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Identification of Capacity Building Interventions for Local Health Authorities in Somalia

Final Report

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Contents

Background

This report was commissioned by the EC Somalia Unit to identify appropriate capacity building interventions for local Ministries of Health in Somalia and, separately, to produce a project proposal for a specific capacity building project using EC funding of €2 million. During the course of the work this figure was revised upwards, to €3 million, in light of the improved financial situation within the EC Somalia Unit. The work was contracted to Nicare, through the ECO consortium, and carried out by Monica M Burns a consultant in health financing and planning.

The Terms of Reference for the work were discussed at the very outset of the mission and clarification sought about the anticipated outputs, there being some initial confusion as to whether this work constituted an EC Feasibility mission, an Identification mission, or a Formulation mission, since elements of all of these were included in the TORs. Normally these distinct parts of the EC Project Cycle Management are undertaken as separate pieces of work, with a project proposal, TORs, and a financing proposal coming out of the Formulation phase. In the case of these TORs, the 'feasibility study' is seen as the immediate precursor to the Project Proposal. The feasibility study and the project proposal were prepared and presented separately for EC approval. Agreement was reached on the outputs and these were later formally agreed after submission of an inception report, which also outlined a revised proposed timetable and plan of activities for the work. One additional element agreed to be included in the TORs was to research the feasibility of contracting for the proposed project through the usual EC tendering and bidding process with international executing agencies and organisations, as per the EC Project Cycle Management. The findings from this research are also included in this report. After discussions with the Health TA and the EC senior staff it was agreed that what was needed from this report was not a detailed evaluation of previous and current projects, since there is ample documentation covering these. Neither was it considered useful to assess individuals' capacities in the health sector. A view of the bigger picture was needed to help in the decision making process about how to proceed and where to target resources. For these reasons, some of the elements contained in the very detailed TORs were not undertaken and are reflected in this report from a more strategic perspective, in terms of how they, together, fit into a pattern of capacity and development issues. The original TORs provided to the consultant are attached to this report at Appendix 1.

This report is a precursor to a detailed project proposal which forms a separate output of the TORs. This report provides the findings from discussions, visits, observations and research on Ministries of Health in Somalia, and the links between the Ministries and local authorities and providers. It also provides an analysis of the findings in relation to capacity building and development in the health sector and, further, provides recommendations for a systematic approach to capacity building. The main focus of the work was to identify systems and procedures in place to support the running of the health sector, as well as capacities of individuals appointed to Ministry of Health positions and local health authorities. In Chapter 1 of the report the main findings are presented. In some instances generic findings are presented; in other

cases findings specific to one area are identified. Given the wide spectrum of organisational and human capacity, and the need to look at the situation from a

strategic perspective, as far as possible individuals are not specifically identified. An attempt is made to reflect the issues in a generic way, which would facilitate the introduction of a capacity building programme across the whole of Somalia. Chapter 2 presents an analysis from a strategic perspective, in the context of capacity building and in the wider context of health sector development, taking into account issues other than the Somali health sector *per se*, including the current arrangements for interventions by donors and their contribution to increased systems stability, and the ongoing debate within the EC Somalia Unit about the wisdom of working in a sector specific approach as opposed to a system-wide approach in relation to capacity building. Chapter 3 reflects the recommendations for potential interventions in the context of health sector systems and procedures and human resource development. There is a body of opinion among some in the international community working in Somalia that design and implementation of a development programme for the health sector would in some way condone the political upheaval prevailing in Somalia. Others insist that significant development interventions should only be considered if and when stability is achieved: that development should be used as a carrot and stick to allow access to development funds. This report does not presume to adopt any political stance but looks at the options and potential for developing and establishing a functioning health system for all of the people of Somalia. So, the 'do nothing' approach is mentioned but quickly dismissed in the report.

Rather than recommend a piecemeal approach to capacity building interventions the report will take a much wider approach, taking into account the expressed interest of Somali Ministers of Health and a number of international agencies to have a plan or strategy with which to work, to start on the road to sustainable development in health care. In doing so, this report acknowledges the opportunity and responsibility felt within the EC Somalia Unit to take an initial lead on issues of sustainable development. The fact that the report was commissioned indicates the recognition by the EC Somalia Unit - and others - of the need to establish a cohesive approach to development interventions while acknowledging that a parallel range of emergency relief interventions and vertical programmes will continue to be necessary for some time.

The report, when accepted by the client (the EC Somalia Unit) will be made available to all those with whom discussions were held and other interested parties in an attempt to achieve a degree of commonality of approach and to give indications of where resources for development might best be directed in the health sector.

At the start of the mission a large volume of documents was made available to provide background information and a starting point from which to proceed with discussions, interviews and field visits. The body of documents grew significantly as the work progressed. All of the documents consulted are noted in Appendix 2 of this report.

Due to the particular nature of Somalia and its continued instability many of the discussions with international personnel and with many Somali personnel took place

in Nairobi. While all of these discussions were undoubtedly useful, the visits to health facilities and Ministries of Health in Somalia provided much better opportunities for professional observation and confirmation (or otherwise) of reported situations. Despite the TORs relating only to health authorities, it was felt that the relationships between health providers and authorities and the information and communication flows between them also needed to be assessed. The range of facilities visited, therefore, included health posts, clinics, hospitals, district health boards and Ministries of Health. Public, donor supported, and private provider facilities were visited, where possible, given the mix of provision prevailing in Somalia. Visits were also made to Ministries with direct relevance to health, such as Ministry of Planning, Ministry of Finance. Visits were made on an opportunistic basis rather than planned (indeed, on a number of occasions, attempts to plan visits as recommended in the TORs were thwarted due to the facilities not being open or having no-one available to meet with). Due to timescales and distances not all of the locations and projects identified in the TORs were visited but other locations, projects and facilities were: the objective was to observe and gather impressions to feed into the overall analysis.

Despite repeated attempts to visit central and southern region it was considered to be too volatile a situation to allow a 'non-essential' visit. It was hoped that the situation would allow for a visit in November / December when the consultant returned but in fact by that time travel to all parts of Somalia had been suspended for internationals. Many discussions were held with Mogadishu-based health personnel in Nairobi: however, the inability to visit one region of the country does have implications for the validity of some of the generic findings and recommendations in the report, since no direct observations were able to be made of the facilities and the capacities.

Acknowledgements

The list of people who provided assistance to the consultant during the course of the research and mission relating to this work is a long one. Most of those who provided technical inputs are included in the list at Appendix 3. Thanks to all of them for their inputs. Others who were not consulted in a technical capacity provided essential logistical, aeronautical and administrative services. They aren't listed in the Appendix but have been thanked individually.

Special thanks go to Mario Maritano, Technical Assistant at the EC Somalia Unit, who provided initial briefing and ongoing support without in any way trying to influence the findings. Imanol Berakoetxea from SACB provided invaluable briefings and historical perspective throughout the mission and beyond. Abshir Jama from ADRA acted as facilitator extraordinaire in Galkaio and Garowe: his enthusiasm, energy, local knowledge and constant good humour made him a real joy to work with. And thanks to Steve Cooper for making Abshir available to the mission. Paul Crook and Alberto Fait provided both practical and technical support to the mission: discussions with them were always interesting and often provocative and were much appreciated. They both provided very necessary reality checks to some of the initial ideas.

While all of the people listed in Appendix 2 contributed to the contents of this report, responsibility for inevitable inaccuracies and any controversial views rests entirely with the consultant. The views expressed in the report do not necessarily reflect the views of the European Commission - Somalia Unit.

Executive Summary

Somalia has been in a fairly constant state of crisis and instability for at least fifteen years. International agencies and bilateral NGOs have been providing emergency support and intervention over a prolonged period, to the extent that the interventions have now become accepted as the norm rather than the exception. Multinational organisations and bilateral NGOs have provided most of the support to the health system over this time. The support ranges from emergency food distribution, vertical programmes of immunisation and vaccination, cold chain distribution programmes, provision of basic health services and health service supplies, building and maintenance of facilities in which to provide health care, training of local paramedic staff, providing international professional staff to health facilities and other essential services. Due to a variety of reasons (funding instability and gaps, personnel changes, attrition of local staff) the health services available are of relatively poor quality, are relatively inaccessible to large portions of the population, and are run on an ad-hoc rather than a systematic basis. In recent years there has been a proliferation of private health care, usually provided by returning Somali doctors with funds from the diaspora and charitable organisations. Any approach to establishing a functioning health service will need to acknowledge (and welcome) the private sector as a full partner in health provision.

While the continuation of the 'chronic crisis' situation is an unfortunate fact, there is clearly a need to prepare the country for increased stability. It is unrealistic to expect emergency interventions to continue ad infinitum and, while the need for such prolonged emergency interventions could not have been predicted at the outset, it is clear to all of the international players and many of the key national players that establishment of systems and procedures in all sectors are critical precursors to a functioning health system. At the same time, there is a continued need for the emergency relief interventions and the vertical support programmes to continue until such times as stability is established and all of the interventions can be integrated into a functioning health service, with international support to enable Somali nationals to run it.

A number of issues are addressed in this report which reflect the 'knock-on' effects of multiple system failure: the health system is not by any means the only failing system in Somalia. (Indeed, part of the reluctance within the EC Somalia Unit to address capacity building on a sector by sector basis is the recognition of system failure in all sectors and the need for capacity building across all the sectors.) Where there are obvious links to other sectors these are highlighted. In some instances it is the failure of a specific function of another Ministry which adversely affects the capacity of the health sector (such as Ministry of Planning, for example, in relation to registration of births and deaths). In other instances the failures in the health system will have resonance for other sectors and might be useful indicators of more generic systems issues.

The prolonged crisis in Somalia has many implications for human resources, specifically in the health sector, which is the focus of this report, but in other sectors as well, which impacts directly on the potential functioning of systems and procedures

which support the provision of appropriate health services to the population. Ministries of Health, where they exist, are staffed by people who have little experience and negligible skills in health care management, planning, financing, or human resource development. A long term effect of the prolonged crisis is the lengthy interruption in the education system, in terms of both academic development and skills capacity. This, along with the historical massive exodus of the country's professionals, means that there is a very limited pool of people available with skills, expertise or experience of running critical services and systems such as the health service. Add to this the entrenched dependence on the international community to provide funds, supplies and services and it is clear that a piecemeal approach to reinstatement of health systems and procedures is not a feasible option. Rather, the need is for a concerted, targeted, focused programme of system development, capacity building and integration of existing support interventions, to prepare people gradually to assume responsibilities and ownership of essential services such as the health system.

It is not anticipated that Somalia will be in a position to be self financing for many years to come. Nor is the health sector likely to be in a position of independence from international assistance and aid. This report will reflect a number of basic premises.

? The first of these is that all development activity, including integration of existing support programmes, development of more coherent development programmes, the implementation of projects and programmes to support the Somali health sector, should continue to be undertaken under the aegis of the SACB Health Co-ordination Committee. The existence of the Health Committee provides a crucial element in supporting both capacity building and development in a more co-ordinated way. If it didn't exist it would have to be created, to guarantee any degree of success in undertaking development of the health system. That is not to say that the current ACB Health Co-ordination Committee is working to its full potential - indeed it may be appropriate to rationalise some of the tasks currently undertaken by the SACB Health Co-ordination Committee. But the fact of its existence and its ownership by all of the key players, in conceptual terms at least, provides a very useful basis from which to plan and implement a comprehensive development programme.
? It is unlikely that there will be a smooth uninterrupted transition in Somalia from its current unstable situation to one where the development process can be planned and implemented in a secure and supportive environment. Measurements of success for any development process in Somalia must take that fact into account and develop some pragmatic success indicators. This is particularly relevant for the European Commission, where success indicators for projects tend to be more generic rather than country or situation specific. In addition, conditions for undertaking a development programme should be clear and unambiguous, for both the Somali counterparts and the international agencies. Conditions for participation in programmes could include inter alia, guaranteed freedom of access and movement both for Somalis participating in the programmes and internationals providing technical assistance; selection of Somali participants based on objective criteria; availability of appropriate Somali counterparts.
? Alongside the emergency interventions there is a continued need for transitional development interventions such as the vertical programmes and provision of direct

technical assistance to health facilities. There is also a need to integrate these transitional programmes and add significant longer term development interventions within an overall health sector development programme, to prepare individuals and groups for a new era. It is not a case of either emergency intervention or development assistance. Both must work in tandem, with the proportions changing over time to reflect the changing circumstances of the country.

? By all accounts (and by observation) there is absolutely no point in providing assistance to reinstate systems and procedures which prevailed before the onset of the chronic crisis. The systems didn't work well then and, two generations later, are now sufficiently outdated as to make them administratively archaic.

What is needed is an agreement between Somalis and international organisations about the systems and procedures to be adopted, which can be adopted as and when a health authority is ready to move into an explicit development phase. The preferred way forward, in the view of the consultant, is the development of a broad based 'jigsaw' of interventions, the pieces of which together make up a functioning health system. The jigsaw would encompass a full strategy for the health sector, agreed and accepted by all of the key players, with associated competence-based skills and management development programmes. The jigsaw would allow for the gradual adoption of systems and procedures, the building up of skills and knowledge about the health system (as opposed to project-specific training) which would enable Somalis to take full control of the health sector in terms of management and planning. As part of that jigsaw a range of training and development programmes would be included to support the development of individuals and groups in carrying out the jobs to which they have been appointed (without the benefit of previous experience or training). The complete jigsaw, including the significant piece for capacity building programmes, would be available to all international donors and lenders from which to choose to support interventions appropriate to their own organisational agendas.

This report recommends the funding by EC of a project to the value of €3 million, to be utilised over a two year period, which will provide (a) a Health Sector Development Programme, detailing the components of a health system and the interventions necessary in Somalia to establish such a system and (b) a targeted, limited capacity building programme for key strategic skills and responsibilities, as will be required by functioning Ministry(ies) of Health. The preparation of the Health Sector Development Programme will include detailed collaboration and consultation with Somali Ministries of Health and senior health personnel and with international colleague donors working in Somalia to arrive at a clear, comprehensive health system jigsaw. It will also use the outputs from similar activities in other post-conflict countries, which could provide a useful template for components of a health system. In parallel with the preparation of the Health Sector Development Programme a targeted limited capacity building programme for Ministry of Health personnel will be provided, addressing issues such as planning; financing and financial management; co-ordination of international assistance; data collection, health records and production and use of information; human resource issues, and general management skills.

Chapter 1

Main findings

Given the unstable situation in and the geopolitical circumstances peculiar to Somalia there is no single analysis which reflects the health sector across the whole country. Indeed no single analysis would even fully reflect any of the three loosely accepted zones at this stage. While this makes it more difficult to reach generalised conclusions about the situation and needs, it should be noted that in this respect it is not so very different from many post conflict countries. That being said, it is possible to make a strategic analysis of issues and situations which pertain to the health sector, bearing in mind that the analysis reflects a spectrum along which different parts of the country will be positioned at any one point in time. In other words, not everywhere reflects the worst of what is presented here. The focus of research was on the functionality of the Ministries of Health and how the core systems and procedures (if and where they exist) are transmitted and understood by local health authorities and facility managers.

Some of the findings may not be welcome to Somalis, some others may not be welcome to international organisations or NGOs. They are presented here not to be controversial *per se* but are an honest reflection of observations from a fresh pair of eyes. A number of the issues are well rehearsed by both the key Somali players and the international organisations and are presented here simply as a marker to show where and if they fit into a wider strategic picture of the situation. Indeed, there are a number of findings over which the Ministries of Health have no direct control, but which adversely affect the operation of the health sector: these relate mainly to legislative and governance shortcomings.

1.1 Chronic crisis and its implications

1.1.1 General implications

The political challenges facing Somalia are well outside the remit of this report and will not be addressed except to the extent that the report is premised on an ultimate agreement to a very decentralised system. The length of the crisis has both operational and strategic implications and has implications both for Somalis themselves and for international organisations who would wish to help establish an equitable and fair system of health care and other essential services.

Access to health care

As it stands currently, geographical disparity in terms of functioning health facilities and human resources means that many pockets of the population do not have easy access to health care. UNDP estimates that at least 40% of the population have no access to health facilities. The mapping of health facilities by the SACB Health Co-ordination Committee shows a variable distribution across the country, not surprisingly with the highest density in and around the urban conurbations. Somalia has the lowest population density in Africa, which means that there is a real balancing act between geographical coverage and quality of care provided. Much of the essential health care that is available is either provided or financed through the international organisations, especially in remote and very remote areas. Despite the

fact that Somalis are traditionally nomadic there is ample evidence that when modern health care interventions are needed people will go to accessible, affordable facilities which offer a good (and trusted) standard of health care. There is some evidence (even taking into account the acknowledged limitations of population data) that some of the core health status indicators in Somalia are better now than they were in the 1980s. This gives some indication that the relief interventions and the thrust towards development activities such as vertical programmes, have had an observable impact. Recently, public hospitals have been able to function marginally more effectively by accruing very limited resources though cost recovery mechanisms. However, any hopes that a cost recovery programme will accrue significant resources for the health system are almost certainly not going to be met. Significant research, specifically in Africa, on cost recovery schemes shows that they are unlikely to yield more than 5% of running costs[1]. As a counterweight to this empirical finding across a number of African countries, a recent analysis of cost recovery in the EC/ Italian co-financed project, executed by CISP, which involves targeted community involvement and advocacy, indicates that up to one third of costs are being recovered[2]. Some of the reported critical success factors of this are that there were no long funding gaps between the (five) different phases of the project; there is a long term capacity building component in the project TORs, and there have been only a small number of experienced international experts leading the project since its inception in 1995.

A growing private sector is providing health care to those who can afford it, often at only marginally higher cost to the patient than would be charged in a public hospital. Some people also opt to access health care at significant cost in neighbouring developed health systems.

Legal and governance framework

The absence of a government or multiple governments in Somalia means that there is no legal framework within which authorities can legitimately operate. The chaos that ensues, in health care at least, is worrying in the extreme. Certainly health facilities do function and do provide health care but they are not organised, there is little evidence of systems or procedures which guide their operation and there is negligible contact between health facilities and any more strategic authority, such as the Ministry of Health. There is similarly little evidence that Ministries of Health are working to establish systems or procedures through legal channels of government. There being no effective legal framework it is difficult to enforce correct procedures: no one has the authority to do so. This leaves the way wide open for abuses of power and fraud.

