frameworks and as well as dispute resolution framework".

MoH Senior Officer (Key informant)

Through the private sector lenses, it was also noted that the lack of policy framework is often exacerbated by government officials' office turnover which sometimes leads to a change in MoH strategic priorities.

"Besides the absence of a framework, the private sector is reeling from the constant changes in Somalia's governments, with each new official introducing a different new policy, which in turn hampers the agreements signed".

Senior PPP Facility Administrator (Key informant)

Secondly, the study has shown that weak government agencies cannot deliver its duties, roles and responsibilities related to public-private partnerships and this causes uncertainty or even distrust of the private sector.

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"*To me, weak institutions cause confusion and uncertainty in the private sector, making it difficult to predict that the agreements signed will be implemented as planned. Moreover, these government institutions can be exploited unfairly by the private sectors since they lack the capacity comply with complex agreements*".

Ward in-charge (Key informant)

Thirdly, it was identified that the demarcation between the public and private sectors is blurred with individuals often playing the role of both the public and private sector actors interchangeably. There is an overlap between the public and private sectors. This is either due to a personal relationship between the corporate owners and the public officials or these public officials are the owners of the private organizations.

"Although in many instances this is done inadvertently oblivious of the need to keep the two entities apart. In some situations, the ambiguity is taken advantage of by individuals within the public sector who also seek to benefit from engaging in private ventures.

PPP Health Facility's Senior Manager (Key informant)

Fourthly, the newly established government institutions in post-conflict states lack the capacity to oversee a smooth implementation of PPP and proper regulation.

However, due to weak government institutions and lack of transparency, some signed PPP agreements have not been implemented. To put it bluntly, to my knowledge, there have been two hospital operate-transfer agreements with private organizations that have been unfairly taken over the private sector and still operating privately in government facilities. The ministry of health has tried several times to address the issue, but it couldn't make it because the private sector was backed by members of parliament and senior government officials.

MoH Senior Officer (Key informant)

Fifthly, it was also noted that limited revenue and low levels of accountability within government systems in conflict and post-conflict political orders have also reduced their economic bargaining power. This exposes political administrations to manipulation and bribery by the financially robust and profit-driven private sector looking for opportunities to invest and return quick profits.

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Sixthly, the other challenge raised in the study is insecurity which is a serious issue in Somalia. The lack of security has impeded humanitarian access, increased displacement of the population, and contributed to the rise in criminal activity. Consequently, many donors are decreasing their humanitarian assistance.

"Besides all the challenges I have mentioned, the biggest challenge that Somalia has been suffering since the collapse of the central government in 1991 is insecurity which prevented the private sector to partner with public sector."

PPP Senior Officer (Key informant)

Discussion

Generally, the delivery of the health care in almost every country involves some form of public-private partnership in both the developed and developing countries. It is now common knowledge that the private sector, the government and the community can all benefit from the public-private partnership if there are genuine concerted efforts to work together.

It is worth noting that public-private partnerships in Somalia have the potential to create synergy that can help spur economic growth, create employment and generate income to the local people, achieving universal health coverage and bringing a new meaning to the life of an ordinary person. However, there are several pre-requisites that must be met before the execution of public-private partnership agreements. According to the findings, there are four structural foundations that must be in place to maximize the probability of public-private partnership success. The recommended necessary conditions include: political will, strong government institutions, policy framework and technical teams.

This study has revealed that most of the public-private agreements signed by the federal government of Somalia with private parties were based on build-operate-transfer (BOT) model. The government has chosen this model due to its reduced development and infrastructure budget, better management and transfer of risk to the concession company. However, a study undertaken in Rwanda revealed the contrary.

According to the findings of the study, since its inception in Somalia in 2011, the role of public private partnership for health has been revolving around four key functions. Among the functions of public-private partnership include investing in health sector, managing the available resources, delivering health services and managing the risk expenditure. The result of this study is consistent

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with other research studies conducted in the region that have discovered almost identical functions. For instance, regarding the role of PPP arrangements, Ojba (2016) argues that in most situations, public-private partnership for health plays three significant roles including health financing, health service delivery and monitoring of health services. Similarly, Alexander (2013) has stressed the importance of ambitious financing focused not only on growth but also on efficiencies and reallocation of health resources.

