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Resources for Health Care in Somaliland: From the International to the Communal?

Health care in Somaliland is provided by public, private and traditional actors. The health care system in Somaliland faces huge challenges and the government cannot guarantee sufficient health care provision for its citizens. The government is also not in a position to regulate health care services provided by private and charitable actors. One cause of these challenges is the limited national budget available for public health facilities. While a considerable share of resources for health care is provided by international donors and NGOs, there have also been some initiatives in Somaliland to encourage community involvement through cost-sharing initiatives. Such initiatives have largely failed, but where they have succeeded they guarantee more sustainable sources of income and less dependency on external funding sources that come with external health care priorities.

Brief Points

- International donor support to health care in Somaliland creates accountability challenges as donor support is temporary and depends on the analyses and interest areas of foreign actors
- Research on accountability in health services shows that cost-sharing initiatives involving the (local and transnational) Somaliland community may address the sustainability challenge
- Such cost-sharing initiatives however do not currently come with community ownership and accountability
- Expanding community involvement through greater patient participation is one way to increase the accountability of the system

Cindy Horst
Peace Research Institute Oslo (PRIO)

Nasra Jama

Peace Research Institute Oslo (PRIO)
PO Box 9229 Grønland, NO-0134 Oslo, Norway
Visiting Address: Hausmanns gate 3

www.prio.org
Facebook: PRIO.org
Twitter: PRIOUpdates

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The Health Care System in Somaliland: History and Present Realities

In Somaliland's history, the health care sector has largely been insufficient and underfunded. Before the 1970s, some of Somaliland's facilities, especially those in the capital, were in good shape. After independence from the British and then unity with South Somalia, administration of public institutions including the health system started to decline in the North. Attempts to improve conditions were not appreciated centrally. During the Ogaden War in 1977–1978, international organizations came to Hargeisa providing assistance to the refugees coming in from Ethiopia. Local doctors lobbied with them for financial support, improving the conditions at Hargeisa Group Hospital (HGH).

Dissatisfaction with what were seen as the regime's deliberate attempts to weaken the quality of services provided in Somaliland grew, and resistance took place both in the shape of community engagement to improve public services like healthcare, and later also politically and militarily, with the establishment of the Somali National Movement (SNM) in 1981 from London. HGH was a central hub of activities.

> *We were young professionals my age from Europe and Arab countries and locals. We started with improving the sanitation of the hospital. We bought the cleaning equipment ourselves. We encouraged people not to wait for anything from the regime but to do something themselves. We used to purchase the essentials with donations from the diaspora in the Middle East.*
>
> Abdi Mursal, Hargeisa

Several of those involved in activities at HGH were arrested and imprisoned for years. The civil war that started in the North in the late 1980s, and its aftermath in the 1990s, made the situation worse. Health workers died or fled and medical facilities were destroyed.

Our research on accountability practices in the Somaliland health care system, based on 40 in-depth interviews with key informants in the country's six regions, focused in particular on present-day realities and challenges. The current public health system in Somaliland comprises primary health care units, health centers, referral health centers and regional hospitals. Data on the numbers of active public health facilities is limited, but according to the Ministry of Health there are at least 7 national hospitals and 97 health centers.[1] Regional differences in health care provisions are large, and in many remote parts of the country the nearest health care facilities are hours away. But even major regional centers, in for example Sool and Sanaag regions in the East, are very poorly served.

One of the major changes that happened after the civil war is that the private health sector proliferated. While lack of data makes it impossible to quantify, the private sector often provides the only point of contact for patients. The sector is both unregulated and widely used. As an example of the challenges this poses, a recent report on the sector illustrates that there are currently at least 1000 active pharmacies across Somaliland handing out medication, though none are actively regulated by any government body.

Qualified health professionals in Somaliland are in high demand and staff shortages are a problem across the public health sector. This is particularly the case outside Hargeisa and a few other main cities. Many health professionals work in both the public and private sectors, making attendance another big concern in the public sector. In 2013, the National Health Professions Commission (NHPC) was established with the mandate to regulate health providers across the public and private sectors, but its work has so far been limited.

Much of the funding for health services comes from international donors and NGOs as well as from the Somaliland diaspora, through direct support to the health sector and private remittances. Somaliland's government budget for 2015 was USD 150 million for an estimated population of 3.5 million people.[2] Recently, allocations for health dropped as a percentage of the budget from approximately 3.9 percent to 3.3 percent. Over 60 percent of this is spent on human resources.[3]

International Health Care Support

There are a range of donors and INGOs that provide health care support in Somaliland, including UNICEF, WHO, the Somaliland Development Fund (SDF), MSF and others. The type of support provided varies from medical supplies and supporting qualified health professionals to running health facilities. Supplies that are provided to hospitals and Medical Health Centers (MHCs) include medication and food. Initiatives to improve the availability of qualified health professionals include providing them with training as well as establishing medical training programs in Somaliland. Furthermore, some organizations send qualified staff who are not available in Somaliland, such as optical surgeons. Besides recruiting these foreign doctors and paying their salaries, at times international support goes to topping up local staff salaries to create greater incentives for them to remain in regional health centers where the need is greatest. Finally, international support has been provided to construct particular health facilities, and even in some instances to run hospitals or several regional MHCs.

