

Cost Recovery or Community Recovery?
Rehabilitating Local Health Services in the Aftermath
of Conflict and War

Sean Deely

Doctor of Philosophy in Post-war Recovery Studies

Postwar Reconstruction and Development Unit,
Department of Politics
The University of York

April, 2005

This thesis is dedicated to my wife, Macarena Aguilar, whose encouragement, expectation, patience and support made it possible.

Abstract

This thesis addresses the chronic failure of health service provision in conflict-affected developing countries, with specific reference to Somalia. It reviews the main arguments on how these services should be sustained: on the one hand, that these countries lack the resources to provide essential services and that the solution is through vastly increased financial assistance, and the opposing view that aid has consistently failed to produce improvements in service provision and the solution is for health services to become 'self-financing' through the imposition of user-fees. The thesis examines the effectiveness of cost recovery approaches employed by governments particularly in the context of structural adjustment and analyses their impact on the health and well-being of people in African countries in terms of reduced access to health services, indebtedness and increased morbidity. The thesis develops an alternative model for sustaining health services supported by the National Red Crescent Society in Somalia, which has been field tested in the Puntland region of Somalia. The new model is based on local empowerment to participate in the management of the community health service, and adopts financing modalities based on local coping capacities, seasonal income flows and user involvement in decision making about priority services and treatments, and sustaining the service. By empowering people to identify the broader causes of ill-health and to address these causes within the terms of the social and political context that determines their health status, the approach goes beyond dealing with the immediate causes of their illness, and supports collective mobilization to address deeper structural causes of sickness and ill-health.

Contents

Abstract.....	iii
Contents.....	iv
List of Tables, Figures and Maps.....	xii
Acknowledgement.....	xiv
Declaration.....	xv

The Preamble

P.1 The Context of the Research	xvi
P.2 The Research Problem and the Importance of the Research	xvii
P.3 The Research Question and the Hypotheses	xviii
P.4 Towards a New Approach	xxii
P.5 Overview of the Empirical Research Strategy	xxv
P.6 Structure of the Thesis	xxvi

Cost Recovery or Community Recovery? Rehabilitating Local Health Services in the Aftermath of Conflict and War

1. Weak States, Conflict, Declining Health and Welfare	1
Introduction	1
From Nation States to Failed States	2
Collapsed Economies	4
Contested Sovereignty	6
The Emergence of the Fourth World	8
Structural Adjustment and Health	10
Withdrawal of Government Funding	11
Exchange Rate Devaluation	12
Liberalised Markets	13

Access to Public Health	15
Structural Adjustment and HIV/AIDS	17
HIV/AIDS and State Failure	20
The Impact of Conflict on Health and Health Systems	24
Increased Health Needs of the Conflict-Affected Population	24
Diminished Capacity of Health Services	28
Distortion of the Health System	31
The Challenge of Health Service Recovery	34
Accessing International Support	34
Increasing Service Delivery Capacity	36
Sustainability	37
Conclusion	39
2. Financing Health Services: Between Theory and Practise	41
Introduction	41
Objectives of Health Financing Systems	42
Issues to be Considered	42
Criteria for Effective Health Financing Systems	43
Health Financing Systems	45
Universal Systems	45
Private Insurance Systems	48
Community-Based Insurance Schemes	50
Direct Payment Systems	51
External Aid	53
The Reality of Health Financing in the Fourth World	55
Informal Payments	55
Donor Funding	57
Cost Recovery	59
The Impact of Globalization and Inequality	61
Tax Collection	61
Health Budget Efficiencies	64

Development of Cost-effective Treatment	67
Conclusion	70
3. Cost Recovery: Sustainability or Exclusion?	73
Introduction	73
Competing Models of Cost Recovery	74
The Standard Model	74
The Bamako Model	75
In Search of a Transitional Health Service Recovery Model	76
The Bamako Initiative	76
Aim and Objectives	76
Experience in West Africa	79
Successes: Expanding Services, Ensuring Drug Supplies	79
Efficiency: Improved Childhood Mortality and Immunization	80
Increased Physical Access	81
Equity: Increased Income from User Fees	82
Some Community Participation	83
Failures: Low utilization, Exclusion, Token Participation	83
Inefficiency compared with increased number of facilities	84
Barriers to Access: Excluding the Majority	87
Equity: Inability to Pay	88
Top-Down Participation	93
Lessons from the Cost Recovery Approach	95
Efficiency	95
Ability to Pay for Health	97
Sustainability	100
Neoliberal Globalization, Poverty and Ill-health	102
Conclusion	104
4. Community Recovery: Health as Development	106
Introduction	106

Development Theory	107
Early Theories of Development	107
From Economic Development to Social Development	109
Participatory Development, ‘Another Development’ and BHN	111
Democratic Governance and Civil Society	114
Development as a Discourse of Domination	117
Development and Health	119
Participatory Development	119
Participation in Health Development	122
Community Involvement in Health	124
The Feasibility of Community Organisation of Health Services	128
Constraints	130
Community Financing of Health Services	131
Participatory Health Financing	131
The Feasibility of Community Financing Schemes	133
Strengths of Community Financing Schemes	137
Weaknesses of Community Financing Schemes	139
Outcome: increased Access and Affordability	141
Conclusion	142
5. Methodology	145
Introduction	145
Research Considerations	146
The origins of the research question	147
Action Research: Promoting Change and Understanding	149
Traditional Research Strategies: Application in Conflict Setting	151
The Research Strategy	152
Selecting a Research Strategy	152
Dealing with Uncertainty: Combined Strategies	153
Participatory Action Research	156
Research Tactics	157

