Health Care Services in Transitional Somalia: Challenges and Recommendations

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I. Introduction

Universal access to health care is an ideal goal for all nations. Nations often base their health care development plans on this principle. In Somalia, provision of health care services was also driven by this principle, and delivery of services was publicly funded like other social services, such as education. However, that goal was never achieved and the health status indicators for Somalia, even before the collapse of the central government, showed grim statistics.[1]

Health care services in Somalia were shaped by various administrations that adopted different policies, priorities, and health care service approaches, often influenced by local and international paradigms and resolutions. The parliamentary government in the 1960s and the military government in the 1970s to 1990s shared common deficiencies in their national plans. Development plans were driven by institutional history, political interest, and personal desires, instead of need and resource capacities based on empirical evidence. Both administrations failed to maintain established health care delivery infrastructures or sustain their core operations, let alone expand services to the rural population and other vulnerable groups or modernize the system and improve its quality. As a result, health care facilities in many districts collapsed and were unable to provide even the minimum required clinical and preventive services.

In addition, high population growth, environmental degradation, desertification, frequent droughts and famines, urbanization and hap-

hazard settlement, poverty and a weak economy, and poor governance created an unbearable burden of health problems that overwhelmed the nation's staggering health care system and its coping mechanisms. These problems stifled the health care system and contributed to the poor health status of the Somali people.

The Ministry of Health (MOH) never developed a core health care services package nor gauged the extent of resources and infrastructure needed to deliver them. It could have saved wasted resources and eased its management burden if sound leadership had been practiced. As a result of poor leadership, the needs of the health care system and its effective operation were misconceptualized. Furthermore, the type and competencies of health manpower for the provision of a core health care services package, at different levels of delivery points, were never determined. Development of a national health plan with such attributes could have traced an efficient and progressive path for the Somali health care system.

A prominent weakness of the Somali health care system was the lack of a strong regulatory body on drug importation and utilization. Disappointing outcomes of treatable diseases, such as tuberculosis, malaria, typhoid, and dysentery, were mainly attributed to the poor quality of imported drugs. As a result, many patients succumbed, in addition to those who fell victim to provider negligence and ignorance. The currently flourishing drugstores across the country could dangerously worsen an already dire health situation.

There were several milestones in the history of health care services in Somalia. In 1966, a nursing school was established in Hargeisa, and another one in Mogadishu in 1970. In 1973, a faculty of medicine and surgery was set up in Mogadishu. These training institutions boosted the human resources for health. The smallpox eradication campaign in the mid-1970s, and introduction to primary health care (PHC) and new tuberculosis (TB) treatment regimens by the Finnish International Development Agency (FINIDA) in the 1980s, brought in massive external assistance. It established PHC training institutions and opened the door for medical specialty training in TB and lung diseases. These inputs expanded access to health care services and improved the quality of care, particularly with regard to TB. However, the massive resources injected into the health care system were not used properly and their contributions faded soon. Another landmark was the formation of a semi-autonomous refugee health unit (RHU) in the Ministry of Health to serve the refugees from Ethiopia in 1977, which attracted

massive foreign aid and expatriate health professionals. The RHU introduced sound health care planning and effective operations, which positively influenced the overall MOH functions and operations. The RHU staff gained valuable experience and knowledge about public health concepts and practices. This produced competent public health professionals and raised the awareness and practice of public health in Somalia. Also in the 1980s, research in medical sciences was initiated by the faculty of medicine, in collaboration with several universities in Sweden, through the National Academy of Science and Arts in Mogadishu. This was a new dawn for research in medical sciences and other fields in Somalia. This initiative and the others mentioned earlier mainly contributed to health manpower production and development. However, these gains were reversed by the economic downturn and political turmoil of the 1980s and civil war of the 1990s.

All in all, the health status indicators in Somalia remained at the bottom among the developing countries.[2] Currently, in the absence of a central government, health care services have become a local initiative, and with mixed success. Therefore, to avoid misguided national health development plans and policy, it is essential to examine the deficiencies and gaps in the operation of the past health care systems, and to provide a basic framework to ensure a functional and sustainable health care system in the future.

