4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

Until the collapse of the national government in 1991, the organization and administration of health services were the responsibility of the Ministry of Health, although regional medical officers had some authority. The Siad Barre regime had ended private medical practice in 1972, but in the late 1980s private practice returned as Somalis became dissatisfied with the quality of government health care.

From 1973 to 1978, there was a substantial increase in the number of physicians, and a far greater proportion of them were Somalis. Of 198 physicians in 1978, a total of 118 were Somalis, whereas only 37 of 96 had been Somalis in 1973.

In the 1970s, an effort was made to increase the number of other health personnel and to foster the construction of health facilities. To that end, two nursing schools opened and several other health-related educational programs were instituted. Of equal importance was the countrywide distribution of medical personnel and facilities. In the early 1970s, most personnel and facilities were concentrated in Mogadishu and a few other towns. The situation had improved somewhat by the late 1970s, but the distribution of health care remained unsatisfactory. [x]

The Somali health system was already in disarray at the time of Siad Barre, with wide inequalities in access to health services between Mogadishu and the rest of the country. According to the policy adopted at the time, health and education were free of charge. The capacity of transforming policies into action was, however, limited, and so were the resources, largely provided by the international assistance (94% of the health budget in 1989). As a result, an indigenous, coherent health system never took off. No sector-wide adoption of the PHC approach took place in those years.

Government spending for health progressively declined, from 4-5% of total spending in the 70s and beginning of 80s to only 2% in the second half of the 80s. Access to health care further diminished, with only Mogadishu and areas supported by the international community providing some health services. By the early 90s, an estimated 80% of the population had no access to basic health care. As expected, the impact of 15 years of conflict on the health system has been profound, affecting all its components: human resources, infrastructure, management, service delivery and support systems.

International agencies and the private sector have struggled to fill some of the widening gaps affecting public health services. However, in the absence of effective coordination, security, adequate incentives and regulation, inequality in access to basic health services has grown worse, with urban and secure areas benefiting the most from NGOs and private providers. Most externally-financed programs are emergency and/or vertical programs, such as nutrition, polio eradication, EPI, HIV/AIDS, tuberculosis and malaria control. It is well known that these modalities of service delivery lead to both vertical and horizontal fragmentation of interventions and, therefore, to low efficiency in the use of already scarce resources.

4.2 Public Health Care System

Before the collapse of its state in early 1991, Somalia had a public health system – though rudimentary but reasonable by African standards – which had painstakingly been built over the previous 30 years by both civilian and military administrations. The country had a good number of general hospitals (though they were mainly concentrated in big urban areas, like Mogadishu), some regional hospitals, clinics, child and mother health (CMH) centers and out-patient dispensaries. Starting from the early 1970s, for instance, the number of physicians increased significantly, the greater proportion of them being native Somalis. For example, out of about 200 medical doctors in the entire country in 1978, around 120 were Somalis, whereas only 37 out of 96 physicians had been Somalis in 1973. Besides, in the 1970s and 1980s, great efforts were made to increase the number and quality of other health personnel and to enhance the construction of medical facilities. For this purpose, two new nursing schools were set up and several other health educational programs were established.

The opening of the faculty (department) of medicine of the country's single university, i.e., Somali National University (SNU), Mogadishu, was a very important step in this direction. Another important step was the countrywide distribution, as much as possible, of medical personnel and facilities. Nonetheless, the overall situation of the country's public health remained unsatisfactory. This is testified by the fact that, prior to the civil war, Somalia's health sub-sector was significantly under-funded. Less than 2% of the government's recurrent budget was allocated to health; the average in Sub-Saharan Africa was 6%. The reason for this serious under-funding was obvious, as Siad Barre's military/socialist regime was devoting most of its resources and energy to security and defense, particularly after the commencement of the anti-government rebel movements by 1979. When these armed opposition forces became victorious and the state collapsed, Somalia's public health – which was essentially funded by the government – collapsed with it.

