ANALYSIS OF FACTORS AFFECTING PROVISION OF QUALITY HEALTH SERVICES BY THE GOVERNMENT TO THE POPULATION IN SOMALILAND

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DECLARATION

This management research project is my original work and has never been presented for a degree in any other University.

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DEDICATION

I dedicate this to my parents, Victor Louis and Phyllis Njeri Kamau, for raising me the best that they could, and giving me the most important things in my life, a Catholic Foundation, Unlimited Love and a good education. Thank you Almighty God, for the blessing of my wonderful parents, and their continued long life.

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ABSTRACT

Universal access to quality health care is an ideal goal for all nations. Governments often base their health care development plans on this principle. Indeed according to the World Health Organisation, better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more. As globalization spreads its effects on various aspects of human livelihood, global health is increasingly of international concern, especially with regard to disease prevention and control, and more so, promotion of good health worldwide.

This research was undertaken to establish what factors affect the provision of quality health services by the government of Somaliland to the population it serves. The little known region is located to the North-west of Somalia, and is a breakaway Republic operating under a de facto government since 1991. The study was undertaken as a cross-sectional survey of identified stakeholders supporting the health sector in Somaliland, including the Ministry of Health and Labour staff, the UN and International agencies directly providing financial and technical support to health care operations. In total, the sample size target was 40 respondents. The data collection effort was performed using a mixture of structured interviews and questionnaires distributed using the 'drop and pick' method. The survey instruments were pretested before being finalised, the analysis of the interviews was quantitative as well as qualitative.

The study found that the problems affecting quality of health services at Somaliland were; Unqualified staff, Lack of specialized professionals, Lack of enough funds, Health facilities being in poor condition, lack of enough health facilities, attendance of too many workshops/trainings by health staff, Inadequate supervision by managers, Staff preferring to refer patients to private services offered, Cost of services, Lack of drugs / supplies, Lack of equipment, Poor infrastructure / road network, Inadequate transportation services and Poor coordination of supporting agencies

The study recommends that in the government in Somaliland should train more professional staff, provide quality drugs, ensure better management of health facilities, build more health facilities, work closely with local NGO in provision of health facilities, overcome cultural and traditional barriers and increase security for those providing health services.

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ABBREVIATIONS

FGM:	Female Genital Mutilation
INGO:	International NGO
MCH:	Maternal and Child Health (Centre)l ·
MOHL:	Ministry of Health and Labour
NGO:	Non-Governmental Organisation
TB:	Tuberculosis
UN:	United Nations (Agency)
UNDP:	United Nations Development Agency
UNICEF:	United Nations Childrens' Fund
WHO:	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Universal access to quality health care is an ideal goal for all nations. Nations often base their health care development plans on this principle (Qayad, 2008). Indeed according to the World Health Organisation (2009), better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more. As globalization and its effects on various aspects of human livelihood, global health is increasingly of international concern, especially with regard to disease prevention and control, and more so, promotion of good health worldwide.

1.1.1 Quality Health Care Services

Tang, Eisenberg and Meyer (2004) argued that Government's responsibility to protect and advance the interests of society includes the delivery of high-quality health care. They went on to explain that because the market forces alone cannot ensure all citizens access to quality health care, the government must preserve the interests of its people by supplementing the market where there are gaps and regulating the market where there is inefficiency or unfairness. The ultimate goal of achieving high quality of care will require strong partnerships among federal, state, and local governments and the private sector. They then advise that "translating general principles regarding the appropriate role of government into specific actions within a rapidly changing, decentralized delivery system will require the combined efforts of the public and private sectors".

Many factors influence a country's ability to provide quality health services for its people (WHO, 2009). All around the world, governments hold the major responsibility for ensuring equitable access to such services for the populations they govern. While Ministries of health are important actors, so are supporting stakeholders including other government departments, donor organizations, civil society groups or Non-Governmental organisations and the communities themselves. For example, investments in roads can improve access to health services; inflation targets can constrain health spending; and civil service reform can create opportunities - or limits - to hiring more health workers.

Developing countries in particular face wide and varied challenges in providing health care services, especially in the resource constrained environments within which their governments operate. The demand for health services far outstrips the available resources and therefore continuous efforts must be made by various stakeholders, to periodically assess performance of the health system, so as to strive for continual-improvements in quality of health care services provided and increased access to the same by the population.

Leather, et al (2006) explained that "the health sector in a post-conflict country can be severely limited by three factors: 1) a total absence of central government funding for health; 2) a disintegrated system of health care; and 3) a void in teaching and training of all cadres of health workers dating back to the pre-conflict era". They went on to explain that "the effect of these issues in a developing country already struggling with the usual health challenges, including high maternal and child mortality, poor access to health services, and infectious diseases such as malaria, tuberculosis, and HIV, is even more devastating".

Somaliland is one such country.

1.1.2 Somaliland: Historical Background

Somaliland is situated on the North-West region of the Horn of Africa and shares borders with Republic of Djibouti to the west, Federal Republic of Ethiopia to the south and the rest of better known Somalia to the east (Map on page 44). Historically, Somaliland existed as a separate country when it was known as the Somaliland Protectorate under the British rule. She obtained her independence from Great Britain on June 26, 1960 and was recognized as an independent and sovereign state by many member states of the United Nations, including the five permanent members of the Security Council. Five days later on July 1st 1960, Somaliland voluntarily merged with the former Italian-administered United Nations Trust Territory of Somalia to form the Somali Republic.

The dream to unite all Somali people in the Horn of Africa under one sovereignty was thwarted by several events: the independence of Kenya in 1963; the loss of ethnic Somali people to Ethiopia in 1964 and 1977-78; and when French Somaliland became the Republic of Djibouti in 1977. Nine years of parliamentary civilian rule of the Somali Republic ended with the assassination of the president on Oct 21, 1969. The military dictator, General

Mohamed Siad Barre, took control and established a regime of so-called scientific socialism (Leather A, 2006).

The mainly Isaac tribe of the former northwest area of Somaliland suffered greatly under Siad Barre, and their struggle led to the formation of the Somali National Movement in London in 1981. The Isaacs clan live mainly in Somaliland and were targeted by the government of Somalia and the Siad Barre regime because they were fighting for the freedom of Somaliland. A major offensive by the movement against government positions in May, 1988, was followed by a 3-month government bombardment of the north of the region. Planes took off from Hargeisa airport to bomb the townspeople of the same city. These raids resulted in almost total destruction of the capital. Reportedly more than 500 000 people fled to Ethiopia and at least 50,000 died during these attacks. However in 1991, the Somali National Movement recaptured Hargeisa and the government troops fled south, leading to the re-declaration of independence of Somaliland on May 18, 1991. A slow and painful process of recovery was launched.

The government based in Hargeisa, the capital, and the people of Somaliland started to reconstruct the country, laid the foundations for reconciliation, peace and stability and the setting-up of modern good governance institutions in the country. Since the declaration of her independence in 1991, she has existed as a "de facto" independent country during which time, the government and the people have made extraordinary achievements in the areas of social, economic and political development. This self-declared state has of yet failed to obtain recognition by any foreign government or international governmental organisation. The government remains determined to continue lobbying for its sovereignty and proceed as an independent state (Svedjemo, 2002).

Somaliland has six regions with a population of 2 to 3.5 million people (population figures are not reliable as the last census was done in the unified republic in 1975). It has an elected functioning government and a parliament (comprising of clan leaders, elders and elected MPs from different political parties), a functioning administration, and is relatively peaceful and stable.

More than 60% of the Somaliland population is believed to be nomadic pastoralists residing in the rural part of the country (TOR, 2008). 10% agro-pastoralists and the remainder settled

in urban settlement areas. The climate is arid and the economy is highly dependent on livestock production and export to Saudi Arabia and Gulf countries. However, a while back a ban on livestock from Africa was instituted by the Saudi Government because of cases of Rift Valley Fever in East Africa, and the possible transmission through infected animals. Livestock production is the main economic activity in the region providing food, income and employment. Remittances from relatives abroad are also an important economic factor; moreover, the gradual return of the Somali Diaspora themselves is gradually making a difference to the economy.

Somalia (which includes Somaliland) remains one of the poorest and most deprived countries in the world (TOR, 2008). It ranks in the bottom three of the United Nation's Human Development Index, but even then remains one of the most neglected places in the world. The civil war of 1990 has resulted in the death of countless people including children, the displacement of whole populations (both as refugee and IDPs), collapse of all basic services, a high number of orphaned children, lack of peace and stability, destruction of livelihoods, among others.

1.1.3 Somaliland: Health Sector Profile

The Somaliland Health Sector Reform Policy, launched in 1998 has a vision to "attain the highest health status and social well-being of all Somalilanders". Its mission is to "Create an enabling environment for the provision of affordable, quality equitable access and sustainable health care in Somaliland" (MOHL, Somaliland). The Ministry of Heatlh and Labour oversees implementation of health programs which offer essential basic Preventive, Promotive, and Curative health care services for the population living across the six regions in the country i.e. Marodi-Jeex, Awdal, Sahil, Togdheer, Sool and Sanaag. There are different health facilities that deliver basic health services to the communities. There are three levels of public health care facilities in Somaliland, namely; health posts (HPs), Maternal and Child Health Centres (better known as MCHs) and hospitals. At last count these include 10 public hospitals (including the TB and Mental Hospitals), 79 MCHs and 162 HPs (MOHL Quarterly HMIS report, 2008).

Health posts are situated at village level and are staffed by community health workers. The MCHs form the second level and are located mainly at district level where qualified nurses and auxiliaries are assigned. The hospital is the referral point or the top tier in the health system. Besides the public sector, there's a vibrant private sector that runs parallel providing health care to the communities which include private clinics and traditional healers.

The major agency supporting MOHL in operationalising the health care service delivery system is UNICEF, which distributes medicines and medical supplies either directly to health facilities or through a network of partners. There are a host of implementing partners drawing funds from various sources including UNICEF, supporting MOHL by providing technical and financial support in running the various health programmes.

Most health care services are under cost sharing scheme, where the users pay for consultation, admission, drug costs and all other costs with regard to the health care services provided. The cost sharing system was introduced in 1993 for sustainability purposes, and it is widely believed that the initiative has negatively affected the accessibility of poor community to obtain health care services.

The quality of public healthcare services are generally poor and not appropriate or sensitive to the needs of women, adolescents and children and also fail to involve users in the design and development of services. Key issues in the health sector include a chronic shortage of qualified health professionals, poor governance, and few resources to finance the health service. This has led to a total lack of public confidence and hence utilisation of public health services. This has also led to increased use of a host of private sector services. It is estimated that in urban areas where all the MOH health facilities are concentrated, 90 percent (this is of those that have access, mostly urban groups – 15% of the population) of all curative care in Somaliland is currently being provided by the private sector. These include private pharmacists, private doctors (qualified and unqualified), clinics and consultation rooms, untrained traditional birth attendants, traditional healers and herbalists, traditional orthopaedists and spiritual healers. The private sector however, is unregulated which means that the quality of services is often dubious if not harmful.