II. Background

The Ministry of Health (MOH) in Somalia had six departments: planning and training, personnel, prevention services, curative services, finance and administration, and procurement and medical supplies (figure 1). In the mid-1980s a new structure was introduced (figure 2) but was later abandoned. The MOH practiced a centralized system for decision-making and had links to the 18 administrative regions through regional medical officers (RMO) that reported to the curative services department. However, the regional primary health care project coordinators had semi-independent management from the RMO and worked under the directives and authority of the national PHC coordinator, who reported to the prevention services department. The MOH was responsible for the health care services of the civilian portion of the nine million Somalis who were mostly rural inhabitants.

Information on access and utilization of the health care services is skimpy. It is often reported, however, that less than 30% of the popula-

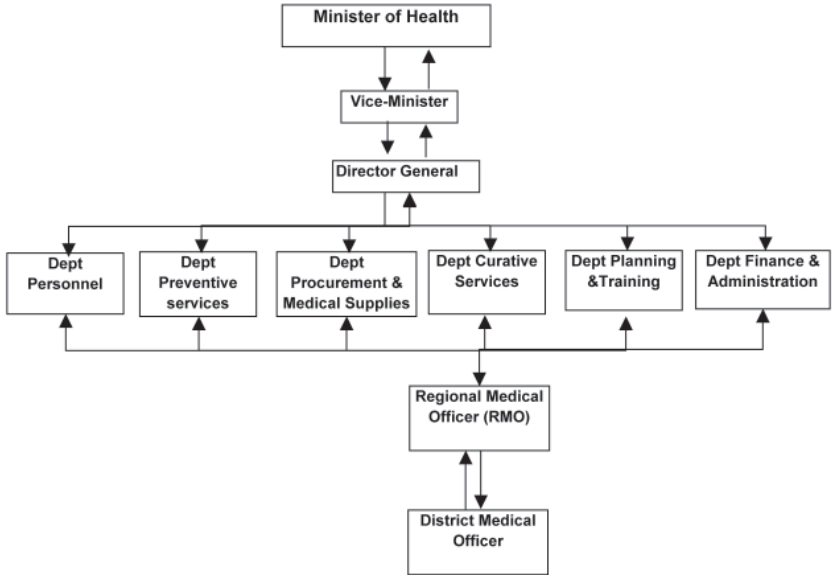

Figure 1. Organogram of the Ministry of Health—Somalia

tion has access to health care services, The most common illnesses are infectious diseases, related to poor personal hygiene and environmental sanitation, human behavior, chronic illnesses, and events related to lack of basic services, such as obstetric and preventive services.[3] The MOH staffs clinics, hospitals, health posts, and vertical programs. It is involved in projects dealing with malaria, schistosomiasis, tuberculosis, leprosy, the Expanded Program on Immunization (EPI), PHC, and family planning, and attempted to provide needed services throughout the country.

Due to the dissatisfaction of the consumers and health care providers with the quality of health care services and low remuneration, the government allowed private practice for medical doctors in the late 1980s. This raised the health care providers' income and partially remedied their income problem. However, health care suffered further, indicating that the problem was wrongly conceived and the solution was not appropriate. The declining economy and rising inflation in the 1980s, and the war against Ethiopia in the late 1970s, pushed the system into almost complete collapse.

The vertical programs that had disease-specific objectives were funded almost entirely by international organizations and development agencies, like WHO, UNICEF, UNFPA, FINIDA, USAID, UNDP,

SIDA, and the EU. Although WHO's contribution was mainly technical, it funded a couple of PHC programs that were experimental, whereas some of the other agencies were involved in program development, implementation, and evaluation. Despite such involvement, their contributions were not effective. For example, UNICEF was involved in the Expanded Program on Immunization (EPI) operations, in collaboration with the WHO, but the percentage of children under 5 years old who are fully immunized is currently below 40%. Likewise, FINIDA funded the national TB control program for at least six regions, but no change on the disease burden has been observed. The current TB prevalence among asylum seekers screened at Heathrow Airport in London is 1,045 per 100,000 population, which is relatively high in spite of the continued FINIDA funding until early 1990, when the central government collapsed.[4]