Before this tragic collapse, the organization and administration of health services were in the hands of the Ministry of Health, headquartered in Mogadishu, the capital, with some authority delegated to the regional medical officers. One major function that the ministry used to perform was to regulate both medical and pharmaceutical practices in the country – an extremely important role. On the other hand, medical services were practically free for all citizens; but at times you had to buy the prescribed medication, particularly if it was not available at the government hospitals or public health centers. As such, most Somalis, especially the poor and people with a very limited income could get a reasonable degree of health care, free of charge. Another positive feature of this public health, when the country had a functioning national government, was that Somalia had arrangements with some friendly foreign countries, like Italy, Germany or Egypt, to treat Somali patients or perform surgical operations for them if the required facilities were not available at home. Around 1972, at the start of the application of the "Scientific Socialism" in the country, Siad Barre's regime had banned private medical practice to oblige the small core of physicians in the country to devote all their time and energy to serving their needy people and not to run after personal gains. However, by the late 1980s, the ban on private practice of health care was lifted, after the regime realized that the quality of government health care was unsatisfactory; this started initially by allowing the doctors to practice in their private clinics in the evening, after finishing their official work in government hospitals.

With the onslaught of the devastating civil war in 1991, the modest health infrastructure of the country was destroyed or seriously damaged; most of its premises

were looted, vandalized or taken over by poor squatters, internally displaced people and at times armed tribal militias. One of the favorite ways of vandalizing these hospitals, clinics and health centers, it was reported, was to take away their wooden doors, windows, marbles (if any) and the plumbing and electric fixtures – after looting the medical equipment- to sell them or to be used for building the looters' own houses or shacks. The famous Mogadishu General Hospital, which used to be one of the most comprehensive and well equipped hospitals in the Horn of Africa – is now occupied by some destitute families. Besides, the well known Medina Police Hospital and Banadir Mother and Child Hospital, all situated in Mogadishu, have been closed down until very recently. These important hospitals were built with funding from the European Union, Italy and China; now some local merchants want to reopen the last two hospitals. But the severest blow that has befallen the country's health system was the departure of the overwhelming majority of the limited number of qualified doctors, nurses, technicians and other medical professionals either for lack of security, work facilities or to find greener pastures abroad; some of them were also murdered during the civil war. Again, as the faculty of medicine of the national university and other educational facilities for training the required medical personnel were either destroyed, vandalized or closed down, no meaningful number of these badly needed staff have been produced in the past 15 years. The numerous yearly scholarships which foreign governments used to offer Somalia to train its future physicians and other medical personnel were also lost during this period as there was no a functioning central government to deal with.

Current Status of the Health System

Presently, health standards in Somalia are reported to be among the worst in Sub-Saharan African because of widespread poverty, frequent famines and civil strife that has been going on in the past 15 years. According to the World Bank data-base, life expectancy, for instance, is only 47 years in Somalia (in Saudi Arabia, the figure is 73 years); infant mortality (per 1,000 babies): 133; under 5-year old mortality rate (per 1,000 kids): 225; child malnutrition (% of under 5 years): 26; and child immunization, for measles, (% of under 12 months): 40% only. If we compare these figures with those obtaining in neighboring Kenya, for example, we find that although the life expectancy figures are very close in the two countries, the situation in Kenya is much better with regard to all the other categories, i.e., infant mortality, malnutrition and child immunization, etc.

However, there were some positive developments in the recent years, especially in regions where relative peace and security prevailed. For instance, about 30 hospitals, 73 mother and child health centers (MCH) and 132 health posts were opened with the help of foreign donors and Non-governmental Organizations (NGOs), such as *Medicins Sans Frontieres* (of France). Moreover, out-patient dispensaries, and health posts (in rural and nomadic areas) also exist in some regions. Still, most childbirth (88%) is reported to take place without adequate medical facilities (in neighboring Kenya, the figure is 41%). And in Somalia's rural and nomadic areas, the situation is even worse; no nurses or even midwives (except traditional ones) are said to be available there. Another complicating factor is the severe shortage of proper sanitation, as safe drinking water is generally unavailable, and half of the population in Somalia has no access to toilets. Besides, uncollected garbage constitutes a major environmental as well as health hazard in big urban areas, like Mogadishu, since proper municipality functions do not exist anymore.