Other characteristics of the health sector in Somaliland are as follows; Health services are inaccessible for the remote marginalized pastoral nomadic in the rural settings particularly to

the nomadic population that have <10% of health care services (TOR, 2008). These pastoral communities, who are mobile and travel in search for better pasture and water which makes it difficult for them to visit the health care centre. Additionally, the road infrastructure is generally poor and virtually non-existent in many areas. At times the road passages become muddy during rainy seasons which make them impassable, hence further complicating access to the health services for the population.

The health of the people of Somaliland is among the worst in Africa. This statement is supported by the fact that even before the civil war and the separation of the two Somali states, Somalia had one of the highest Maternal and Child Mortality rates in the world of 160 maternal deaths per 10,000 live births (UNICEF, The Progress of Nations, 1997). While recent valid data is not available, what national Maternal and Child Mortality rates have become after the destruction that has taken place in country is a frightening thought; One out of 8 babies dies before the age of 12 months, Every year nearly 4,000 Somali women die in childbirth, One out of 5 children dies before the age of five, Life expectancy is only 48 years (Edna hospital statistics, 2009). In terms of mortality, obstetric deaths are high and sick children and mothers are brought to the Hospital when there is severe complication and it is often too late to resolve health problems.

Finally because of the limited development or enforcement of appropriate health policies, as well as the lack of an up-to-date strategic plan (the last documented effort was in 2003), implementation of the various health programs suffers from many setbacks. Hence the outcomes are usually less than satisfactory both from the perspective of those providing resources, the administrators managing the health system, and for those reluctantly accessing the services as users.

1.2 Statement of the Problem

Governments, through ministries of health and other related ministries and agencies, play an important role in health development, through strengthening health systems and generation of human, financial and other resources (WHO EMRO, 2006). This allows health systems to achieve their goals of improving health, reducing health inequalities, securing equity in health care financing and responding to population needs. The role of governments in health development is well documented worldwide and is illustrated by the impressive growth of

health systems, initiated and supported by governments and pursued through partnership with the private sector, nongovernmental organizations and charitable institutions.

The mission statement of the health sector reform policy of the ministry of health and Labour is: "to attain the highest possible health status and social well-being of all Somalilanders", and its mission statement aims: "To create an enabling environment for the provision of affordable, quality, equitable access and sustainable health care in Somaliland" (MOHL, 1998)

Yet, health indicators for Somaliland are some of the worst in the world and are poor even in relation to other countries in sub-Saharan Africa. Key issues in the health sector include a chronic shortage of qualified health professionals, poor governance, and few resources to finance the health service (Leather, 2006). The inability of the government to pay adequate salaries for health workers greatly hampers the rebuilding of capacity in hospitals and health centres throughout the country.

Recently the country celebrated 18 years of self-declared independence. The country has received much assistance from United Nations (UN) agencies, International Non-Governmental Organisations (NGOs), Somali nationals in the Diaspora and local businesses supporting health initiatives. There are many and varied efforts that have been applied to improve the quality of health care, with much improvement in some areas, and struggling efforts bearing not much fruit in others. Nevertheless the MOHL in Somaliland continues to be committed to providing effective health services in Somaliland, even though there's heavy reliance on external assistance, especially from UNICEF, through whom most of the programs supporting health sector development are funded.

Meanwhile, major surveys regarding the status of the health system and inherent challenges faced by the government and MOHL have been carried out by several UN agencies, INGOs and other researchers over the years before and after the conflict era. Unfortunately, because of the persistent care not to 'recognise' the sovereignty of Somaliland (a highly sensitive matter), many of these have covered the entire Somalia Republic, though acknowledging that there are self-declared States therein. However, in the fasting changing situation of the regions over the years, many of the study findings presented may not be reflective of the current situation. Furthermore, literature (both published and grey) on Somaliland in particular is not easy to come by, despite the fact that the de facto State has been in existence

for the past 18 years. Research is generally limited for the country, and access to various studies is even more restricted.

Whereas it should be acknowledged that international recognition, and steady financing are not the 'silver bullet' (will not automatically solve the health system problems), a critical overview of the problems in the context of the government, and the country as a whole, prioritising, and better applying the current limited available resources to the most needy aspects of the health care system, may better prepare for this much anticipated eventuality.

Leather. et al (2006) studied the health sector in a post conflict era focusing on challenges of hospital care and highlighted international support in linking of teaching institutions in the UK with suitable ones in Somaliland. Mohamed (2003) undertook an extensive literature review of documented health studies and efforts over the years past, but focused on the extent to which children's health situation was addressed. Alkan and Ali (2001), documented findings of a medical mission undertaken to assess health facilities in the country. Varied other organisational efforts are documented as evaluations, pre-assessments or periodic project progress, with focus on their areas of implementation.

As expected, general problems of the health care system are well documented. but with a more or less 'inward' focus on challenges within the health sector, mostly within the context of MOHL responsibilities. However, for a wholesome picture of issues affecting provision of quality health care, external factors in the environment also need to be taken into account. There does not appear to be any studies documented thus far, that take a comprehensive review of the challenges facing the health system beyond looking health facilities and professionals serving in the sector, as well as the management constraints at the leadership level within.

This research is expected to make a unique contribution in looking at the health system in Somaliland as a whole, and the role of government in its entirety, in facilitating its efficient functioning. The findings will make a useful addition to the limited literature available on Somaliland, on the challenges the government faces in provision of quality health care.
The aim of this study is therefore to determine the factors affecting provision of quality health services by the government to the population in Somaliland.

1.3 Research Objectives

The objectives of this study were therefore to:

a. Find out the factors affecting provision of quality health services by the government to the population in Somaliland
b. Draw recommendations on how the government of Somaliland can improve the quality of the health services provided to the population.

1.4 Importance of the Study

The study is useful for the various stakeholders committed to supporting the continued development of health services in Somaliland especially the Government of Somaliland and more specifically, the MOHL charged with overall responsibility of coordinating the provision of health services in the country. Donor agencies providing much needed financial and technical assistance directly or through implementing agencies may be able to appreciate why some it may be necessary financing different strategies or new interventions.

International NGOs implementing various development programs supporting the delivery of health care services may recognise the value of viewing health care delivery challenges in the context of the entire environment. Health professionals and Scholars in general who have an interest in supporting the improvement in quality of health care provision of services in the country will be able to be updated on the current status of the health system. The study should also be of interest to the general public and other nationals in the Diaspora who are current and potential providers of resources, as well as users of the health services.

Finally, the academic community in neighbouring Kenya may want to compare the challenges faced by health systems in neighbouring countries within the region, both in the post-conflict context as well as in a similarly developing country context.

CHAPTER TWO: LITERATURE REVIEW

2.1 Environment Analysis

To assess the performance of an institution, team or system, there are various well researched models that can be appropriately applied, depending on the targeted view. One such model is the PESTLE Framework of Analysis (Gillespie, 1992), which elaborated means looking at Political Economic, Social, Technical, Legal and Ecological / Environmental factors affecting or influencing the operations of the organisation. The targeted view in this case would be the factors external to the operating environment of the firm under review. The acronym is also written in other forms such as PEST, PESTEL, STEPLE, etc depending on the preference of the scholar or academic institution. Each of the PESTEL factors are outlined in brief below.

The political aspect generally refers to the degree of political stability in a country, its preferred trading partners and the influence of the government in general. Political decisions can impact on many vital areas for business such as the education of the workforce, the health of the nation and the quality of the infrastructure of the economy such as the transportation system. Economic analysis focuses on the degree of market vibrancy, together with the availability and cost of labour and resources. It also focuses on the national income, unemployment, Stock Market, efficiency of financial markets and the general stability of the exchange rate and economy in general. Other factors include interest and inflation rates, whether the economy is developed or developing, and the current stage of the business cycle and the rate of economic growth.

The key social factors tend to be the demographics and culture of the population. For example, whether the country has a high population, growing rapidly, the proportion of working class people, or whether in contrast, it has a lower population which is not growing as strongly, or whether it has an ageing population, etc.. Social characteristics also include education levels, religious practices, attitudes to work, income distribution leisure interests and attitudes to factors such as health and the environment.

The technological side tends to be concerned with the level of technological development applied in the various fields of medicine, health care delivery, research, etc., and how they impacts on the general level and quality of health care services and the population's attitude

towards technology. This can also be driven by the current rate of technological development, innovation, new product development, rate of technological obsolescence and technological diffusion. Finally, the impact of technology on the cost and distribution of supplies needs to be considered.

Ecological, or environmental, tend to be more concerned with the natural world, global warming, environmental issues and how the health services may be affected by such factors. With major climate changes occurring due to global warming and with greater environmental awareness this external factor is becoming a significant issue for governments to consider, especially because of their impact on emergence of new health problems. For example, companies must be aware of any endangered species or habitats in locations where they plan to construct facilities. Even if the social factors of the country where they are operating do not support maintaining the environment, governments can still see a backlash from community if they do not consider ecological factors in their health care provision strategies.

Legal factors are often connected to political factors, particularly if the analysis is abbreviated to PEST. However, in many economies the legal factors are influenced by regulators and bodies which are separate from the government of the time. They include the legal basis for policy enforcement; any trade or product regulations; the existence of labour laws; drug and supply sourcing and distribution policies; and health and safety regulations. A PESTEL Analysis can be particularly useful when performance assessment has become to inward-looking. This is to ensure that cognisance is taken of the fact that power and effect of external pressures influencing performance of internal side of systems. As such, we can apply PESTEL to any health system to draw out the factors affecting its performance.

2.2 Health Systems

While the World Health Organization (2000) defines a health system as "all the activities whose primary purpose is to promote, restore, or maintain health," the World Bank (2007) defines health systems more broadly to include factors interrelated to health, such as poverty, education, infrastructure and the broader social and political environment. Indeed, no matter how well resourced the health system is to provide quality health services, other factors external to the operating environment, play a key role in determining the success of enabling access to health care providers by the communities in need.

According to the Global Health Council (2009), the term "health system" encompasses the personnel, institutions, commodities, information, financing and governance strategies that support the delivery of prevention and treatment services. It comprises all organizations, institutions and resources devoted to producing actions whose primary intent is to improve health. Most national health systems include public, private, traditional and informal sectors. The main objectives of a health system are to respond to people's needs and expectations by providing services in a fair and equitable manner. Health systems research identifies challenges in providing care and delivering interventions at all levels of health systems and provides innovative solutions to improve the delivery of care.

Developing countries face many challenges in building robust, reliable health systems (GHC, 2009). Both public and private sectors have a role to play in addressing the complex and unique challenges faced in developing and maintaining effective health systems. These challenges include insufficient financing, lack of inter-agency coordination, poorly-functioning information systems, health worker shortages and supply interruptions.