III. Demographic and Health Profiles

A precise count of the Somali population is hard to find. Local and international organizations use estimated figures to plan their humanitarian and service operations. Currently, the population estimates quoted by these organizations range from seven to ten million, with crude birth and death rates of 46 and 18 per 1,000 population, respectively, and an annual growth rate of 2.8% with a dependency ratio of 101%.[5] The total fertility rate is 7.3 babies per woman of reproductive age, underlining the importance of obstetric services and the risk of maternal deaths. The life expectancy at birth is 46 years for males and 49 years for females. High mortality rates in the early stages of life are responsible for this poor life expectancy at birth. The infant and under-5 mortality rate estimates in 2000 were 130 per 1,000 live births and 224 per 1,000 live births, respectively. These rates have not changed much since 1970, despite a functioning government in Somalia. During the civil war, disasters exacerbated these rates substantially and the overall crude mortality rates surpassed those recorded in Ethiopia and Sudan during the famine in 1984–85.[6] Maternal mortality ratios, an indicator of poor access to basic obstetric services, is estimated at 1,600 per 100,000 live births.

The majority of the population (59%) practices a nomadic lifestyle with no access to health care or other social services.[7] They are at great risk for malnutrition and disease, although the extent of their suffering is not often documented. From 1950 to 2002, the population in Somalia

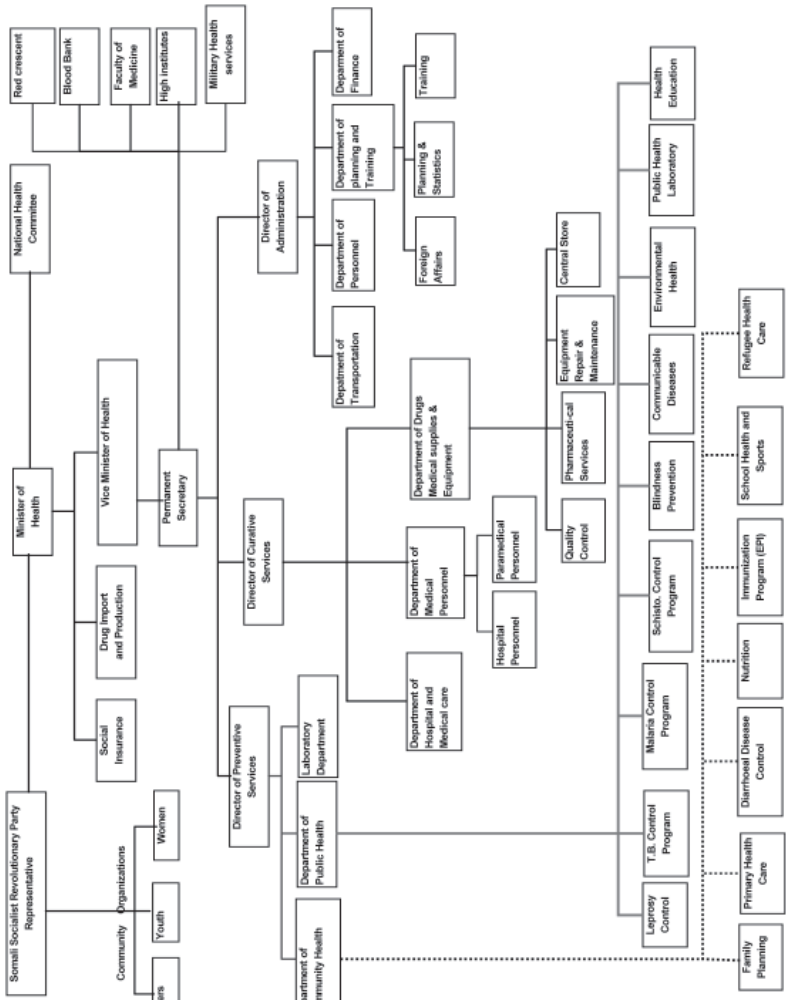

Figure 2. Organogram of Ministry of Health (Source: World Bank 1985: 81)

almost tripled. Currently, around 45% is under 15 years of age and 3% is 65 years and over. Conversely, the basic social services have been declining or remained stagnant.

IV. Health Care Resources

The health problems causing outpatient visits, hospitalizations, and calls to traditional healers do not differ from those in the neighboring countries, with the exception of HIV/AIDS and a few country-specific diseases.[8] Provision of preventive and curative services at the individual and population levels needs to focus on these issues, and ensure adequate resources and the establishment of essential infrastructures to deliver the services.

In Somalia currently, there are 196 MCH clinics and outpatient dispensaries, and 520 health posts that provide preventive and outpatient curative services, mostly to urban dwellers. Prior to the demise of the central government, their utilization was limited to those who could afford to pay necessary enabling services. The rural population and urban poor were quite neglected and few facilities were accessible to them.