Some Recent Positive Developments

An important positive development was that with the initiative of the few medical professionals who remained in the country in collaboration with some businessmen, some good health care facilities, albeit much smaller than what the country currently needs, have been established. These include general hospitals like Al-Hayat, Arafat and SOS for Children, all situated in Mogadishu. Several health facilities have also been set up in Self-declared Somaliland Republic, chief among them being the modern and well equipped Maternity Hospital which was constructed in Hargeisa at the personal initiative of Mrs. Edna Ismail (Somaliland's current Foreign Minister). Also, in the cities of Bossaso and Galcaio (in the autonomous region of Puntland), some new general hospitals and other health facilities were established through the help of the local government, businessmen as well as individual doctors who relocated to their regions. In the case of Galcaio, for instance, these new or rehabilitated health facilities serve not only the inhabitants of Mudug region – where it is the capital - but also those of neighboring regions, like Galgudud Nugal and Sol, and even patients from the eastern Somali Region of Ethiopia. On the other hand, the new universities of Amoud, East Africa (Bossaso), Hargeisa and Mogadishu, are also reported to have started to open faculties of medicine within their premises, or plan to do so in future. This would undoubtedly go a long way in addressing the serious shortage of qualified human resources in health delivery and management due to brain drain and lack of training facilities, as alluded to earlier.

Periodic immunization campaigns, against polio and other infectious diseases, have been conducted whenever security permits with the help of the specialized UN agencies and donor-funded NGOs. Malnutrition is also reported to have declined, but is still a serious problem in a county ravaged by civil strife and where low rainfall and frequent famines are the order of the day. This malnutrition which, of course, makes its victims more susceptible to more serious illnesses, is said to be prevalent in children between 5 and 13 years old.

Notwithstanding the fact that these new medical facilities have been filling in the wide gap that has been created by the collapse of Somalia's public health service, the problems facing the citizens in this regard are huge. For one thing, since these medical services are essentially being offered by the private sector, there is no free or cheap health care in Somalia at all. Everybody, no matter how poor he or she might be, has to pay for it dearly, by local standard. Today, a medical visit costs about So. Sh. 50,000 or around 3 US dollars. This is in a country where nearly 45% of its population in urban areas currently lives in extreme poverty, i.e., less than $1 per day (the situation in rural and nomadic areas is even worse). On top of that, the patient has to undergo medical tests, such as x-rays, laboratory tests, etc., some of which might be unnecessary and which could cost him/her hundreds of thousands of Shillings. In a very poor, war-torn country like Somalia, where avenues for gainful employment are extremely limited, only a minority of its citizens who get regular remittances from their relatives in the Diaspora, can afford this kind of medical fees. Those who are lucky enough or have the means also seek better health facilities in neighboring cities like Dubai, Nairobi, Jeddah or Addis Ababa.

Most private hospitals and clinics, everywhere, generate the greater part of their revenues from the above-cited medical tests. It is, therefore, natural that their doctors would often ask people to undergo some superfluous tests, to augment their income. Apart from that, they could prescribe more medicines than are required – some of it could also be available only in a certain pharmacy that is in collusion with the

prescribing physician. But in the opinion of some experts, one of the most serious problems currently facing Somalia's health care system is that there is no governmental authority to regulate this crucial sector. Consequently, in a country whose economy is in shambles, where very few job opportunities exist, where law and order seriously lack, anybody – irrespective of his educational qualifications and work experience – could engage in this lucrative sector. He can then sell his products/services at the highest price possible. Some pseudo-doctors, unqualified pharmacists (or petty traders in medicine) or ignorant traditional healers could also advise you to take quite inappropriate medicines, which could have serious side effects on your health – and some of which may have already expired.[xi]

There is a functional the Ministry of Health in Puntland which has a policy and strategy framework. However, resources available to the Ministry are limited and its role has been primarily to coordinate the activities of international agencies and NGOs as well as local NGOs who support health services and responsibilities that were previously handled by the Ministry of Health during the pre-war period. Improving the health of the population of Puntland through increased access to health services is the goal of the Ministry of Health. In order to improve health services in urban areas that have higher population densities, the International and local NGOs have constructed MCHs and health posts. CHWs and TBAs have also been trained on basic health services.xiii

In the public sector in **Somaliland**, the functioning health facilities in the country are divided into three main categories such as:

1. **Health posts:**

   There are 135 health posts (HPs) evenly distributed in all the regions of the country. These health facilities are available at village level. Ideally there should be at least one Traditional Birth attendant (TBA) and one community health worker (CHW) in every health post *(MOHL, 2001).*

   Major problems Identified:

   - Many HPs are not functioning for one reason or another.
   - Drug supplies are irregular and insufficient.
   - Only UNICEF provides drugs for all the Health posts
   - Motivation of TBAs and CHWs is usually low since they depend on community support only for their needs that is not mostly covered.
   - Insufficient training of CHWs in general and towards children in particular.