Primary health care

There is no observable ongoing primary health care system which could provide a solid basis for treatment of minor illnesses and diseases, maintenance of patients with chronic illnesses and disease and referral to appropriate secondary health care. Some aspects of primary care interventions are provided across most of the country, in the form of vertical programmes of immunisation and vaccination and some limited health interventions are available intermittently in some areas. These vertical

[1] See, for example, Sara Bennet et al, Cost Recovery in Sub Saharan Africa, WHO Geneva, 1993
[2] 'Gradual handover of health service management to the communities of Eldere and Hararderе districts, Galgadud and Mudug regions, Phase 5, Co-funded by Italian government and EC

programmes are essential for preventive measures but need to be integrated with curative, treatment and care programmes into a primary health care system. The vertical programmes and limited health interventions are almost exclusively funded by international donors.

1.1.2 Implications for Somalis

Aid dependency

The prolonged crisis has contributed to a dependency - or even entitlement - mentality among some Somali communities, whereby the international organisations are seen as responsible to provide food, health care and other basic services. This is by no means universal but anecdotal evidence and documented reports indicate that it is a feature of life. Unsustainable as this is in the long term, people have become very adept at securing assistance through the emergency relief routes. Despite there being an SACB Health Strategic Framework which is accepted by all of the key players, and despite there being three health strategies (developed with external assistance) from the Ministries of Health there is no evidence that the interventions are being implemented in a joined-up or integrated way, thus allowing the current situation to prevail.

Cash transfers and investment

By all accounts from Somalis in-country, outside the country and from many NGOs and international organisations working in Somalia there are significant financial resources coming into Somalia from the diaspora: the proliferation of currency exchanges and money transfer offices bears witness to this. Much of the money is being sent to individuals and families, some of it is being used by returning individuals, families and groups to invest in businesses (not least health facilities, hotels and building operations). There is evidence that some resources are coming into the country specifically to support the health sector but there is no co-ordination or management of the resources. No-one group, in any part of the country, appears to have taken the initiative to direct or manage the resources to appropriate target facilities. Where resources are coming into the country the focal point in observed cases seems to be (a) to an individual doctor or small group of doctors who then use the resources to help establish a private clinic and (b) to individuals who establish - almost certainly without qualified personnel - laboratory and x-ray services. While it is understandable that there is very significant frustration by returning clinicians, nurses and other health professionals at the poor quality of facilities, equipment and human and financial resources available in the public sector, targeting the incoming resources towards the private sector does little to improve the public sector facilities.

Ministries of Health

There are few people in Ministries of Health in Somalia and fewer still who have experience of health sector systems, procedures, planning, finance, management, information, human resources or any of the other usual and necessary Ministry of Health functions. Through limited exposure to other Ministries it appears that this is the case for many of the authorities. Through meetings, discussions and observations with Ministries of Health personnel it was clear that few of those in post have any of the necessary skills or capacity for strategic thinking or systems organisation. The reasons for this situation are numerous. Some of the most significant are:

- the chronic crisis situation which means that 'normal' business of Ministries of Health is dispensed, since all of the resources coming into the country for health care are through emergency and relief routes, not through Ministries of Health;
- the government budget for health care is not disbursed through the Ministries, 75% of the budget goes direct to Ministry-nominated employees (who do not necessarily work in the appointed facilities), the rest going on equipment and supplies;
- in some cases people are appointed to posts who do not have the capacity - or the interest to develop the capacity - to do the designated job;
- where capable and interested people are in posts they do not have the experience or expertise to undertake the jobs effectively or to articulate what sort of capacity building support and technical skills development they need;
- there are few (in some places no) recognisable systems or procedures in place to operate effectively as a Ministry. For example, because of the disparate funding systems in place for relief and supplies, and the lack of knowledge and capacity of senior personnel, it is impossible currently to identify how much is being spent on health care in any area;
- there are no effective systems or procedures in place to capture information about the health sector in general, in terms of provision of services, utilisation of services etc. Neither is there any understanding of how the statistics and information could be used;
- there is a belief that the only 'professionals' in the health sector are doctors and that no training or professional development is required for the strategic roles of planning, management, finance etc.

Despite all this there was evidence that there is a (slowly) growing cadre of younger people, in the Ministries and in hospitals, who are interested and involved in the health sector and are keen to develop their skills and knowledge. Given the absence of systems and procedures and the negligible salaries paid to health personnel this growing band of people should be encouraged and developed to ready them to take on the responsibilities of the future health system. People with potential to develop were identified in all parts of the country visited: they are not exclusive to one particular area, Ministry, or facility: this offers real opportunities for capacity building.

Growth of the private health sector

The presence of the private facilities are not, of themselves, a negative finding in terms of the chronic crisis. Indeed a number of them provide essential clinical services much in demand by local populations and not available through the extremely poor public services. Where public health facilities exist in areas which have got private health facilities it is normal for the clinicians who own and run the private facilities also to provide services on a limited but reasonably predictable basis in the public facilities. While the development of private clinics and hospitals is often dubbed counterproductive, recent research[3] indicates that it can actually have a positive effect on the health sector. Dual practice (as it is called when a clinician works in both

[3] DFID funded research undertaken by London School of Hygiene and Tropical Medicine, looking at doctors who work in both the public and private sectors, 'Dual practice in selected countries', LSH News, Autumn 2003

public and private sectors) can be viewed as a possible policy solution in circumstances where public sector resources are inadequate. Private clinics will also tend to operate at times which suit patients, outside normal working hours. And private clinics are more attractive to establish for some clinicians where a public facility doesn't exist and where demand for services is therefore guaranteed. For the system to work properly there need to be clear, effective and enforced regulations stating the acceptable boundaries for such activities. These are not in place anywhere in Somalia. Few of the returning doctors and nurses are being paid anything through the public purse and depend entirely on payments from patients (either in the public or private facilities) or on international organisations to make an income. In general, private practice does not pose a threat to public practice. In most developing countries private practice alleviates the burden of health costs from the public purse, by spreading the same amount of public resources over a smaller population group. In the Somali context, this is a useful alleviation of the burden since the resources available to the public sector are negligible, many people are very poor and cannot afford even the limited cost recovery charges imposed by health facilities and therefore have to be subsidised by others who can afford to pay the charges. So, separate clinics which address the health needs of wealthier Somalis will reduce the burden on poorly equipped and poorly functioning public facilities. The key to dual practice working effectively, though, is the regulation and enforcement of it and the infrastructure is not in place in Somalia to allow this to happen. There would be a chance of success for the introduction and enforcement of such regulations if an integrated approach to the health sector is accepted and adopted: currently health care is being provided in a type of administrative limbo with no real planning, control, monitoring or evaluation as part of the system.

Bogus doctors

A situation which seems to have resolved itself through peer group activity in the last year or so is the presence of individuals who call themselves doctors but who are not medically qualified. This was a much bigger problem until the recent return of more qualified clinicians and is reported as having been a problem in all parts of the country. While the fraud has been curtailed, through the intervention of the embryonic Medical Associations using various media, the legitimate clinicians are having to remain vigilant to stop people masquerading as doctors when they are not. In at least two areas the Medical Association issues lists to the local radio station and the local papers about every six months of qualified doctors living and practising in the area, so that people will have some idea of who is legitimate and who is not. In an attempt to reduce the proliferation of bogus laboratories and x-ray facilities (also very lucrative) one Medical Association also publishes lists of the facilities which have qualified staff and appropriate equipment. Significantly improved systems need to be in place to ensure that patients are not being 'diagnosed' or 'treated' by untrained, unqualified practitioners. This issue - in terms of registration and licensing of doctors and other health professionals - is addressed in Section 1.3. Clearly the actions of the legitimate doctors have had a positive impact on reducing the number of bogus doctors operating: the issue would normally fall under the aegis of a Ministry of Health's regulatory function.

Crisis-as-norm

The chronic crisis has observable anthropological and psychological implications for Somalis. In anthropological terms a generation is assumed to be ten years. Somalia can therefore be assumed to have at least one full generation of the population for whom the norm is a chronic state of crisis and instability. Prolonged instability produces strange effects, not least an exaggerated ability to adjust to crisis-as-norm. This was apparent among Somali health workers and international aid workers (many of the latter of whom were young and inexperienced in systems and procedures themselves). In the context of Somalia and aid, this is represented through the ability of Somalis to utilise known relief routes (financial, human resource and geographical) to alleviate their situation. Also it is obvious that without a robust administrative system (in any of the sectors) other than the 'system' of relief inputs, then the normal administrative systems lose their relevance. Over a prolonged period of time any skills, expertise and experience of systems and procedures simply disappear as people respond to a different set of challenges. Hence, in Somalia, the absence of systems or structures which reflect usual administrative functions. This doesn't have to be the case: with a strong impetus towards integration by all of the players, Somalis and donors, and good technical support to develop the skills and knowledge necessary, the system can be established and can function in a more normal way, albeit still dependent on international support for financial and technical resources.

The crisis-as-norm phenomenon is observably true of Somalis but is also observably true of NGOs who move from donor to donor as resources run out or are not renewed for particular activities. There is internationally documented evidence from conflict and post conflict literature to show that the establishment or return of relative stability after a prolonged period of crisis, having lived at a higher level of alertness, has its own effects, the main one of which is often clinical depression. This often presents as apathy and withdrawal from society. Motivation of communities in general and individuals in particular to take on the tasks and responsibilities of administrative functions (irrespective of the financial and clannic issues which also pertain) may prove difficult and slow. However, evidence from a number of the advocacy and civil society inputs supported by the donor community have shown that, when given steady encouragement, given basic skills and training, and given some degree of control over resources, local communities can and do take on a strong role in the management and oversight of local projects. The challenge now is to motivate those working in the public sector to learn the skills and techniques and develop the expertise needed to undertake their jobs effectively. With negligible salaries, and the need to have multiple jobs to support families, it will be hard to ensure the uptake of systems development and capacity building programmes. In this latter respect, the recent position paper from the EC Somalia Unit[4] offers a clear and sensible approach to public sector salaries, if advances are to be made to establish and develop functioning systems. Similar approaches have been taken in other countries faced with very similar problems.[5]

[4] Remuneration of Public Employees in Education and Health, ECSU Position Paper, November 2003
[5] DFID Project Memorandum, Institutional Development and Performance-based Salary Incentive Component of Health Sector Support Programme Cambodia, February 2003.

Education and skills gaps

The absence of an education system has left more than one generation of Somalis without the basic academic skills and knowledge needed to develop the administrative systems within the country. The generation which would normally be expected to be in the forefront of development of the systems is either absent, uninterested and apathetic about public services or completely untrained and inexperienced in public sector roles and responsibilities. That, coupled with the exodus of the vast majority of the educated classes during the course of the instability, means that there are few - and in some places no - personnel available who have any experience whatsoever of running an administrative structure using recognised systems and procedures. In addition to both of these, the culture and tradition of Somalia is an oral rather than a written one, which doesn't facilitate the maintenance of good documentation, systems or administrative procedures to apply generically across authorities. There is an absence of educated, trained or qualified individuals to take on strategic roles, such as those in central, regional or district administrations. Even where a Ministry of Health appears to be functioning reasonably well (with international support) there is no-one responsible to co-ordinate international aid or support, in a way which fits with the strategic direction or plans of the Ministry or the agreed SACB strategic framework. Nor is there sufficient experience or expertise to be able to convert the theory (as presented through the Strategic Plans) into the practice of a functioning integrated health system. As if these issues weren't enough of a challenge there is the further complication of people being appointed to posts in Ministries of Health simply because of their clan connections and not because of any knowledge, aptitude for or even any observable interest in the health system. Irrespective of the rights or wrongs of clan influence, it is hard to believe that, within the appointing clan, individuals cannot be found who have at least the aptitude for or interest in some of the major issues facing the health system, who could be developed into functioning health officials. One response to this clearly observable problem, mentioned by a variety of people from Somali health professionals to donors, is to recruit into strategic posts people from the diaspora. It is clear that returnees would certainly alleviate the 'numbers' issue in human resource terms, but it is unlikely that returnees would positively affect the 'skills and knowledge' issue. There is little evidence from before the conflict to indicate that skills and knowledge of strategic and management issues was prevalent in the Somali health sector and there is no reason to suppose that the necessary skills have been developed subsequently. There is no history in Somalia of strategic planning and management being considered specific and legitimate specialities or professions (this is borne out through discussions with returning clinicians who don't believe that training is needed for these roles), so it is unlikely that significant numbers of refugees have secured qualifications, experience or expertise in these fields.

In the health sector the absence of education and training of doctors, nurses, pharmacists and other paramedic personnel has not only left a huge gap in the professional pool but also fosters an environment within which bogus and unqualified individuals can establish a lucrative career for themselves (see above). For the professional cadres the absence of an established and recognised training programme

is further exacerbated by the absence of people who could be trained: without the basic educational background it is not possible or feasible quickly to train people in

the technical or interpersonal skills required of doctors, nurses and pharmacists. While many of the international agencies do provide training courses, there is significant evidence (anecdotal and documentary) to indicate that the courses relate specifically to the international organisations' relief programme or vertical programme rather than to a broader knowledge and skill based programme. A number of clinicians in different parts of the country complained that people working in the health sector who had received training by international organisations during the crisis were only trained in specific issues and do not have the basic knowledge of the subject to allow them to bring the various training interventions together: the training is not 'joined up'.

Qat

Qat chewing cannot be ignored as one of the implications of the chronic crisis. Qat chewing is endemic right across the country. It is even tacitly accepted as an acceptable 'pastime' by many in the international community, despite it causing major social problems, in terms of capacity to work, violence and exacerbation of mental illness and post traumatic stress symptoms. Qat chewing is almost entirely a male preserve. A recent informal estimate by WHO in Somalia indicates that a conservative estimate of $100,000 is being spent each day on the purchase of qat in Somalia. Given the observable poverty - and the observable mental illness - the addiction to qat has major long term implications for the economy and stability of Somalia. By extension, qat addiction has major implications for the public services in Somalia both in terms of finding people without a qat addiction to perform the necessary tasks and roles within society and in terms of having to deal with those who are addicted and unable to function productively to support an economy but who will become a long term drain on any system.

Self diagnosis and treatment

The absence of a primary health care system means that most people self diagnose and self treat by purchasing drugs and medicines from street vendors and pharmacy shops. While this may, in some circumstances, be a sensible response for some minor illnesses and diseases, if the illness or disease is not treated correctly in the first instance it can lead to a chronic condition requiring long term treatment. Worse, a patient could be treating an illness or disease with entirely inappropriate drugs and medicines and cause even further medical problems requiring much more radical (and expensive) intervention This has long term major implications for health status and for drug resistance. There is much anecdotal evidence of drugs purchased from unqualified vendors causing more illness that the original complaint. One of the biggest issues in this respect is the proliferation of 'pharmacies' in Somalia: it is clearly a profitable business (some of the earnings being made on the back of donor drug and medicine supplies which are 'reallocated' or misappropriated). The fact that drugs and medicines (often toxic) are being sold with equanimity by completely unqualified individuals poses an immediate and long term health risk in Somalia. The qualification and registration issue is addressed below in section 1.3.

1.1.3 Implications for donors and NGOs

The continuing crisis has major implications not only for Somali people themselves but also for the international donor institutions and organisations on which Somalis depend for aid and assistance. No organisation can sustain emergency or relief aid

indefinitely in a world where the latest crisis is what grabs the media headlines and where aid is as much about marketing misery and need in order to secure resources as it is about using those resources to provide essential aid and assistance. The attention span is short of both the media and those who contribute to media appeals for funds during crises: a new crisis, be it natural or man-made, will almost certainly displace an existing crisis from the priority list. Donor fatigue is not a new phenomenon, it is simply better understood and documented given the proliferation of crises in the recent past and the observable effects, in terms of sympathy and fund raising, on crises which have become yesterday's news.

The chronic crisis situation has an observable effect on donors. The degree of instability and its duration could not have been predicted, leaving donors who had committed emergency resources at the outset of the crisis bearing a large portion of the burden for a continuing and apparently elastic need. Many of the same donors are also keen to support Somalia to develop a more structured heath system which could integrate some of the current programmes (such as, *inter alia*, the immunisation and vaccination programmes, cold chain distribution, drugs supply) Given the history of Somalia, however, what was predictable was that crises relating to drought would continue. There are a number of business and planning tools which could be employed to help indicate different approaches to the situation, using different scenarios - predictable or unpredictable - as the basis for adapting to and managing the situation.

Donor fatigue

For some agencies it has become increasingly difficult to secure resources for relief activities[6] - expressed as donor fatigue. It is particularly difficult to 'sell' the need for continued funding in a situation which shows little sign to the outside world of being resolved soon, and in the context of well publicised disasters and catastrophes in other countries which are better placed to secure more sympathetic responses. This has resulted in the withdrawal of a number of donors and the downsizing of activities of others.

Vertical programmes and supply chains

Many of the aid programmes being provided in Somalia are vertical programmes, such as for example tuberculosis, malaria, HIV/AIDS, nutrition, immunisation and vaccination[7]. Unlike a number of other developing countries the programmes are not integrated and this causes various overlaps. There are reported overlaps and gaps in terms of coverage of population groups and geographical areas by different organisations, and overlaps in terms of different organisations sometimes undertaking very similar, if not identical, programmes. Similarly, where different organisations have complementary programmes such as provision of pharmaceuticals for different illnesses, diseases, or vaccination supplies, they are not integrated. The absence of integration at international organisation level contributes to an already chaotic

[6] This finding came from discussions with bilateral agencies primarily
[7] Funded, in the main by UNICEF, WHO and EC

situation in terms of development of individuals and groups to understand how to plan and manage a health service, specifically health service supplies. Integration is absent on at least two levels, firstly in terms of the services on the ground being provided by

different organisations and, at a more strategic level, integration into a wider health system. This is despite there being a real effort on the part of the SACB Health Co-ordination Committee (and agreed by all partners) to provide the tools and framework within which aid would be provided (e.g. through the essential drugs list and active encouragement to agencies to achieve economies of scale in terms of delivery and supply of drugs, medicines and vaccines).

There is anecdotal and observational evidence of cynical exploitation of the international organisations by some interested parties using the confusion caused by different supply chains and ordering mechanisms: the resulting oversupplies are sold on the open market. Equally there is evidence that designated supplies do not always reach their target recipients but are 'reallocated' and sold on. The lack of integration by international organisations of the various supply programmes, and the absence of a pharmacy stock control system, covering all pharmaceutical stock used by a facility, encourages this exploitation.