While international health care support adds much-needed resources to the health care system in Somaliland, there are also ways in which bringing in international human resources can be seen as costly, as Dr. Idris Ilmi from HGH reminds us when he discusses how the government's contribution to the hospital is spent:

> *A big portion of the financial support provided by the government is spent on foreign doctors' salaries. … There are approximately 10 foreign specialists in the hospital and each is paid $2000 per month. After the salary of these employees are paid not much will be left from the 1 million.*
>
> Dr. Idiris Ilmi, HGH, Hargeisa

This dilemma is not easily addressed in the case of highly specialized competence that is not available locally. However, it is more problematic in lower medical staff categories, where qualified Somalis are available but NGOs prefer to hire staff from neighboring countries to implement projects. Furthermore, international contributions worsen regional disparities, as security concerns in Sool and Sanaag prevent international medical and project staff access to those regions.

There are two further dilemmas regarding international health care support. The first relates to ownership and the second to

sustainability. In relation to ownership, being dependent on foreign donors for support means that it is often not possible to decide what resources should be used on. INGOs come with full-fledged projects in areas where they have greatest interest or see the greatest needs. This may not match local understandings of needs, as expressed by the national government and by regional health providers.

> *People in the regions are always frustrated because most of the time they see a need which has been added to the government's strategic plan. While you have your own plan, they come to you with unimportant new ones to replace yours. Then you have no choice but to adapt because you are a beggar.*
>
> Dr. Ibrahim Abdifatah,
> Boroma General Hospital, Boroma

Another aspect of ownership relates to accountability. Not only is it impossible to decide prioritization of programming, but it is also very difficult to deal with upwards and downwards accountability in this system. A major challenge is that donor money is not processed bilaterally, through the government. This situation is caused by a lack of a public financial management system and concerns over corruption. If the government had a transparent accounting and management system, donors would be able to channel funding directly to the Ministry of Finance and all programs could be government run. Amina Ahmed at the Ministry of Health (MoH) explains the consequences of the current situation:

> *At present, funding is channeled through organizations; be they UN, local or international. These organizations deduct overhead costs from the project funds for implementation. The government is not involved because it does not control the budget. […] In this system, accountability does not exist.*
>
> Amina Ahmed, MoH, Hargeisa

Implementing organizations have strict accountability procedures towards their foreign donors, but not towards local stakeholders. Information about contracts and terms of references are not shared either, which makes it even more unthinkable that local stakeholders can hold international donors and NGOs accountable. In Somaliland, there is a lot of disgruntlement over the many overlapping foreign projects that exist and that often don't address locally-identified core gaps. There are also many questions asked as to how funding is being spent and how much money ultimately reaches Somaliland. And yet, there is a general sense that foreign actors cannot be held accountable in any way. An added challenge mentioned is that even downward accountability can be affected by international involvement: when MoH staff receive a salary directly from foreign donors, the ministry cannot hold these staff members accountable. In addition, when INGOs decide to engage in health care support without proper communication, for example, selecting medical staff to attend training without informing their superiors, the risk exists that international support in fact weakens the local systems in place.

A second dilemma relates to the lack of sustainability of international support. During our research, we learned of a host of projects in which international organizations assumed particular responsibilities that then collapsed after they withdrew their support. These stories followed a similar pattern, where an NGO comes to town and decides to support the public hospital and make it function well. After some time, the quality of the hospital skyrockets, as professionals start working in the hospital.

> *After the NGO leaves, everything collapses and the hospital goes back to its original state or even worse. Sustainability isn't the target of the project and the professionals leave as soon as the NGO does so.*
>
> Mahdi Abdirahman,
> project manager local NGO, Erigavo

Of great concern in this respect currently is the Essential Public Health Services (EPHS) initiative. First, other organizations had pulled out of providing basic health services as EPHS was supposed to take over. UNICEF, for example, stopped providing support in Las Anod because EPHS was supposed to begin. As it did not, shortages of medicine ensued. Second, the EPHS support is supposed to be phased out, and questions on sustainability exist. Even when an INGO does have advanced sustainability measures, there is no guarantee the system won't collapse within a short time. Hodan Ahmed works as a nurse in Erigavo hospital. She argues:

> *MSF left the hospital in a good shape. Wards had all the equipment needed. Medication for a whole year was provided to the hospital. Within six months after their departure the good system they built collapsed because of the incompetence of the person who was left in charge.*
>
> Hodan Ahmed, nurse, Erigavo

One of the main challenges to sustainability relates to the fact that INGOs largely provide services and supplies free of charge, even where people were used to paying. After the international support ends, local populations will still expect to be assisted for free and will assume that local health professionals are taking their money if they are asked to pay. While international support is central to the functioning of the health system in Somaliland for as long as government revenue remains insufficient, at the same time it is crucial that international support does not reduce or eliminate local resources.