2. **Health centers:**

   There are around 53 health centers throughout the six regions of the country *(MOHL, 1999).* Health centers (previously known as mother and child health care centers) are mostly located at the district capitals, some main villages and sections in the main cities.

   They are staffed with:

   - Qualified nurses (usually 1-3)
   - Auxiliary nurses (1-2)
   - Cleaner
   - Watchman

- Rarely one midwife.

The major units of health centre are:

- Under fives clinic
- Antenatal care unit
- Immunization unit
- Growth monitoring unit
- Adult OPD

Health centers are the most important health facilities providing health services to the children. Both immunization and Growth monitoring units are exclusive for children (except the TT for pregnant women). Some basic essential drugs are available for children. Vaccination, treatment of some endemic diseases and management of minor injuries are the most important health services children receive at health centers where they are available.

Major problem identified in this area:

- In adequate number of health centers, so that there is no health centre services in many rural and Nomadic settlements.
- Irregular supplies in most of the health centers that are not supported by an INGO.
- Total dependency to Unicef as far as supplies are concerned.
- Lack of information channel between the health centers, the regions and Ministry of Health and Labor.
- Poor staff motivation
- Under utilization of people even in those well functioning Health centers.

3. Hospitals:

According to the official documents from the ministry of Health and Labor there are nine functioning Hospitals in the region, which are:

- One National Referral Hospital in Hargeisa
- Five regional Hospitals
- One district Hospital
- One TB Hospital
- One Mental Hospital

National and regional Hospitals have various Departments such as:

- Surgical Department
- Medical Department
- Pediatric (not in all hospitals)
- Gyn/Obstetric Department
- Mental Department in most of the Hospital
- TB sections in most of the Hospitals

- Other specialties (in the national Hospital)

Staff categories of the hospitals include: Doctors, Qualified nurses, Auxiliary Nurses, Lab. Technician assistants, Mid-wives and other sub-ordinate staff.

Hospitals are the highest level of health services provision in the country and therefore, they should provide all medical and surgical services that children need in any given time. Children are treated in the Hospitals and some minor operations for children also took place in the hospital, but how what qualities of services are provided? How many beds are available for children in the hospitals? These questions and others cannot be answered easily and not well documented.

Major problems identified in this area include:

- There are no specialists (pediatricians) in the hospitals. All the doctors working in the pediatric department are practitioners without special skills for child illnesses and their management.
- There are also no pediatric nurses
- Most pediatric equipment are very scarce in the hospital, even emergency materials are hard to get.
- Staff motivation and thus patient care is very poor in almost all the hospitals
- No disease preventive measures are available at the hospitals except BCG Vaccination at the maternity wards. ix

4.3 Private Health Care System

The Somali private health sector has grown considerably in the absence of an effective public sector. This means that the most vulnerable are completely excluded from the new services. Of the 20% of the population who get any care at all, about two thirds of them get it from the private health sector. The growth has thrown up a range of problems. Over-the-counter drug prescriptions, the dispensing of expired drugs, and inadequately trained staff can lead to misdiagnosis and drug resistance (for example to anti-TB drugs, antimalarials or antibiotics). Moreover, private health care is characterised by high charges for services - pricing the poor out of health.xv

The private provision of health services is unregulated and, as such, can be a risk rather than a solution to health problems. For example, the importation of cheap uncertified drugs and self-medication risks developing drug resistance that constitutes a health threat for Somalia and the entire region. Efforts are being made by the administrations in Somaliland and Puntland with international support to tackle this problem.

Overall, curative care provision has been ensured by an expanding private sub-sector, while the coverage and quality of public-health services has suffered, despite the support given by international agencies and special programs. The curative orientation of many health workers has compounded the problem. Access to certain basic services, like maternal health, or tuberculosis and malaria control, has remained extremely limited.