The largest and most specialized referral hospital in the country has been established under public-private partnership. It provides standard healthcare services at affordable user charges.

In the last few years, there has been a paradigm shift in healthcare service delivery in which government seeks a solid partnership with the private sector to assist in public sector investment. This shift seems to be well received by the service users. In an attempt to identify satisfaction of the clients on PPP health services, the study has shown that the majority (92%) of the respondents were satisfied with public-private healthcare services compared to 34% and 21% satisfaction for pure private and pure public service, respectively. The findings of this study has coincided with results of another study conducted in Cyprus which showed high patient satisfaction for public-private partnerships compared pure private or pure public services.

In terms of enhancing Somalia's health systems, the federal government has lately recognized the need of public-private partnerships for health in designing health projects, building or renovating health facilities and securing funds for healthcare service delivery. The role of public-private partnerships in health can be determined by centre performance and customer satisfaction. These are proxy indicators of the quality of care provided by healthcare providers. The country's largest tertiary medical and surgical hospital is under a public-private partnership agreement with employee and patient satisfaction of 98% and 91%, respectively. Patient satisfaction is age, [X2 (3, N = 255) = 24.69, p = 0.0001], education, [X2 (4, N = 255) = 13.32, p = 0.00978], occupation, [X2 (3), N = 255) = 15.84, P = 0.00325] and income [X2 (3, N = 255) = 21.77, p = 0.00007. This result of this study was in some ways consistent with that of Mallat and Vrontis (2020) in Cyprus. However, there are several challenges associated with the implementation of public-private partnership agreements for health in Somalia. Some of these challenges are directly related to partnership agreements while others related to the implementation of the agreements.

The study has found a number of challenges which hinder the progress of effective public-private partnerships for health. The major challenges and obstacles to proper functioning of Somalia's

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public-private partnerships for health include lack of PPP policy framework, weak government institutions, lack of transparency and corruptions and poor implementation of the agreements.

The findings of this research is in line with the results of other studies conducted in Kenya, Ethiopia, Uganda and Somalia, all of which reveal that the biggest challenge of all time was lack of suitable policy frameworks to guide the implementation process. Similarly, another study conducted in Tanzania stated that common challenges of public-private partnerships include lack of analysis capacity to assess investment proposals leading to poor project designs and implementation.

In addition to the lack of framework, the private sector is reeling from the constant changes in Somalia's governments, with each new official introducing a different new policy, which in turn hampers the agreements signed".

Another stumbling block noted is weak government institutions. The study has indicated that weak government agencies cannot deliver its duties, roles and responsibilities related to public-private partnerships and this causes uncertainty or even distrust of the private sector. Somalia's rejuvenating institutions are yet to fully able to enter such complex agreements with getting technical assistance from other parts. As argued by many researchers, newly established government institutions in post conflict states lack the capacity to oversee a smooth implementation of PPP and proper regulation [14].

Another serious impediment to the smooth running of the public-private partnership for health is corruption and lack of transparency. According to many authors, corruption is both one of the leading causes and consequences of endemic political and economic instability in Somalia, which has always been ranked bottom of Transparency International's Corruption Perceptions Index every year since 2006 [15].

The study has demonstrated that it is generally agreed that the smooth operations of the public-private partnership for health is riddled with corruption and misappropriation. The result of this study is consistent with the works of [15] and [16] which point out that corruption occurs at all levels in both the public and private sectors, and is a visible and expected form of behaviour.

Another challenge raised by the study is poor implementation of partnership agreements signed the government health agency with private entities. The efficient implementation of public-private partnership agreements requires strong government institutions. Because these organizations are legally obligated to ensure that agreements are carried out as intended or planned. However, the

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newly established government institutions in post conflict states lack the capacity to oversee a smooth implementation of PPP and proper regulation.