In addition, there are 74 hospitals with 3,405 beds that often provide curative and preventive services to inpatients and clients attending hospital-affiliated outpatient clinics. These hospitals cluster in urban centers like Mogadishu and regional capitals. For many in rural district towns limited services are available, which makes their utilization quasi-irrelevant to the population needs, although there are variations in their capacities. A significant portion of these facilities were disabled by the civil war and continuing disorder.

Diagnostic facilities that are essential to patient care are limited. In 2005, 114 clinical laboratories existed in the country. Statistics on X-ray machines are not available, but every hospital was equipped with at least one, besides those in TB hospitals. Some machines at district hospitals are dysfunctional at the moment. Thus, total X-ray machines in the country must number fewer than 74, although some of those that had been out of order may have been replaced.

Information on some of the health care resources, which include manpower, medical supplies, drugs, and funds, is also limited. In 1973, when the medical school was established, there were 96 physicians, of whom the majority was expatriates. In 1978, the number of physicians increased to 196. In 2004, there were only 240 physicians and

358 nurses in the country, despite the continuous production of physicians and nurses by the medical school and nursing schools till 1990.[9] This indicates how the civil war wiped out the gains in health manpower production and development. It is estimated that more than 330 physicians and close to 500 nurses disappeared during the civil war. Currently, the doctor/population ratio and the nurse/population ratio estimates are one doctor per 31,000 people and one nurse per 20,000 people, indicating severe inadequacy of services.

The national budget ($1.2 billion per annum before the decomposition) that was allocated to the MOH was around 2% ($24 million), and it remained constant over the years. The World Bank estimated $12 per person per annum to cover the cost of basic public health and curative services in low-income countries.[10] In Somalia, with an estimated population of approximately eight million, this amounts to $96 million, which is four times higher than the 2% of the national budget allocated to the MOH. In addition, external funding was often injected into the vertical programs, with little substantive impact. Programs receiving such funds often disappeared after the donor support ceased.

The nation's policies, which were never based on precise facts and figures, failed to provide clear guidance to the frontline decision-makers about the overall health care mission and the driving principles of health care service delivery. However, the campaign against female genital mutilation was given high priority and was one of the positive policies for the nation before 1991. The MOH also endorsed the PHC approach as the principle and guidance for the delivery of health care services. Although it was a positive political decision, the MOH was not aware of the requirements of its implementation. The decision was internationally driven, and compliance with the international community was guaranteed without an in-depth understanding of the nuances of the Alma-Ata communiqué, which is common in international resolutions.[11]

V. Health System Problems

In Somalia, as is the case with the least developing countries, the health and development indicators hardly experienced any improvement. The illnesses that were common early in the 1960s, after independence, have remained prevalent till today, despite progress in some social service sectors in the early 1970s. This illustrates that the country's health care system was incapable of satisfactorily providing curative

and preventive services. Although in Somalia defects responsible for the poor health status indicators were never fully examined, several factors have often been cited for the developing world, particularly for African countries south of the Sahara.[12] These include:

1. Inadequate funds for health service operations
2. Inadequate resources for patient care and public health services
3. Maldistribution of available resources and mismatch of scarce resources to priority health problems
4. Poor management of resources
5. Poor stewardship and lack of accountability
6. Poor health development planning, resulting in misguided priorities and unclear or unachievable objectives
7. Corruption and manpower dissatisfaction
8. Poor quality of available health care services
9. Lack of clear understanding of the mission and objectives of the MOH by the frontline health care workers

Some of these factors are interdependent and influenced by the nation's overall development plan and policy, but many fall within the MOH responsibilities that are amenable to corrective measures. The latter include quality assurance and improvement of the health care services, health manpower development, adoption of sound management and accountability practices, and establishment of strong regulatory policies and practices. The severe drought in the 1970s, the 1977–78 war with Ethiopia, and the economic downturn in the 1980s all had a major impact on the national health development plan and health care services. As a result, both patient care and public health services suffered.

There were missed opportunities to establish a solid health care system and expand into the rural areas where a large part of the population lives. The introduction of PHC and external funds given to the TB control programs by FINIDA were excellent opportunities to extend health system infrastructures and adopt clear policies for its operations and sustenance. Instead, the PHC, which required changes in policy and organization of the entire health care system, was initiated as a vertical program running parallel with the established health care system in some regions. It was wrongly viewed as a project rather than an approach based on principles of decentralization, community par-

ticipation, inter-sectoral collaboration, rational allocation of resources, and the comprehensive implementation of all elements of PHC.