The obstacle of distance

The fact that none of the international donor organisations or international agencies - with WHO as the notable exception - has a permanent presence in Somalia does have an impact on the continuity and responsiveness of technical support and advice available to the health sector. Reports from international colleagues and from direct observation indicate that that there are some parts of the country where it would be possible to base an international organisation. Remaining in Nairobi is, for many of the international agencies, a political and a policy decision. Rather than standing in judgement over the validity of such a decision, this report simply makes the point that it is impossible to interpret, manage, plan and develop a situation, be it health or another sector, at arms length. And this despite the fact that many of the international staff working on Somalia have long experience of on-the-ground relief work in Somalia. International staff from a range of agencies with whom discussions were held expressed great frustration at the limited time they could spend in Somalia working on their own sector development.

1.2 The relief - development axis

Expertise

The chronic crisis situation also has detrimental effects on the relief - development axis issue. This relief - development axis has been mentioned in a number of other reports, not all of which are health service oriented[8]. One of the effects is the long term focus on relief and the associated absence of an in-country donor community who have experience of international development. Many of the staff now working in the donor organisations in Somalia have moved from posts in the field in Somalia

[8] The most recent of these, which is cross sectoral, is UNICEF's Evaluation of Country Programme in Somalia, Final Report, October 2002. In it the report notes the 'emergency and disaster prone environment' in Somalia', in addition to the conflict situation. It also mentions the different approach required for institutional development as opposed to a relief project approach.

with NGOs and emergency aid agencies during earlier phases of the crisis, where the emphasis was on sustaining lives through direct intervention rather than developing systems and procedures at a strategic level for the health service. While many of them

have long term relief experience in Somalia, few of them have international development experience[9]. They have moved to posts which are at least one step removed (both literally and metaphorically) from the direct interventions they have been used to. This would suggest that donor organisations operating in Somalia now have few core staff who have explicit development experience in Somalia, since the expertise which has been prevalent over the last fifteen has been in relief.

The relief - development axis issue is as relevant for Somali nationals as it is for international NGOs and donors. While there is demand coming from individuals for development interventions (expressed in the main in terms of strategic developments) there is not enough experience among the key players to articulate their development needs. Also there is at least one generation of people whose only experience is in either emergency relief or in the operation of vertical programmes and they have no idea how to express development issues or to plan strategically, or how these programmes would fit into an established health system or an institutional development programme. In a number of instances around the country there was clear frustration expressed about the helplessness of Somalis to influence donors about the types of projects needed or 'to hold them accountable' for projects.

In terms of capacity for institutional issues and strategic thinking there was some evidence that previous and current projects have gone some way to creating a basis of knowledge and skills useful for institutional development, at least to the extent that individuals and groups have an understanding of the issues and have an appreciation of the skills and knowledge gaps. Examples of this included the previous Save the Children Fund (SCF) 3 year capacity building project with the Ministry of Health in Hargeisa from 1993. While few of the original Directors (who were 'shadowed' by international experts) are still in place, there is evidence that some of the systems, skills and knowledge have become part of the institutional memory and practice. The findings from observation and very intensive discussion with the senior Ministry of Health personnel bear out the findings of the evaluation of that project undertaken on behalf of SCF by Catriona Waddington. A similar project was undertaken in Mogadishu and while there is anecdotal evidence to suggest that some of the senior people who were in post in the 1980s have benefited from the training and transfer of skills and knowledge they received then, it is hard to measure, given that the Ministry of Health has only two people in post currently. Those who are still in Mogadishu and who were part of the SCF training are now employed by international agencies. A further example is the capacity demonstrated by the staff of Garrowe Community Hospital, supported currently by IFRC, with capacity building of senior staff a key element of their technical inputs. Direct observation of how they work as a team, how roles and tasks are distributed, the levels of understanding of the issues, all reflect a unit able to function (however frustrated they are at not being able to accrue more resources through cost recovery, since they do not have services such as x-ray or laboratory for which they could charge). Both these examples reflect to some degree

[9] This finding is based on discussions in Somalia and in Nairobi with international aid workers, donor staff and staff of NGOs

the absorption capacity at different levels of the health system and the longer term impact of capacity building inputs.

The development of lay health boards at district level and regional level, and the building of advocacy skills and practical management skills among health board members has, based on observation and reports, contributed to a much better understanding of issues relating to health care, its management and financing. In some respects - and in some places (such as the regional health board based in Hargeisa, supported with advocacy training by ICD and Kings College Hospital in London, and the health boards in Gedo, supported by advocacy training through the Gedo Health Consortium) - the advocacy skills transfer has been more successful than with health personnel. There are some obvious reasons for this, of course, not least that it is always easier for people outside the 'system' to judge performance of staff and to offer suggestions for improvement than it is to implement actions in a severely cash strapped situation. However, there is evidence that the health boards manage to take ownership of local issues to the extent of understanding the financial issues and indeed to generating resources. In the regional health board based in Hargeisa, this translates as a particular interest in the financial sustainability of the hospital and in the mobilisation of resources for the hospital and staff, rather than region-wide health issues. But there is evidence that there is potential to develop the skills and knowledge to a wider degree[10]. Some of the root causes of staffing problems, specifically with doctors, for example, have been gathered and acted on: the regional health board reports that the problem is not just that doctors are working in both the public sector (in their case with supplemented salaries to bring them up to $100 per month) and in the private sector but that the doctors "go chasing after NGOs to find work on HIV and FGM. These are the big earners for doctors". Issues such as this reflect the shortage of personnel available to take on all the health issues, as well as the natural inclination of staff (as everywhere) to maximise their earnings.

Different focus

Relief and development are both critical pillars of reconstruction and institutional development. Emergency relief and development require different, complementary, skills and approaches. The approaches of those who work in emergency relief and those who work in development are also different. In relief work, the focus is on saving and maintaining lives, on immediate and emergency relief of either man made or natural disasters: the focus is necessarily short-term - even when the crisis lasts for a prolonged time. (In this context, given the very prolonged crisis in Somalia the question needs to be raised as to why some of the relief interventions such as, for example, the annually predictable cholera outbreak, continue to require planning and management by the international community on each occurrence? Why are these predictable situations not integrated into a system managed by Somalis?). In development work the focus is enabling individuals and organisations gradually to take on responsibility for systems and procedures, which should be robust enough to be sustained when the international support has gone (though it is hard to predict when this might be the case in Somalia).

[10] For example, the RHB has developed an annual budget for the hospital, based on recurrent costs and capital costs; they are advocating for a 2% tax on qat sales to go towards the regional hospital.

One of the dangers of the chronic crisis situation in Somalia is that many of the NGOs and not a few of the emergency aid organisations are adjusting their remits to take on development roles primarily because of their own organisational need to secure

resources which are drying up from traditional sources, and not because their organisations have specific skills or demonstrated ability in development. In many instances - and this was borne out through discussions with NGOs and some international agencies - the adoption of a development role was predicated simply on the fact that some of the donors had recognised the need for sustainable development and planning to be undertaking in tandem with emergency relief and had stipulated that capacity building needed to be part of a future project. The potential executing agencies reluctantly had to agree to take on some development activities (capacity building) in order to secure project funds[11], though without necessarily having the internal capacity to undertake the work. In some cases the implementing agency was not at all reluctant to take on the capacity building components but later evaluations then found weaknesses in the implementing agencies' own capacity in supervision, monitoring and sustainable systems development[12]. The most frequently reported comment from NGOs about the capacity building components of their projects was that they did not have any sense of the capacity building elements being part of an overall structure. This is important in terms of predicting the success or failure of capacity building components in current projects being funded by the EC and other donors. While it is laudable that the donors recognise the need for development to be undertaken in parallel with relief programmes, in order to prepare Somalia for future stability, it does a disservice to Somalia to assume that hitherto emergency relief NGOs and agencies are able to work as effectively in development as they do in relief. Even the use of certain words and technical terms revealed differences in understanding between relief and development organisations and individuals (and these cannot be put down to simple linguistic or translation issues between different nationalities). Emergency relief and development are different. The relief projects which do contain a development component usually relate to clinical training and capacity building, not to systems development or planning or institution building. As mentioned elsewhere, training related specifically to a vertical programme will not equip an individual or group with the wider range of skills required to operate effectively in isolation from that vertical programme. A broader and more systematic approach is needed to ensure that there are trained staff able to take on the responsibilities of an emerging system.

Time to adopt a development approach?

Some donors and agencies recognise the different approaches and skill mixes needed for relief and development[13] but feel they have no option but to use the relief organisations who have a presence in the country to undertake development projects. Other organisations bemoan the lack of institutions through which to focus development activity[14]. The IFRC/ World Bank Qarhis Pilot Project Evaluation

[11] This finding came out of discussions with NGOs active in projects in Somalia. Understandably the NGOs concerned asked not to be specifically identified in relation to this 'remit - stretch'.

[12] See, for example, IFRC/World Bank Health Sector Recovery Project: Qarhis Pilot Project Evaluation Report

[13] Refer to UNICEF's Evaluation of Country Programme in Somalia, and Master Plan of Operations 2004-2008, Section on Health

[14] Refer to IFRC/World Bank Health Sector Recovery Project: Qarhis Pilot Project Evaluation Report

Report puts the situation succinctly: "…in the context of 'chronic emergency' and formal post conflict recovery, the strategies, systems and tools to sustain these basic health services during the years of transition to reconstruction and recovery are either

weak or completely absent". Later in the report, in similar vein: "The result is extended relief programming focused on short-term, externally planned, vertical interventions". Following similar reasoning, the comments from Nick Maddock on the (?draft) EC Governance Strategy are also pertinent to development strategy for health: "… it is hard to believe that reliance on international NGOs, which generally have no track record in this area, will lead to greater improvements. Further, why rely also only on UN agencies when there is specialist consulting capability in this area? … I assume you will want the EC to have a greater role in project design in the future and to have access to the benefits that competition can bring in the choice of contractor".

There is certainly a strategic advantage in an organisation having a long term presence during the period of crisis, but in terms of development work that strategic advantage is more about logistics and organisation than it is about capacity or skills in strategic development issues. A number of the donors who are interested in development work believe that international consultancy organisations would not be prepared to work in Somalia. This is borne out by the arrangements in place - including in the EC Somalia Unit - of allocating projects to an executing agency rather than undertaking the usual tendering and bidding process, which is the norm for the EC for development work in other countries. As an extension to the TORs for this piece of work, it was agreed that a small number of respected international development consultancy organisations would be consulted to determine whether or not they would be prepared (a) to undertake work in Somalia and (b) to express interest in, develop bids and tenders for projects as they might become available. This was a purely exploratory exercise. There was no offer made of any work, project or contract. The consulting organisations contacted are all health oriented and may not reflect other sectors. Each of the organisations contacted were very positive about undertaking work in Somalia and were happy to express interest in and bid for work for which their organisations were qualified and had demonstrable expertise and aptitude. The consultancy companies ranged from universities with a consulting capacity in health issues, to small and larger consulting firms. During discussion with the companies (some in person, some by phone and some by email) about issues in Somalia, many of them reported that they undertook development work during very unstable times in countries such as Bosnia and Herzegovina, Croatia, Uganda, Ethiopia, and Palestine. In one case a consulting company have already signed an agreement to undertake consultancy work in Somalia, for the Diploma in Public Health, Disease Surveillance and Control, through WHO Somalia[15]. Unless specifically instructed by the donor not to undertake missions due to an acute phase of instability in a country, most organisation representatives indicated that they took normal security precautions relevant to working in developing and least developed countries. A number of them also mentioned the challenge of transition between relief and development, and in this context each of the aforementioned countries was used as an example of that transition issue.

[15] Diploma in Public Health, Disease Surveillance and Control, Memorandum of Understanding, Liverpool School of Tropical Medicine and WHO Somalia

1.3 Absence of systems and procedures in the health system

1.3.1 Governance issues

General

The governance issues in Somalia are massive and wide ranging and are unlikely to be addressed systematically until some political agreement is reached about the future composition and organisation of the country, though there are some early encouraging signs that there may be some movement to support governance in areas where security can be guaranteed. There is much debate as to whether it might be more useful to address the governance issues piecemeal, as they affect specific authorities, institutions or systems. In Somalia there is little evidence of basic structures or legislative context within which systems can operate. Even where legislation or regulations do exist, they cannot be enforced. Some of the local parliaments do have procedures for adopting regulations and for authorising groups, organisations and local authorities to undertake certain activities. Again, there is no capacity for enforcement. A number of the governance issues have major implications for the health sector - but the health sector is not in a powerful position to resolve them nor does the health sector have the authority to take unilateral action which would temporarily address the issues.

Basic statistics

There is no formal system of registration of births and deaths in Somalia. Population numbers and demographic change are basic planning tools for any sector, including health. Without them (and a reliable age/sex breakdown of the population) and associated utilisation figures it is difficult to predict health priorities or to plan appropriate provision of health care. There are isolated instances of health facilities which do register births, but there is no central (or zonal or area) authority in which to lodge the data. Some TBAs who are associated with particular hospitals or clinics register home deliveries with the hospital or clinic. Again, there is no central registration system by which a person gains formal identity. There is no systematic data collection or collation system in place to identify who is born (and therefore in need of a lifetime's worth of health interventions with the critical immunisation and vaccination programmes to start with) or who has died (from what cause or at what age). There being no central registration of deaths, or the causes of death, it will be difficult to develop a clear epidemiological picture on which to predicate health plans or strategies. The only recently aggregated data available about causes of death comes from the World Bank-funded, UNDP-executed Watching Brief. The figures presented from the household survey of 3,600 households makes for intriguing reading. Deaths occurring within a household during the preceding year were recorded, with 19% of deaths due to 'old age' and 61% of deaths 'due to sickness'! The report comments that 'the stated causes of death may be taken as indicators, as old age is subjective and not really a cause of death'. Both the figures and the comment say more about the questions posed to households and the capacity to interpret the answers than they do about the respondents. What is intriguing about the cause of death figures presented is the 61% apparently 'due to sickness'. Even the least clinically knowledgeable of

people will usually be able to be more specific than that: it suggests that those undertaking the survey didn't know how to interpret answers or asked the question in such a way as to allow only extremely vague answers. Whatever the reason, the

resulting figures do not provide the basis for any projection or planning. Even where there is recognition of the importance of capturing basic population change data, there is no authority charged with collecting or collating the data. One suggestion by an international agency (UNDP) is to establish a statistical office through an NGO initially, until such times as a political decision is taken about the administrative structure of the country.

Population, demographic and health status indicators are the basic statistical tools for planning and managing the health sector. In the absence of official figures different international organisations are using different population figures. There is an urgent need to get consensus between organisations about what figure is to be used as the population base: given that significant achievements have been achieved in the field of polio eradication it is at least worth considering using that population figure as the population 'control' figure, which can be updated as and when a census is possible.

Registration and licensing of health personnel

As discussed above in 1.1.2 the proliferation of bogus doctors (and nurses, laboratory technicians and radiographers) is now under some degree of control in the larger conurbations through peer pressure. Before the return to Somalia of a number of respected clinicians the generally chaotic (?anarchic) situation clearly facilitated the instigation of much fraudulent and criminal behaviour. It is to the credit of the returning clinicians, working in tandem with the legitimate clinicians who had stayed in Somalia, that the situation in relation to bogus doctors was handled effectively (and apparently without sinister reaction from the offending individuals). Registration of health personnel - doctors, nurses, pharmacists, paramedical staff - is a basic precursor to forming a legitimate health system. Patients are entitled to know that when they are ill, and more vulnerable than usual, they can depend on getting advice from someone who is qualified to give advice, who has been trained, examined and licensed by a legitimate authority to practice medicine. Registration and licensing are also critical governance procedures to have in place as the private sector grows. There is no absolute need for Ministries of Health to be the registering or licensing body for health personnel: the authority to do so could be vested in another legitimate organisation or institution, such as a university or a professional association, but the authority must come from the government to establish and maintain the registration and licensing system and to determine the intervals between licensing and re-licensing of personnel.

Licensing of nurses and TBAs is also a priority for exactly the same reasons as licensing of doctors. Patients are entitled to know that people from whom they access health care are legitimate bona fide professionals, able to give appropriate advice. The same goes for radiographers and laboratory technicians and other paramedical staff.

Licensing of pharmacists - and pharmacies - may be the single biggest factor to improving the health status of Somalis in the short term. The proliferation of pharmacies in Somalia - even in remote areas - is an indication of the business

opportunities afforded by the sale of drugs and medicines, in the absence of a systematic health system, particularly reflecting the absence of a functioning primary health care structure. Licensing of the individuals who operate them and / or their

businesses may also prove the single biggest challenge to the health sector. A number of countries which have experienced similar problems have chosen either to license the pharmacy shops or to license the pharmacists. Licensing of pharmacy outlets is usually done on a tiered basis, of three tiers, with a requirement for licenses to be prominently and permanently displayed, usually as part of the shop front. The lowest tier of licensing entitles very straightforward items such as paracetamol, cold mixtures and aspirins to be sold. The next level might be allowed to sell simple antibiotics, but with a requirement that a pharmacist of a designated level has to be in attendance to dispense. At the highest level, the pharmacy would be allowed to dispense and sell the full range of drugs but would require a fully qualified pharmacist to be in attendance to dispense. The licensing of the shops may not reduce the numbers of pharmacies but would certainly contribute to a reduction of inappropriate dispensing. Licensing of pharmacists would inevitably cause a reduction in the number of pharmacy shops, since there are reportedly no fully qualified pharmacists in Somalia currently.

None of the above should be taken as an indication that there is no place for traditional medicine. Indeed, it is often only after traditional medicine has failed that people think of accessing more modern forms of medicine. It is certain that people will continue to access health care through traditional sources as long as they have trust in it.