Modern, for-profit

The private sector stepped into the vacuum left by government to run social services, such as education, health care, and veterinary services. The Somaliland administration provides a modest public financing for education and health services, but as elsewhere, these services are heavily subsidized by communities, international aid agencies or Islamic foundations. The privatization of social services began prior to the war, when a lack of investment resulted in their virtual collapse. To compensate for this, the government began to decentralize responsibility for public sector financing to regional and district levels, and users were encouraged to contribute directly to the financing of these services. International donors responded with substantial resources to re-establish essential social services in the early 1990s, but from 1995 onwards, as donor financing declined and in the absence of competent public administrations, aid policy reverted to encouraging greater self-financing of services.

Private health care services are concentrated in a few major urban areas, where physicians and nurses run private clinics or attach themselves to a local pharmacy. Despite the low fees charged for a consultation (typically around US $0.50), doctors complain that people still attempt self-diagnosis, running the risk of misuse of antibiotics and other medicines that are readily available in local pharmacies. Pharmacies themselves are often run by business people with no training in medicine.

Private sector consists of several facilities that provide health and these include:

1. **Pharmacies:**

   There are out-numbered pharmacies available in almost all sections of main cities, small town and even some villages; most of them are just drug sellers (Asha Hashi, 1997). They sell drugs of all types, and to every body. There is no quality control of the drugs they sell; there are no regulations and control of any sort. In most of them the persons running the pharmacy is unqualified and may even have no Health background.

2. **Clinics:**

   These are some facilities in which there are inpatients, they are found in the main cities, and mostly run by Doctors. The premises usually consists very few rooms. Almost all of them are in appropriate to admit any patient because of their low standard of sanitation measures, unqualified personnel and unavailability of basic medical supplies. Children are admitted in some of these so- called clinics.

3. **Hospitals:**

   There is only one private Hospital throughout the country and that is Mrs. Edna Aden maternity Hospital. In this hospital Neonates and mothers receive an international standard of health care services.

4. **Consultation rooms:**

   These are the facilities in which doctors work to receive patients, they usually deal with outpatients for drug prescriptions and some investigations.

It has been proved that 83% of the clients of the private sector are women and children *(Asha Hashi, 1997),* but the qualities of services they receive are very questionable. The cost is also very high that most of the families cannot afford to pay for their sick children. In fact some children may get some helpful health services in the private sector, but also there is many who suffer from malpractices, harmful interventions, and inappropriate and/or ineffective drugs.

No document, which tells something about the magnitude of the problem of traditional harmful practices, is available; and the whole area is so far obscure.

The major problems that exist in this sector can be summarized in the following points:

- Poor quality of drugs.
- Lack of rules, regulations and control
- Untrained staff involved
- Unclean and unhygienic premises
- Inappropriate and insufficient medical equipment,
- Profit seeking, rather than patient's interests. ix

Availability of private health services: 2003

(No.)

Selected towns and hospitals	X-Ray technicians	Beds	Doctors	Nurses	Midwives	Laboratory technologists
Hargeisa						
Edna maternity hospital	0	45	4	3	20	2
Ugbaad maternity hospital	0	6	1	0	3	1
Ghalib hospital	1	15	5	10	4	1
Kaah hospital	0	16	3	0	3	1
Borama						
Allale hospital	1	25	3	3	3	2
Total	2	107	16	16	33	7

Source: Ministry of Health and Labour [15]

There are currently 62 private health facilities in Mogadishu. The quality of services varies from fair to very poor. Of the existing 62 health facilities, 33 are run by qualified doctors and nurses, but the remaining 29 are run by people with little or no medical training. Clinics offer health services ranging from normal checkups to major surgery. There are no controls in place to regulate these facilities. xvii

Modern, not-for-profit

As a complement to the emerging regional government structures, is the large presence of local and international NGOs throughout Somalia, with organizations in the North West zone tending to be more development oriented then in the other zones.