Pre-studies	160
The Pre-study Design	162
The Research Question	162
Hypothesis	164
Units of Analysis	165
Linking Data to the Hypothesis	165
Criteria for Interpreting the Findings	166
The Pre-study Protocol	168
Overview	168
Field Procedures	169
Pre-study Questions	172
Practical Lessons from Fieldwork	174
Preparation	174
Security	175
Consideration	177
Effectiveness	178
Conclusion	180
6. The Pre-study: Profiling Puntland	181
Introduction	181
The Data	182
The Somali State of Puntland	182
The Health Sector	192
The Somali Red Crescent Society	202
Analysis and Outcomes	207
Analysis	207
Elaborating the Working Hypotheses	220
The Research Strategy and Plan	223
Conclusion	225
7. Measuring Communities' Willingness and Ability to Participate	228

Introduction	228
Enabling Local People to Take Responsibility	229
Feasibility of Participatory Methods	231
Participatory Surveying – The Concept	233
The Survey: Key Findings	239
Lifestyle	239
Utilization of Health Facilities	240
Community Participation	241
Validation of the Findings	243
Health Behaviour	244
Ability to Participate	247
Willingness to Participate	248
In Search of a Community Financing Model	250
Selection of a ‘Test’ Community	251
A Representative Community	252
Towards a Participatory Management Model	253
Conclusion	254
8. Qarhis: The Field Experiment	256
Introduction	256
The Case Study as a Field Experiment	257
The Case Study of Qarhis	260
Demographic Features	261
Governance Systems	262
Communal Needs	264
Health Needs and Service Providers	267
The Red Crescent Clinic	270
Ability to Participate	274
Willingness to Participate	77
Presentation of the Findings	280
Conclusions of the Study	280

Participants' Positions	282
Developing Proposals for Action	283
Agreeing a Community Health Management Plan	284
Participant Engagement	285
Breakdown	286
The Community Health Management Plan	286
Conclusion	290
9. Lessons from the Qarhis Field Experiment	292
Introduction	292
Implementation of the Community Health Plan	292
Contextual Factors	293
Access	295
Evaluating the Field Experiment	296
Findings of the Evaluation	296
Increase the Level of Community Participation	297
Upgrade the Quality and Range of services provided	301
Establish a Community Financing Scheme	304
Strengthen Partnerships	306
Results vs. Hypotheses: Towards a New Programming Model	308
Community Management	308
Community Financing	312
Health Service Recovery	315
Community Recovery	320
Implications for the Thesis	323
Beyond Qarhis: A Generic Programming Model for Community Management	325
Conclusion	327
10. Conclusions: Extending the Boundaries	329
Extending the Boundaries	329
Conclusion	329

Strengths and Weaknesses	331
Recommendations for Practice	332
Future Research	333
Annexes	334
Annex 1: Review of Traditional Research Methods	334
Annex 2: Pre-study Data Collection Program	349
Annex 3: Planning and Organizing the Survey	351
Annex 4: Survey Preparation Checklist	366
Annex 5: Puntland Household Survey Questionnaire	367
Annex 6: Guide for Interviewing Respondents	378
Annex 7: Planning Your Interviews	380
Glossary	382
Bibliography	384

List of Tables, Figures, Boxes and Maps

	Page
Table 1.1: Life Expectancy by Access to Public Health	16
Table 1.2: Life Expectancy by Income Group	16
Table 1.3: HIV Prevalence in Selected African Militaries	20
Table 1.4: Calculated Loss of Life Expectancy Due to HIV/AIDS	22
Figure 2: Who bears the risk of health care costs?	44
Table 2.1: Donor Assistance to Health, 1997-1999	57
Table 2.2: Taxation as a Percentage of GDP	62
Figure 3.1: Benin, Guinea, Mali: Improvements in Child Mortality, 1980-2002	80
Figure 3.2: DPT3 Immunization Coverage in Benin, Guinea and Mali, 1988-1999	81
Table 3.1: Number of Primary Health Care Centres and Level of Access	81
Figure 3.3: Evolution of PHC Centres and CMR, Mali 1987 to 2002	86
Figure 3.4: % change in CMR, DPT3 by number of PHC Centres, Mali 1988-2000	86
Figure 3.5: % decrease in CMR by % Increase in Health Centres, Guinea, 1992-99	87
Table 3.2: Private Health Expenditures, Mali, 1997 (FCFA billions)	89
Table 3.3: Selected Health Indicators from Mali, Benin, Guinea, Least Developed Countries, Sub-Saharan Africa	96
Table 3.4: Selected Wealth Indicators Mali, Benin, Guinea, Least Developed Countries, Sub-Saharan Africa	96
Table 3.5: Per Capita Household Expenditures on Health in Selected African Countries (US\$)	97
Box 4: 'Target-oriented' and 'Empowerment' Approaches to Participation	124
Table 5: Selecting a Research Strategy	152
Figure 5: Action Research Cycle	154
Box 5.1: Participatory Action Research Criteria	155
Box 5.1: Steps for Undertaking Participatory Action Research	158
Figure 5: TOPLAD Analytical Strategy	167
Map 1: Somalia, Regions and Districts	177
Box 6: Key Events in the development of the Somalia Red Crescent Society	204
Table 7.1: Community Participation in Clinic Support	253