Medical Associations

In the absence of a properly functioning Ministry of Health anywhere in Somalia, and as a response to the bogus doctor situation, the doctors (thus far only doctors: not nurses or pharmacists) have established Medical Associations. There are currently three in the country (one based in Hargeisa, one in Galkaio and one in Mogadishu). The Medical Associations are still in embryonic form, collecting interested individuals both within Somalia and among the diaspora still living abroad. In some instances the connections are extremely productive, such as the regular clinical visit to Somalia of a respected gynaecologist for a predictable time each year; the development of computer based distance learning packages to assist in continuing professional development; and tentative continuing medical education programmes. While there are emphatically no formal links between the three Medical Associations, there are informal links with individuals providing services on request to distant health facilities on an intermittent basis. One of the Medical Associations (based in Puntland, under the chairmanship of Professor Mohamed Jama Salad) is keen to take on the role of registration and licensing of doctors but is having difficulty persuading the Ministry of Health (a) of the need for such an action and (b) to authorise the Medical Association formally to do so through the issuing of a government decree. Through the use of internet links the Medical Associations are mobilising to develop their own Ethics Committees, which would provide the basis of good governance for clinical practice. While licensing and medical ethics are exactly the sort of governance issues which need urgently to be addressed in health care, there is no institutional framework within which to establish the legitimacy of the activities. A major concern expressed by doctors in Somalia is that while many of them continued to gain

experience, expertise and qualifications while they were abroad, there is no younger generation of doctors poised to take on the junior clinical roles. A small number of Somali nationals have graduated in medicine while living abroad and some

may be prepared to return either to their country of birth or to the country of their parents. The figures for these possible returns are pure speculation but do not, even optimistically, stretch to more than twenty. As more doctors return the services provided in the health sector increase and, in many instances because of resources coming with the returning clinicians, the quality of health care available improves. But this is a false dawn: when the current generation of doctors get older there will be no replacements to succeed them. Research with the organisations which usually facilitate return of people to their homes post conflict (UNHCR and IOM) did not reveal any formal list of health professionals willing or interested in returning.[16]

The Medical Associations provide a very reasonable basis to discuss health strategy. Their (separate) analyses of the health situation were considered and sensible, rooted in reality, though without any real understanding of how health systems should function strategically. There was a recognition that there is no 'management platform' on which to build capacity in the health sector, for crucial issues such as planning, financing or human resources. Each of the Associations recognised the need for a health strategy to follow and for a health system to be established and institutionalised but admitted that they don't know where to start or how to do it. There is little evidence of professional interaction between clinicians and Ministries of Health, either about practical issues or strategic issues. Some doctors, frustrated at returning to a system which is so basic, argue that until things like adequate kitchen facilities, food, sheets for beds, cleaning materials and theatre supplies can be addressed there is little point in addressing the strategic issues. Others, more pragmatically, recognise the need for both to be addressed. The frustration to some extent echoes the relief - development axis issue but could also reflect the innate professional focus of doctors on service provision rather than strategic management, planning or finance. This is not so unusual, even in developed countries.

1.3.2 Health information

All of the documentation available about Somalia makes it clear that the statistics presented are either unreliable, have a wide tolerance margin or are based on old accepted figures which have been updated with varying degrees of accuracy. It is not easy to plan a health system - or indeed any other public service - based on knowingly inaccurate data. The absence of reliable data is not unusual in a post conflict situation. What is different in Somalia is that the crisis has been going on for so long that there are now no reliable base data on which to base guesstimates, assumptions or projections. All of the international relief organisations have devised their own data collection systems to reflect their own activities and targets: those systems are not necessarily compatible and do not provide a basis for planning and management of the health sector as a whole. Nor were they intended to. An initiative to develop a Health Information System (HIS) has had an unaccountably long history and is still not operational. Originally led by WHO and now led by UNICEF the idea was to develop the data set based on international donor programme needs, which are largely vertical

[16] Lists such as this were developed and maintained through IOM and IFRC after the conflict in Bosnia and Herzegovina, and were very useful in matching personnel to understaffed areas.

programmes. If the information provided about the health information system is correct then the name is a misnomer. A health information system, if it is to have any hope of successful application, needs to contain data elements which can be

converted into information by and for the people who collect the data as well as for institutional and strategic purposes. So the main data elements of a health information system would include activity data relating to numbers and types of patients, their treatments etc. It is reported that it was planned to further develop the information system to make it a 'key learning tool' for Ministry of Health teams, who would then help to determine more health system data elements. Despite repeated requests for the data set of the health information system (HIS) it was not available to review, nor was information available about where the system was being piloted. During a visit to Garrowe Community Hospital, however, it was clear that the staff at management level, supported until now through IFRC funding (coming through the Italian government), are familiar with the concepts and practices of collecting, collating and analysing activity and utilisation data. The information system in use there is a useful potential model.

Rather than wait interminably for an information system which they were unsure was going to meet their internal information needs, one Ministry of Health (in Hargeisa) proceeded to develop a separate Health Information System with assistance from ICD. This has caused some disquiet among the international agencies, though it seems entirely understandable that a Ministry should proceed to address a management issue when the promised system did not materialise. The system, in use in only a few places in Somaliland, is a useful basis from which to further develop, though there are all sorts of issues about compatibility with other systems being developed which must be addressed.

The health information system needs to meet the needs of all of the players; Ministries of Health, providers, donors, international executing agencies. It is relatively straightforward to develop such a system quickly - it requires a strong systems analysis (systems - not computer!) capacity to determine the information needs of the various players and from those information needs flow the data items which need to be collected. Analysis of information needs is usually based on the information pyramid, with the greatest amount of data available at provider level, becoming successively aggregated and distilled at each level of the health system up to the strategic level, which would incorporate the needs of the donors and international executing agencies on the way. Most of the work to develop an information system is not based on computers but on people, managers, planners, providers, and their information needs, which are often not very clear to them at initial discussions but which can be gleaned through expert supportive and sensitive consulting skills.

1.4 SACB (Health and Nutrition)

The establishment of a full time position working on co-ordination of health, as part of the Somalia Aid Co-ordination Body, is a very welcome and necessary link for Somali health professionals, health donors, NGOs and international agencies. The role of co-ordinator has facilitated much better collaboration between agencies, and has contributed to achieving economies of scale in terms of logistics for relief

programmes, emergency interventions and vertical programmes. The effort and organisational demands involved in getting practical collaboration such as this should not be underestimated. Of all the donor and NGO organisations working in Somalia only WHO appears to be reluctant to collaborate in information sharing through SACB. This is unfortunate since WHO are undertaking a wide range of useful interventions in vertical programmes and, in a wider context, through the development of a Diploma in Public Health. The potential synergy of working together as part of a collaborative team is being lost as long as WHO continues to work at arms length from the SACB, though it should be emphasised that participation in the SACB is voluntary.

The success of the SACB in securing international funding through GAVI and the Global Fund should not be underestimated. No other organisation in Somalia would have been acceptable to the Global Fund as a recognised national body which could disburse resources as per the Global Fund priorities and regulations[17] and monitor the use of those resources for reporting purposes.

These successes notwithstanding, some of the tasks currently undertaken by the SACB Health Co-ordination Committee could be rationalised: the post needs to be dynamic, responding to opportunities and constraints in a planned way. The challenge of the transition from relief to development is well demonstrated in the SACB health co-ordination role. While the office continues to build up the collaboration between agencies and organisations, with sometimes disparate objectives, and dealing with frequent queries from international governments about the safety or otherwise (diplomatically and practically) of returning Somalis to their homes, they are also faced with addressing the many objectives and activities contained in the Health Strategic Framework and in ensuring that their Somali counterparts' voices are heard, despite the distance.

The Health Strategic Framework - with eleven strategic objectives - is almost entirely development focused rather than relief oriented. The Strategic Framework presents a logical but immensely challenging agenda which has been developed through exhaustive consultation. It is a significant building block for development of the health sector (the tabular format of the strategic framework is particularly useful as a basis for development. It is attached at Appendix 4). The Strategic Framework is accepted by senior Somali health personnel, the Ministers of Health and donors and NGOs. However, it is not used as the springboard for project proposals. There is a disassociation between what is adopted as a co-ordinated approach and the practical application of that approach. It is possible that the disassociation stems simply from a lack of marketing of the framework: if so, that is relatively easily remedied. But it could be expected that if donors are really interested in targeting resources to development activities then they would routinely use the agreed strategic framework as the seminal document on which to base proposals for interventions.

[17] The success of SACB Health Co-ordination Committee in mobilising very significant resources for EPI ($3m), Malaria ($12.9m over three years) and TB ($5.6m over two years) should offer a huge potential to integrate the responses to these within an institutional framework

The SACB Health Co-ordination Committee has invested significant skills and time to develop standards and tools for a wide range of communicable diseases and for

planning health interventions, such as food security, coverage, HIV/AIDS, maternity services, FGM. The list of those developed are attached at Appendix 5. However, the tools are not widely used (none of the documents was available in any of the facilities

visited by the consultant) This poses a question about the extent to which the donor and NGO members of the SACB are actually using the facilities offered by the SACB to adopt a consistent approach to health interventions. While these tools are demonstrably structured responses to prevailing health issues, they do not fit into an integrated health system where they are accepted as common practice by all health providers and planners. Until they are integrated it is likely that they will continue to be treated as 'optional extras' both by Somali practitioners and by donors and executing agencies. Similarly if the tools were to be adopted on a routine basis (and if donors explicitly required implementing agencies to use the tools) they would become, by custom and practice, the accepted approach. It is hard to ascertain why the tools are not being used routinely. Again, it could be a matter of marketing, in which case promotion of the tools and making them available through mass distribution and regular follow up with donors about their use in projects, should help to establish them as common practice.

In the absence of functioning Ministries of Health with clear agendas for planning, management and control of the health sector, and given the range of activities which continue to be necessary to co-ordinate the relief interventions, it is unrealistic to expect one person to cover all of the necessary activities. And, it should be stressed, all of the activities are necessary, both relief oriented and development oriented, if the health system and the people working within it are to develop and become more self-reliant. It is unlikely in the extreme that Somalia will, in the near to medium term future, become more self reliant in terms of supplies and equipment, for example, but the supplies and equipment issues need to be seen and acted on as part of the institutional issues rather than tangential issues: they need to be integrated into the health system. It is essential to develop the human resource capacity and the systems and procedures increasingly to take responsibility for co-ordination of interventions, management and planning of the health sector. That will not and cannot happen without a concerted and holistic approach to systems and institutional development by both Somali authorities and the donor community: a piecemeal approach, providing training for very specific aspects of programmes, will not suffice.

If the international community is serious about sustainable development of the health system, then there is a specific, separate, additional role within the SACB Health Co-ordination Committee for a post to oversee the 'jigsaw' of a comprehensive development programme. This role is not about 'control', rather it is about facilitation of the interested donors in funding or undertaking different aspects of a development programme which can be seen by all to fit into the strategic jigsaw making up the health system.

1.5 EC Somalia Unit

Ambivalence of EC

There is a degree of ambivalence within the EC Somalia Unit about the wisdom of pursuing either a development path or pursuing a sector-specific capacity building programme in Somalia. The ambivalence is understandable given the unstable situation in Somalia and the difficulties in working there on a continuing basis: there is significant frustration about this within the ECSU among the technical assistants. There is also a slight mismatch between the agenda of the European Commission as an organisation committed to development and the long operational relief experience in Somalia of most of the technical assistants. It may be that 'deconcentration' has had a temporary destabilising effect on the operation of the ECSU: this is hard to judge. But none of the issues identified in relation to the ambivalence is insurmountable.

There is also an apparent ambivalence about the added value to the EC of the SACB. In the context of health, as stated elsewhere in this report, if the SACB Health Co-ordination Committee did not exist, it would have to be created. It offers a real potential (not yet realised) to co-ordinate donor activities towards agreed targets and goals and has already gone through the initial stages of wariness by donor agencies, observed in other countries where this approach is being tried. The SACB also offers the EC - and other members - an umbrella under which to take cover when taking risks. Where the intervention has been approved by the SACB then the SACB takes collective responsibility for it. The SACB Health Co-ordination Committee clearly needs to evolve and be dynamic in responding to the opportunities and constraints developing in Somalia. And there are clearly improvements which could be made to the functioning of the co-ordination, particularly in relation to strategic development activities. Significant progress has been made in relation to emergency interventions, development of tools and mapping, and vertical programme co-ordination and collaboration. Commitment to further strengthening the co-ordination of development activities and interventions should be unambiguous.

Funding gaps and financial cycles

Gaps in funding between different phases of projects are extremely destabilising factors both for Somalis who depend on the international inputs, and for the executing agencies. It is more difficult to re-start activities after a gap in funding, given the perceived 'breach of trust' and the interruption of activities, than it is to start a project from scratch. There is a good deal of evidence that in the health sector the funding gaps have caused projects to close rather peremptorily, without a clear exist strategy being observed and sometimes without informing Somali counterparts of the closure, to avoid the risk of adverse or sinister reaction from local populations. While it is clear that the EC budget cycle is a significant contributing factor to this funding gap frustration, there is at least one example of an international organisation changing the budget cycle for Somalia to avoid just such circumstances. In recognition of the problems - and instability - caused by funding gaps UNICEF expanded it's budget

cycle from two years to three years and have now further expanded the cycle to five years (for Somalia only), arguing successfully that despite the volatility and the extremely limited human resource capacity of counterparts, they needed a longer financial cycle programme.

EC role in health in Somalia

The European Commission, in its various guises, has been a major player in the provision of aid in Somalia. In 2002 the ECSU and ECHO between them contributed more than €8.3 million[18] out of a total budget of €26.28million[19], in other words, EC contribution amounted to almost a third of the total international budget for health. This is a significant amount. Figures for 2003 are not yet available, nor are projections for 2004. Assuming the overall figure will remain roughly the same, and if the ECHO figures are discounted (assuming they will either be phased out or deployed primarily for emergency relief interventions) and the EC Somalia Unit figure is maintained, that still indicates that the ECSU would be contributing about 20% of the budget for health care[20]. It is crucial that the best possible value for money for these resources is achieved, in full awareness of the risks involved in the Somali context. Given the size of the health budget (both overall and specifically that of the EC), and given the explicit requirement in most project TORs to provide capacity building inputs, it is essential that there is a cohesive approach to it. It is not enough to assume that building capacity of itself will somehow transform the Somali health sector. Unless there is an institutional and strategic framework within which those whose capacity has been built can play a role in the health system, much of the capacity building will be wasted or have minimal effect.

The fact that the EC is a well respected player in the health field in Somalia, and given the resources the EC directs to health, it could be argued that there is a moral responsibility to take the lead on issues such as capacity building and development on behalf of other donors and (possibly in the future) lenders. The transition from relief to development will not happen without some catalysing factor. The EC could be that catalyst, given its access to well experienced European specialists and people with solid experience of development in conflict and post conflict situations. The added value of the EC could be in providing for its donor partners and Somali counterparts, and in close consultation with them, a clear strategy and jigsaw to develop and establish a functioning health sector. Acting as catalyst, however necessary, carries its own risks, which would need to be sensitively managed (preferably through the SACB). Among these risks could be the accusation by other donors that the EC is arrogant if it takes on the leadership role in the field of development. There is precedence for the EC to do so, however, in a number of other post conflict situations. That - and the percentage stake represented by the EC in the resource pool for health - will help to mitigate that risk.

Risks of adopting a development approach

Capacity building and the building of systems and procedures to provide an institutional framework within which to operate cannot be undertaken without risks.

[18] EC contribution €5.052m, ECHO €2.873m
[19] Excluding the WHO budget, for which figures are not available
[20] This does not take account of the very significant sums coming through GAVI and the Global Fund, which may change the characteristics of the health sector considerably

There are risks of attrition of counterpart staff, risks of inaccessibility to different parts of the country, risks that there is little or very limited political commitment to development of a functioning health system, risks that the EC and other donors would see very little visible result in the short to medium term, risks of corruption in a

chronically unstable society, and others. But the risks need to be explicit and need to be managed. Nor can capacity building or the building of infrastructures and systems be undertaken without a long term financial commitment to the process - not an exclusive commitment but a commitment which, together with other donors, offers some chance of success in the medium to long term. It will take at least one generation, probably more depending on attrition, to achieve a degree of sustainability of health authorities, where Somalis are in a position to have some control over the direction of the health sector and implementation of regular appropriate programmes. They will almost undoubtedly continue to need support from the international community (it is hard to envisage a time or a set of circumstances when this will not be necessary).

Chapter 2

Analysis and conclusions

This chapter aims to provide a succinct objective analysis of the issues relating to capacity building for local health authorities and the systems and procedures necessary to be in place to allow the health system to function. The documentary and literature research, combined with observations and visits to provider facilities, Ministries and district and regional health boards, along with the information, views and opinions of key Somali players and international colleagues have been distilled and synthesised to contribute to this analysis.

The health indicators of Somalia are among the worst in the world, though they are reportedly better than they were pre-conflict. Natural disasters such as drought and man made crises continue to plague the country but the responses to these disasters are now well rehearsed and in place when necessary.

The 'do nothing' option

The option to do nothing about capacity building in Somalia is simply not feasible. Given the significant resources (financial and human) being directed to health care by the international community there is a moral obligation to initiate a process which will facilitate the development of systems and procedures and provide skills and knowledge to personnel, thus allowing a health system to be established and to function.

There has been recognition since 1997 of the need for capacity building in the health sector in Somalia but the immediate demands of relief (both financial and human resource) mitigated against the establishment of a cohesive programme. Some capacity building has been undertaken, usually as part of either emergency relief or vertical programmes, mostly in the clinical and paramedical fields but with some attention given to management. There are a small number of examples of direct capacity building in strategic management skills and, where these have been identified, there is evidence that the learning and some of the skills have survived to a limited extent, despite the absence of functional structures within which to operate.

Capacity building in a system vacuum

In many of the projects and programmes being undertaken currently, capacity building forms an integral part of the TORs but, in many cases, is not understood by the executing agencies, who do not see where the training fits into a wider context or perspective. Where capacity building inputs are undertaken in vertical programmes the value is limited to the operation of the programme and is rarely applicable on a wider basis.

For capacity building to have a long term positive effect it needs to be undertaken in the context of a functional structure or system, such as a Ministry of Health or a regional health board or a hospital, for example. Transferring skills and knowledge, however enthusiastic and amenable the recipient, where there is no structure within which to practice and further develop the skills, is not helpful. Where the institutional

structure does not exist it needs to be created, in tandem with the skills and knowledge transfer. Where the institutional structure does exist, it inevitably needs to be strengthened, particularly in post conflict situations where either the skilled personnel are no longer there or, as in the case of Somalia, there is no history of well-functioning systems and procedures even before the conflict.

While there has been absolute acceptance by the donors for some time - and increasingly by Somali nationals - for capacity building of both systems and people, there is no real understanding as to how it can be done. All recognise the extent of the problem but are unclear about how effectively to address it. With a few notable exceptions, so far the inputs have had marginal impact. One of the reasons for this relates less to the instability of the country than to the fact that there is no context within which those trained can use the competence gained: in other words there is no system within which to operate.