Weak infrastructures also hampered access to and utilization of functioning health care facilities. Consequently, health care services catered to the urban population and barely reached the rural inhabitants or the urban poor.

VI. Major Challenges and Recommendations

The first and foremost challenge to the development of a sound health care plan is a lack of strategic information and data on the health care system and its operations, and information on other related sectors. Most of the health service facilities record basic client information but these were never analyzed or utilized. The MOH mandated several diseases to be reported to its national surveillance office. Such information was occasionally tabulated and sent to the central office in Mogadishu by the regional MOH authorities. However, the data was haphazardly collected and had little use for effective planning and operational decisions.

In addition, the capacity to gather, analyze and disseminate surveillance data and other information was not developed well. The MOH lacked necessary infrastructure and equipment as well as skilled manpower that could use such information for strategic planning and policy development. Some donor nations provided scholarships to MOH personnel for public health training, and the faculty of Medicine of the Somali National University started postgraduate training in public health in the early 1980s. However, most of those who completed their training either joined international organizations or sought better opportunities in the oil-rich Arabian countries in the Gulf. Thus, a massive brain drain in the 1980s hampered any planned progress in this area.

International paradigms and resolutions have both positive and negative influences on the health care plans in developing countries, and Somalia is no exception. In the 1980s, health for all by the year 2000, through the PHC approach, dominated the health sector and national policies in the developing countries. Currently, the Millennium Development Goals, Kyoto Protocol, health sector reform, poverty reduction, G-8 New Partnership for Africa's Development (G8/NEPAD), globalization, and other initiatives all shape the way in which developing countries operate, set policies, and receive funding from international

organizations and donor countries.[13] These paradigms and resolutions place an unnecessary burden on developing countries, particularly on the strategic planning and policy developments. Poor countries are obliged to satisfy donor requirements based on these resolutions before addressing their national priorities. The donors thus exert a stronger influence than what the loans or donations deserve. Therefore, development funds should not be expected to make tangible changes in health status indicators.

Financing health care operations will remain a major challenge for Somalia due to the growing health needs as well as the absence of a central government responsible for social services. The nation's economic capacity, as in the past, cannot finance the health care needs adequately. Private health care services, which predominate in the country, may create the foundation for a sustainable health care system in the future. This could lead to the development of a rational health care plan that capitalizes on the strength of public and private health care services, and fits into the economic realities of the nation. This amalgam might maintain the safety-net attribute of the publicly funded system, support the quality of health care services that accompanies the private ownership, and provide incentives for growth and development in the system.

The high fertility rates and resultant population growth increase the burden of diseases and the need for health care, in addition to the low capacity of MOH to provide health care services. The imbalance between services and needs was always a major challenge and will continue to be unabated into the future. This situation is very common in low-income countries and deserves proper attention in the national planning process to allocate adequate services proportional to the magnitude and type of problems. Here, continuous monitoring and determination to insert health concerns into any development plan is indispensable.

The HIV/AIDS epidemic is an urgent challenge in health care and development in Sub-Saharan Africa, where two-thirds of the world's HIV/AIDS victims live (although they constitute only 10% of the world's population). The socio-economic impact in high HIV/AIDS incidence countries is staggering. Although the HIV/AIDS prevalence in Somalia is around 1%, according to the WHO sero-prevalence survey in 2004, the factors that could propel the epidemic are not uncommon.[14] Therefore, the HIV/AIDS impact observed in high prevalence countries may not spare Somalia.

The cost of medical and social services for people living with HIV/AIDS is beyond the budget of the ministries of health in most of Sub-Saharan Africa, according to a study in Haiti.[15] In Somalia, the annual cost of services, for example, for one-third of the HIV/AIDS cases amounts to approximately $42 million. This shows how the epidemic could be economically devastating even in low prevalence countries.

The impact of HIV/AIDS affects all aspects of human life, such as livelihood, education, family, agriculture, and security. Therefore, solving the problems in these sectors and combating the spread of the disease require global resource mobilization and collaboration to muster adequate resources. Focusing only on the consequences of the disease will be fruitless and self-defeating. The main cost-effective tool at this time, for Somalia and other developing countries, is investing in prevention activities.