There is both coordination and competition between these organizations as well as competition between agencies and local authorities in the North West and North East zones for resources and institutional space. The capacity, competency and commitment of organizations vary within the NGO sector within Somalia. A large proportion is donor driven, and many organizations are essentially program contractors and creations of international aid availability. In many cases, the NGO sector has provided the only institutional vehicle for delivery of social services in the absence of government systems. However, the multiplicity of organizations has resulted in a multiplicity of developmental methodologies and approaches, based on the varying mandates and motivations of the organizations.

Somali NGOs Consortiums

Over the years, Somali NGOs/CSOs have shown varying levels of credibility and capability. Recently, a number of capable and committed NGOs/CSOs have emerged with a strong commitment to community development needs. Recognizing their own limited capacities and the need for information sharing, NGOs/CSOs have formed umbrella organizations to disseminate information on community development needs or human rights to strengthen their combined knowledge and skills base. Among others, these include:

The Consortium of Somaliland Non-Governmental Organizations, COSONGO, was founded in 1998. COSONGO believes that NGOs can build their capacities by pooling resources and sharing information. COSONGO aims to 'give local NGOs a stronger voice to disseminate information about development, to improve the capacity of its members, and to continue advocating for local NGOs in Somaliland.' The Network for Somali NGOs, NETSON was launched in southern Somalia in 1999. NETSON members implement relief and development projects in a diverse number of locations, but aim to maintain mutual relations and co-operation since they all have common goals. NETSON's goals are to establish a public information centre on socio-economic indicators for Somalia, to provide training to NGOs/CSOs to improve their capacities, and to assist member NGOs to develop technically sound proposals and secure funding. The Talawadag Network of NGOs in Puntland was founded in 2000. It aims to strengthen the capacity of local NGOs, improve their project implementation skills, initiate contact and dialogue with local and international stakeholders.

Traditional

1. **Traditional operations sites:**

   Such facilities are operational in almost every corner of a city, town and village. Traditional surgical Practitioners run these sites; they usually deal with children and carryout all the traditional surgical operations such as: Tonsillectomy, uvulectomy, teeth-extractions, nose bleeding and other harmful practices.

   There are no sanitation measures available in these sites and children usually suffer from such practices. Apart from the psychological trauma that children experience from these practices it has a direct and indirect health problem such as: Severe hemorrhages, infections, nerve damages and many other complications. Unknown number of children dies due to such complications every day. Unfortunately there is no specific study carried out on this matter.

2. **Traditional healers and herbalists:**

   These traditional healers use different methods of treatment. Some of them claim that they inherited the skill from their father and grandfathers. They mostly use

various herbs and chemicals of unknown origin. The side effects of such drugs are unknown and there are no fixed dosages. Problems that result from such chemicals are very common among the population.

3. **Tibi practitioners:**

These claim that they treat their patients with some religious based practices in very different ways from reciting of Quran to using plants as medicines.

4. **Spiritual healers:**

These are very common individuals who claim that the treat their patients through spiritual and supra-natural actions. Their actions are other superstitious or psychological. Some of them claim that "Satan" or "evil "affects their patients; and that they know how to fight against such unnatural elements. ix