Tools, standards and mappings

The SACB, through its co-ordinating role, has developed tools and mappings for use in Somalia which, if used and applied systematically, would help to standardise approaches to emergency responses and for common situations which warrant clinical interventions. The tools are not widely used either by donors or by Somalis: it is hard to determine if this is simply a problem of supply and dissemination or if the problem is lack of ownership by the family of donors and NGOs who make up the SACB. While these development tools are (potentially) extremely useful, they do not of themselves assist the establishment or development of a recognisable health structure. Certainly at Ministry of Health levels the work of the Ministry is still a 'virtual' reality, since all of the interventions, planning and financing of health services in health care goes on outwith the Ministries.

Limitations of capacity building outside the context of a recognisable system

A health system cannot begin to operate effectively until those who are in recognised key posts are also responsible for (at least) decision making about priority setting, planning, resource allocation and financial management. It is absurd to transfer skills and knowledge to health personnel at health board or Ministry level while the resource flow is operating entirely outside their jurisdiction. The original proposal of investing €2 million for a capacity building project could have a significant impact if those trained are then given decision making responsibilities, and can function within a recognisable health structure, supported and accepted by the international community. If the system is not there within which to make these decisions then there continues to be a mismatch between the key personnel and the resource flows, which simply exacerbates the situation. But a piecemeal approach to capacity building (whether it is of systems or human resources) will simply not address the problem. The approach needs to be holistic. If the donors are serious about capacity building and need a catalyst to help them move from concern about the issue to proactive involvement in its resolution, then there needs to be a comprehensive approach to systems development, capacity building, skills and knowledge training - and a commitment gradually to direct their resources for health interventions through

the Ministries of Health and other official health channels. The revised budget of €3 million for a health development project could support the development and introduction of that comprehensive approach. The broader approach of health system development in tandem with targeted capacity building in strategic management skills is presented in this report as the main recommendation.

Conditions

If a programme of infrastructure building, of systems and procedures, in tandem with capacity building of those working in the system, is to take place then certain conditions will need to be met by the Somali health authorities before a commitment to invest is made by the donors. These conditions would include - at least - appointment of appropriate people to key posts (i.e. people who at least have an interest in the health sector and are amenable to training and development of their skills and knowledge); people available for a defined number of hours per working day; freedom of access for both Somali nationals taking part in the programmes and for international consultants providing the skills and management development inputs.

Over the years of international inputs in relief activities a culture of corruption has grown and become established in Somalia, whereby supply lines and chains of control are exploited to provide a ready source of illicit income for a small number of people. The corruption is recognised as being well organised as opposed to being opportunistic. The visible side of the corruption presents itself in the form of drugs and medicines purchased by international organisations and intended for use in health facilities being freely available in marketplaces around the country. Drugs and medicines which should have been provided to patients at a nominal co-payment at a health facility, and vaccines which should have been available to children free of charge, are being sold apparently without fear of any legal comeback. One of the conditions for inclusion in a development programme must be the agreement to eradicate and control this type of criminal activity. Agreement to this will, inevitably, have implications for the earnings of the black market racketeers but may also have more sinister implications for those who are tasked with enforcing the clean-up.

Equally, if a cohesive approach to development of the health sector is agreed by the donor community there are some conditions which would also need to be accepted and agreed by the donors, not least of which is the need for a common approach to the issue of remuneration of health staff. The recent paper produced by the EC Somalia Unit[21] offers a clear approach for the whole donor community to an explicit problem. If the paper is accepted by the SACB Health and Education Committees it offers a real opportunity to standardise approaches and to reduce the counterproductive and undermining wrangling over salary subsidies and enhancements. Donors have to be prepared to impose the sanctions as well as the benefits of such an approach, irrespective of organisational pressures to 'commit and spend'. The remuneration issue is an example of one challenge among many of trying to take a common approach to development in the health sector[22].

[21] EC Somalia Unit Position Paper, Remuneration of Public Employees in Education and Health, November 2003

[22] It would be worth keeping a professional eye on how a project to address these issues in Cambodia is progressing. DFID Memorandum of Understanding: Institutional development and performance based

System development

While the investment of €2million in capacity building for local health authorities would be a welcome contribution to development of the health sector personnel it is unlikely, of itself, to contribute to the establishment and development of the health system *per se*. The establishment of the health system is a crucial development , so that capacities built can be put to effective use. The recommendations presented in the following chapter reflect a considered approach to the capacity building issue – in the context of the finding that what is needed is ***development of the system***.

incentive component of health sector support programme, dated February 2003. Implementation of the project started in January 2004

Chapter 3

Proposals and recommendations

Somalia cannot hope realistically in the near future to have a streamlined fully functioning health service. The resources (both financial and human) and the infrastructure simply aren't there, though there are isolated pockets where some tentative systems are developing. What Somalis can hope for is a start to be made to develop the basic infrastructure and to develop the necessary personnel in a way which will facilitate ongoing development in a systematic and planned way to establish a health system. Such a development will not happen of its own accord: significant international commitment and support will be needed to kick-start it and to help sustain and develop it. From a very optimistic perspective (and bearing in mind the continuing instability in different parts of the country) the fact that there are few, if any, health professionals such as planners -strategic and operational-, finance officers, information specialists, managers, public health specialists, human resource specialists, programme co-ordinators etc, means that a new cadre of these specialist groups can be developed and established who do not have the baggage of previous systems to unlearn or adapt. Health is one of the few sectors which has the potential to stand outside politics and there are early indications in Somalia that most of the key personnel are ready to be constructive about health sector development.

The health sector is made up of different levels of direct and indirect intervention, from health posts, through clinics, hospitals, community health boards, district health boards, regional health authorities and Ministries of Health. At each level there are different roles and responsibilities for both employed heath personnel and the representational role of individuals on behalf of communities. Together these levels make up the health system.

For all of the reasons presented in both the findings and the analysis, this report is not recommending the utilisation of EC resources only for direct capacity building to local health authorities. To do so would be to disregard the findings. The recommendations presented in this chapter emerge from the trends and patterns described in the preceding chapters and reflect an ambitious but achievable approach to the whole issue of capacity in the health system.

Recommendation 1: Health Sector Development Programme with limited targeted capacity building for Ministry of Health personnel

The objective of this work was an assessment of capacity in terms of human resources and systems and procedures in local health authorities in Somalia, and to use the information to develop a project proposal[23] for capacity building to the value of €2 million. Following discussions of the findings and an analysis of the issues with EC Somalia Unit colleagues it was agreed that a broader approach for the health sector could be pursued in this report and an increased amount (€3 million) would be

[23] The term 'project proposal' is one of the terms referred to in Section 1.2 which is used by both relief and development people but which means different things to the two groups.

available to target a development approach. It would have been quite straightforward to develop a project proposal to undertake only capacity building but it is acknowledged that such a project would only, at best, be able to add marginal value to what is a big issue. A relatively small capacity building project, while potentially useful, is really only nibbling round the edges of the systems and skills gaps in the health sector. Additionally, implementing a project outside the context of a wider strategic framework of development runs the risk of having very limited returns in the short to medium term, due to inevitable attrition which happens when people are provided with marketable skills.

Following on from the analysis of the systems and procedures and the capacity of personnel to take on the necessary roles and responsibilities of the health sector, it is clear that what is really needed is a more concerted and holistic approach to the development of the health system. This would provide the framework against which all development activities could be undertaken and would show where individual projects and programmes fit into that framework.

In order to maximise the value of EC resources, this report **recommends** that the €3 million now available for a health project within the EC Somalia Unit budget should be directed to the development of a **Health Sector Development Programme in tandem with a limited, targeted, strategic skills and knowledge programme for Ministry of Health personnel**. The HSDP should use the SACB Health Strategic Framework as a starting point, since the clearly specified strategic objectives of the SACB Health Strategic Framework are already accepted by all of the key players. The HSDP should reflect the full range of health sector development issues which need to be addressed.

The EC recognises the need for a concerted approach to development and there are a number of other international agencies that wish to start on a development process in Somalia but are reluctant to develop piecemeal projects in the absence of a health system. A Health Sector Development Programme will be needed irrespective of the political decisions about the future of the country, if any development interventions are to have a chance of lasting success.

Preparation of a Health Sector Development Programme

The SACB Health Strategic Framework (see Appendix 4) is a good first step at identifying many of the issues which need to be addressed in the health sector. A Health Sector Development Programme would incorporate the full spectrum of health sector issues such as, for example:

- a generic health sector strategy, applicable to the whole country, irrespective of the ultimate decision about government(s)
- governance (cross sectoral and health-specific)
- regulations
- systems
- procedures
- capital development and refurbishment
- equipment management
- planning

? co-ordination (of international aid)

? short and medium term financial planning and management
? longer term financial planning (such as the types of financing mechanisms to be adopted longer term)
? recruitment and retention of personnel (and the intrinsic issues of negligible pay for health personnel, high levels of absenteeism, the need for people to have multiple jobs to get enough income to support their families)
? critical issues such as transparent criteria for appointment to posts in Ministries of Health
? the technical skills and aptitudes required from health personnel
? a comprehensive capacity building programme with a wide range of components which could be supported by different donors and agencies but which, together, would constitute a jigsaw of capacity building.

The Health Sector Development Programme would provide the necessary skills and systems to enable the Ministries of Health to begin to operate more effectively - more like Ministries of Health. It would also provide operational health personnel with the basic skills needed to manage and plan the health sector and provide clinical services, using both knowledge-intensive and skills-intensive programmes.

This list of what would be included in the Health Sector Development Programme (HSDP) is by no means exhaustive, it simply illustrates the range and scope of the different pieces of a health sector jigsaw. The full range of components and elements would be developed through the consultative process of undertaking the project.

Limited, targeted strategic skills and knowledge programme

During the same project period as the preparation of the Health Sector Development Programme a limited strategic skills and knowledge programme should be provided for Ministry of Health and health authority personnel. Provision of such a programme will make it possible for strategic skills and knowledge to be transferred to Somali counterparts while components of the Health Sector Development Programme are being designed. The targeted skills and knowledge programme will enable key Somali health counterparts to have a more informed involvement in the preparation of and subsequent marketing and implementation of the Health Sector Development Programme. As skills and knowledge of systems begins to grow Somali Ministry of Health personnel will be better able to carry forward the programmes and projects identified in the 'jigsaw' of the HSDP, thus establishing a workable system. Further, they will be enabled to adopt a more proactive role in working with international organisations to target resources and projects to priority issues in the health sector. The strategic skills and knowledge programme would be targeted at Ministry of Health and health authority personnel - those with strategic roles and responsibilities - and would include skills and role training in strategic planning (capital and resource), financial planning and management, human resource planning, health needs analysis, data collection, health records and use of information, and health sector supplies systems.

For an approach like this to succeed it is essential that at least one of the major players in health in Somalia is prepared to have long term vision and long term technical capacity and leadership to 'champion' the Health Sector Development Programme.

That is not to say that one organisation should be funding it: rather that one organisation needs to act as the catalyst for the programme and a key challenge will be to build up support and momentum with Somali partners, other donors and (future) lenders. The EC has been a significant contributor to health in Somalia during the prolonged relief phase: the EC is now prepared to commit its resources to kick start a comprehensive development programme.

The major risk involved in funding the development of a Health Sector Development Programme is that the key Somali players, other donors and lenders might not accept it as the agreed programme for development of the health sector. This risk can be mitigated in a number of ways: firstly, by consulting widely with Somali key personnel and existing and potential development agencies; and secondly, by using existing mechanisms such as the SACB Health Co-ordination Committee to 'sell' the idea and to capitalise on the frustrations expressed by a number of the donors and lenders and many of the Somali officials about slowness of development.

The approach proposed in this report poses a major challenge to the EC Somalia Unit. It will require courage, leadership capacity, political will and long term vision to carry this initiative forward.

While it is not the intention to pre-empt the outcome of the work to develop the Health Sector Development Programme, it might be useful to those who will decide whether or not to take on this challenge to identify a number of the jigsaw pieces, to give some indication of the range and scope of the different issues to be covered and to show that many different donors and lenders would have an interest in adopting or funding certain aspects of it. Separate projects (parts of the jigsaw), in no priority order but for illustrative purposes only, might include:

- Structure, roles and responsibilities of Ministries of Health (specialities and expertise required, functions of different departments, job descriptions for key personnel, training needs analysis etc)
- Relationship between Ministries of Health and other Ministries
- Rationalisation of secondary health facilities[24]
- Operation and management of hospitals
- Comprehensive technical and skills capacity building programme for all health personnel
- Refurbishment of health facilities and building of new health facilities based on verifiable clinical and health needs
- Equipment programme
- Development of a primary health care programme (clinical and organisational)
- Pharmaceutical supply and stock control system
- Licensing and accreditation of health personnel (the legal and administrative issues to be addressed, application of the regulations, establishment of a legitimate licensing body etc)

[24] Observed occupancy levels are generally at 50%, with some notable exceptions such as Galkaio Hospital.

- Establishment of a 'national' statistics function (possibly in three sites) to deal with registrations of births, deaths, epidemiological patterns, etc
- Development of realistic strategic plans for Ministries of Health
- Establishment of professional associations - Medical and Dental, Nursing, Pharmaceutical - the legal, administrative, continuing professional development, examining roles, succession planning, peer review, etc
- Regulation and licensing of private sector - of individuals and premises, including clinics, hospitals, pharmacies, laboratories, radiology services etc
- General Management Development Programme covering planning, information, finance, record keeping and documentation, human resources, communications, supplies, engineering and maintenance, co-ordination of international aid, etc. There would be a mixture of a Foundation Programme and separate but linked tiered specialist programmes[25]. Programmes such as the international MPH distance learning programme, already developed, could be adapted for use in Somalia (the template for this is included in the tender documentation)
- 'Sponsorship' of posts by donors[26]
- Development of performance related salary enhancements for health personnel[27]

By tackling the whole issue of development of the health sector, rather than addressing aspects of the problem piecemeal, at least at the design stage, this creates an opportunity to facilitate proactive collaboration between the lead organisations, Somali partners, international donors and lenders who are interested in participating in such a programme.

This comprehensive programme would be the 'jigsaw' for health sector development. It needs to be flexible. In the absence of stability it may be that the capacity building pillar is started before any capital works, for example. Since it is a reasonable projection that this will be the case, then it is further recommended that the capacity building part of the HSDP jigsaw should be developed in more detail, with each component (such as for hospital directors, or laboratory technicians, or medical officers, for example) having a project description, target beneficiaries, where it fits into the wider capacity building jigsaw, and approximate projected cost. Preconditions for undertaking each project would be defined, and these would include such issues as availability of appropriate personnel to undertake development programmes, commitment of Ministry(ies) of Health to adopt the roles and responsibilities of a Ministry, relatively stable environment in which to bring international consultants. If the approach can be sufficiently flexible (such as different places coming on-stream for parts of the programme when they achieve an acceptable level of stability) this could help support the 'peace dividend' approach. Preconditions would be specified for each of the projects.

[25] A programme like this has been developed for Palestine, funded by DFID.
[26] As happened in Thailand Ministry of Health, through WHO funding. It is important that sponsorship of posts is owned by all donors: individuals sponsored should not be identified as 'the EC' person or 'USAID person'. A number of posts are currently being sponsored in the Ministry of Health in Hargeisa with WHO funding
[27] This is happening in Ethiopia, under the Health Sector Plan arrangements. Also a performance-based salary enhancement project has just started (January 2004) in Cambodia, funded by DFID.

Development of such a comprehensive programme would require multiple technical skills and strategic vision in a health development context, as well as sens itivity to the realities of a divided country where the systems have collapsed. Those undertaking the work would require close consultation with other donors and lenders and with Ministries of Health (where they are functioning), health facilities, and key interested Somali players. Many of the elements of a Health Sector Development Programme have been developed in other difficult and divided post-conflict situations. It should not be necessary to develop from scratch all of the components. It will be important to ensure that those selected to undertake the task of developing the Health Sector Development Programme have long-term experience of post conflict situations and development programmes and understand the implications of transition from relief to development. They should also have access to a network of contacts to access the TORs of other programmes and projects from other post-conflict situations, be able to interpret the evidence of success or failure of programmes, customise successful programmes for the Somali situation, develop new projects and programmes where necessary, and come up with a comprehensive Health Sector Development Programme for Somalia.

Targeted strategic capacity building of Ministry of Health personnel will provide strategic skills and knowledge to a limited key group within the health sector. It is important that those selected to provide this important aspect of the project have experience of working in conflict and post conflict situation where any previously existing systems have completely broken down and become established instead as a 'crisis-as-norm' situation, operating outside any recognisable health system. The consultants will need to be sensitive to the technical limitations of strategic skills and knowledge within the Somali health sector.

It is estimated that the development of a comprehensive development jigsaw, and the building of ownership of it, would take up to eighteen months to complete, if it is undertaken by a small designated team. Once completed, the jigsaw would be available to EC and all other donors and lenders to fund, sponsor, or work in partnership with other agencies to jointly sponsor. It would also be available to Somali Ministries of Health to use as the basis for requesting funds for development. The strategic capacity building programme which will run in tandem with the preparation of the HSDP should run for a period of two years, taking into account the time needed for identification of appropriate personnel, tailoring of a programme and provision of the programme. As the strategic capacity building programme gathers pace, participants will increasingly be able to contribute to the preparation and design of the HSDP and develop ownership of the concepts and components.

It is possible with such a comprehensive programme specified, that a number of donors might come together to pool resources to fund significant chunks of the jigsaw through the usual competitive tendering process. It may also be the case that bilateral donors who are currently not funding programmes in Somalia would be persuaded to do so, if there was sufficient evidence that their inputs were clearly part of a wider, accepted, development programme. Discussions with a number of the bilateral donors gave cause for hope in this context. Such a programme has been developed and is being proactively followed in Cambodia, where all of the donors and lenders and

Ministry of Health personnel participate in the decision making process and reporting process (with a generic reporting mechanism to all donors from the Ministry). The donors and lenders use the agreed strategy to develop projects which fit with accepted health sector needs and with funding institutions' agendas. All of the donors operating in the health sector in Cambodia follow this strategy to determine appropriate activities and projects. The Ministry of Health has power of veto on any proposed project, if it does not fit into the strategy. Separately, in Cambodia, a pool of funding has been established using funds from Asian Development Bank, World Bank and DFID (of approximately $80 million, mostly grants) to support a range of projects and programmes included in the strategy. Each of the agencies is also separately funding independent projects, but which still fit absolutely into the wider strategy. An example of this is the DFID project (of approximately €8 million over 5 years), implementation of which started in January 2004, which creates a mechanism for performance related salary enhancements for health personnel. (There are many similarities between the health sectors in Cambodia and Somalia, not least of which are the very low salaries of health personnel, officers having multiple jobs to maximise their income, chronic absenteeism).