2.3 Health System Strengthening

Health systems strengthening aims to improve health by responding to people's needs and expectations, and by providing services in a fair and equitable manner (GHC, 2009). Interventions include improving leadership and governance, ensuring a steady supply of medical products and creating more effective and efficient delivery systems.

Health system reforms are a common process that all countries are faced with; no matter how advanced the stage of development is, because there is always room for improvement. In the last World Health Report (2008), WHO Director General, Dr. Margaret Chan, outlines the various reforms that should be applied which are universal coverage, service delivery, public policy and leadership reforms. She goes on to emphasise that the need for reforms cuts across all contexts (advanced countries and others), but that "such reforms where applied, must be driven by specific conditions and contexts, drawing on the best available evidence". She concludes by encouraging that "there are no reasons why any country – rich or poor – should wait to begin moving forward with these reforms. As the last three decades have demonstrated, substantial progress is possible. With continued support from the various agencies supporting the country in different sectors, and the government's commitment, such reforms are indeed realisable in Somaliland.

2.4 Role of Government

It is generally acknowledged that for all the abundant resources available in a country as large as the USA, the health care system is one of the most inequitable, yet one of the most expensively managed in the world! This is a true demonstration that resources are not enough to make a system work. However, the quality and standards of the said health system are without question, exemplary for other nations to admire.

Tang, Eisenberg and Meyer (2004), provided the following framework for the role of government in improving health care: A framework is provided for understanding the 10 roles that government plays in improving health care quality and safety in the United States. Examples of proposed federal actions to reduce medical errors and enhance patient safety are provided to illustrate the 10 roles: (1) purchase health care, (2) provide health care, (3) ensure access to quality care for vulnerable populations, (4) regulate health care markets, (5) support acquisition of new knowledge, (6) develop and evaluate health technologies and practices, (7) monitor health care quality, (8) inform health care decision makers, (9) develop the health care workforce, and (10) convene stakeholders from across the health care system. Government's responsibility therefore, is to protect and advance the interests of society includes the delivery of high-quality health care. Because the market alone cannot ensure all Americans access to quality health care, the government must preserve the interests of its citizens by supplementing the market where there are gaps and regulating the market where there is inefficiency or unfairness. The ultimate goal of achieving high quality of care will require strong partnerships among federal, state, and local governments and the private sector. Translating general principles regarding the appropriate role of government into specific actions within a rapidly changing, decentralized delivery system will require the combined efforts of the public and private sectors

Consequently, for many developing countries, achieving efficiency in a government to the extent of having the ability to fulfil all the roles outlined by Tang et al, appear to be a distant dream. And with the advent of globalisation, many of these countries are faced with the double burden of disease to cope with – preventable diseases such as diarrhoea, measles, etc. as well as the modern diseases of development such as cancer, hypertension, diabetes, etc. all afflicting the population and causing high strain on the poorly functioning health care systems.

Somaliland suffers much the same disease burden amongst their relatively small population spread over a vast land, yet this is the population on which the government is dependent to participate in nation building. In looking at key health indicators that have a significant impact on general well being and survival of the population: Neonatal mortality rate, Infant mortality rate and Child mortality rates are defined as the proportions of children died under one month, under one year and under five years of age respectively, in every 1000 live births. Maternal mortality is defined as the proportion of women of child bearing age (15-49 years) dying as a result of child birth or pregnancy related complications, out of every 100,000.

Child mortality rate in Somaliland is among the highest in the world, it is documented that child mortality rate (CMR) is Around 328/1000 live births, IMR (infant mortality rate) is 113/1000 and NMR (Neonatal mortality rate) is 28/1000 (WHO office for Somalia, 1999). Over one quarter of all under-five deaths occur in the first week of life due to complication of Pregnancy and delivery (Unicef Somalia, 1999). The very high maternal mortality rate in the country which is estimated to be around 1600/100000, also contribute to the sufferings of the new-borns in addition to yearly 110000 Pregnancies with complications, Illnesses or permanent disability for the mother and/or the child (Noreen Prendiville, 1999). This is a grave situation for a country where no ongoing civil war and when there is no acute epidemic. The development efforts in progress need healthy able people to engage, so as to build a better future for the country.

2.5 Factors Affecting Provision of Health Services

Political Factors

While achieving worldwide recognition as a Sovereign State will not automatically solve all current problems facing Somaliland, the fact that they are operating as a de facto state probably presents one of the most significant challenges for the government and for the country as a whole. As such, they cannot have bi-lateral agreements with any country, and therefore usually receive financial support channelled through the UN and INGOs. As an unrecognised sovereign state, Somaliland also continues to be branded together with the rest of the Somalia, especially by the UN agencies, which is rather frustrating for Somalilanders in general.

Somaliland has been destroyed in the prolonged civil conflict and the fight against a brutal dictatorship (Abdillahi, 1997). The utter destruction of the economy, the infrastructure and all institutions, both civil and governmental, has created an extraordinarily difficult and chaotic situation in which to start the recovery process. The brutalities of the civil conflict, and the violence and lawlessness it unleashed, resulted in tremendous social, economic and cultural upheavals. Core traditional values were eroded, and society was left anchorless and at the mercy of young gun toting, traumatized clan militia. At the same time, the pervasive clan politicking, which operated in a political vacuum, resulted in a chronic instability that still affects the region.

This impossible situation was exacerbated in the early years by two things. First, there was a lack of institutional framework support and an absence of tradition or access to experience and lessons learned about locally based, vibrant NGOs in other parts of the world. Second, there was critical infrastructure problems related to a lack of public telephones, banks, postal services and other communication facilities, and a lack, or poor conditions, of roads in most of the rural areas.

However, over the past five years, tremendous development has taken place. There are numerous NGOs, both local and international providing technical support in implementing programs across all the sectors of the economy. On the business scene, there are many successfully operating private companies providing various services e.g. land and mobile phone (three major operators), internet, banking (Dahabshil is international money transfer

establishment with over 200 branches across the world), hotels (two 3-star operating), restaurants, car hire services, security (by UNDP) and many others.

The country is relatively stable, recent bombing attacks on the presidential palace, UNDP and the Ethiopian Embassy on October 29th, 2008 with casualties resulted in being downgraded by the UN from a Level 3 to Level 4 security level operation. This means that the environment is now one of high alert high level security, and international staff are required to be on guard at all times, hire security escort when travelling outside the capital city, and restrict movement at night. This therefore gives the impression that foreign investment is not viable yet there is a vibrant market that could present viable economic opportunity. Additionally, the cost of maintaining this level of security significantly increases the cost of operations for supporting agencies, thereby limited the amount of funds that can actually be disbursed directly to improving quality of health care services.

The political situation therefore limits the extent of support that the MOHL and government can attract from health focused donors around the world.

Economic factors

As mentioned earlier, a post-conflict country is constrained by a lack of centralised government for funding. While the centralised government does exist in Somaliland, 90% funding is sourced from donors and 10% from other sources. Policies in existence and enforced to facilitate revenue collection through taxation do not generate enough to meet the vast demands of all sectors. 60% of the population is nomadic and relies on livestock for their livelihood, while the rest is urbanised in the more or less arid towns around the country. Poverty levels are high and hence basic hygiene practices as well as proper nutrition is also not up to standard, which places a huge burden on the health care system.

Cost-sharing in health care, whereby the users pay a small fee for services is also said to be further impoverishing the already constrained poor population, who have limited resources and choices for health care. There exists a Somaliland currency (Somaliland Shillings) which is not recognised and is therefore regulated internally. Just like in some other countries, the exchange rate is regulated by the Central Bank of Somaliland. The only available and acceptable foreign currency that can be exchanged is the US Dollar (at present 1 USD =

6,500 Slsh). Gross National Product (GNP) and other data are not available. A recent report on the southern region reveals that people are poor, and they depend on livestock.

Approximately 50-75% of the income of the poor is spent on basic food and non-food items, including: sugar, wheat flour, oil and meat. Calorie and protein intake are not always adequate. Other expenses include: soap, 8 pieces per month, (approximately $30/year), clothes $35-45/year, schooling, kerosene, approximately $35/year. Veterinary and human drugs are selectively purchased depending on income available at the time and the situation, but may range from $70-90/year. Tractor hire (8-15 hours at $4-6 per hour), $30-90 per year.

There's also be some expenditure on khat, which is an intoxicating leaf, chewed by majority of the population (especially adult men) as a social habit, and whose effects on health are explained later in this section.

Duration of government working hours (and health services provision)

According to Kitts and Roberts (1996), the hours when health clinics are open may not be sensitive to the gender division of labour and the timing of women's work. As a result of the daytime responsibilities of women – such as fetching water, feeding animals, collecting the firewood, and attending to casual jobs – it might be easier for women to visit clinics in the evening instead of in the daytime when modern health services are usually open. Women's work patterns should therefore be considered when setting clinic hours.

With increasing poverty, internally displaced families and unemployment, a majority of women from poor households have entered the workforce in urban centres (UNICEF, 2002). Indeed in Somaliland, the opening hours for public health facilities, from 8 am to 12 pm is not only too short in duration, but doesn't take into account how the competing social commitments that women, the major users of health care, may be a barrier to timely access to the services.

Poor coordination of agencies supporting health sector

Somalia offers a unique, extremely difficult and challenging environment for programming to any international organisation wanting to work beyond emergency response (UNICEF, 2002). However, to complement to the emerging regional government structures, is the large presence of local and international NGOs throughout Somalia, with organisations in Somaliland tending to be more development oriented then in the other zones. There is both coordination and competition between these organisations as well as competition between agencies and local authorities in for resources and institutional space. The capacity, competency and commitment of organisations varies within the NGO sector. A large proportion are donor driven, and many organisations are essentially programme contractors and creations of international aid availability. In many cases, the NGO sector has provided the only institutional vehicle for delivery of social services in the absence of government systems. However, the multiplicity of organisations has resulted in a multiplicity of developmental methodologies and approaches, based on the varying mandates and motivations of the organisations.

It is therefore the responsibility of government of Somaliland and in their best interests to coordinate activities of all stakeholders supporting the health care system, so as to avoid duplication and ensure efficient investment of the limited resources. At times the lack of coordination is deliberate so as to gain from multiplicity of activities implemented, or payment of incentives (form of top-up salary to identified MOHL staff) by unsuspecting INGOs whose staff rarely consult one another on such matters when embarking on project implementation. Though there is a coordination body for INGOs operating in all of Somalia, it is based in Nairobi and has little involvement of any of the government authorities.

Meanwhile, the lack of disclosure by national staff is at times on purpose especially when it comes to receipt of incentives, allowances, office support etc by MOHL staff at all levels (so as not to highlight duplicate payments for same roles by different organisations). For a country in dire need of financial and technical support, it is regrettable that most goes to waste in this manner. As it were, implementing programs in Somaliland is highly expensive due to the security requirements, restrictive environment, general cost of living and cost of hiring qualified foreign staff (who need high remuneration to be motivated to stay long enough in the challenging environment to commit to implement required project activities!).