Map 2: Qarhis Community	260
Box 8: Excerpt from an interview with Shire Elmi Yusuf	265
Table 8: Children Attending Qarhis Primary School	265
Box 8.1: Interview with a Traditional Healer	269
Box A7: Time-budget for a survey of about 1,000 interviews	337
Figure A9: A complex household, one husband, Abiib, with four households	361

Acknowledgements

I am deeply indebted to my supervisor Professor Sultan Barakat whose guidance and infinite patience made it possible to complete this doctorate. His support during the pre-study, assistance training the local interviewers and subsequently his willingness to act as neutral facilitator during the participatory action planning event in the village of Qarhis were invaluable. His ability to translate complex concepts across cultural boundaries was critical in engaging key informants, participants and authorities. He remains an inspiration.

I would like to express my heartfelt thanks and appreciation Peter Walker, Jean Roy and Eva von Oelreich: their encouragement and support in the early stages of the research created an atmosphere of positive expectation which helped dispel the doubts and occasional low morale. I am also grateful for the support of fellow students Ghassan El Kahlout, Gareth Wardell and Simon Weatherbed in carrying out the field surveys and to all those people in Somalia and Nairobi who made the field research possible. Special thanks are due to Serad Aden and Ahmed Jama and their fellow staff at the Garowe and Galkayo branches of the Somali Red Crescent, and the people of Qarhis village. I am also indebted to those who provided assistance, support and guidance along the way: Hakan Sandbladh, Ola Skuterud, Francoise Le Goff, Ahmed Gizo, Kwame Darko, Zaitun Ibrahim (all IFRC), Dr. Ahmed Hassan Mohammed (SRCS), Michel Dufour (ICRC), His Excellency Mr Farah Warsame Osman, (Minister of Social Affairs of the Puntland State of Somalia), Dr Abdul Rahman, (Director General of Health in the Puntland Ministry of Social Affairs), and President Abdullah Yusuf.

Special thanks are also due to my brother Barry Deely for five years of relevant and accessible information and analysis on a host of topics related to the research, and for his unwavering moral support. I am indebted to Joaquin Ronda for his suggestions on additional literature, numerous debates and frequent hospitality.

Declaration

I declare that this thesis represents my own work and that the contents have not been published before, with the exception of the following which were published in the course of undertaking the research:

- 2005 **Violent Conflict, Health, and the Challenge of Sustainable Recovery** in *After the Conflict*, Sultan Barakat (Ed) IB Taurus (London)
- 2005 **Community Managed Health Services: Sustainability through Ownership and Control** (with Sultan Barakat) in *After the Conflict*, Sultan Barakat (Ed) IB Taurus (London)
- 2001. **Programming for Sustainable Health Care** (with Sultan Barakat) in *World Disasters Report 2001: Focus on Recovery*. IFRC. (Geneva)
- 2001. **Care in the Desert** in *Red Cross Red Crescent Magazine*, June 2001
- 2001. **Health Service Recovery in Somalia** in *Humanitarian Affairs Review*, April 2001
- 2000. **Forgotten, Not Forgiven – Somalia’s Painful Transition** in *Humanitarian Exchange Issue 17*, ODI (London)

The Preamble

P1. The Context

Beginning in the 1970s, Fourth World governments built up massive, dollar-denominated debts as a result of collapsed commodity prices, soaring oil prices, increased military spending, economic mismanagement and corruption. In the 1980s and early 1990s, Structural Adjustment Programs were imposed on many of these countries as a condition for new loans and the rescheduling of debt servicing. With the end of the Cold War, economic recession was compounded by declining political relevance and many of these states were relegated to the periphery of an increasingly regionalized world system. The impact of conflict, poverty and the virtual collapse of already very limited public services produced sharp declines in the health and well-being of the populations in many of these countries.

Since the early 1990s, international aid organizations have been increasingly drawn into the provision of health and other services in these countries where health services have collapsed following years of underinvestment, de facto dismantling under structural adjustment programs, and destruction by warring parties. As time passes and the focus shifts to long term recovery, these essentially short-term projects give way to rehabilitation assistance whose primary aim is to help restore local services and pave the way for recovery. Rehabilitation theory suggests that during this transition, humanitarian agencies should provide ongoing assistance to the affected population pending the restoration of appropriate services by the responsible authorities. In reality however, the chronic nature of today's conflicts and the frequent failure of low-income countries to provide essential services means that agencies end up replacing formal services rather than helping to bridge the transition between relief and reconstruction. As the international community's attention moves on to the next crisis, agencies adjust to declining donor interest and under-funded annual appeals by cutting programs and providing fewer or lower quality services. Fear of further reductions in funding or donor withdrawal causes a 'commitment trap' where a general reluctance to invest in a medium- to long-term strategy to build local systems and

capacities to take over services, locks the agency into a cycle of relief provision. A downward spiral of budget cuts, reduced support, fewer benefits, lower staff salaries, and less frequent monitoring and supervision inevitably affects the quality and range of services, and local people revert to traditional healers, drug peddlers and self medication with expired or otherwise inappropriate drugs – often with seriously detrimental affects on their health.