The adoption by Somali Ministries of Health and donors and lenders of a Health Sector Development Programme is not without risks. The most obvious risk is that there will be no improvement in the stability of the country. This would have an immediate impact on the potential to undertake any of the capital works planned in the Programme. But the continued instability would not necessarily impact adversely on much of the systems development activities or the capacity building programme. The risks associated with the capacity building programme are attrition of staff who receive skills, knowledge training, and development and who then opt to seek alternative - and almost certainly more lucrative - employment. Attrition is predictable and therefore needs to be built in to project plans: a longer term vision and commitment is needed from the donors. However, where there are a number of capacity building projects under way, and people can see that training and development is available, it does make the health sector a more attractive place to work, which may help to improve the recruitment situation.

The detailed EC project proposal and terms of reference for this recommendation, for an EC funded project of €3 million, are available as a separate output to this report.

Recommendation 2: Health Development Co-ordinator

The SACB Health Sector Committee is providing the co-ordinating role for relief and emergency intervention activities, development of tools to address common illnesses and diseases, mapping of facilities, relationships with foreign governments about safe return of refugees, as well as providing a legitimate focal point for securing Global Fund grants to address some of the world's big health issues. Co-ordination of relief interventions continues to be a proactive and demanding activity. While recognising the useful co-ordinating role being undertaken in relief, and acknowledging that the relief programme will continue indefinitely, the SACB provides a very useful umbrella organisation to work with all of the donors to sensitise them to the need for a

co-ordinated development approach. This was clearly a major objective of the SACB Health Strategic Framework and should be significantly built on to provide proactive support for development. Development of the health sector needs to run in tandem with the relief programme.

A separate post of Development Co-ordinator should be considered in addition to the current role of the SACB Health Co-ordinator. It is not feasible to try to merge the roles of relief co-ordination and development co-ordination, for all the reasons identified in the section on the relief-development axis in Chapter 1. The approaches are different; there are different donors involved, and different funding and contracting systems. Key Somali health personnel[28] are in agreement that a focused development programme is necessary and that Ministries of Health need to develop skills and expertise to allow them effectively to co-ordinate the international assistance. Until those skills and capacities are in place it is appropriate to provide the skills under the SACB umbrella.

The role of Development Co-ordinator, under the SACB umbrella, offers an opportunity to facilitate the collaboration of donor activities in development. In the first instance, the Development Co-ordinator would closely collaborate with the work on preparing the Health Sector Development Programme, which would lead to proactive and linked interventions by donors. It would be inappropriate - and probably counterproductive - for an individual donor organisation to take a direct lead role in co-ordinating development. One of the real benefits of having the SACB already established means that the lead role would be undertaken on behalf of all donors who are participating in the development process.

Key characteristics of the person who would best perform the role of Health Development Co-ordinator would be a strong background in health sector development, specifically in conflict and post conflict situations. Strategic vision would be an essential characteristic, as would strong leadership and facilitation skills.

[28] Including all three Ministers of Health in post in October 2003

Appendix 1

TERMS OF REFERENCE
IDENTIFICATION OF CAPACITY BUILDING INTERVENTIONS FOR LOCAL HEALTH AUTHORITIES IN SOMALIA

1 BACKGROUND

1.1 Health Status

O*verview*

Somalia remains a fragmented nation, whose diverse realities continue to demand different programmes and implementation approaches. While a measure of stability in some areas allow for an increased development approach, deteriorating security in others seriously limits rehabilitation and humanitarian operations. The Human Development Report for Somalia, 2001, estimates the population at 6.3 million, and the annual population growth rate at 2.7%. The population is highly mobile, primarily due to the large number of nomads moving mainly in the central and northern areas, and as a result of population movements in response to food shortages and clan warfare.

Health Indicators

No reliable data exists for the health sector in Somalia, and accurate data on mortality and morbidity is difficult to ascertain. *To this end to invest in a census*, at least in the peaceful and stable areas of the country, would provide local administrations with a priceless tool for planning purposes.

The infant mortality rate (IMR) is 132 per 1000;
Under five-mortality rate (U-5MR) is 224 per 1000;
Maternal Mortality Rate (MMR) was 1600 per 100,000 in 1990 and it is maintained as such today. This places Somali women among the population groups at a highest-risk in the world. *Hemorrhage, prolonged and obstructed labor, late search for qualified assisted deliveries, severe anemia, infections and eclampsia* are the major causes of mothers and child death at childbirth.
The leading cause of the above severe health disorders is linked to the female genital mutilation (FGM).

Main Diseases

Infectious diseases, endemic all over the country are characterized by epidemic picks and represent the main burden to the health of Somali populations. *Respiratory infections, Diarrhea diseases, Malaria, Neonatal tetanus and dehydration, Measles and Tuberculosis* are among the most frequent diseases among the Somali populations. *HIV/AIDS* prevalence in Somalia is fortunately still low, though major threats are represented by: (i) the high prevalence of the pandemic in neighboring countries: Djibouti, Ethiopia and Kenya; (ii) the increase in the number of returnees from Ethiopia and Djibouti and (iii) the high prevalence of STDs in the country associated to cultural biases, extremely poor awareness and ill social behavior.

The level of immunization remains relatively low, despite efforts made in this sector and improvements in coverage has been achieved in comparison to the early nineties. The present global immunization coverage of about 30 percent is far from being sufficient to prevent a spread of EPI preventable diseases. Only about 10 percent of children have all five (BCG, DPT1/2/3, Measles) recommended vaccinations in the first 12 months of life. The persistence of the wild-polio virus in the country calls for more emphasis on the quality of planned national immunization days (NIDs).

1.2 Management of the Health Sector

It is challenging to highlight technical and institutional strengths and weaknesses of the public and private health sector in the diverse areas of Somalia ***because the geographical differences related to the performance of the sector in Somaliland, Puntland and South Somalia are minimum.*** The medical profession in the public and private health sector is merely profit-oriented disregarding the quality of care provided, ethical principles and patients safeguard. Medical and paramedical practitioners operate in an environment with little control, supervision, guidance, proper management, legislative backup, training opportunities and motivation. Moreover the management of the public health sector is rendered even more difficult by the historical attitude of Somali populations and

authorities to delegate the delivery of the Somali Health Care System to the International Community. This has brought along the years an almost absent sense of ownership and a high dependency on external aid.

Underlying causes for poor management in the Health Sector

General:

The prolonged effects of the war continue to negate the socio-economic development of Somalia and to hinder the growth of national revenue earnings;

Policy and administrations:

1. Health is not necessarily felt as a priority by the existing administrations in Somalia;
   Highly centralized decisions have been taken by the Somaliland administration for example in the past few years in open contradiction with the decentralized MOHL Health Sector Reform Policy;
2. Gaps in guiding principles and regulations all over the country;
3. Poor possibilities/capacities/interest/administration support to strengthen the content of few existing laws and regulations in the health sector (e.g. rationalization of medical and paramedical staff based on solidly proven technical capacities). This brought:

   - An uneven distribution of health facilities and staff in geographical areas;
   - Lack of possibilities to retrench any staff poorly performing due to poor law reinforcement, capacities and tools;
   - Overstaffing in many public health facilities;
   - Inability to pay highly motivating salaries;
   - Unknown training needs for the staff operating in the majority of the areas of the country;
   - Poor or not existing supervision practices which negatively affect the quality of the delivery services.

4. Referral systems, where they exist, are weak and exacerbated by a lack of quality training and effective supervision;
5. Weak willingness from local authorities to work constructively in partnerships with the international community, associated with a limited community involvement in the decision making process by the very authorities who promoted a highly decentralized Health Policy (e.g. Somaliland and Puntland);
6. Severe limitations in structural, managerial and resource capacities;
7. Lack of transparency by the existing administrations;

Health Staff:

8. A crisis of confidence ensues low productivity of health care professionals while increasing rates of absenteeism due to the low remuneration, incentives, poor training and lack of supervision. Health workers compete to have access to per diems paid by some International agencies in exchange to their participation to training courses of often doubtful quality and usefulness;
9. Loss of up to 50 percent of well knowledgeable health professionals as a result of the war (Diaspora), limited certification and registration. This brought a steep decrease in the number of health staff capable to guarantee and provide health services within acceptable health standards;
10. Inadequate supervision and misappropriation of funds from cost-sharing schemes in several public health facilities;

Beneficiaries:

11. Poor patients attendance to health facilities due to:

    - Loss of community confidence towards public institutions which belongs to the Somali history;
    - Biased population perception towards public bodies. Government officials are the ones who have access to funds from the International Community. These funds, within the past

and present Somali perspective, should be utilized to pursue economic interests of elite groups such as doctors and politicians, through clan distribution mechanisms;

- ? Poor control on patients' safeguard and total absence of ethical principles;
- ? Communities not involved at all by the health authorities in discussions and in the decision making process. Communities are often considered by the existing administrations as mere recipients of support and with a consequent absence of ownership towards the services provided by the public sector;
- ? Health related knowledge is still perceived as an almost *"supernatural"* power by nomadic populations. This is a contributing cause leading to poorly professionally oriented, un-ethical and often dangerous practices carried out by many health practitioners who have a social ground allowing them to do so.

International Organizations:

- ? High rotation of international staff to a variety of reasons and above all poor rewards in exchange to high professional skills and experience;
- ? Short term funding brings unhealthy gaps between project phases;
- ? Attitude to give priority to geographical coverage rather than quality of services delivered;
- ? Frequent poor professionalism.

1.3 EC strategies and priorities

As a result of the 1999 EC Health Strategy for Somalia and the 2002 EC Strategy for the Implementation of Special Aid for Somalia the main EC funding priorities for the Health Sector in the years to come (2002-2007) can be summarized as follows:

- ? Provision of technical support to the Local Health Administrations at national, regional and district level. This will aim at strengthening local operational capacities in the implementation of a decentralized Health Sector Reforms Process in the country. This support should come along with technical assistance to the Regional and District Health Boards where existing and operational;
- ? To contribute to set up basic training courses in Public Health for a new generation of paramedical staff and technicians as well as to create new properly trained trainers (SOMALIA HUMAN RESOURCES DEVELOPMENT PLAN). This is to overcome and make unbearable the risk to assist to a further, letal, depletion of qualified health professionals in few years time, as evidence suggests, up to the point in which no more qualified health professionals will be available in Somalia;
- ? To establish common and standardized procedures for basic surgical, and laboratory techniques in regional and district hospitals all over the country;
- ? To strengthen participatory supervision mechanisms to referral and PHC facilities as fundamental part of the health operations of the EC funded health projects.

1.4 Other Existing Strategies and Frameworks

A number of other Health Policies and Strategic Frameworks have been developed in Somalia since 1998: SACB Health Strategy Framework (Nakuru Kenya, May 1999), Somaliland Ministry of Health and Labour Health Policy to support Health Sector Reforms (Hargeysa 1999) and the Puntland Ministry of Social Affairs Health Strategy (Garowe, 2000).

Overall, all interventions in the health sector in Somalia are coordinated by a specific SACB Health Coordinator, within the framework of the SACB Health Sector coordination Committee and its various more specific sub-committees.

2 DESCRIPTION OF THE ASSIGNMENT

2.1 Beneficiaries

The following stakeholders should benefit from this study:

2.1.1. The EC will receive key technical and financial planning information, as a contracting agency;
2.1.2. The Health authorities in Somalia at central and regional level, as well as Somali professionals, will obtain inputs on their present capacities to manage their own health service management system;
2.1.3. The Health authorities and Somali professionals will benefit from a medium-long term support programme of capacity building on the basis of clearly identified operational priorities and needs;
2.1.4. The Somali populations will indirectly benefit, being this study the first step to set up the foundations to ameliorate the quality of the health delivery services in Somalia.

2.2 Global and Specific objectives

2.2.1 The overall objective of the proposed study is to assist the EC in identifying main technical and institutional priorities that will be tackled by a capacity building programme which will strengthen the health system delivery services in Somalia.

2.2.2 Specific Objectives

- To identify the areas in Somalia which are more conducive to initiate Phase I of an Institutional Capacity Building Programme in the Health Sector;
- To carry out a SWOT analysis of the present human resources capacities (number, motivation, ownership, knowledge, legislations, procedures, regulations, supervision and systems in place) in the areas of Somalia where local health administrations are in place;
- To identify and analyze successes, failures, constraints, existing gaps regarding ongoing pilot projects which have been providing various components of technical capacity building to the health administrations and professionals;
- To prepare a project proposal for the establishment and implementation of a rolling medium-long term institutional capacity building programme in support of the health administrations in Somalia at central and regional level;
- To recommend approaches for the involvement of other not directly health-related administrative entities whose back up to the health sector is fundamental for the long term establishment of an effective Public Health delivery System in Somalia;
- To identify ways, means, content, roles and responsibilities of various stakeholders to develop an effective operational agreement regarding the implementation of Phase I of Institutional Capacity Building Programme in Support to the Health sector in Somalia;

2.3 Requested Services

This study will provide decision makers in the EC with a detailed proposal for a coherent countrywide institution capacity building programme in support to the emerging Somali Health Administrations at central and regional level

2.4. Expected Results

1. The study is expected to contain the following outcomes:

- Background information of the health delivery system management in Somalia (Review of existing documents, interviews and field visits) - see Annex I & II -;
- Evaluation of ongoing key pilot health projects in support to the health administrations in Somalia:

(i) The MOHL-UNICEF Health Sector Reform (HSR): i.e. Gabiley, Togwajale, Arabsyo;
(ii) WHO Basic Development Needs (BDN);
(iii) Other community based projects such as the one under implementation by the International Federation of the Red Cross (IFRC) in partnership with the Somali Red Crescent Society (SRCS) both in Somaliland and Puntland (funding from the World Bank);

(iv) A Selection of some EC funded project in NW, NE, Central and South Somalia;

- A SWOT analysis of the existing health delivery system management capacities in Somalia;
- Clear identification of needs and priorities to provide an institutional capacity building support to the existing Somali Health Authorities in the field of human resources, laws, regulations, supervision procurement, administration and system management;

To achieve the expected results the consultant/s is expected to utilize the following methodology and tools:

- He/she will work in close collaboration with the MOH administrations in Somalia and Regional/District Health Boards where present and functioning;
- The consultant/s will also closely cooperate with relevant representatives from international organizations such as: the EC, SACB/HSC, SHSC, WHO, UNICEF, INGOs;
- The SWOT analysis should be a tool for utilization in investigating the health system performance in Somalia, including the perception from the public;
- Focus-group discussions on future plans modalities of implementation, modes of distribution and monitoring of tasks, means to promote acceptance by the public should contribute to trigger a local sense of ownership towards the future Somali Public Health System (see Annex II);
- Presentation of the study findings, recommendations, needs and priorities identified to all stakeholders (workshops both in Nairobi - SACB/HSC - and Somalia - Administrations and INGOs -

3. EXPERT PROFILE

3.1 The main consultant should have the following qualifications and experience:

3.1.1 Post-graduate degree in health policy planning and health care financing, with extensive working experience (at least 15 years) in the development of health systems and policies, particularly in developing countries;
3.1.2 He/she should master the Project Cycle Management and log frame
3.1.3 Good management, team building skills as well as good communication skills;
3.1.4 Ability to organize and facilitate planning workshops;
3.1.5 Willingness to work in difficult circumstances;
3.1.6 Experience of the cultural setting of Somalia, preferably with previous working experience at health policy level in the country and good knowledge of the health sector environment in Somalia will be an asset;
3.1.7 Excellent analytical skills and knowledge of the English language;
3.1.8 Well versed in computer skills.

3.2 The main consultant should recruit **a Somali facilitator** who should assist him/her in the organization and facilitation of meetings and workshops in the areas visited in Somalia. This facilitator should be a person presenting the following capacities:

3.2.1 Excellent communication skills
3.2.2 Excellent mastering of the English language
3.2.3 Well introduced in the local administration

The EC may assist the consultant in identifying a suitable candidate at the time of commencement of the assignment. Therefore his/her CV should not be attached to the bid and will not form part of the evaluation of the bid. This support should however be budgeted in your offer and it is recommended not to exceed € 120 as daily fees and € 88 as daily allowances.

4. LOCATION AND DURATION

The consultancy will be conducted in various stages as follow:

Phase I: NAIROBI

- Revision of existing Health Policy/ies and strategies (EC-SU, MOHL, MOSA, SACB) as well as pilot project documents under implementation in Somalia -see Annex I;
- Preparation of questionnaires for the various key stakeholders - see Annex II -;
- Interviews of relevant stakeholders and partners based in Nairobi - Annex II -;
- Sampling of projects to be visited;
- Preparation of check lists to assess the projects in the field;
- Preparation of a work plan for the following stages;
- Preparation of inception report for EC approval;
- Presentation of the inception report to main implementing partners: UNICEF, SACB/HSC, NGO consortium (workshop).

This phase should be of 23 days

Phase II: SOMALIA

- Presentation of the inception report to Somali Health officials at Central and Regional level, UN agencies operating in the Health Sector in Somalia and Health INGOs (workshop);
- Individual and focus groups interviews in Somalia;
- Review and analysis of the existing health administrations:
  i. Administration organigramme, coordination along the MOH pyramid;
  ii. Coordination and interactions with other administrative entities;
  iii. Project reporting;
  iv. Laws, regulations, procedures, guidelines;
  v. Human resources;
  vi. Implementing capacities (i.e. filing system, accountancy, budget management, meetings reporting and distribution, supervision mechanisms in place);
- Review and analysis of the sampled projects;
- Presentation of preliminary findings at least in two locations in Somalia (workshop).

This phase should be of 83 days

PHASE III: NAIROBI

- Presentation of the Draft Project Proposal to the EC
- Presentation of the draft final report to the main Nairobi-based stakeholders (workshop);
- Submission of the final report to the EC for approval;
- Distribution of the final report to the main stakeholders involved in the process.

This phase should be of 23 days

The total period of this study amounts then to 129 days

Work Plan

The consultant will prepare a work plan and he/she will include this in his/her offer. The work plan will contain a task analysis chart that should represent the consultant's view of the distribution of tasks highlighted above (Phase I-III).

Time schedule

The consultant in the offer should respond to the timetable below and clearly indicate whether and how he/she can adhere to or improve on it. The timetable gives an indication of the maximum period of time within which the activities have to be carried out.