As disasters increase, mental health problems increase as well. Mental health was neglected before, and currently the need is vast and critical. This will be a growing challenge that any future government must address in terms of resources and access to adequate mental health attention. Few health care professionals are trained in this field. The establishment of a mental health institute for training professionals is badly needed. Oral health care faces a similar situation. It is a forgotten service although almost every individual in the country needs dental services. The proposed mental health institute could be coupled with an oral health institute. These two areas will fill a void in the Somali post-independence health care system.

To ensure adequate and equitable quality health care services for the population, concrete information is needed to develop a proper health care development plan. Such information provides policymakers with the means and abilities to identify the health care needs, prioritize, determine the basic health care service package for the people, and develop sustainable approaches for service delivery.

A strategic planning approach is often prescribed for countries with limited resources, like Somalia, to ensure efficiency in the delivery of health care services. Many countries have used this approach in their health sector reform endeavors.[16] Other approaches were also employed to make the system operational and sustainable, such as health sector reform, cost sharing, improving the quality of services, and decentralization of management and decision-making.

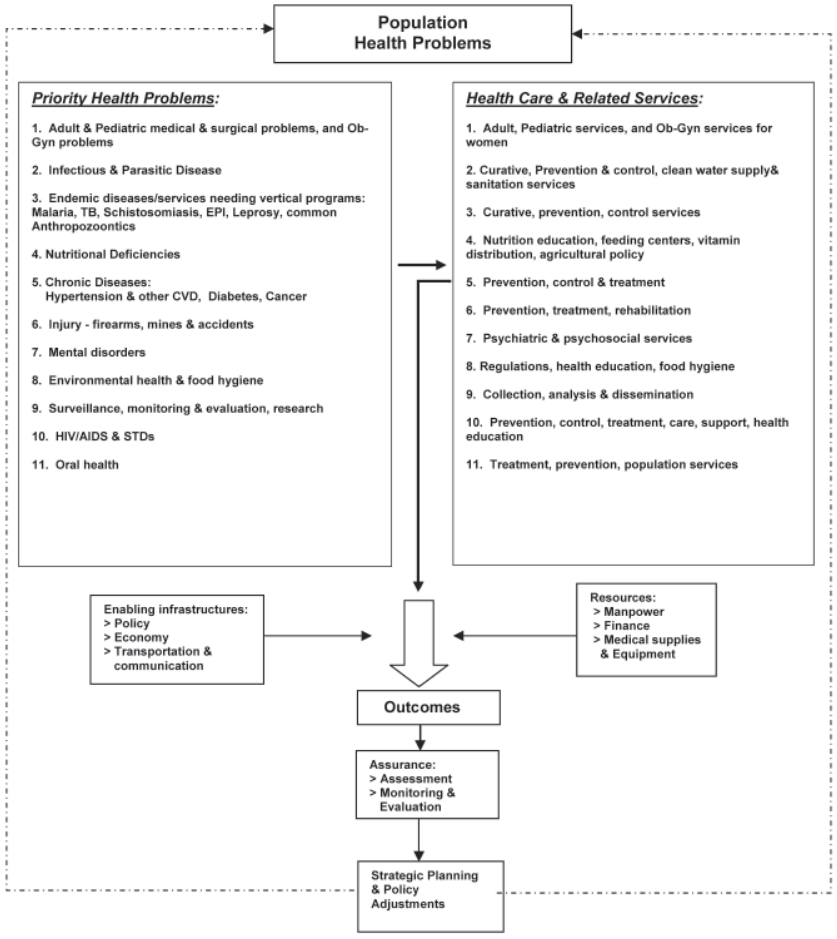

Figure 3. Health Care Service Framework

The future health care development plan, based on the framework in Figure 3, should address adequately the core functions of the health care system, namely:

- Financing
- Resource generation
- Service delivery
- Stewardship oversight

The financing of health care involves the budget allocated to the MOH from the national ministerial budget, which is part of the national development plan and its sources. Without adequate funds for basic health care services and overall operations, the health status of the population cannot be improved. Earlier MOH budgets were not adequate and the government's income was incapable of sufficient allocation of funds to the MOH. Therefore, health care services should be able to contribute some capital while maintaining the safety net for the poor, the majority of the population. The health care system will gradually move to partial privatization as the economic well-being of the society improves and consumers become capable of paying for their basic services.