P2. The Research Problem and the Importance of the Research

Caught in the vacuum between donor disengagement and a grossly inadequate national health system, the challenge for humanitarian organizations and national NGOs providing these essential services is to identify and harness resources that can help sustain the service at local level, while gradually integrating the service into an emerging national strategy for health service recovery supported by external organisations.

Individual within all communities have the innate ability and in some case already possess the skills to support the running of their own services. Teachers, nurses, administrators, clerics and others with professional backgrounds support health and other local services in many communities throughout the Fourth World. Traditional councils of elders implement long standing inter- and intra-clan agreements, providing systematic rulings on issues of ownership, entitlement, and access to land, adjudicating in disputes and determining compensation. In some cases, village or community committees support or oversee the implementation of social sector programs for health, primary education, women's development, water supply. Yet these local capacities are frequently ignored, sidelined and even undermined by short-term, externally-driven interventions. Instead of building on local governance mechanisms, external agencies create new structures with limited legitimacy and authority that remain foreign bodies dependent on external support, or impose services from provincial or regional capitals without any local support structure. Existing capacities that could be harnessed to provide legitimacy, inject local views, priorities and concerns into the design and planning of the program, provide governance support and oversight, and mobilize community resources to sustain services in the long

run, are ignored or left untapped by programming strategies that are often as inappropriate as they are unsustainable.

Aid programming that promotes community involvement requires organizations to identify and engage local people and their governance systems, develop institutional and individual capacities, strengthen partnerships, help identify and generate resources, and build the sustainability of local services. It also requires a significant shift in health staff's mindset from the monopolistic control of health knowledge to the promotion of this knowledge as a basis for improved community health, and from the 'upwards-accountability' that aims to satisfy donor requirements, towards 'downwards-accountability' to community members and facility users. The development of local structures, systems and capacities to support essential service provision in Fourth World countries implies a significant change in humanitarian organizations' operating styles and strategies.

Yet humanitarian organizations working in conflict-affected countries are ill-equipped to develop these local capacities and resources. Standard relief programming is based on externally-designed, planned and driven vertical interventions whose effectiveness is measured in lives saved, patients treated and units delivered, with little real involvement of local people. Agencies and donors are aware of these shortcomings, but numerous obstacles hamper the development of appropriate models for sustainable community health service programs in long-term unstable, conflict-affected countries:

- the absence of reliable background data on the socio-economic conditions of the target population, perceived time restrictions and limited financial resources;
- inadequate training of local and international organization staff in data gathering, community development and economics;
- reliance on health service program planning tools and methods that are largely inappropriate in conflict-affected and unstable environments.

P3. The Research Question and Hypotheses

Central to this research proposal was the belief that by studying the context in which the community health programming was taking place and the nature of the problem of

sustainability of the service, it would be possible to validate hypotheses and design and test solutions to overcome these obstacles. By adopting a problem solving approach to the research question, studying and documenting the programming experience, specific technical guidelines for health service rehabilitation programming could be developed. This research and documentation activity might also provide a foundation for the formation of policy, strategy and best practice papers by the international agencies and national NGOs who are faced with the challenge of bridging the post-conflict, pre-functioning government gap in essential service provision.

The literature review presented in the first four chapters generated the following research question:

Within the context of post-conflict recovery in the Fourth World, how can humanitarian organizations, working in partnership with local NGOs and emerging health authorities, harness the potential and resources of communities and empower them to participate meaningfully in the running and resourcing of their local health services?

A pre-study or exploratory case study was then undertaken in Somalia to generate a series of working hypotheses in the. The aim of the pre-study was to explore and understand health service recovery in the real world context of conflict and state collapse in order to generate a series of hypotheses about the type of programming approach that might be used to improve international organizations support to local NGOs and emerging health authorities. It would also serve to elaborate a methodology and plan to test these working hypotheses through a further, more focused phase of research.

Based on the initial literature review the pre-study took the following thesis as its starting point:

In the context of post-conflict recovery in Puntland, the Somali Red Crescent, working with communities and emerging health authorities, can build the necessary capacities and systems within communities to enable them to play a central role in the running and resourcing of their health services, and in doing

so, increase the sustainability of community health facilities and contribute to the creation of an effective public health system.

Building on the conclusions drawn from the extensive literature review carried out in chapters 1 to 4, and following careful examination of the conflict-affected Somalia region of Puntland during the pre-study, four hypotheses and related underpinning assumptions were elaborated:

Hypothesis 1: In the context of post-conflict health sector recovery, community involvement in planning and management can lead to significant improvements in the quality, appropriateness and sustainability of local services.

In support of this hypothesis, the research set out to test the following assumptions:

A.1.1: Conflict-affected communities would make better use of their local health service, and be more concerned about ensuring its sustainability, if they were given the opportunity to participate meaningfully in its organization and development.

A.1.2: Programming approaches that are based on locally-appropriate solutions – instead of standardized, ‘one-size-fits-all’ kits – and are informed by the expressed needs, priorities and concerns of local residents, and the socio-economic circumstances of individual communities, can engage the involvement of local people in the provision of sustainable health services.