Doc t	Activity	Location/ Weeks	1		3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Nai (Ph	Review	Nairobi			N	N															
	Interviews		N		N																
	Work-plan		N																		
	Inception Report (EC)																				
	Workshop (SACB/HSC 1)																				
	TOTAL DAYS NAIROBI																				
Fiel (Ph	Workshop (scope/inceptio n report 3)	Somalia				S	S														
	Interviews						S														
	Analysis						S	S	S	S	S	S	S	S	S	S	S				
	Project visits								S	S	S	S									
	Project Prop.														S	S	S				
	Workshop (findings 1)																S	S			
	TOTAL DAYS SOMALIA																				
Nai (Ph	Project Proposal final (EC)	Nairobi																N	N		
	Workshop (SACB/HSC 1)																			N	N
	Final report (EC)																	N	N	N	N

N.B. The consultant will work in close collaboration with existing and accessible Somali health authorities and with the SACB/HSC. He/she will work under the direct guidance and overall supervision of the EC Health Sector Technical Assistant.

The study should then start the 25th August 2003

5. REPORTING

5.1 Inception Report: The consultant will present to the EC in four (4) copies a brief inception report of no more than 7-8 pages, within 2 weeks since the beginning of the study. This inception draft report should be presented for discussion and comments to:

5.1.1. The SACB/HSC members in Nairobi during a one-hour Power-Point presentation;
5.1.2. To the local health authorities, UN agencies and INGOs in at least two locations of Somalia, during a half day workshop;

Major comments and recommendations received by the stakeholders both in Nairobi (SACB/HSC) and Somalia should be incorporated in the final report.

5.2 *Final Report and Project Proposal:*
5.2.1. The consultant is expected to share with the main stakeholders in Somalia (before the end of Phase II), through the organization of two workshops to be held in at least two locations of the country, key findings of the feasibility study, including draft identified priority areas for intervention in Support Phase I of a Capacity Building Programme to the Health Sector in Somalia;

5.2.2. The consultant is expected to present to the SACB/HSC in Nairobi (beginning of Phase III of the study), through the organization of two hours Power-Point presentation, key findings of the feasibility study, including identified priority areas of intervention in Support to a Capacity Building Programme to the Health Sector in Somalia (Phase I);

5.2.3. The consultant will present to the EC four (4) copies of a draft final report within 10 working days since the beginning of Phase III of the study. The final report should not exceed a 30 pages document, excluding the annexes. This report should contain a document called *"Capacity Building Programme in Support to the Health Sector in Somalia (Phase I)"* as Annex I. Within two (2) weeks feedback will be received from the Contracting Authority.

5.2.4. The consultant will take into account comments received which will be incorporated both in the final feasibility study report and in the project proposal, which have to be submitted to the EC in English in eight (8) copies one (1) week after reception of comments from the Contracting Authority

5.2.5. The *"Capacity Building Programme in Support to the Health Sector in Somalia (Phase I)"* project proposal should be presented following the Project Cycle Management and Logical-Frame work (see Annex III);

5.2.6. I addition to the hard copies the consultant has to submit all documents in a CD-ROM in PDF format.

ANNEX I: Available Reference Documents

- EC Strategy for the Implementation of Special Aid for Somalia (2002);
- EC Health Strategy for Somalia (EC Nairobi, Jan. 1999);
- The SACB Health Strategic Framework for Somalia (Nakuru, Kenya, May 1999);
- The National Health Policy, Republic of Somaliland (MOHL, April 1999);
- Guidelines for Strategic and Operational Planning: Workshop for Primary Health Care, Awdal, Republic of Somaliland, COOPI, June 1999;
- Togdheer Regional Health Strategy, Somaliland, MOHL 1999
- Towards a Sustainable Health System for Puntland, (MOSA Garowe, Oct. 1999);
- Master plan 1999-2003 and Operational Plan 2000-2001 (MOHL, July 1999);
- Strategic Framework in support for the health sector in Somalia Vol. I, (SACB, Nov. 2000);
- Compiled feed back from SACB/HSC members on summary table of SACB strategic objectives for the health sector**;**
- UNICEF country program evaluation report 2001
- Project documents of pilot projects of HSR by UNICEF Somaliland**;**
- Project documents compiled by MOSA from all Int. Organizations active in Puntland **(**Nov 2000 and March 2001**);**
- Health financing in Somalia, feasibility study (EC/DSA Nairobi, 1997);
- Somalia end – decade Multiple indicator cluster survey (UNICEF, January 2001)**;**
- Minutes and documentation of the Puntland health coordination meetings November 2000 and March 2001**:**
- Minutes and documentation of Somaliland Health Secretariat for the HSR;
- Plan of action (investment guide) for Somaliland on essential drugs. Mtana Lewa (UNICEF consultant, December 01) and related documents;
- Human Development Report Somalia 2001, UNDP;
- EC Strategy and Programme of Action in Support of Local and Regional Administrations in Somalia in the field of Institution Building (1996).
- EC- funded selected Health Project Proposals

ANNEX II: Key Resource Persons (Indicative list)

Interviews to be conducted through structured questionnaires. In case of limitations to access, the questionnaire could be forwarded through e-mail. Responses to the questionnaires will be included as Annexes to the final report of the consultancy.

Local authorities

MOHL Hargeisa and members of the Somaliland Administration

Dr. Hassan Ismail Yusuf	Minister of Health & Labor
Dr. Abdi Aw Daher	Former minister of Health & Labor
Mahamoud Jama Warfa	V.M MOHL
Ahmed Abdi Jama	DG MOHL
Health Sector Reforms Secretariat	
Key members of the Civil Servants Commission	Hargeysa
Random Selection of RMOs/DMOs	
Random Selection of Regional and District Health Boards members of Awdal, Sahil, Togdher	

Any other available senior officer of relevant ministries (e.g. Planning and Cooperation, Finance, Treasury, M. of presidency) should be contacted and interviewed, if possible.

MOH Puntland

Minister of MOH	Garowe
Dr. Cabdi Awad (MOH DG)	Garowe
Random Selection of RMOs/DMOs	
Random Selection of Regional and District Health Boards members	Bari (Bosaso), Gardo (Bari)
Members of medical associations	Where existing

Any other available senior officer of relevant ministries (e.g. Planning and Cooperation, Finance, Treasury, M. of presidency) should be contacted and interviewed, if possible.

Mogadishu
Questionnaires via e-mail if no access or via ECLO.

International organizations

UNICEF

Leila Pakkala SPO	Nairobi
Awil Haji Ali	Hargeysa
Dr. Roberto Bernardi	Nairobi

WHO

Dr. Ibrahim Bet Elmal	W.R. Somalia, Nairobi
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Local officers	Hargeisa

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P.Simkin	TA SME/Peace Building and Governance, Chair of the SACB Governance W.G., Nbi
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Gary Jones	NPA country coordinator, chair NGO consortium Nairobi

COOPI

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Dr. George Yang	Project coordinator, Burao
Dr. Haan	Project coordinator, Boroma

IFRC

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ICD

Boniface Muia	Medical Coordinator, Hargeisa

WSP

Matt Bryden	Project Manager

APD (Academy for Peace & development)

Hussein Bulham	Director

ANNEX III Structure of the Project Proposal

COVER PAGE

Name and contact of the Submitting Organization	**(to keep empty)**
Title of the Project:	**Capacity Building Support to the Health Sector in Somalia (Phase I)**
Sector:	Health
Location:	(To be defined by the study based on accessibility, priorities identified and structure of the local health administrations)
Duration:	2 Years
Amount requested from the EC:	Financing Proposal from the consultant

1. **EXECUTIVE SUMMARY (MAX 2-3 PAGES)**
1.1 INTRODUCTION
1.2 BRIEF DESCRIPTION OF THE PROPOSED PROJECT
1.3 BUDGET SUMMARY
1.4 OTHER INTERVENTIONS IN THE AREA AND SECTOR
1.5 LOCAL AUTHORITIES AND COMMUNITIES CONSULTED

2 THE MAIN TEXT (MAX 15 PAGES)

2.1. BACKGROUND
2.1.1. Features of the Sector;
2.1.2. Results achieved in previous phases (if applicable)
2.1.3. Beneficiaries and parties involved
2.1.4. Problems to be addressed

2.2. INTERVENTION
2.2.1. Overall objective;
2.2.2. Project Purpose;
2.2.3. Results
2.2.4. Activities

2.3 ASSUMPTIONS
2.3.1. Assumptions at different level
2.3.2. Risks and flexibility

2.4 IMPLEMENTATION
2.4.1. Physical and non-physical means
2.4.2. Organization and Implementation Procedures
2.4.3. Time-table
2.4.4. Costs and financing Plan

2.4.5. FACTORS ENSURING SUSTAINABILITY
2.4.6. Appropriate technology
2.4.7. Environmental protection
2.4.8. Socio-cultural aspects
2.4.9. Institutional and management capacity
2.4.10. Economic and financial analysis

2.5. MONITORING AND EVALUATION
2.5.1. Monitoring indicators;
2.5.2. Reviews/Evaluation reports

3. LIST OF ANNEXES

Annex 1	Logical Framework
Annex 2	Detailed Budget
Annex 3	Implementation Timetable
Annex 4	Agreement letter with local Authorities
Annex 5	CVs of expatriate personnel;
Annex 6	Map of the area
Annex 7	Organization work in Somalia up to date

Appendix 2

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Appendix 3

People with whom discussions were held

In Nairobi

Mario Maritano	EC Technical Assistant Health Sector
Imanol Berakoetxea	Somalia Health Co-ordinator for International Organisations
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Giovanna Solari	Head of Office CISP Brussels
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Una MacAskill	Gedo Health Consortium
Leila Pakkala	UNICEF, Officer in Charge
??Henric Frazier	ECHO ???

In Somalia

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Ahmed Abdi Jama	Director General of Ministry of Health and Labour
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*Helena	Project manager, COOPI
Abdulah Sulieman	Medical doctor, Berbera regional hospital
Osman Ibrahim Haid	Director of Berbera Regional Hospital
Ahmed Omar Hirsi	Director of Berbera Mental Health Hospital
Mahmoud Sulieman	Regional Medical Officer, Berbera
Mohamoud Apokor	Accountant, Berbera Regional Hospital
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Ahmed Deaud	Director General of Ministry of Finance, Hargeisa
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Full team of UNICEF	
Edna Aden	Director of Edna Maternity Hospital, Hargeisa
Ali Jirde	Somali Red Crescent Society, Hargeisa
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Abdi Saherdid Askisi	Deputy Chairman, Civil Service Commission, Hargeisa
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Sakin Jirde Hussein	Member, Regional Health Board, Hargeisa
Amina Youssuf	Member, Regional Health Board, Hargeisa
Leyla Salin	Member, Regional Health Board, Hargeisa
Yassein Arab Abdi	Director, Hargeisa Hospital and Member of Regional Health Board, Hargeisa
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Asia Osman Ahmed	Officer in charge, WHO Hargeisa office
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Nur Hassan	National Primary Health Care Focal Point, WHO
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*Ivance	Polio eradication officer, WHO
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*Waqar Poutt	Medical officer for malaria control, WHO
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???? statistics officer	Bosasso General Hospital
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Abdul Hamid	Garowe Community Hospital, Administration
Muhamed Ali	Garowe Community Hospital, Personnel
Mohamed Abdi	Garowe Community Hospital, Information
Ahmed Warsame	Garowe Community Hospital, Administration
Mohamed Hasan	Garowe Community Hospital, Administration
Abdul Hamid	Garowe Community Hospital, Administrator
Hasan Shire	Director of Administration, Finance and Personnel, Ministry of Health Puntland
Ismail ???	Chairman, Garowe Somali Red Crescent
Abdi Risak Mohamed Jama	Director, Galkaio Hospital
Mohamed Jama Salad	President Puntland Medical Association, member of Hospital Management Team Galkaio, Director of private hospital
Bashir Ali Bihi	Surgeon, Hospital Management team, Galkaio, Surgeons Group Clinic
Axhed Bashir Halif	Internist, Hospital Management team, Galkaio
Abdisalon Hassan	Public Health Specialist, Hospital Management team, Galkaio
Ahmed Xaji	Hospital Adminsitrator, Galkaio
Ahmed Husen	Mudug Regional Medical Officer
Ahmed Jama Brie	Somali Red Crescent, member of Hospital Management team, Galkaio
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Susan Matthies	Bearing Point
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Strategic Framework	1.1 Activities	Area	Resources Required	1.1.1 Lead agency	Time schedule
1. To support the establishment of effective decentralized Health Governance Systems for implementation and management of a decentralized health care delivery system.	**1.1 To support the development of organizational and institutional structures** for delivery and management of health services, with clear functions and responsibilities per level. **1.2 To support the function of the "central health authorities" as policy body leading the process** and providing technical support and adequate management tools, for planning, management, supervision and coordination. **1.3 To support the decentralised approach towards increasing managerial capacities** at regional, district and community level. **1.4 To provide tools and guidelines for implementation of decentralised governance structures** (regional health authorities, district health management boards and Community health management boards) **1.5 To provide training to build the managerial capacity of the members of the decentralised governance structures.** **1.6 To monitor and evaluate the outcomes of the pilot interventions** so as to benefit from lessons learned and expand the model in suitable areas accordingly thus encouraging experience sharing between projects/zones. **1.7 To support the development of regulatory tools and procedures of the private sector** and ensure acceptable quality of services.				
2. To support the establishment and development of efficient management support systems: **(This strategy requires the implementation of the information systems and participation in surveillance activities in all health projects).**	**2. 1 Support and development of HIS:** ✍ Editing and provision of the standard registers to all public health facilities ✍ Maintain regular standard reporting, supervision and feedback in TB program. ✍ Establishment of data flow with clear responsibilities for timely data collection and processing at all levels ✍ Establish a common database (in Nbi, Hargeisa, Garowe) updated on a monthly basis and accessible to all partners. ✍ Support to analytical capacity (national and regional profiles, trends) by epidemiologist. ✍ Capacity building and supervision of local staff (central, regional and district level) ✍ Promote the use of information in decision making process at all levels of the decentralized health system. ✍ Regular feed back to all partners. ✍ Finalize the standard HIS Software ✍ Promotion of use of standard software package (& "cascade" training) **2..2 Outbreak surveillance:** ✍ Support establishment of weekly reporting at field level ✍ Support establishment of focal point for collection of data				

	✍ Support establishment of central data base (NBI, Hargeisa and Garowe) and basic analysis on regional profiles, trends, thresholds ✍ Technical support in field assessment of suspected outbreaks. ✍ Establish linkages with preparedness and response plans at national/regional/district level. ✍ Quick feed back and technical advice to all partners. **2..3 Nutritional surveillance:** ✍ Health projects to join the alert sites system ✍ Continue support to develop and expand sentinel alert sites (training and supervision) ✍ Continue with data collection at central level ✍ Support analysis of data with other information from food security system ✍ Regular and timely feed back to the field and to relevant stakeholders. ✍ Support with surveys in identified "sensitive"(at risk) areas using standard methodology. ✍ Use of information for decision making **2.4 Health management system** ✍ Simple database, linking services provided with targets (e.g. availability of resources, geographical accessibility, utilization of services, compliance and effective coverage, such as outlined in the Bamako initiative) ✍ Establishment of standard indicators (inputs, outputs, outcomes) ✍ Simple analytical package enabling to analyze indicators of performance of the service ✍ Drug and medical material management system (including monitoring of selected drugs) ✍ Capacity building of staff in decision making, based on use of management tools ✍ Supportive supervision (tools, training, implementation) **2..5 Geographic Information System (GIS):** ✍ Geographic information can be linked to the HIS and provide useful tools for planning and management (coverage analysis, regional epidemiological patterns…) ✍ Technical support to be provided by UNDOS GIS unit at Nairobi level. ✍ GIS capacity to be implemented in Somaliland and Puntland.				
3. To support the development of community involvement / partnerships in planning, management and financing of Health Service Delivery	3.1 To develop tools and guidelines for establishment of participatory structures in management **(e.g. community health boards), ensuring improved participatory planning processes, transparency and accountability on effective utilization of resources.** ✍ **Standardized guidelines on community involvement strategy** ✍ **Communication training package** ✍ Job descriptions ✍ Management tools **3.2 To provide staff (national and expatriate) with the appropriate skills** in communication for proper involvement and participation.				