Financial constraints

The government is in the paradoxical position of having had to go its own way given the lack of international recognition, but its poverty and lack of resources means that it is in fact very dependent on the outside – both in terms of economic support and how the outside community views events in (wider) Somalia. Creative engagement on sensitively overcoming such dependence between those living in Somaliland including the government and those outside (diaspora or friends) will remain key for many years (Kibble, 2006). The government is dependent on donors / aid and hence is highly constrained in planning for and disbursing resources with any level of efficiency or effectiveness. Financial institutions are lacking, and while there are many money transfer companies which operate highly efficiently, access to finances services such as loans for investment are not available on the market. The remittances from Somalis in the Diaspora make a huge difference in terms of money circulation, as well as investments in housing by those living abroad does help the situation. Visitors and NGOs want to contribute, and the easy way is to contribute a piece of equipment, or a month supply of an expensive medication. This is definitely not the way to go. Sharing knowledge, teaching skills, upgrading health care professionals is an investment which will last for much longer, and will improve the well being of the population.

As to be expected, given the current situation and the Somali socio-cultural context, it is unlikely that the provision of social services through a centralised, modern, welfare state system is a model that will be relevant or applicable for some time to come (UNICEF, 2002). The only vibrant form of welfare is continued remittance of funds by Somalis in the Diaspora, which has created a high form of dependency by much of the population. The competition for resources in a devastated country, greatly dependent on donor aid is a real challenge for economic development, as much as it is for improvement of quality of health services.

Poor Infrastructure

Devastation of war and its effects on infrastructure cannot be underscored. Poor road network and limited access to water makes health services virtually inaccessible. Delivery of supplies

and retention of qualified competent staff is also made more difficult by poor infrastructure. People should be able to receive reliable care close to where they live (Kitts and Roberts, 1996). However, health facilities are often poorly distributed, and health personnel and financial resources tend to be concentrated in urban hospitals (World Bank 1993; Atai-Okei 1994). Rural areas, where the vast majority of women in the developing world live, are less likely to have adequate health services.

Kitts and Roberts also explain that "difficulties in reaching health facilities, as a result of distances, lack of transportation, or poor roads, are well-documented impediments to care" (World Bank 1993; Atai-Okei 1994; Kaendi 1994; Iqbal 1995; Ren et al. 1995). In a study on malaria and visceral leishmaniasis that took place in Baringo, Kenya, during 1992¬93, Kaendi (1994) found that distance was the major determining factor in the use of health care. Gender differences were reported, and 62% of the women (compared with 48% of the men) indicated that distance influenced their health-seeking behaviour. Malaria can be a serious problem where there is no health-care facility -- "many ... have died of illness before getting to hospital" (Anyangwe et al. 1994, p. 78). This directly impacts on maternal health care and contributes directly to the high maternal mortality, as many of child birth complications suffer the same consequence.

Human Resource Factors

The World Health Report (2006) titled, "Working together for health", contained an expert assessment of the current crisis in the global health workforce and ambitious proposals to tackle it over the next ten years, starting then. The report revealed an estimated shortage of almost 4.3 million doctors, midwives, nurses and support workers worldwide. As to be expected, the shortage was said to be "most severe in the poorest countries, especially in sub-Saharan Africa, where health workers are most needed". The report went on to explain; at the heart of each and every health system, the workforce is central to advancing health. There is ample evidence that worker numbers and quality are positively associated with immunization coverage, outreach of primary care, and infant, child and maternal survival. The quality of doctors and the density of their distribution have been shown to correlate with positive outcomes in cardiovascular diseases. Conversely, child malnutrition has worsened with staff cutbacks during health sector reform. Cutting-edge quality improvements of health care are

best initiated by workers themselves because they are in the unique position of identifying opportunities for innovation. In health systems, workers function as gatekeepers and navigators for the effective, or wasteful, application of all other resources such as drugs, vaccines and supplies (WHO World Health Report, 2006).

In Somaliland the situation is quite grim. While official statistics on the number of professionals serving the health sector are difficult to come by, it is safe to say that the health system is grossly understaffed. Apart from the losses suffered by those who died or migrated out during the civil war, the lack of training institutions has presented challenges in supplying qualified personnel to the market. Specialists are even harder to come by, many of them going abroad to seek greener pastures. Additionally, refresher courses for those who remained to provide their services have also been few and far between. Fortunately in recent times thanks to collaborative support to local institutions by various medical universities and colleges, there are now at least three teaching hospitals producing about 30 medical doctors a year combined. These are Amoud University in Boroma, Hargeisa Group Hospital (highest referral unit of the MOHL) and Edna Hospital (a private community supported facility located in Hargeisa and recognised for its high standards of Maternal Health care). There's also a recently launched Nursing Training Institute in the city with enrolled students in the process of training. This, though still inadequate, is a significant improvement on the situation. However, the fresh graduates also require well qualified professionals operating in a conducive environment to be able to properly mentor their skills to required standards, an issue that will need to be addressed with supporting partners sooner rather than later, so as to ensure quality of care is improved.

Shortage of workers is a result of many factors related, but more so to low literacy levels (further explained below) and few training schools. Additionally due to poor remuneration, inconsistent supplies and lack of supportive supervision, even those in service are not well motivated and hence do not appear to be very committed in their efforts at providing quality health care. This lack of motivation is generally seen at all levels of the health system, and it greatly contributes to the poor performance of the health system. Furthermore, the few qualified well performing staff also tends to run parallel services at private level, and naturally pay more attention to providing services that will result in more personal financial gain.

Another human resource factor that constraints quality of health care is the fact that the few health workers providing services are the same ones targeted by all supporting agencies and MOHL for trainings, capacity building, refresher courses, etc. All these activities often result in time spent away from the health facilities to travel and attend meetings or trainings. Additionally, supplementary health activities like outreach or campaigns are expected to be implemented by the same health staff. This greatly affects the "real" time spent by the health workers in providing services at the health facilities. Uncoordinated activities also contribute greatly to this because the same staff can receive the same training many times over, the major motivation being the hefty allowances earned from agencies organising these trainings.

Literacy Levels

According to the CIA World Facts website (2009), literacy levels in Somalia are very low. The site defines literacy as 'a person of age 15 and over who can read and write'. The statistics provided are that only 37.8% of the population (of entire Somalia including Somaliland) is literate, further estimating this to be 49.7% of the male population and 25.8% of the female population (2001 estimate).

Literacy levels therefore affect the available population who can be trained, and capacity built to provide quality health care. One limitation that isn't much documented is the challenge of English as the medium of instruction, and documentation. It is purported that English is used as the teaching language starting from secondary school, and then used in all higher level education institutions. However what is of grave concern is that most health professionals, especially the nurses cannot communicate using the language, let alone write. Consequently, the fact that all drugs, supplies and their related guidelines and manuals are usually in English or Arabic (depending on supplier or source) lends concern as to the extent to which diagnosis is correctly made, and prescriptions correctly given.

Literacy also applies to the extent to which the community understands their right to quality health care, and the fact that they should be involved in decision making in such matters as related to services provided to them. The community may not feel empowered to demand better services e.g. if attitude of health worker is hindering quality of care by opening facility late or being rude.

Socio-Cultural factors

Everyone, regardless of religion, ethnicity, or background, brings culturally defined beliefs and practices to the experience of illness that shape their encounters with the health care system and their responses to clinical care (Picker Issue 21, 2000). Invariably, this applies to how clinical care is provided as well.

The Khat Habit

The use of khat has a long-standing history within the Somali culture in particular. Before the civil war, khat chewing was a traditional social activity in Somalia and would bring people together for relaxation and to stimulate conversation. Khat use would normally be restricted to particular times of the day and session length. Some people also chewed khat in order to remain alert for studying or work reasons(Patel et al, 2005). Attitudes towards khat use vary but it is generally perceived as a legitimate activity, by substantial proportions of the communities who use it and not censured in the way that those communities censure alcohol and illicit drug use.

There have, however, been some concerns about the effects of khat. Research on a Somali population in London in the 1990s, reported health effects of khat use including sleeping difficulties, paranoia and mood swings. Other research indicates that frequent khat use can have physical health implications, such as oral infections or problems with digestion. There is also concern that people who do not wash khat before consuming it will ingest pesticides.

The present widespread use (and often abuse) of khat is directly related to the trials and traumas of the country's recent history. It has had a devastating effect on the economy, the health and well being of citizens, and on the chances of the country's recovery. Khat also affects the resources and performance of many of the staff because it is expensive, time consuming and causes insomnia, a dangerous combination that adversely affects efficiency and effectiveness. It is therefore a double-edged sword for the health care system because on the one hand it is the cause of various health problems amongst users, and on the other, it affects the performance of health staff who use it on a regular basis.

Further to this, the countrywide use by the population also enhances economic disempowerment as much of disposable income is utilised to finance the habit, and as a result enriches the supplier countries, i.e. Ethiopia and Kenya. Informal reports indicate that out of the entire region of the former Somali Union, its use and abuse is most widespread in Somaliland, which is therefore worst hit by the negative effects.

Clanism and recruitment

Somalis are a relatively homogeneous ethnic group from a cultural linguistic point of view, stretching across at least four countries in the Horn of Africa: Somalia, Ethiopia, Kenya, and Djibouti (EQUIP1, 2005). Their main internal social differentiation is on the basis of clans and sub-clans, but even within the clan system, most clans and sub-clans are transnational. In this system, lacking a hierarchical chain of authority or anything resembling the state or a judiciary, social relationships are defined in terms of kinship based on descent from a common ancestor. In Somali society, as in most pastoral societies, kinship is traced through patrilineal descent. The genealogies, which traditionally both Somali boys and girls have to learn by heart as part of their initiation to adulthood, define an individual's place in society as well as political relations.

A rather sensitive challenge brought about by the strong clan system is in the recruitment or appointment practices of Somalilanders. If a job opportunity arises, either in a government office or an NGO, the appointment is made based on whoever is in charge, and it will apply to a preferred clan member in need of the job, regardless of whether qualifications meet the requirements of not. Furthermore, if this appointed person is unable to carry out their duties, or leaves for greener pastures (similarly identified), the position now belongs to the 'clan' and it is therefore the responsibility of the person departing to find a replacement. As to be expected, in the health facilities, health workers are appointed in a similar fashion, at times over populating the service, yet with highly unqualified personnel. This has led to continued deterioration of quality of health services, resulting in a total lack of confidence by communities and supporting agencies alike. This is not a practice that can easily be eliminated as it is applied across all sectors of the economy. The consequences are dire, at the very least, and life threatening at the worst. Tales are told of services provided in some HPs

where staff are appointed and supported by community. Because of incompetence complicated by illiteracy, the diagnosis and dispensing of drugs is done by identifying the location of complaint on the body, and matched with colour of drugs in possession. E.g. for any aches and pains from the stomach upwards, give the blue drugs, and for the rest of the body, give the white one. This may sound like a laughing matter but where it concerns the very survival of communities dependent on such services as their only option, the consequences are pitiful!