This necessitates establishing assets that generate income in order for the local health care system to maintain basic quality services and have the versatility to accommodate increasing service needs brought on by population growth, disasters, and epidemics. The resources generated by these assets should be sustainable, managed properly, and invested to expand revenues. Funds from the central and local government could cover the basic health care services.

Resource generation mainly encompasses human resources, drugs, and medical supplies. The MOH should establish manpower development institutions and collaborate with other training institutions, such as universities, colleges, and institutes. This increases the production of skilled manpower that can improve the quality of clinical and preventive services, assess the health needs of the population, monitor and evaluate the performance of the health care system, and contribute to better development of the national health care plan.

Self-sufficiency in essential drug supplies can only be achieved through local production. Therefore, the government should develop long-term goals and establish drug industries for local production. In the meantime, the quantity and quality of drugs imported and utilized should follow clearly defined regulatory policies developed by informed professionals capable of gauging international rules and regulations governing drug marketing. These drugs should be appropriate to the common health problems of the society. The government should also plan to invest in researching medicinal plants to search out raw materials for local production.

The delivery of health care services needs to be decentralized. The main entry point for health care services should be at the district level. District authorities, in collaboration with community leaders and

members, will carry out management and other decisions on health care issues locally. The regional and national authorities must have supervisory, support and accountability roles. Funds allocated by the central authorities should be transferred directly to the districts without intermediate bureaucratic red tape. The disbursement of funds to the districts should follow a formula that takes into account the population size, burden of diseases and other health care problems, availability of infrastructures, local resources and number of hospital beds, size and categories of health personnel, and other relevant issues.

At the district level, people will receive basic health care services. Such services should be based on priority health problems determined through concrete population needs assessments and determination of standard service packages and appropriate capacities for the providers at specific facilities. This includes curative and preventive services for the majority of the population, and basic obstetric and reproductive health services for women. Essential infrastructures that support such services must be developed and sustained by the local authorities and communities in collaboration with the regional and central governments and international agencies. The local district governments should participate in funding the health care services and contribute to an agreed upon portion of district revenues. All external funding from international organizations should be time-delimited to avoid creating dependency and negative impacts on the local health care plan and policies upon its cessation.

The MOH must develop a strong hierarchical referral system and enabling mechanisms to guarantee communication and transportation of patients from one level to the next. It should also develop standard services as well as personnel and their capacity to ensure good quality. Adequate and proper resources should be allocated to these facilities to ensure continuity, sustainability, and quality. Such resources should be shared by the districts and regions that benefit (on top of the funds allocated by the central government).

The proposed approach for the health care delivery system cannot function without good stewardship, which oversees the nation's health system and coordinates local resources and donor contributions. Good stewardship sets the vision, direction, and policies that ensure the provision of a basic health care service package to the population. This should be fed by valid information, collected and synthesized continuously and strategically.

The MOH needs to establish an autonomous unit that is responsible for assessment, monitoring, evaluation, policy analysis, health system research, and coordination of resources, that feeds strategic information to the decision-makers at all levels. This enables rational allocation and utilization of resources and taking timely actions to redress any shortcomings in the system and avoid derailment from the national goals and objectives.

Certain health problems (such as tuberculosis, malaria, EPI, schistosomiasis, leprosy, anthropozoontic diseases like brucellosis, viral hemorrhagic diseases, etc.) that are endemic in particular localities or have wide distribution can be managed better through vertical programs. This should, however, come under the district health management, while allowing flexibility in its operations to collaborate with regional and national authorities and international agencies. This facilitates support from external donor governments and agencies.

Establishment of functional and sustainable health care systems takes many forms and approaches.[17] Some of these forms and approaches have merits to be pursued further for the strengthening and reorganization of the health care system, but others may not address the pressing issues in Somalia. Many proposed reforms and interventions were confined to localities and their effectiveness, when applied to wider administrative areas, couldn't be replicated.[18]

In addition, health sector reform strategies have been developed and proposed by non-native experts on the developing world. Although some of these experts produce technically and scientifically sound guidelines, a lack of cultural and local competence to fully understand the system problems has been a source of ultimate failure. Moreover, these experts control the mechanisms for financing the proposed reforms and rarely accommodate legitimate concerns from locals if it conflicts with their philosophy and paradigm. Therefore, the locals sacrifice their priorities at the expense of receiving external funds that may benefit them and the system only temporarily.