	3.3. To develop community capacities (training) for increased partnership**, in the transparent and accountable co-management of health care services and activities.** 3. 4 To build the capacity of all stakeholders in participatory approaches and to develop joint partnership **(donors/ Int. agencies/** Government / community) in participatory planning, monitoring and evaluation of the projects. **3.5 To develop adequate and effective coordination amongst supporting organisations towards community involvement** ✍ To facilitate the development of mechanisms for collaboration at community level among agencies in the field (including those working in different sectors) ✍ To create a forum (central level) for discussion on community involvement and participation issues. ✍ Organize intersectoral meetings at central level on community participation.				
4. To increase the human resource capacity of the health sector, thus facilitating adequate service delivery of the Minimum Health Care Package.	**4.1 To increase numbers and range of trained and skilled health care providers in the health sector within the plan period.** Various options outlined were ✍ Complete interrupted training of professionals outside the country. ✍ Training of new professionals outside the country. ✍ Promoting return of Somali professionals from the Diaspora. ✍ Establishing new training centers in Somalia. **4.2 To increase through refresher training skills and competence of health providers for delivery of quality services.** ✍ Develop and implement continuing education modules (for all areas) ✍ Development of standards and guidelines for provision of services of the minimum package, and their adoption /utilisation. (all areas) ✍ Supportive supervision (all areas) ✍ Develop a Post basic education strategy **4.3 To improve health personnel management, deployment and distribution of health care providers for increased efficiency in health care delivery.** ✍ Establish an adequate registration and certification system.(mainly for recovery areas) ✍ Adequate standards/job descriptions (for all areas) ✍ Standardization of selection and recruitment procedures. (for areas of recovery and at least at regional level in other zones) ✍ Establishment of plan and procedures for deployment of existing human resources.(for recovery areas) ✍ Adequate provision of resources for the service delivery.(all areas) **4.4 To improve health workers terms and conditions of services, so as to increase their commitment and performance.**				

	✍ Standard contracts with clear conditions, responsibilities and obligations (recovery areas and in other areas at least at regional level). ✍ Standard salaries adequate to qualifications and location. (all areas) ✍ Establishment of professional associations.(recovery areas) ✍ Supportive regulations (e.g. laws requiring registered/certified staff to operate a private pharmacy or health service) (recovery areas) **4.5 To provide support to strengthen health project development and management.** ✍ To improve support to int. NGOs to provide orientation training to expatriates coming to work to Somalia. ✍ To prioritize the training and supervisory components and activities of the expatriates in the Somalia projects. ✍ To request training experience as a pre-condition for the recruitment of the expatriates for projects in support to Somalia				
5 & 6 To support the strengthening of the capacity of health care delivery systems to meet the health care needs and demands of Somalia and reduce disease burdens, by providing good quality Minimum Package of health Services (MPS).	**5. 1.To strengthen and standardise coordinated planning and management systems** ✍ Inventory and mapping of existing health facilities for all regions ✍ Endorsement and implementation of the MPS at regional level. ✍ Implementation of existing guidelines for the implementation of the Minimum package (MPS) ✍ Development of remaining standard guidelines and indicators for the provision of the MPS ✍ Costing of the MPS ✍ Implement HIS and link information to action by strengthening focal points. ✍ Use of GIS as a planning tool. ✍ Define catchment areas for each facility, with targets and mapping ✍ Set targets for facility and monitoring tools ✍ Set supportive supervision guidelines and tools ✍ Implement supportive supervision ✍ To develop a common Health Management System package. ✍ To establish an adequate referral system per region. **5.2 To support rationally planned rehabilitation and development of Curative Health Services to increase equity and access to the health care service delivery point** ✍ To use above mentioned planning tools (demographic and epidemiological) to identify priority areas for rehabilitation and development of health services ✍ To extend KAB research on utilisation of health services/facilities in remaining areas. ✍ To focus/prioritise the coverage of urban areas and large human settlements (as higher potential risk and more efficient utilisation of services as higher potential coverage) ✍ Research on cost-efficiency of mobile teams in extending accessibility and coverage. ✍ To research on possible strategies to serve nomadic populations and areas with low density of population ✍ To develop a combination of on-site and outreach activities tailored to the needs and operational conditions of each region. ✍ To consider realistic possibilities of referral for the most vulnerable population and consolidate links between all levels of health services CHWs, TBAS and health facilities. ✍ To improve logistics, maintenance and support **5.3 To provide support to increase capacity of health workers to provide quality services and manage**				

	health service efficiently. ✍ Refresher training in standard service delivery guidelines ✍ Capacity building in management ✍ Supportive supervision by adequately trained supervisors plays a crucial role. **5.4 To increase cooperation and complementarity between public and private health care sectors and provide support to establish regulatory and monitoring mechanisms to ensure quality of health care delivery in both private and public services.** Crucial for the recovery areas. **5.5 To support the development of effective preventive and promotive health care services** (within the service delivery units), to reduce childhood communicable diseases. **5.6 To support development of intersectoral nutritional strategies and support relevant activities at health service level** (nutritional surveillance, nutritional education, nutritional and micronutrients supplementation when required). **5.7 To provide support to establish effective maternal and reproductive health services** to reduce the high maternal morbidity and mortality. ✍ Improve access to adequate emergency obstetric services in hospitals and health centres. ✍ IEC program to aim at positive changes on specific targeted behaviours and practices **5.8 To provide support to establish effective Public Health programs for prevention and control of major communicable diseases** such as: Malaria, TB, Measles, Cholera, HIV/AIDS. ✍ Overall outbreak surveillance, preparedness and response need to be established (including field assessment capacity) for all areas. ✍ Control of Communicable diseases to be a strategic priority to be addressed by all health projects in Somalia.(all areas) ✍ Rapid reaction capacity needs to be established for areas not covered by existing health projects.(all areas) ✍ Concrete control programs to be established/expanded. (all areas where access is possible)see bellow **Priority Disease Control programmes** ✍ **TB control programme**: exist already and is supported (technically and supplies) by WHO. Main challenge remains extension of coverage maintaining quality in the program (DOTS). Implementation of TB programs should be a priority for all health facilities where conditions in the area are conducive for its implementation. (all recovery areas and transition areas when feasible). ✍ **Malaria:** RBM strategy needs to be adapted to Somalia and concrete options according to epidemiological (and governance) strata to be developed, implemented and monitored. Intersectoral coordination collaboration is required. Treatment protocols to be followed according to guidelines in all regions. ✍ **HIV/AIDS:** awareness in process, plan needs to be finalised and components implemented and monitored. Intersectoral coordination and collaboration is paramount. Pilot projects on Syndromic management of STDs are being planned (for the year 2000) ✍ **Cholera/Dysentery preparedness** plans need to be continued and adapted every year. Coverage of the plan remains a challenge. High needs for intersectoral coordination/collaboration. Need for mobile technical assessment and support for areas where international presence is weak or non-existent, remains a major				

	challenge. ✍ **Meningitis plans** (general plan already exists) to be updated regularly. ✍ **RVF/hemorragic virosis**: favourable/epidemic risk conditions to be assessed through satellite information system. Field component of vital importance. ✍ **Polio eradication:** adequate planning and coordination of the implementation, to enhance impact and synergies with other priority interventions. Process to be built on lessons learned. ✍ **EPI :** to support implementation of agreed strategy and to expand effective coverage, mainly focused on urban areas and large settlements. Surveys to be conducted so as to follow up progress. Effective strategy to address Measles remains to be developed. ✍ **Kala Azar :** the need for developing a control program has emerged in the year 2000 (in progress) **5.9 To provide support to establish community sensitisation programme for prevention of harmful traditional practices such as FGM.** Due to its special relevance as a health and human rights problem, FGM needs to be addressed through a multisectoral approach. Health services have to play an important role in promotion of FGM eradication. **5.10 To provide support for establishment of effective public health education in communities aiming at creating positive changes in behaviours, attitudes , and practices that condition the health of the population**.(see section) **5.12 To promote community participation and create sense of ownership of the health services.** (See section on community participation strategies). **5.13 To strengthen coordination partnership between donor, int. agencies, local authorities and communities.** ✍ Development, promotion and adherence to operational strategies and guidelines for Somalia. ✍ Reinforcement of field coordination structures and procedures ✍ To share experiences between projects, areas/zones.				
7. To support the supply, adequate management and rational use of good quality essential drugs and medical/laboratory supplies for the delivery of the Minimum Package of Services.	**7.1 To implement the essential drugs list in all facilities** (in all areas) **7.2 To implement training on the use of the essential drugs** (based on existing manual) **7.3 To distribute and field test the Essential drugs manual** (draft) **7.4 To edit and translate into Somali language the final version of the manual**. **7.5 To develop a simple drugs management system, procedures and tools** (including monitoring & analysis of drugs consumption, eg. Of selected life saving drugs) **7.6 To include drugs management and rational use in the supportive supervision** **7.7 To continue the support to health facilities with quality essential drugs according to the standard list** (all areas)				

	7.8 To continue support with quality drugs and laboratory supplies for disease control programs (TB, Leprosy, HIV) were appropriate **7.9. To conduct a feasibility study on the use of an efficient common drug procurement system for international agencies.**(countrywide) **7.10 To support local authorities in their effort to regulate drug management in the health sector** (in areas of recovery)				
8. To increase sustainability of health care system by supporting development and implementation of adequate health financing strategies.	**8.1 To support the development of effective coordination mechanisms** between donors, local authorities, and implementing agencies, to optimise financial resource utilisation. **8.2 To support development of appropriate local resource mobilisation efforts** ✍ Identify resources available in the area/region. ✍ Support the development of local plans and guidelines, based on recommendations of the 1997 SACB Health Care Financing study ✍ Support and follow up of implementation of Health Financing strategies in pilot projects **8.3 To analyse and determine the cost of the Minimum Package of health Services** **8.4 To support development of prioritisation of financial resources allocation to cater for the basic health care needs** (Minimum Package of Health Care) **8.5 To support development of mechanisms for cost effective use of available resources enhancing transparency and accountability.** ✍ Support the development of Health Management System (Financial guidelines & tools, Drug logistics and management…) ✍ Training in management of staff and community/boards ✍ Supportive supervision ✍ Introduction of well planned pilot exercises for implementation of the proposed strategies and guidelines (cost sharing, cost recovery…) ✍ Joint monitoring and evaluation of the pilot exercises (donors, authorities, implementing agencies, staff & community) ✍ Dissemination of lessons learned. ✍ Phased implementation of the strategy. **8.6 To support the dissemination of information on health needs of Somalia.** **8.7 To support the development of appropriate mechanisms to broaden the resource base**. ✍ Municipal taxes ✍ Allocation of % from taxes on Khat & tobacco (proposed by Somaliland) ✍ Remittances ✍ Health insurance schemes (pilot projects ?)				

	✍ Contributions from micro-enterprises projects (pilot projects) ✍ Food monetisation				
9.Support to the development of mechanisms ensuring regulation and enhancing partnership with the private sector, to improve complementarity and quality in the provision of health services.	**9.1 To focus the public sector on preventive, promotive and live saving services for most vulnerable people** **9.2 To establish pilot experiences of collaboration with the private sector for provision of essential curative and preventive care** (e.g. midwives, privatisation of elective surgery in hospitals) **9.3 To disseminate and promote use of agreed standards and guidelines** (including refresher training) also amongst private practitioners **9.4 To support local authorities in the development of rules and regulations for the private sector.** **9.5 To explore the possibility of a common procurement, storage and distribution system of quality and affordable essential drugs for the pubic and the private sector** (for recovery areas and within the above mentioned feasibility study) **9.6 To promote involvement of the private sector in public health interventions** (e.g. outbreak preparedness and response)				
10.To increase the effectiveness of the role of SACB Health Sector, in supporting coordination of health care service delivery and development in Somalia and supporting the improvement of intersectoral coordination.	**10.1 To develop a common strategic framework (this document) and a strategic plan.** **10.2 To promote through the SACB Health sector Committee the development and implementation of standards and guidelines outlined in the strategic framework.** **10.3 To develop SACB 's capacity to provide technical guidance to stakeholders.** **10.4 To develop SACB's capacity for mobilisation of resources (technical and financial) to support priorities identified by the strategic framework.** **10.5 To promote Somali participation at all levels.** **10.6 To strengthen the links between Nairobi and the field.** **10.7 To support the strengthening of field coordination.** **10.8 To provide technical support to local authorities in leading effective coordination in their areas of governance.** 1**0.9 To promote intersectoral coordination in priority areas** (Administrative, Community participation, HIV awareness, FGM eradication, Nutritional strategy, Outbreak preparedness, NIDS….)				

11. Promote countrywide, positive changes at household level in crucial attitudes, behaviours and practices related to health.	The overall IEC strategy focuses on: ✍ **Opportunistic approach by selecting areas for intervention with high mobilisation potential**: thematic (Cholera/diarrhoea, NIDS, HIV/AIDS) or geographical (where there are more partners involved/interested in IEC activities. ✍ **Maintaining sustained interventions on crucial areas** such as FGM eradication, breast feeding and EPI promotion. ✍ **Selection of main behaviours to be targeted for a specific problem**, through KAPB studies and through participation of IEC experts in thematic working groups. ✍ **Development of messages targeting positive changes on the identified behaviour** ✍ **Identification of the best channels & methods for dissemination of the messages** ✍ **Implementation of the IEC interventions** ✍ **Regular monitoring and evaluation of the interventions.** ✍ **Dissemination of lessons learned and practical tools among stakeholders** ✍ **Islamic teachings, if correctly interpreted, can promote urgently needed improvements in hygiene and the eradication of the traditional (but un-Islamic) practices of Female Genital Mutilation (FGM).** ✍ **To support promotion of behavioral changes through inclusion of main topics in formal education.**				

Appendix 5

1.1.1.1.1 Update to ANNEX III

SACB health strategic framework
November 2003

Update on existing and missing standards: tools, guidelines, and procedures:

Since May 1995 the SACB Health sector Coordination has developed through a democratic (consensus based) participatory process, the following tools/standards in order to guide the support from Int. Organisations to the health sector in Somalia:

Thematic area	1.1.1.2 Developed	In process	Pending/project to address it	Type of tool
EPI :	EPI strategy for the different areas in Somalia Guidelines for Polio NIDs EPI Strategy review 2001 EPI plan for 2002-2005 Gavi application 2002		Injection safety (GAVI)	Dev
Nutrition ;	**Nutritional information standards for reporting (growth monitoring),** Alert sites sentinel network (weekly reporting through FSAU),		Nutritional strategy framework (draft, not finalized) Anemia reduction strategy (and other micronutrients deficiencies)	Dev

	Methodology for conducting nutritional surveys.			
Essential drugs	Essential drugs list for PHC and Hospitals.	Essential drugs manual including basic protocols for treatment at PHC clinics level of the most common diseases (draft under review, ***needs field testing to be finalized and translated)***	***Simple monitoring tools for rational use of drugs not developed/adapted yet*** **Monitoring of management and rational use of drugs to be included in supportive supervision** **Support local authorities in regulating drug management in the health sector in areas of recovery** (the three areas could be addressed by capacity building project)	DEV
HIS	Standard formats for monthly reporting (Morbidity, EPI and Nutrition) Standard format for outbreak surveillance Standard case definitions Standard registers for MCH/OPDs and health Posts . Table with all existing health facilities/staff and population estimates per region/district.	***Functioning data flow (on going consultancy)*** HIS Software including data base, analysis and reporting Linkages from HIS software with GIS (Geographic Information System) Health facilities/population data to be updated	***Regional profiles with thresholds to allow comparison for monthly analysis remains to be established (to be addressed by consultant epidemiologist)*** ***Functioning central database (NBI, Somaliland, and Puntland)*** **1.1.2 Monthly analytical reports on outbreak surveillance to be implemented** ***Outbreak surveillance system to be re-established***	DEV
Hospitals	Definition of basic minimum package and life saving services.		***Standard reporting forms draft circulated for field testing (no feed back so far from partners to finalize it)***	DEV

	Standard basic indicators of performance for hospital services Essential drugs list (already mentioned in 3.3)		***Managerial tools package remains to be developed*** ***Standard procedures for surgery, anesthesia, diagnostic techniques (laboratory, xrays ,ultrasound)*** ***To be developed by consultancy on hospitals and capacity building projects*** ***Standardized salaries remains to be agreed upon.(internal process within the EC on going)***	
TB :	TB control strategy framework for Somalia All tools for management of the TB control program. Cross border coordination system on TB control (as part of WHO/HATCI program)	**Fixed combination to be introduced from 2004** (global fund proposal) (**guidelines to be reviewed in 2004).**	***Quality control of laboratories and supportive supervision to be enhanced, WHO global fund***	DEV
Malaria	1st and 2nd line treatment protocols (**to be reviewed 2004 outcome of resistance studies)** Severe malaria treatment protocol	***Contradiction between essential drugs manual and maternal health guidelines about the prophylaxis recommended in pregnant women has been resolved (to be harmonized in the final version of the manual)***	***Operational research on :*** ***Epidemiological strata (Merlin, epidemiologist ?) malariometric studies (global fund)*** ***ITNS intervention (modalities of***	DEV

		Resistance to chloroquine and SP (on going)	***distribution x maximum impact)*** ***Merlin int/global fund.*** ***Capacity building on case management, prophylaxis and ITNs interventions*** ***ALL THESE INTERVENTIONS ARE PART OF OBJECTIVE 1 OF THE APPROVED PROPOSAL TO THE GLOBAL FUND***	
Training	Job descriptions (in English and Somali languages) for main positions at PHC clinics and health Posts. Guidelines for provision of Maternal services in Somalia		***Guidelines for sterilisation of dressing materials to be developed.*** ***To be addressed by consultancy on hospitals*** ***National or zonal human resources strategy remains to be developed.*** ***To be addressed by Human resources development project*** ***Supportive Supervision tools & guidelines remain to be developed.*** ***To be addressed by Capacity building project***	DEV
IEC :	Identification of main priorities and behaviours to be targeted. IEC strategy for Cholera prevention IEC component for Polio Eradication. IEC component for EPI Communication strategy for	***IEC materials development (includes field testing, production , distribution and evaluation) UNICEF in process***		DEV

	HIV/AIDS (being finalized)			
Minimum package	Minimum package of Health services recommended for Somalia Life saving services that can be supported in areas under SACB ban (of rehabilitation activities).	Guidelines for delivery of services (protocols of treatment main diseases under review and maternal health guidelines re-endorsed)	***Integrated supportive Supervision guidelines*** ***Indicators for the services***	DEV
Health Care Financing	Identification of a strategy and basic guidelines Elaboration of a proposal for its implementation (not funded) Chart with basic NGO salaries for local staff (not standardised)		***Cost of the proposed minimum package remains to be established.*** *1.2 Financial management tools, remain to be developed* ***To be addressed by capacity building project***	
Health management system	***Nothing has been developed yet*** ***(***excepted the HIS components mentioned above		***To be addressed by capacity building project***	DEV
Community participation			***Guidelines and tools remain to be developed.*** To be addressed jointly with SACB governance sector w.g. and collaboration with capacity building project and leading NGOs (e.g. AAH, GHC, CISP	DEV
Cholera	Guidelines for preparedness have been developed and are adapted every year at Cholera Task Force workshops.	***Yearly update based on lessons learnt reported at annual workshop***		DEV & relief
RVF:	Guidelines for Surveillance have been developed by the SACB			DEV & relief

Kala Azar :	Manual with guidelines and procedures for KA control in Somalia produced (2001 and reviewed 2002 at SACB workshops)	***Annual reviews based on analysis on control program performance (by healthnet int. in a SACB workshop)*** ***Assessment on feasibility of regional control program (Kenya, Uganda, Sudan, Ethiopia, Somalia on going***		DEV & relief
Meningitis	Guidelines for preparedness have been developed by WHO. Report on lessons learnt on joint SACB vaccination campaign in Hargeisa , January 2002			DEV and Relief
Safe motherhood	**2 Guidelines for maternal services for MCHs**		HIS tools (registers, reporting format, indicators) **Capacity building of referral sites** **Cervical cancer prevention** **Training curriculum**	DEV
HIV/AIDS/STDs:	**HIV/AIDs control strategic framework (finalized June 2002)**	**3 HIV aids action plans for the three zones (being finalized)** **HIV/aids communication strategy (being finalized)** **Protocol for prevalence study and 2nd generation**	Pilot syndromic STD treatment sites in progress since March 02 needs to be evaluated **Joint proposal to the Global fund to be developed by SACB**	DEV

		surveillance (being finalized)		
FGM eradication:	**SACB statement finalized and endorsed**	**4**		DEV