Poor monitoring systems

Population of the country varies, depending on who's counting. Last census was done in 1975 when country was unified. Since then, and the breakout of the war, there hasn't been any successful census. Statistics were affected by death and out-migration of 1.5 million refugees. According to the government of Somaliland, there are 3.5 million people, while amongst UNDP, WHO, UNICEF and others, the figure varies between 1.5 and 2 million people (figures not officially published to avoid conflict). This makes planning for any countrywide operations rather difficult and establishing progress or extent of coverage of services virtually guess work. Supporting agencies and government are therefore challenged in determining where to prioritise efforts when it comes to system strengthening efforts, since the success of interventions is not consistent across stakeholders. It is argued that the ministry inflates the figures to draw more resources, yet they don't realise that the donors will use population estimates they consider more accurate, which results in the inflated cost of operations. This further discourages the funding partners from committing to long term support because of the normal uncertainty of future resource availability, especially within the global financial crunch context.

Technological Factors

The technological side tends to be concerned with the level of technological development applied in the various fields of medicine, health care delivery, research, etc., and how they impacts on the general level and quality of health care services and the population's attitude towards technology. In Somaliland, while state of the art technology has been applied in the

communications industry though mobile telephony sector, the advancement hasn't been matched in the health sector. While efforts have been made by many agencies, well wishers in the Diaspora and local business men to donate and purchase equipment for hospitals, their functionality is challenged by obsolescence as well as lack of required skills to manage and maintain equipment. Meanwhile research is virtually non-existent as the educational institutions are still developing slowly, and lack the requisite skills or funds to undertake relevant medical studies whose findings could be applied locally.

Legal Factors

In general, the legal framework remains weak in all aspects of government operations. There's no proper national system, and it operates under a mixture of English common law, Islamic Sharia, and Somali customary law. It is therefore very challenging to seek legal redress in health matters, especially with regard to malpractices that usually occur in all manners of ways, and at various levels of the health system. A story is told of a child who was prepared for immunisation by applying a pressure band tightly around the arm of the child, so as to easily locate the blood vein for injection. Due to negligence or incompetence or other unknown reasons, the band was forgotten on the child. Poor ignorant mother had to cope with the unhappy child who suffered the discomfort until it was too late; when the result was that the arm had to be amputated to safe the child's life. It is not clear if the mother ever took up the matter with the authorities, or if any compensation was received in any form.

Other factors

While it may appear that most factors negatively affect the ability of the government to provide quality health services, the situation is not entirely grave. There is promising progress towards institutional development as ministries are being established and networks of regional, district, and local authorities are being designed (UNICEF, 2002). As such, there's gradual rise in the number of INGOs and international staff migrating to Somaliland from the increasingly hostile southern region of Somalia, and settling down to support government efforts in the country. Additionally, over the past two years, the population of has increased dramatically due to the large number of returnees arriving in Somaliland from the camps in

Ethiopia (EQUIP1, 2005). National and international efforts to urge the return of Somalis from all over the world to their homeland are also bearing fruit; many of those returning from wider Diaspora are professionally exposed and making contributions in many sectors, including health care to improve systems.

Slowly but gradually there's increasing exposure and acknowledgement of the country as an island of peace, and increased efforts to realise international recognition as a state is also encouraging financial support from Somalis in the Diaspora. Finally, increased commitment by the government to make a concerted effort to manage the systems better is also encouraging more financial and technical support from donors.

2.6 Conceptual Framework

In summary, the conceptual framework for factors affecting provision of quality health care services by the government is illustrated in Figure 2.1:

Figure 2.1: Conceptual Framework of factors affecting government's provision of quality health care services

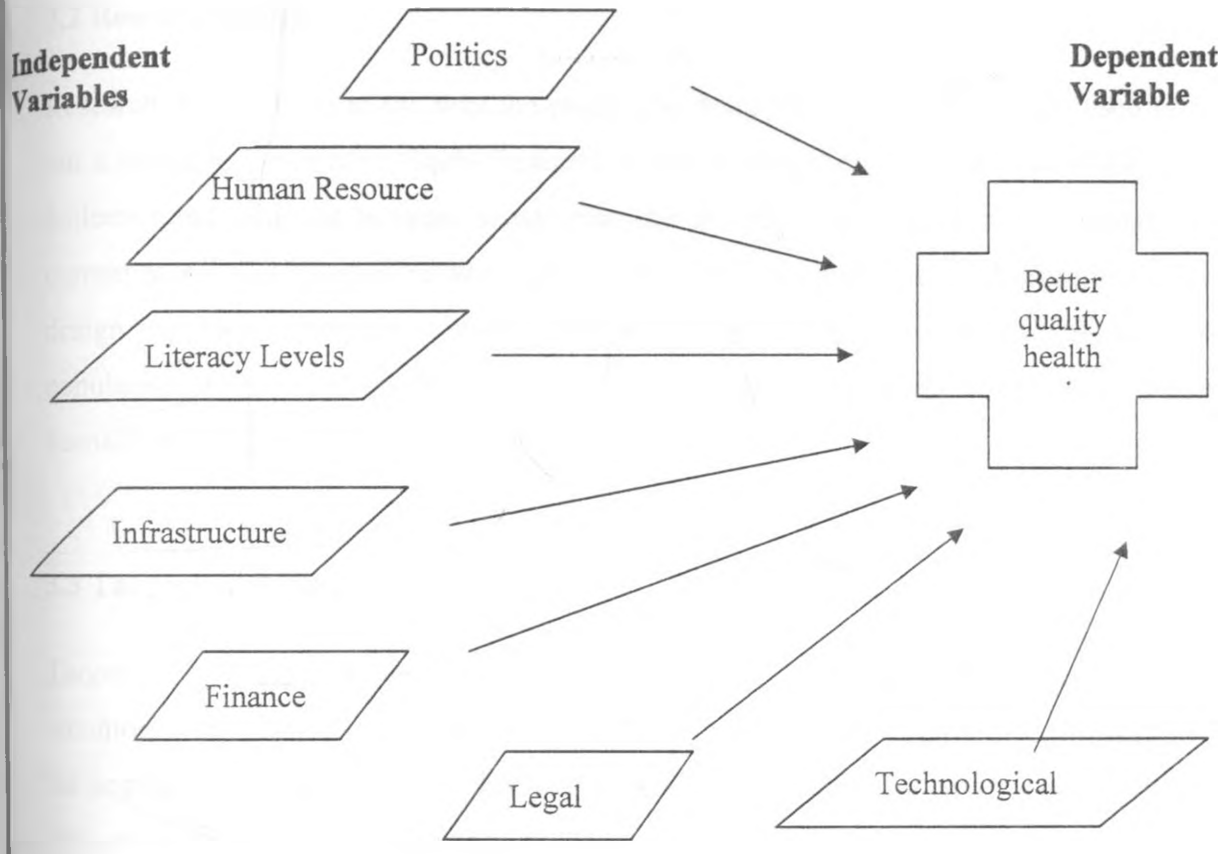


Figure 2.1 illustrates the different independent variables, or factors, that if addressed in the context of how they are affecting quality of health care, this could bring about significant improvements for the country's health system which would greatly benefit the steadily increasing population of Somaliland.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research design and methodology that was used to carry out the research. It presents the research design, the population, sample size and sampling procedure, data collection and analysis.

3.2 Research design

Research design refers to the way the study was designed, that is, the method used to carry out a research. Descriptive Study Research is the investigation in which quantitative data is collected and analysed in order to describe the specific phenomenon in its current trends, current events and linkages between different factors at the current time. Descriptive research design was chosen because it enabled the researcher to generalise the findings to a larger population. This study was therefore able to generalise the findings of the health sector in Somaliland.

3.3 Target Population

Target population can be defined as a complete set of individuals, cases/objects with some common observable characteristics of a particular nature distinct from other population. It is the population to which a researcher will generalize the result of a study. The population of this study was the high ranking MOHL officials, UN agencies (focusing on health), International NGOs (also financed by UN and focusing on health sector support), Government hospitals located in the capital city and MCHs (Maternal and Child Health centres) located within the region where the capital is located.

3.4 Sampling Design

Due to travel restrictions for international staff to the rural areas, the study was confined to Hargeisa. The study targeted all six MOHL directors, two hospitals in town, the 12 Urban MCHs, five UN agencies and all international NGOs currently in operation implementing

health activities, which are few in number (about 15), The sample size targeted was 40 respondents in total.

The chosen samples were expected to be representative of the severely under-developed region, given that Somalia was declared as one of the Least Developed Countries in the world (UN).

3.5 Data collection

The Researcher developed instruments which helped collect the necessary information. A questionnaire was used to obtain important information about the population. The semi-structured questionnaire consisted of closed-ended questions and also a few open ended ones. These questions were accompanied by a list of possible alternatives from which respondents was required to select the answer that best describes their situation. The main advantage of close ended questions is that they are easier to analyse since they are in an immediate usable form. They are also easy to administer because each item is followed by an alternative answers and is economical to use in time saving terms.

The researcher used the 'drop and pick' method of distributing the questionnaires. Each questionnaire was delivered to the selected organisations and institutions with a request directed to those identified, or in charge to fill out the form. The questionnaires were later collected for review and use in data entry.

The study collected both primary and secondary data. Primary data was the information the researcher collected from the field using semi-structured questionnaires. Secondary data was obtained from various project progress and evaluation reports.

3.6 Data analysis

The researcher used both qualitative and quantitative techniques in analyzing the data. After receiving questionnaires from the respondents, the responses was edited, classified, coded and tabulated to analyze quantitative data. Tables and charts were used for further representation of findings.

CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter presents analysis and findings of the research. From the study population target of 40 respondents, 33 respondents completed the questionnaire, constituting 82.5% response rate.

4.2 Respondent Profile

On the respondents' age, the study found that this ranged between 25 to 51 years. On the occupation of respondents, the study found a varying occupations such as Capacity building Officer, Social workers, Project managers, Health Management Information Systems (HMIS) experts, national MOHL directors, health program advisors, health planners, medical advisors, doctors and nurses. The researcher also sought to find out the length of time in years that the respondents had been in their Somaliland. From the findings, the length of time ranged from one to 15 years. The study also sought to find out where the respondents were based. From the study, the international respondents were from various countries in Africa and Europe.

The study also sought to know the organization which the respondents were working for. From the findings of the study it was revealed that the respondents were working for various organizations such as Progressio, CCM-ITALY, UNICEF, TPO, Nation link, various MCHs and MOHL among others. On the role of the respondent in the organisation, the study found that the respondents had various roles such as Capacity Building, Monitoring and evaluation advisors, clinicians, technical advisors, communication experts, health care providers and HMIS zonal coordinators among others. On the sector supported by the organisation, the study found that these included health care management, Health, Education, Water and Sanitation, Child protection, human rights, community development and environment among others. On the major activities supported by the organization were; Technical Support to civil society organisations working in the field of Human Rights, capacity building, advocacy, social mobilisation, providing preventive and promotive health care services, environment and Health Systems strengthening. The key sector supported by the organisations was health and human rights.