A.1.3: If the range and quality of services and treatments responded to local people’s priorities, they would have less need to use alternative providers and could be persuaded to redirect out-of-pocket expenditures into some form of community fund for the facility.

Hypothesis 2: In conflict-affected contexts, collective financing schemes that accommodate communities’ seasonal income and asset realization cycles can provide a significant proportion of the direct costs of basic health services.

In support of this hypothesis, the research will test the following assumptions:

A.2.1: Collective community financing schemes that are based on an appropriate assessment of people's willingness and ability to pay can maximize local contributions by facilitating households' participation while helping protect household asset bases and contribute to long term recovery.

A.2.2: Communities are willing and able to contribute to financing schemes that are based on an appreciation of their income from livestock-trading, migratory and seasonal work patterns, and remittances linked to religious celebrations.

A.2.3: Community financing schemes based on local traditions and mechanisms to take care of the poor and the vulnerable, can overcome the inequities inherent in user fee and cost recovery systems that exclude the poor from health services, force people to borrow money for fees, increase indebtedness and spread the burden of ill-health throughout the community.

Hypothesis 3: The Somali Red Crescent can provide an institutional platform for the post-conflict rehabilitation of local health services, channelling the efforts of a wide range of actors and donors into a community-owned strategy for sustainable recovery.

A.3.1: Coordinated action among the various public and private stakeholders involved in health service provision, based on a shared vision and strengthened partnership, can contribute significantly to the creation of an effective public health system in Puntland.

A.3.2: The traditional mandate of the Somali Red Crescent as auxiliary to the government in the field of health and disaster response, and its unique position as the de facto public health service in Puntland confer a unique authority to inform the development of policy by the Directorate of Health.

A.3.3: Programmes which recognize – and where possible include – other local service providers, both formal and informal, have a better chance of long term success than those which ignore the potential winners and losers from changes in the structure and provision of health services in a community.

Hypothesis 4: The Somali Red Crescent is uniquely positioned to harness the driving potential of communities in the recovery process and empower local people to take control of their health services. Given the appropriate investment, the Red Crescent can build the institutional and individual capacities to enable communities to take responsibility for their health.

In support of this hypothesis, the research set out to test the following assumptions:

A.4.1: Token community participation paying lip-service to donor requirements ignores the skills, talents and capacities that exist in local communities for planning, organizing and managing services, and the role of traditional leadership and institutions in meeting community needs.

A.4.2: A strategic investment in the operational capacities of the Somali Red Crescent could produce a shift in its role from direct service provider to facilitator and supporter of communities in co-management of the health services.

A.4.3: The Red Crescent can develop the structures, systems and capacities at local level to enable local people play central role in the running and resourcing of their health service.

P4. Towards a New Approach

Much has been written about the challenge of sustaining health services for poor people in developing countries. The impact of structural adjustment and the application of cost recovery schemes have been the subject of a burgeoning body of literature (Nolan and Turbat 1995; Kreese & Kutzin, 1995; Turshen, 1999, 2001; Waitzkin, 2000; Gershman &

Irwin, 2000; Kim *et al*, 2000; Farmer, 2001, 2003; World Bank, 1993, 1998, 1999, 2003, 2003a; Henry and Bloom, 2000; Simms, 1999; Schoepf *et al*, 2000; Barakat & Deely, 2001; WHO 2001 Witter, 2001; UNDP, 2001, 2003; Whitehead *et al*, 2001; Gilson, 2000; Kim *et al*, 2001; Deely, 2001, 2005; Cliffe, 2000; Griffin and Ainsworth, 1995; Shaw, 1994, 1995; Schuftan, 1999 Chossudovsky, 1999; etc.). The application of participatory models to provide or sustain services or engage local people in planning has also been the subject of a great deal of literature including by, *inter alia*, Stringer, 1996; Robson, 1993; Ong and Humphris, 1994; Long, 2001; Kahssay and Oakley, 1999; Hintjens, 1999; Hart and Bond, 1999; Hakim, 2000; Golooba-Mutebi, 2004; Freire, 1974; Eade and Hill, 2000; Eade, 2000; Diskett and Nickson, 1997; Chambers, 1999; Chambers, 1983; Bowling, 2002; Barakat *et al* 2002; Witter, 2002. However, both researchers and practitioners have generally tended to maintain a clear division between the application of participatory models in development contexts where there are varying degrees of functioning government services, and conflict-affected contexts of state failure and collapse, which are portrayed as ‘humanitarian’. Participatory models are not normally applied and a host of institutional divisions ranging from mandate to funding sources to project cycles and staff profiles and competencies effectively prevent the application of these developmental approaches in conflict-affected contexts.

However, it is now widely recognized that the transition from conflict to post-conflict is neither clearly defined nor linear, and although low-level conflicts can break out periodically or affect isolated pockets for years even as post-conflict recovery progresses in most parts of the country.