The WHO Eastern Mediterranean Regional Office (EMRO) supported the Basic Development Needs (BDN) approach to improve the quality of life, cognizant of the relationship between poverty and heath.[19] The BDN was first introduced into the region in the late 1980s. It was used experimentally in some villages in Somalia. However, the BDN addresses areas beyond the domain of the MOH. Its realization entails national policy change and the reorientation of ministerial operations into social development, community empowerment, and equity

of social services. The BDN approach is similar to that of the PHC, but incorporates experiences gained from the PHC programs, which lead to adjustment of the shortcomings of the PHC approach. It encounters, however, similar challenges experienced by the PHC (i.e., inter-sectoral collaboration, policy issues, external resources, and donor policies).

The BDN has some advantages. It reverses the centralized system of health care planning and policy development, and empowers the community to determine its own health care needs. It also introduces the concept of community development into the local communities and raises their political standing, awareness, and responsibilities, which could have a lasting legacy for better governance and local development approaches. In the case of Somalia, the BDN was operating under the MOH, which did not change its practices or policies to satisfy the needs of its implementation. It is noteworthy that the calls for reform and changes did not emerge from the local authority that faces these problems daily. Therefore, their implementation will be undermined by the absence of an appropriate conceptualization.

Health care systems in the developing world, particularly Africa, need the technical and financial support of international and U.N. organizations, and donor countries. However, the current vicious cycle of dependency on external aid must not continue. It benefits neither the systems nor the donors. A new partnership mechanism that guarantees constructive contribution of funds to the health care system should be developed. Such partnership should also place a high priority on sustainable contributions to the system, even though it demands solid commitment and a change of culture in operations from both the donor and recipient countries.

Non-governmental organizations and U.N. agencies must adopt a system of genuine accountability, appraised by independent groups that represent all stakeholders. The findings and recommendations of such appraisals must be binding and translated into actions that will be subsequently monitored and evaluated. This enables early detection and adjustment of derailments from the set course of action. Such checks and balances bring credibility into the system and affirm the realization of the mission and goals commissioned by the United Nations and other international organizations.

Recipient countries should also lay out transparent policy guidelines on spending and coordination of external aid. This should be piloted in a few districts first, before massive resources are wasted if it fails. This assumes a nurturing and mature political climate wherein both

the recipient and the donor share a common philosophy and clearly state their intentions and concerns for the well-being of the population. Such a practice can only take root and flourish in a democratic and law-abiding context.

IX. Conclusion

Somalia's health care system has suffered from inadequate funding, mismanagement, and poor planning and policy development ever since independence. As a result, the people's health suffered. Currently, the health care system is obviously in crisis from the protracted civil war of more than a decade. The population has been growing annually at a rate of 2.8%, although it experienced high mortality rates during the civil war in the early 1990s. The health care needs were increasing while resources and enabling infrastructures were diminishing or ceased to function.

The health status indicators rarely experienced any significant improvements. Many factors were attributed to this desperate situation:

- Haphazard planning and policy development
- Overwhelming health problems
- Inadequate and maldistribution of resources
- Corrupted management and absence of strong regulatory policies and fair practices
- Poor governance
- Underdevelopment
- Poverty
- Social inequities
- Continuous natural and man-made disasters

The health care system experienced several milestones that brought opportunities to strengthen the system and improve the health status of the population. However, these opportunities were wasted and many insurmountable challenges paralyzed the health care system. The current HIV/AIDS epidemic could exacerbate these challenges.

Therefore, provision of health care services should address and redress the critical challenges and ensure access to basic health care services to the majority of the population, while giving high priority to

vulnerable groups. This entails sound planning and policies from the government, based on rational judgment and empirical evidence, as well as contributions from the consumers and community through cost sharing and resource mobilization. The health care system should also adopt innovative financing mechanisms, decentralization of resources and decisions, and sound management and strong stewardship from the central government through continuous support, guidance, and monitoring and evaluation of health care system performances.

In Somalia, now under foreign military occupation and a new phase of bloody civil strife, the health concerns of the population may have to wait until the invading Ethiopian forces leave and a new legitimate order is born. In short, to get back to the great challenges of public health, it seems that Somalia will have to get the politics right first.

Notes

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