4.3 Main Issues

Table 4.1: Overall view of the health care system in Somaliland

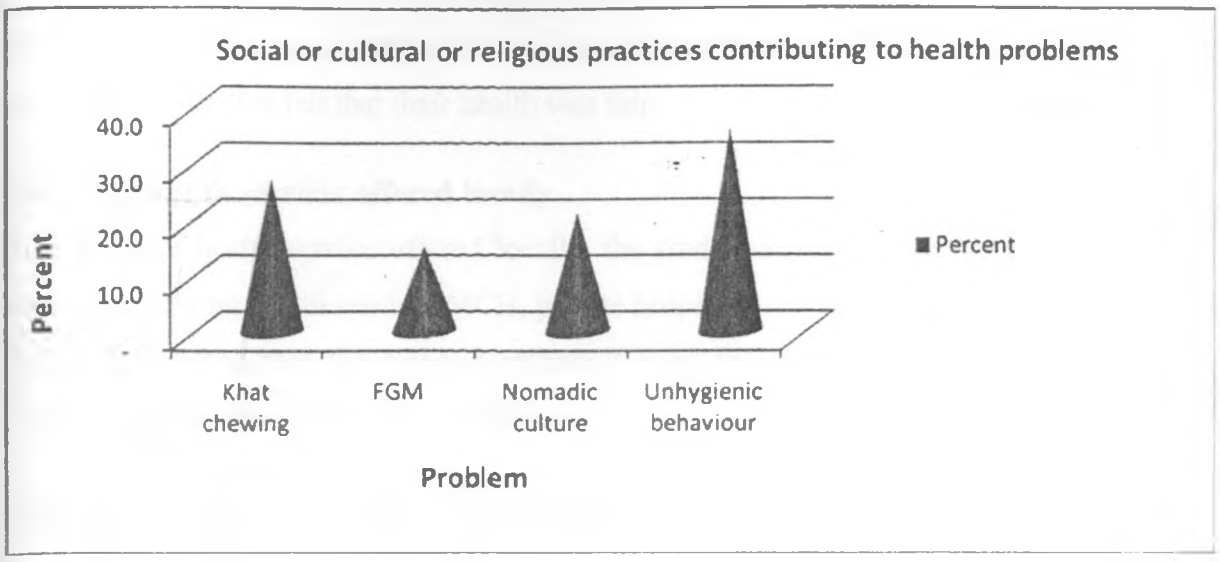
	Frequency	Percent
There are some good things in our health care system, but fundamental changes are needed to make it work better.	23	69.7
Our health care system has so much wrong with it that we need to completely rebuild it	7	21.3
Virtually non-functional	3	9.0
Total	**33**	**100.0**

Source, Author (2009)

On the respondents expressing the overall view of the health care system in Somaliland, from the analysis of findings in Table 4.1, majority of the respondents (70%) felt that there were some good things in their health care system, but fundamental changes are needed to make it work better, 21% of the respondent were of the opinion that their health care system has so much wrong with it that we need to completely rebuild it, while 7% were of the opinion that the health system was Virtually non-functional.

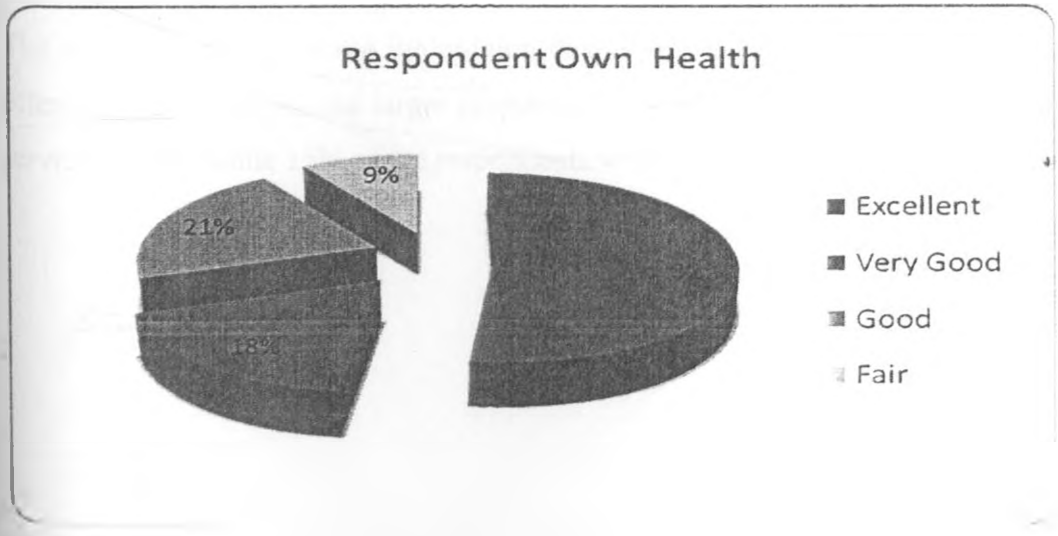
The study also sought to know the problems that may be affecting quality of health services provided by the government to the population in Somaliland. The study established that the problems affecting quality of health services in Somaliland were; Unqualified staff, Lack of specialised professionals, Lack of enough funds, Health facilities being in poor condition, lack of enough health facilities, Too much workshops/trainings, Inadequate supervision by managers, Staff preferring to refer patients to private services offered, Cost of service, Lack of drugs / supplies, Lack of equipment, Poor infrastructure / road network, Inadequate transportation services and Poor coordination of supporting agencies.

Figure 4.2: Social or Cultural practices contributing to health problems



On the social, cultural or religious practices that may be contributing to health problems amongst the community, the study established that these were; Khat chewing, Nomadic culture, Unhygienic behaviour and FGM. As shown in Figure 4.2, 36% said that unhygienic behaviour contributed, 27% said that the khat chewing practice contributed, 21% said that the nomadic culture kind of life contributed as they had to monitor and give information and also the areas they moved to hardly have enough resources like clean water while 15% said that the FGM practice contributed to the health problems.

Figure 4.3: Respondent own health



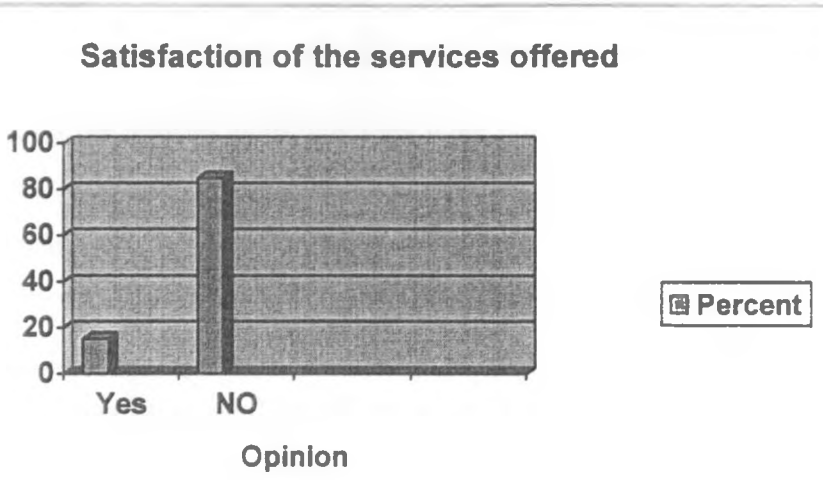
Source, Author (2009)

On how the respondents would describe his own health, from majority of the respondents (52%) were of the opinion that their health was excellent as shown 21% of the respondent felt that their health was good, 18% of the respondent felt that their health was very good, while 9% of the respondent felt that their health was fair.

Use of the health services offered locally

On the use of health service offered locally, the study established that the respondents had used the following health service; MCH, private hospitals, private clinic and pharmacy, it was further established that the respondent hadn't used the following health services; public hospital, health post and traditional healers.

Figure 4.4: Satisfaction of the services offered



Source, Author (2009)

The study sought to find out the opinion of the respondent on satisfaction with the services offered. From figure 4.4 the larger proportion of respondent (86%) weren't satisfied with the service offered, while 15% of the respondents were satisfied with the services offered.

Those who weren't satisfied with the services cited various reasons including;

Table 4.2: Reasons for dissatisfaction with health services

	Frequency	Mean
Staff being too busy	6	0.9
Wrong drug prescription	2	0.3
Drugs not available	10	1.5
Lack of technology	6	0.9
Lack of service (no lab)	12	1.8
Wrong diagnosis	11	1.7
Staff unwilling to serve	4	0.6
Non-qualified staff	8	1.2
Drugs too expensive	5	0.8
Lack of equipment	11	1.7
Facility closed	9	1.4

Table 4.2 shows the reasons as to why they were not satisfied with the services being offered; these included lack of laboratory services with a mean of 1.8 and lack of equipment and wrong diagnosis were the major reasons with a mean of 1.7, lack of drugs with a mean of 1.5, facility closure with a mean of 1.4 and non qualified staff with a mean of 1.2 were the reasons that followed. Lack of technology and staff being too busy reasons had a mean of 0.9 while drugs being too expensive, staff unwilling to serve, and wrong drug prescription were reasons that were cited with a mean of 0.8, 0.6 and 0.3 respectively.

On who should be the provider of health services in the country, majority of the respondent felt that the provider of health service in the country should are the government, pharmacies and local NGO.

Table 4.3: Factors important in the functioning of health system

Factors	No effects at all	Low importance	Neutral	Very important	Highly important	Mean
Road Network	0	0	1	2	30	4.9
Opening hours of health facilities	0	0	3	26	4	3.8
Opening hours of government offices	0	0	0	4	29	4.8
Clean running water for all	0	0	1	1	31	3.9
Electricity	0	1	1	7	24	4.6
Recognition as a sovereign State	3	13	14	2	1	2.5
Increase allocation of funds through improved tax collection	0	1	3	4	25	4.6
Better pay for health workers	0	0	0	2	31	4.9
Better structures for health facilities	0	0	3	1	29	4.8
More foreign health professionals	0	0	6	23	4	3.9
More female health workers	0	5	19	6	3	3.2
More research into local health problems	0	5	17	6	5	3.3
Better training for health professionals	0	0	1	2	30	4.8
Better management of	0	1	3	27	2	3.9

Factors	No effects at all	Low importance	Neutral	Very important	Highly important	Mean
health services by leaders						
Involvement of community in health services management	0	4	6	20	3	3.6
Better recruitment procedures	0	1	1	5	26	4.6
Functioning regulatory bodies	0	0	15	16	2	4.5
Better quality drugs	0	0	0	1	32	4.9
Completely free-of-charge health services	0	0	1	1	31	4.9
Better health education in schools	0	1	2	7	23	4.5
Better monitoring systems (use of information for management)	0	0	30	2	1	3.1
Increase number of health workers / professionals	0	0	1	1	31	4.9
Better coordination of International supporting agency operations	0	0	24	6	3	3.4
Less Khat chewing by health professionals	0	2	6	24	1	3.7

Source, Author (2009)

The findings in table 4.3 show a detailed analysis of ratings of responses related to the importance of various factors in functioning of health system. From the findings, the factors rated very important to a functioning of health system by the majority of the respondents

were; road network, better pay for health workers, better quality drugs and completely free-of-charge health services as shown by a mean of 4.9 in each case, Opening hours of government offices, better structures for health facilities and better training for health professionals as shown by a mean score of 4.8 in each case, better recruitment procedures, increase allocation of funds through improved tax collection and electricity as shown by a mean score of 4.6, functioning regulatory bodies and Better health education in schools as shown by a mean score of 4.5 in each case.