Therefore, in order to test the series of assumptions presented above, the research developed an original participatory action research strategy which built on and extended the theoretical literature in the field of Action Research and Action Research in relation to health but had not previously been applied to conflict-affected communities in collapsed. The strategy was designed to engage local people – the users of the Puntland clinics – in an enquiry to develop a model for community-managed health service provision. In the first phase of participatory action research local people from 12 Puntland communities were trained and participated in the design and administration of a household survey to explore

the health priorities, socio-economic circumstances and traditions of participation in communities being served by Red Crescent clinics, and provide baseline data to be used to inform the design of the participatory model for health service provision. The second phase trained and engaged the same local people in the development of a participatory research and planning exercise to test this model using a rigorous case study to achieve conditions of experimental isolation in one carefully selected community. The results were used to inform the development of a new health service programming model which was subsequently replicated in communities throughout Puntland and Somaliland. The training and research materials developed to conduct the research were subsequently used by the Somali Red Crescent Society to develop a system and tools to promote local enablement of communities to participate meaningfully in the running and resourcing of their health services.

The field research also contributed to the development of original case study materials about the situation in Somalia. Relatively little was known about the Puntland state of Somalia, in 2000 when the field research began, and there was a pressing need for an objective enquiry into the health behaviours and conditions of the population there, and the socio-economic factors affecting them, in order to inform relevant, appropriate health service programming. There was a general lack of basic data and much of the existing data on demography, levels and sources of income, the state of the informal sector, coping mechanisms and capacities; inter-group relations, reconstruction and recovery, etc. have been questioned by different actors.

- The field research provided in-depth information on the socio-economic conditions within the 12 local communities in Puntland, and their traditional and contemporary coping capacities and strategies.
- The field experiment-case study produced a detailed profile of life and living conditions in the community of Qarhis in Puntland.
- The evaluation of the field experiment presents a detailed critique of local people's willingness and ability to participate in the planning, management and resourcing of their local health services.

P5. Overview of the Empirical Research Strategy

The research problem confronted here is to understand how community health services in conflict-affected countries can be sustained in the absence of a stable government and a functioning public health system. This dilemma exists or has existed in an increasing number of countries or territories since the early 1990s: for example, Afghanistan, Angola, Cambodia, East Timor, Haiti, Iraq, Kosovo, Liberia and Rwanda. Arguably, the most extreme case is Somalia; collapse has been total and fourteen formal internationally-supported initiatives at reconciliation and restoration of legitimate state authority have failed. It is here that the field research would be conducted. The assumption was that any new programming strategy or model which could produce an improvement in service provision in such an extreme case would find some application in a range of other less extreme situations.

A comprehensive review of the literature suggested that a case study strategy would be best suited to this context, incorporating an exploratory case study, a survey and a field experiment to overcome the obstacles confronted by research in conflict-affected areas. In addition to the literature review, an extensive review was conducted of unpublished programme and project plans and reports on post-conflict rehabilitation programming in Somalia, Afghanistan, Palestine and Kosovo by the International Federation of Red Cross and Red Crescent Societies, relevant National Red Cross and Red Crescent Societies UNICEF, UNDP, the World Bank, and other agencies.

An exploratory case study was used to explore the context and generate working hypotheses about the nature of the challenge of health service recovery in country affected by conflict and collapsed public health services. Most case studies articulate a series of propositions or hypotheses about the phenomenon being studied. The scope of the study can thus be narrowed considerably and attention directed towards the issues that should be examined in the search for relevant evidence. A household survey was then combined with a case study - field experiment to inform an understanding of the socio-economic conditions and coping capacities within local communities and develop a participatory model for health service provision. The survey explored the health priorities, socio-economic circumstances and traditions of participation in communities being served by Red

Crescent clinics, and provided baseline data to be used to inform the design of the participatory model for health service provision. This model was then tested using a rigorous case study to achieve conditions of experimental isolation in a carefully selected community. The results were used to inform the development of a new programming strategy.

The involvement of the Somali Red Crescent provided access to a range of primary sources and material that would not otherwise have been available. In addition, the participation of the staff from their clinics in Puntland and Somaliland in the field research provided an important opportunity to build capacities, extend knowledge and test solutions developed through the research. The involvement of the clinics provided invaluable real world inputs and responses to test the assumptions, and design practical solutions that could be translated into programming and policy. The Red Crescent provided access to a wide range of agency program assessments and reports, facilitated key informant interviews with government and local administration officials, and their policy papers and development plans, in addition to local NGOs and representatives from a variety of communities. This facilitated the collection of a large amount of data through literature and document reviews, key informant and focus group interviews, observation, and several workshops with Red Crescent and Federation staff in Puntland and Nairobi. Many meetings were also held over the course of the research with a range of UN and NGO actors working in Somalia

P6. Structure of the Thesis

The thesis is composed of ten chapters. **Chapter 1** describes the context in which the challenge of sustainable health service recovery is framed. It presents a brief review of some of the political and economic developments in the second half of the twentieth century that have produced a Fourth World of newly independent countries characterised by an inability to exercise authority over their entire territory, economic exclusion and vulnerability to commodity market volatility, widespread corruption, debt and infrastructural underdevelopment or decay. It goes on to describe the impact of structural and physical violence on health in the Fourth World and the seemingly insurmountable

challenge of health service recovery against the background of collapsed public health systems, the spread of HIV/AIDS and often chronic violent conflict.