Cost-Sharing Pilots in Somaliland

Community involvement in enabling necessary health care service delivery goes back to the 1970s and 1980s, when the community, including local businessmen and diaspora, contributed in order to enable professionals to provide the services the national government was seen to be denying people in the North. Local business and diaspora still play a role in such support even today. During President Muhammad Egal's reign, the Ministry of Health developed a National Health Policy to address the incapability of the government to provide health care services for its citizens because of its very limited resources. This policy entailed a cost-sharing system and also proposed the establishment of a community board to oversee regional hospitals. While mainly set up to address insufficient funds, the National Health Policy was also meant to stimulate cooperation between government and community, in an effort to increase community ownership – aiming to deal with the low levels of trust in the government and the general lack of respect for public property.

While the National Health Policy was meant to be implemented across the different regions

of Somaliland, at present the Regional Health Board and cost-sharing system is only functional in Hargeisa, supporting HGH. There are a number of measures in place that have made the set up in Hargeisa successful. The board opened an account for hospital funds that can only be accessed by board members and that is not allowed to grow in size, because when savings reach a certain amount the money is invested in medical supplies. No one benefits from the system financially, while everything is invested back in the hospital and the money is accounted for. All board members are volunteers. Furthermore, the Regional Board in Hargeisa is independent from the ministry, while the community had a significant role in its establishment and still plays a central role in supporting its main functions. The board is also anchored well in the hospital, since the director of the hospital is a member of the board. The hospital supplements funding by the government and the community with international support, but donors must channel their contributions through the hospital.

The cost-sharing system functions in a number of ways. The Regional Board is actively involved in policy development and in particular fundraising for the hospital. Board members also lobby with the Somaliland diaspora for support. The diaspora in Kuwait donated an oxygen machine, and the diaspora in Iran and UAE donated a dialysis machine, for example. Then, cost-sharing happens because patients pay a small extra sum for a number of services. In the pharmacy, for example, if the medication costs 14,000 ShSl., patients pay 15,000 ShSl. The majority of the medication is purchased that way, allowing those who cannot afford it to get the medication for free. Inpatients are not charged for staying overnight unless they make use of single rooms. That money goes into the cost-sharing system as well. These various ways of raising money on top of the resources provided by the government have, for example, enabled jobs to be provided to health professionals not on the payroll of the government. The money has also contributed to increasing salaries and supporting the pharmacy.

Cost-sharing, ultimately, is a step away from public health insurance, and cannot deal with exempting many patients from payments. Thus, it is based on the premise that most patients can afford to pay the costs. The biggest challenge with the system is that it has not fulfilled its second aim, namely, increasing community ownership. The system as it is currently implemented in HGH does not really allow for accountability and proper community participation. The board is there to offer advice and raise funds, but does not have the power to be involved in the administration of the health facilities or in holding the Ministry of Health accountable. 'Community involvement' in this system means that the wealthy in the community pay for the system, so that everyone can get basic health care services. While the board ultimately does represent the community, this function is underdeveloped. Some people address complaints about health services received to the board, but communication between the board and the wider community is poor, and many patients do not know about the board's existence.

Conclusions and Recommendations

In attempts to find sufficient funding for health care provision in Somaliland, ownership and sustainability are core elements that stakeholders must take into account. The absence of a public financial management system prevents bilateral aid, and as a consequence, international support currently scores poorly on local ownership and sustainability. Considering this reality, local cost-sharing systems are an important option to explore. While such cost-sharing systems may go a long way towards addressing resource scarcity, they have not succeeded in improving community participation and ownership. Based on our research, we recommend the following:

- The reinstitution of Regional Health Boards and cost-sharing systems should be explored, drawing on the successful example of HGH
- The model requires the introduction of a component of community participation in order to install a greater sense of community ownership in health care provision. Regional Boards should be given a greater role in accountability procedures and guaranteeing patient rights
- One component to add to the Regional Boards is the introduction of a system where patients can raise concerns and complaints. This component must be advertised widely using channels within the hospital as well as through media ■

Notes

1. Human Rights Watch Report, www.hrw.org/report/2015/10/25/chained-prisoners/abuses-against-people-psychosocial-disabilities-somaliland.
2. House of Representatives, 'Government Budget', undated, somalilandparliament.net/index.php/parliamentarybusiness/goverment-budget (accessed August 19, 2015).
3. House of Representatives, 'Government Budget. Budget Line 231', undated, somalilandparliament.net/index.php/parliamentary-business/goverment-budget; In its Health Policy the Ministry of Health committed to pushing the government to increase public funding to the health sector to 15% as stipulated by the African Union Abuja agreement, see 'National Health Policy', p.39, on file with Human Rights Watch.

THE AUTHORS

Cindy Horst is Research Director and Research Professor at PRIO.
E-mail: cindy@prio.org

Nasra Jama is a Researcher on the 'Dimensions of Accountability' project.
E-mail: nasra-sagal@hotmail.com

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