Also, the factors that were rated important to a functioning of health system by majority of the respondents were; More foreign health professionals, Clean running water for all and Better management of health services by leaders as shown by a mean of 3.9, Opening hours of health facilities as shown by a mean of 3.8, less Khat chewing by health professionals as shown by a mean of 3.7 and involvement of community in health services management as shown by a mean score of 3.6. Further, majority of the respondent rated the following factors neutral as affecting the functioning of health system, these factors includes, Better coordination of International supporting agency as shown by a mean score of 3.4, more research into local health problems as shown by a mean of 3.3, more female health workers as shown by a mean of 3.2, better monitoring systems (use of information for management) as shown by a mean of 3.1 and recognition as a sovereign State as shown by a mean of 2.5.
On the respondent's general comment or recommendation that would greatly improve the quality of health care services by the government in Somaliland, majority of the respondent felt that, training of more professional staff, provision of quality drugs, better management of health facilities, building of more health facilities, working closely with local NGO in provision of health facilities, trying to overcome cultural and traditional barriers and increasing security for those providing health service.

CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

From the analysis and data collected, the following discussions, conclusions and recommendations were made. The discussions and conclusions are based findings from the study, as they relate to the objectives of the study. The researcher had intended to obtain views on the factors affecting provision of quality health services by the government to the population in Somaliland and to draw recommendations on how the government of Somaliland can improve the quality of the health services provided to the population.

5.2 Discussions

On the respondent profiles, the study found that the respondent's age ranged between 25 tears to 51 years. On the occupation of respondents there were varying occupation such as project manager, Assistant project Manager, chief accountants, managers, medical advisors, medical doctors and nurses. Further on the length of time in years the respondents had been in their Somaliland ranged from one year to 15 years. From the study, the respondents come from various countries in Africa mostly the East African countries.

The respondents were working for various organizations such as Progressio, CCM-ITALY and others and their roles were Capacity Building, Monitoring and evaluation, finance management and HMIS zonal coordinators among others. On the sector supported by the organisation, the study found that the sector supported by the organisation were, health management information systems, public relation, governance, environment and health among others. The researcher also sought to find out the length of time in years the respondents had worked with their organization the length of time ranged from one year to 15 years. The key sectors supported by the organisations were education, environment, health, human rights and governance this is done through technical support to civil society organisations working in the field of Human Rights, environment and Health Management Information Systems.

The problems affecting quality of health services at Somaliland were; unqualified staff, lack of specialized professionals, lack of enough funds, health facilities being in poor condition, lack of enough health facilities, too much workshops/trainings, inadequate supervision by managers, staff preferring to refer patients to private services offered, cost of service, lack of

drugs or supplies, lack of equipment, poor infrastructure or road network, inadequate transportation services and poor coordination of supporting agencies.

The social, cultural or religious practices that may be contributing to health problems amongst the community were; khat chewing, nomadic culture, unhygienic behaviour and FGM. The overall view of the health care system in Somaliland 70% of the respondent felt that there were some good things in their health care system, but fundamental changes are needed to make it work better, 21% were of the opinion that their health care system has so much wrong with it that we need to completely rebuild it, while 7% felt that the health system was Virtually non-functional. This shows that majority of the respondent felt that fundamental changes are needed to make it work better

On the respondent's health 52% were of the opinion that their health was excellent, 21% felt that their health was good, 18% were of the opinion that their health was very good, while 9% felt that their health was fair. Although the provider of health service in the country was the government, pharmacies and local NGO; the study established that the respondent visited private hospitals, private clinic and pharmacy but health services were also being offered by the public hospital, health post, traditional healers and MCH.

Majority of the respondents said that they were satisfied by the health services offered but various problems such as staff being too busy, wrong drug prescription, drugs not available, lack of technology, lack of service (no lab), wrong diagnosis, staff unwilling to serve, non-qualified staff, drugs too expensive, lack of equipment and closure of health facilities were faced.

From the study, the factors that were rated very important to the functioning of health system by the majority of the respondents were; road network, better pay for health workers, better quality drugs and completely free-of-charge health services as shown by a mean of 4.9, opening hours of government offices, better structures for health facilities and better training for health professionals as shown by a mean score of 4.8. Better recruitment procedures, increase allocation of funds through improved tax collection and provision of electricity were important as shown by a mean score of 4.6 while functioning regulatory bodies and better health education in schools as shown by a mean score of 4.5 were other essential factors necessary for a functioning hospital.

From the finding of the study it was established that, the factors that were rated important to a functioning of health system by majority of the respondents were; more foreign health professionals, clean running water for all and better management of health services by leaders shown by a mean of 3.9, opening hours of health facilities with a mean of 3.8, less Khat chewing by health professionals as shown by a mean of 3.7 and involvement of community in health services management with a mean of 3.6. Further, it was established that the respondent rated, better coordination of International supporting agency as shown mean 3.4, more research into local health problems (3.3), more female health workers (3.2), better monitoring systems i.e. use of information for management (3.1) and recognition as a sovereign State (2.5).

5.3 Conclusions

From the study, the researcher concluded that the problems affecting quality of health services at Somaliland were; unqualified staff, lack of specialised professionals, lack of enough funds, health facilities being in poor condition, lack of enough health facilities, too much workshops/trainings, inadequate supervision by managers, staff preferring to refer patients to private services offered, cost of service, lack of drugs and supplies, lack of equipment, poor infrastructure or road network, inadequate transportation services and poor coordination of supporting agencies and social, cultural or religious practices that contribute to health problems amongst the community were; khat chewing by the population, nomadic culture, unhygienic behaviour and FGM.

The study further concludes that the factors that would greatly improve the quality health care by the government to the population in Somaliland includes: the better road network, better pay for health workers, better quality drugs, completely free-of-charge health services, opening hours of government offices, better structures for health facilities, better training for health professionals, better recruitment procedures, increase allocation of funds through improved tax collection, availability of electricity, functioning regulatory bodies and better health education in schools were very important to a functioning of health system. The researcher further concludes that more foreign health professionals, clean running water for all, better management of health services by leaders, opening hours of health facilities, less

Khat chewing by health professionals and involvement of community in health services management were important to a functioning of health system.

5.4 Recommendations

From the findings and conclusions, the study recommends that in order to address the problems facing health sector in Somaliland the Government should train more professional staff, provide quality drugs, ensure better management of health facilities, build more health facilities, work closely with local NGO in provision of health facilities, overcome cultural and traditional barriers and increase security for those providing health services.

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Annex A: Maps of Somaliland

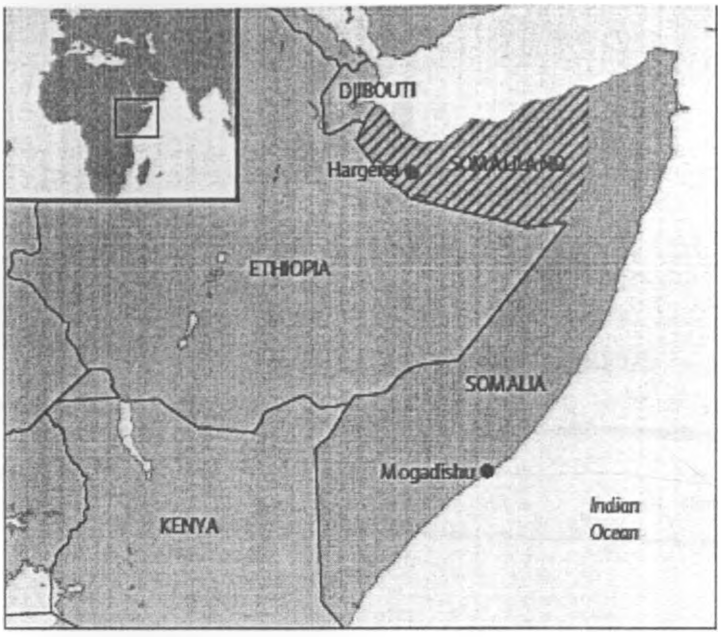
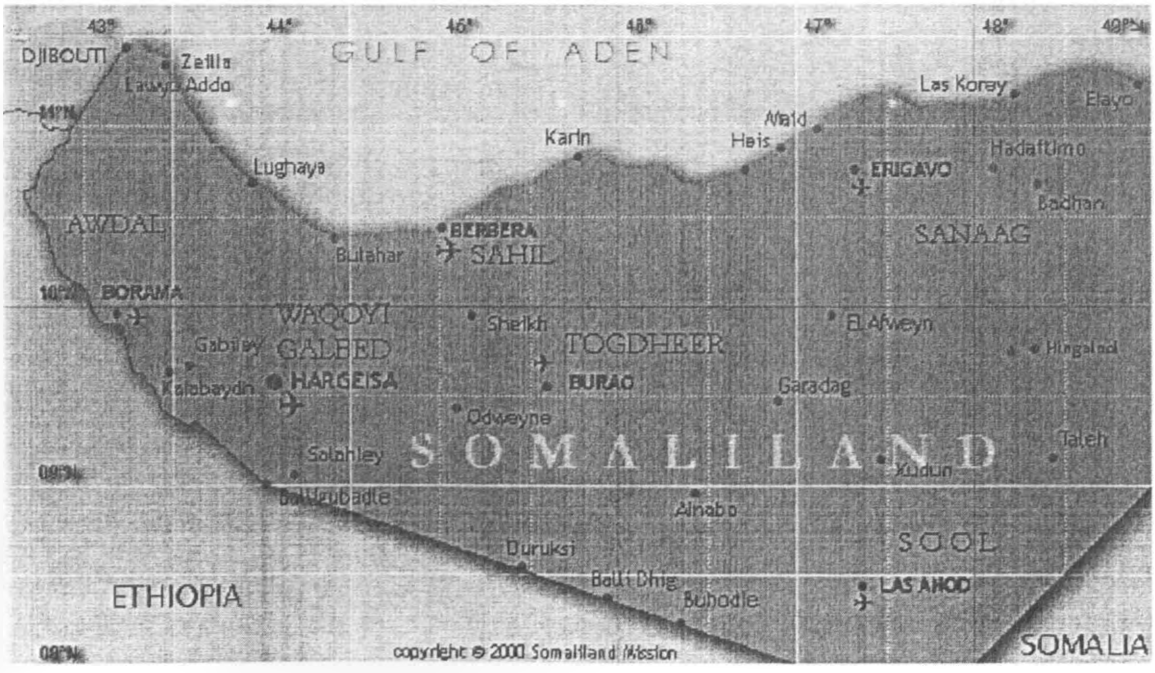


Figure 1: Somaliland
The Somali people can be found within Somalia and Somaliland, and in Ethiopia, Djibouti, and Kenya. There is also a worldwide Diaspora of about 750 000.