Chapter 2 presents a detailed analysis of this challenge, reviewing modern health financing systems and their relevance to the Fourth World, where problems include the very limited tax base, structural barriers to improved efficiency, and the need for new and cost-effective treatments. A conflict emerges between two dominant recovery models: one which presents health services in terms of economics, i.e. - consumption, commoditization, pricing signals and supply-side versus demand-side strategies; and one which embraces a broader vision of health as the basis for human well-being, progress and productivity, an essential element in development. This conflict is explored from two very different perspectives to health resourcing that have emerged over the last fifteen years: a World Bank focus on health financing based on cost recovery as exemplified by the Bamako Initiative, and a developmental approach which locates health service recovery in the broader social and political context of community recovery. **Chapter 3** presents an in-depth analysis of the Bamako approach.. A wide range of World Bank reports and health economics studies are reviewed in an effort to assess the extent to which Bamako-type approaches have contributed to health service recovery. The analysis converges on the question of social and political inequities, and how the free-market forces at the heart of the Bamako approach deal with the dilemma of sustainability versus exclusion. **Chapter 4** reviews the developmental approach that locates health in the broader context of people's living and working conditions and stresses that recovery and development in any society are contingent on the wellbeing of the people that make up that society. The chapter reviews the evolution of development theory as a strategy to advance prosperity in post-colonial states, the emergence of participatory and empowerment approaches to development, and their application to promote better health. It then examines whether it is possible to create a system that reconciles the conflicting concepts of social justice and local-financing, to provide some local resources and contribute to the sustainability of services without excluding those who do not have the means to contribute to social insurance, or contract private insurance, or pay fees.

Chapter 5 introduces the research methodology that was used to guide the field work, which was arrived at following a review of the traditional approaches to social science research and the conditions for their application in volatile, unpredictable and often dangerous conflict-affected environments: The most appropriate strategy to address the research question is identified as the case study strategy, using a composite approach, and beginning with an initial field mission or pre-study to allow the most practical field research plan to be drawn up. The chapter elaborates a formal design for the pre-study and introduces the protocol used to guide the first phase of the field research.

The following three chapters present the field research. **Chapter 6** describes the pre-study – or exploratory case study – which was carried out to explore the context of recovery in the Puntland State of Somalia and to generate working hypotheses, and elaborates a plan for two further phases of field research. **Chapter 7** reports on a participatory survey that was carried out in Puntland to produce baseline data on communities’ socio-economic conditions and determine whether the reality on the ground matches the theoretical propositions in chapter 4. The data is also used to validate the working hypotheses and identify a representative community in which a field experiment could be staged to provide a rigorous test of these hypotheses. **Chapter 8** presents the in-depth study and community action planning event which were carried out in the Qarhis community in Puntland to ascertain whether conditions really do allow communities to provide some local resources and contribute to the sustainability of services without excluding the poorest members, and the agreement that was produced to increase community involvement in health service planning, management and resourcing through a pilot project there.

The final two chapters draw together the different aspects of the research to inform conclusions about the state of health service recovery and prospects for the future. **Chapter 9** presents an evaluation of the Qarhis field experiment comparing the empirical reality against the thesis and hypotheses developed earlier and proposes a new model for community health service delivery which incorporates community empowerment and management and adopts financing modalities compatible with seasonal income flows, and engages stakeholders in the sustainable provision of locally accessible health care. **Chapter 10** discusses the contribution made by the thesis to the literature, presents a summary of the

conclusions reached, and a brief review of the limitations and potential for community management as a basis for sustainable recovery. Recommendations are made for practice, and suggested avenues for future research are identified.

Audience

It is intended that this thesis be of interest to both researchers and practitioners in the fields of Humanitarian Aid, Development Studies, Health and Health Economics, Public Administration and Political Economy. It is further intended to be of particular interest to policy makers and advocacy officials in development and humanitarian organisations, and to programme managers for whom the community planning approaches that have been developed and applied in Somalia may be useful.

1. Weak States, Conflict, Declining Health and Welfare

‘The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.’

US President Franklin Delano Roosevelt, 1945

Introduction

This thesis addresses the failure of health service provision in the context of state weakness, conflict, and post-conflict recovery. This chapter looks at state failure, conflict and collapse in the Fourth World – a group of countries that are characterised by underdevelopment, fragmentation, conflict, and the steadily declining welfare of their populations. It will examine how political and economic exclusion, loss of sovereignty and structural adjustment combined with conflict to destroy health systems and devastate health. In an effort to understand the broader context of health service recovery, it will then trace the dismantling of health systems and decline in health status as a result of structural adjustment which frequently preceded – and was subsequently exacerbated by – conflict. In an attempt to understand the impact of state failure on health and welfare and the challenge of recovery, a number of questions are addressed:

- How did the almost universal imposition of structural adjustment in Fourth World countries affect public health systems?
- What role did structural adjustment play in the spread of HIV/AIDS in Africa?
- What has been the impact of violent conflict on health and health systems?
- What are the main challenges of post-conflict recovery of health services, and how these can be addressed in the context of long term deterioration produced by underdevelopment, economic recession and neoliberal adjustment.

The analysis presented here calls into question the capacity of Fourth World States to determine domestic economic policy independently of global agendas. This provides the

context for remainder of this thesis: the challenge of post-war recovery of health systems in many of these countries.

From Nation States to Failed States

The nation-state that emerged from the Second World War was one in which citizens were entitled not only to political freedoms, but also to share in the general welfare of society through full employment, social services, and poverty alleviation. The egalitarian ideal championed by US President Franklin D. Roosevelt in his 1945 State of the Union address was a beacon in the darkness and helped to shape the global dream of a world in which everyone enjoyed the political, economic and social freedoms essential to human well-being and dignity. It was upon this ideal of the post-war nation state which rested the promise of universal public health services as the obligation of government and the entitlement of citizens (Pelizzon & Casparis, 1996; WHO, 1999).