In this regard, it was noted that several agreements that the Ministry of Health-Somalia signed with private sector have not been implemented as planned due to private sector unfairly taking advantage of the weakness of the government agencies. Although the government has fulfilled its duties at the outset, the private sector took over and currently operating in government facilities without fulfilling their obligations.

Conclusion

From this study, the researcher demonstrated that Somalia's public-private partnerships for health have the potential to create synergy that can help create employment for health workers and contribute towards achieving universal health coverage and bringing a new meaning to the life of an ordinary person. The largest referral tertiary hospital was funded through a public-private partnership agreement. These PPP medical facilities enjoy a high level of employee and customer satisfaction. In addition, the Ministry of Health of Somalia emphasized the role of PPP in strengthening the health system and providing health services. Unfortunately, it faces a number of challenges which hinder the proper implementation of public-private partnerships. The major challenges and obstacles to proper functioning of Somalia's public-private partnerships for health include lack of PPP policy framework, weak government institutions, lack of transparency and corruptions and poor implementation of the agreements.

However, with political will and private sector commitment, public-private partnerships for health can play a significant role in the strengthening and development of effective health system in Somalia.

Conflict of interest

The author doesn't have any conflict of interest associated with the material presented in this paper

References

1. Donald A. B. (2017). American Journal of Public Health January 2007, Vol 97, No.1
2. Buse, K. Walt, G. (2000) Global public–private health partnerships: part II — what are the issues for global governance? Bulletin of the World Health Organization
3. Hodge, Graeme A., and Carsten Greve. 2007. Public–private partnerships: an international performance review. Public Administration Review 67(3), 545-558.
4. The World Bank Group. (2014). Public-Private Partnerships Reference Guide Version 2.0.

Preprint not peer reviewed

This preprint research paper has not been peer reviewed. Electronic copy available at: https://ssrn.com/abstract=4041109

5. IMF (2006), Determinants of Public-Private Partnerships in Infrastructure (2006)
6. Cheng, T. M. (2008). China's latest health reforms: A conversation with Chinese health minister Chen Zhu. Health Affairs, 27, 1103−1110.
7. Nishtar S, et al.: World Heart Federation. World Heart Day: a World Heart Federation enterprise promoting the prevention of heart disease and stroke across the world. Circulation 2003, 108(9):1038-40.
8. WHO (1998). Partnerships for health in the 21stcentury. World Health Statistics Quarterly , 1998, 51: 68–74.
9. Elmi, A. A. (2010). Understanding the Somalia Conflagration: Identity, islam and Peacebuilding. London: Pluto Press.
10. Ahmed I.I and Green, H (1999). The Heritage of War and State Collapse in Somalia and Somaliland: Local-Level Effects, External Interventions and Reconstruction. Third World Quarterly, Feb., 1999, Vol. 20, No. 1, Complex Political Emergencies (Feb., 1999), pp. 113-127
11. Yohannes, D And Dessu, M.K (2019). Facing a new phase of instability, the region needs genuine, inclusive efforts driven by national and local players
12. WHO (2015) Regional Office for the Eastern Mediterranean Region: Somalia health profile 2015 / World Health Organization. WHO-EM/HST/221/E 1. Cairo, Egypt.
13. Astana declaration on primary health care: from Alma-Ata towards universal health coverage and sustainable development goals. Geneva: WHO; 2018
14. Anoop, S. (2009). A Way to Effective Service Delivery in Fragile States: Public-Private-Partnerships. New York: World Bank
15. Somali NDP (2017). National Development plan from 2017-2021. Mogadishu
16. Marqaati (2017). Somalia: Overview of corruption and anti-corruption. https://www.u4.no/publications/somalia-overview-corruption-and-anticorruption
17. Rubinstein A, Barani M, Lopez AS. Quality first for effective universal health coverage in low-income and middle-income countries. Lancet Glob Health. 2020;6(11):PE1142–E3.

Preprint not peer reviewed

This preprint research paper has not been peer reviewed. Electronic copy available at: https://ssrn.com/abstract=4041109