Somaliland is in the Horn of Africa

Detailed Map of Administrative Regions



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DATE 11 - 10 - 2009

TO WHOM IT MAY CONCERN

The bearer of this letter MARIA N. KAMAU

Registration No: D61/P/5032/2004

is a Master of Business Administration (MBA) student of the University of Nairobi.

He/she is required to submit as part of his/her coursework assessment a research project report on a management problem. We would like the students to do their projects on real problems affecting firms in Kenya. We would, therefore, appreciate if you assist him/her by allowing him/her to collect data in your organization for the research.

The results of the report will be used solely for academic purposes and a copy of the same will be availed to the interviewed organizations on request.

Thank you.

UNIVERSITY OF NAIROBI
SCHOOL OF BUSINESS
MBA OFFICE
P. O. Box 30197
NAIROBI

DR. W.N. IRAKI
CO-ORDINATOR, MBA PROGRAM

FACTORS AFFECTING PROVISION OF HEALTH CARE SERVICES BY THE GOVERNMENT TO THE POPULATION OF SOMALILAND

SURVEY QUESTIONNAIRE

(Hello. My name is _____. We are conducting a survey about the factors affecting provision of quality health services by the government to the population in Somaliland. We would very much appreciate your participation in this survey. We will not share your identity or your individual responses with the staff here or anyone else. Only the survey organizers of this study will be able to see the data and it will be used purely for academic purposes. The responses you provide will be kept strictly confidential and will not be shown to other persons. There are no risks involved in participating in the study. Participation in this study or refusal to participate will not affect your ability to access health services or any other services. The interview usually takes between 30 and 45 minutes to complete.

Participation in this survey is voluntary and you can choose not to answer any individual question or all the questions. However, we hope that you will participate fully in this survey since your views are important. At this time, is there anything you would like to ask me about the survey?

By consenting, you indicate that you understand the information I just read about the study and that you are willing to participate.

Signature of interviewee: _____ *Date:* _____

May I begin the interview now? *Start time:* _____

A: FOR SOMALILANDERS & INTERNATIONAL STAFF (PRIVATE SECTOR)

RESPONDENT PROFILE:

Age: _____ Sex: Male / Female

Occupation: _____

Length of stay in Somaliland (completed years): _____

Where are you from / where do you live? _____

Name of Organisation: _____

Role in Organisation: _____

No. of years in Organisation: _____

SURVEY QUESTIONS

Q1. Which of the following statements comes closest to expressing your overall view of the health care system in Somaliland?

a. On the whole, the system works pretty well and only minor changes are necessary to make it work better.
b. There are some good things in our health care system, but fundamental changes are needed to make it work better.
c. Our health care system has so much wrong with it that we need to completely rebuild it.
d. Virtually non-functional
e. Not sure
f. Decline to answer
g. Other: _____

Q2 In general, how would you describe your own health? (READ LIST)

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor
f. Not sure
g. Decline to answer

Q3 In the past two years, have you made use of any of the health services offered locally? Yes / No
If yes, tick all that apply:

a. Hospital: Private
b. Hospital: Public
c. MCH
d. Private Clinic
e. Pharmacy
f. Health Post
g. Traditional Healer
h. Not sure
i. Decline to answer

Q4 Were you satisfied by the services offered? Yes / No / Not sure

If No, please explain why you were not satisfied (tick all that apply):

(Note: do not read out but allow respondent to share freely and tick applicable category)

a.	Staff too busy		b.	Non-qualified staff	
c.	Wrong drug prescription		d.	Drugs too expensive	
e.	Drugs not available		f.	Lack of equipment	
g.	Lack of service (no lab)		h.	Inadequate investigation	
i.	Lack of technology		j.	Lack of supplies (e.g. test kits)	
k.	Discrimination		l.	Referred elsewhere not accessible	
m.	Wrong diagnosis		n.	Facility closed	
o.	Staff absent on Seminar		p.	Staff unwilling to serve	
q.	Not sure		r.	Decline to answer	
s.	Other (explain):				

Q5 Who do you think should be the provider of health services in this country?

a. Government
b. Private services from professionals
c. Local NGO
d. International NGO
e. Traditional healers
f. Pharmacies
g. Other (define): _____
j. Not sure
h. Decline to answer

Q6. What are some of the problems that may be affecting quality of health services?

Note: Select all that apply

a.	Unqualified staff		b.	Cost of service	
c.	Qualified staff who are not motivated (low pay, etc)		d.	Lack of drugs / supplies	
e.	Lack of specialised professionals		f.	Lack of equipment	
g.	Lack of funds		h.	Poor infrastructure / road network	
i.	Health facilities in poor condition		j.	Inadequate transportation services	
k.	Not enough health facilities		l.	Inadequate opening hours	
m.	Lack of committed or disciplined		n.	Patient waiting time	
o.	Staff preferring to refer patients to private services offered		p.	Khat chewing by health staff	
q.	Inadequate supervision by managers		r.	Inadequate female workers	
s.	Too much workshops/trainings		t.	Poor coordination of supporting agencies	
u.	No refresher courses for staff		v.	Decline to answer	
w.	Other (explain):				

Q7 What do you think are some of the social or cultural or religious practices that may be contributing to health problems amongst the community? (Note: tick/list all applicable)

a.	Khat		a.		
b.	FGM		b.		
c.	Nomadic culture		c.		
d.	Unhygienic behaviour		d.		
e.			e.		
f.	None		f.	Decline to answer	

Q8 Considering that there are many factors that are important in functioning of health system e.g. roads, water, etc. Please share your views on which of the following should be considered as the **greatest effect on the current** quality of health services:

Tick: **1** – no effect at all, **2** – Low importance, **3** – Useful; **4** – very important; **5** – Highly important

	FACTOR	**1**	**2**	**3**	**4**	**5**
a.	Road Network					
b.	Opening hours of health facilities					
c.	Opening hours of government offices					
d.	Clean running water for all					
e.	Electricity					
f.	Recognition as a sovereign State					
g.	Increase allocation of funds through improved tax collection					
h.	Better pay for health workers					
i.	Better structures for health facilities					
j.	More foreign health professionals					
k.	More female health workers					
l.	More research into local health problems					
m.	Better training for health professionals					
n.	Better management of health services by leaders					
o.	Involvement of community in health services management					
p.	Better recruitment procedures					
q.	Functioning regulatory bodies					
r.	Better quality drugs					
s.	Completely free-of-charge health services					
t.	Better health education in schools					
u.	Better monitoring systems (use of information for management)					
v.	Increase number of health workers / professionals					
w.	Better coordination of International supporting agency operations					
x.	Less khat chewing by health professionals					
y.	Others: (explain)					
z.						
aa.						
bb.						
cc.						

dd. Decline to answer _____

Q9 Please give any general comments or recommendations that you feel could greatly improve the quality of health care services by the government in Somaliland:

_____

_____

_____

_____

_____

_____

_____

_____

INTERVIEWER remarks:

_____

_____

_____

_____

_____

THANK THE CLIENT FOR THEIR TIME

Record the End time: _____

B: FOR INTERNATIONAL NGO & UN STAFF

RESPONDENT PROFILE:

Age: _____ Sex: Male / Female

Occupation: _____

Length of stay in Somaliland (completed years): _____

Where are you from / where do you live? _____

Name of Organisation: _____

Role in Organisation: _____

Sector supported by Organisation: _____

Major activities supported: _____

Key sector supported: _____

SURVEY QUESTIONS

Q1. Which of the following statements comes closest to expressing your overall view of the health care system in Somaliland?

a. On the whole, the system works pretty well and only minor changes are necessary to make it work better.
b. There are some good things in our health care system, but fundamental changes are needed to make it work better.
c. Our health care system has so much wrong with it that we need to completely rebuild it.
d. Virtually non-functional
e. Other: _____
f. Not sure
g. Decline to answer

Q2. What are some of the problems that may be affecting quality of health services?

Note: Select all that apply

a.	Unqualified staff		b.	Cost of service	
c.	Qualified staff who are not motivated (low pay, etc)		d.	Lack of drugs / supplies	
e.	Lack of specialised professionals		f.	Lack of equipment	
g.	Lack of funds		h.	Poor infrastructure / road network	
i.	Health facilities in poor condition		j.	Inadequate transportation services	
k.	Not enough health facilities		l.	Inadequate opening hours	
m.	Lack of committed or disciplined		n.	Patient waiting time	
o.	Staff preferring to refer patients to private services offered		p.	Khat chewing by health staff	
q.	Inadequate supervision by managers		r.	Inadequate female workers	
s.	Too much workshops/trainings		t.	Poor coordination of supporting agencies	
u.	No refresher courses for staff		v.	Decline to answer	
w.	Other (explain):				

Q3 What do you think are some of the social or cultural or religious practices that may be contributing to health problems amongst the community? (Note: tick/list all applicable)

a.	Khat		b.		
c.	FGM		d.		
e.	Nomadic culture		f.		
g.	Unhygienic behaviour		h.		
i.			j.		
k.	None		l.	Decline to answer	

Q4 Considering that there are many factors that are important in functioning of health system e.g. roads, water, etc. Please share your views on which of the following should be considered as the **greatest effect on the current** quality of health services:

Indicate: **1**- no effect at all, **2** – Low importance, **3** - Neutral; **4** – very important; **5** – Highly important

	FACTOR	1	2	3	4	5
a.	Road Network					
b.	Opening hours of health facilities					
c.	Opening hours of government offices					
d.	Clean running water for all					
e.	Electricity					
f.	Recognition as a sovereign State					
g.	Increase allocation of funds through improved tax collection					
h.	Better pay for health workers					
i.	Better structures for health facilities					
j.	More foreign health professionals					
k.	More female health workers					
l.	More research into local health problems					
m.	Better training for health professionals					
n.	Better management of health services by leaders					
o.	Involvement of community in health services management					
p.	Better recruitment procedures					
q.	Functioning regulatory bodies					
r.	Better quality drugs					
s.	Completely free-of-charge health services					
t.	Better health education in schools					
u.	Better monitoring systems (use of information for management)					
v.	Increase number of health workers / professionals					
w.	Better coordination of International supporting agency operations					
x.	Less khat chewing by health professionals					
y.	Others: (explain)					
z.						
aa.						
bb.						
cc.						

dd. Decline to answer _____