4.4 Overall Health Care System

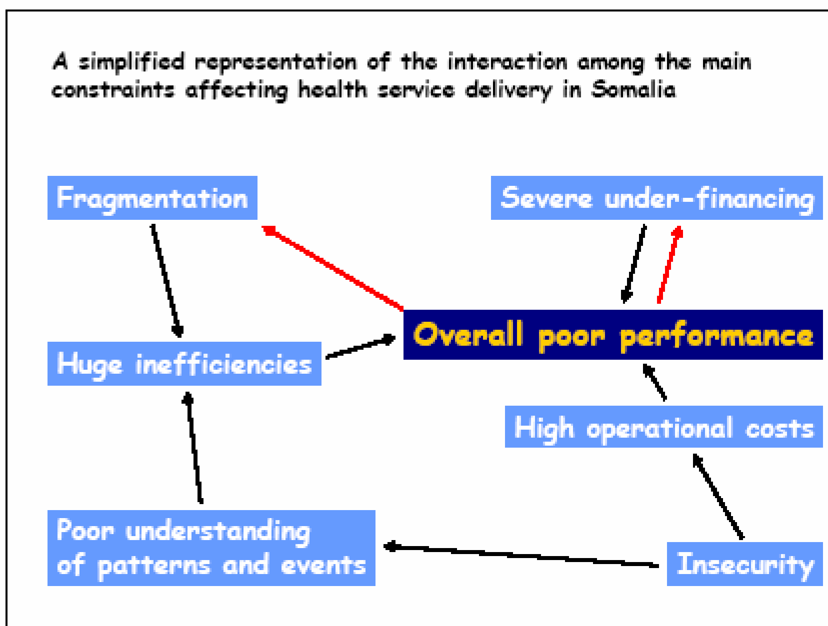
Prior to the war, the provision of public health services was heavily subsidized by foreign aid. In 1989, over 95% of the Ministry of Health's budget was funded by donors, with the government allocating only 2% of its recurrent budget to health. An urban bias and uneven access to health services, poor quality of care due to inadequate training of health care providers, mismanagement and poor knowledge and practice, contributed to generally poor health indicators. Foreign aid continues to subsidize public health services. The Somaliland and Puntland administrations currently allocate some public money to the health sector. In 2000, however, this amounted to as little as 2.9% and 2.5% respectively of Somaliland's and Puntland's recurrent budgets, and was mostly allocated to salaries. Over the past decade, however, private health provision has grown significantly. In 1997, for example, it was estimated that 90% of all curative care was being provided by the private sector, with up to 75% of the population in some areas utilizing private health facilities. This trend is encouraged by declining external finances, a lack of resources or commitment by administrations to support a public health service, and a lack of qualified personnel. In this context, community self-financing of minimal services is considered the only option for sustaining health services. This policy has several consequences. First, privatization and the introduction of user fees limit poor people's access to health services.

Second, there are probably more health facilities in Somalia now than before the civil war, and the distribution of health facilities and health professionals has changed to the advantage of some areas like Puntland. Nevertheless, there is still a bias towards urban areas. Although difficult to measure, it has been estimated that only 15% of rural people have access to health services, compared to 50% of the urban people. In Puntland, for example, 49% of health personnel are in Bosasso while the whole of eastern Sanag has only one doctor. Third, the focus of international assistance is mainly on Primary Health Care (PHC), preventative and life saving health care. Consequently, there has been an increase in community-based health posts since the war, with community health workers and traditional birth attendants providing basic preventative and curative care, but a decline in referral services. Before the war each district, on paper, had a hospital with a qualified doctor. In reality, few of them functioned. A rationalization of the health system in the 1990s has seen the closure of many hospitals. For example, Baidoa has the only hospital for the whole of Bay region, and this has not provided an adequate standard of service for several years. Fourth, with an estimated 0.4 qualified doctors and 2.0 qualified nurses per 100,000 people, there is a chronic lack of qualified health professionals. Most qualified professionals

have migrated overseas and those that remain work in the urban centers. With no newly qualified young people coming in to replace them, the health system will face a major crisis in the next ten years. This requires long-term public investment in basic education and training and a creative strategy to attract professionals to return from the diaspora. Currently the only nurse training facilities are in Bosasso and Hargeisa. Fifth, the private provision of health service is unregulated and, as such, can be a risk rather than a solution to health problems. For example, the importation of cheap uncertified drugs and self-medication risks developing drug resistance that constitutes a health threat for Somalia and the entire region. Efforts are being made by the administrations in Somaliland and Puntland with international support to tackle this problem. Finally, certain health interventions, such as HIV/AIDS prevention, require a wider structure of public support beyond a community-based system. In the absence of a central government authority, attempts have been made in some regions to foster a broader health structure through district and regional health boards.

Summing up, the Somali health sector is trapped in a combination of factors that reinforce each other, resulting in an appallingly poor systemic performance. Crushing constraints, to be tackled in a balanced, phased and coherent way, with adequate resources and within a medium-long term horizon, are displayed in a simplified way in the picture:

- Insecurity,
- Severely inadequate resources and skills, both in health management and clinical care,
- Skepticism, or lack of motivation and vision by politicians and managers,
- International neglect,
- Unclear future political and administrative settings, which encourage piecemeal, short-term initiatives,
- Financial and operational fragmentation,
- Imbalances in the supply of services,
- Low standards of health care,
- Inadequate information.



Source: Joint Needs Assessment- Somalia. 2006