The nation state has been the basic unit of political life, identity and global engagement, and the vehicle for economic expansion for more than three hundred years. Although the modern nation state became the vehicle for the export of the state idea beyond Europe and for establishing global flows of trade, the number of nation states remained small until the Twentieth Century. Decolonization and revolution in the post-1945 period resulted in the establishment of fifty new independently recognised states in Africa, and the emergence of a host of new states in Asia and Latin America (Hobsbawm, 1994:344). The United Nations recognized these new states, facilitating the incorporation of former colonies into the nation-state system.

Prior to 1945, recognition of sovereignty was only accorded to states within the interstate system. Those outside the so-called civilized part of the world were subject to conquest, colonisation and transformation. This only changed after the Second World War when sovereignty became possible for an increasing number of newly independent states¹

¹ Why the change? One school of thought suggests that the 'thirty years' of war between 1914 and 1945 had taught the Powers that peace, stability and growth required a system of independent, sovereign states in a broad alliance, and that the consequences of the plundering of Germany following World War I promoted the

(Wallerstein, 2003). However, by granting sovereignty to many countries that clearly did not, and in all probability could not, control their territories, the UN was ignoring the dilemma presented by independence: would these states succeed in consolidating their rule over sometimes enormous areas, often inhabited by people from different ethnic groups or nations, with few roads and even fewer institutions of government (Herbst & Mills, 21).

The notion of state encompasses the state as the sovereign authority, as an institution capable of decision-making, and as the guarantor of security, law and order (Zartman, 1995:5). Duffield, similarly, defines nation-state competence as ‘the ability of states to independently govern and maintain economic, social and welfare standards in their own territories’ (Duffield, 2000).

The reality of many states that were recognized in the post-1945 period of decolonization and revolution distances them from both Zartman’s and Duffield’s definitions. Many of them never had the abilities Duffield describes. Nor did they fit Zartman’s description from the outset, and were probably ‘suspended’ in the sense that it was only a matter of time before their inability to function as states would be exposed. In this respect many are ‘quasi-states’ (Bull and Watson, 1984) The term refers to ex-colonial states which achieved *de jure* statehood but which lack many of the basic qualities of empirical statehood². Quasi-states:

‘...are states in name only; they are able to survive despite being inefficient, unstable and illegitimate by operational rules implicit in the new international order established after 1945.’

Evans & Newnham, 1998:458

realisation that exclusion was likely to lead to further conflict (Waters, 2001:115). Political economy analysis locates it firmly in the US strategy to consolidate and increase its political and economic domination within the post-war world order. The break-up of the old European colonial empires was thus supported by the US for two reasons: first, it would permit US access to what had been a system of closed trading blocs and second, it helped ensure that these states – many of whom were anyway undergoing a process of revolutionary decolonisation – were brought into the Western as opposed to the Soviet bloc (Reifer & Sudler, 1996:21; Brzezinski, 1997).

² In other analyses, these states are ‘fictitious’ states whose ‘legal substance or juridical reality [...] in terms of their recognition in international affairs and law, eclipses their substantive or “empirical” reality’ (Leftwich, 2000:87).

Some scholars argue that it was only a question of time before the combination of conflictive construction, arbitrary design, vacuous structure, incompetence, predation and corruption would produce a crisis that would culminate in the collapse of these ‘quasi-states’ (Leftwich, 2000: 87-90; Herbst & Mills, 2003:21; Milliken, 2003:10-12). For others, the inevitability stemmed from the combination of exclusion from the benefits of economic globalization (but not the negative effects such as price fluctuations and capital and financial market instability), loss of international relevance in a post-Superpower system, and erosion of already-dubious sovereignty at the hands of an emerging global governance (Yannis, 2003:66; Doornbos, 2003:40-41; Duffield, 2000:50).

Collapsed Economies

Between 1960 and 1990 the poorest 20 percent of countries saw their proportion of global income fall from 2.3 to 1.3 percent, while that going to the richest 20 percent increased from 70 to 83 percent (Thomas, 1997 quoted in Waters, 2000:114). During the same period, real GDP per capita in the least developed countries fell from 9 percent to 5 percent of that of industrial countries, and in Sub-Saharan Africa it fell from 14 percent to 8 percent (UN, 1991, quoted in Hobsbawm, 1994:424).

‘Of the forty-two ‘low income economies’ in 1970, nineteen had zero net foreign investments. In 1990 direct foreign investors had lost total interest in twenty six. Indeed there was substantial investment (more than \$500 million) in only fourteen out of almost 100 low- and middle-income countries outside Europe, and massive investment (from about one billion or so upwards) in only eight, of which four were in East and South-east Asia (China, Thailand, Malaysia, Indonesia), and three in Latin America (Argentina, Mexico, Brazil). [...] However, on the whole, a large part of the world was dropping out of the world economy.’

Hobsbawm, 1994:424-5

Demery *et al* (2002) argue that the economic policy reforms introduced under structural adjustment prescriptions (“improving macroeconomic balances and liberalizing markets”) have been conducive to reductions in poverty in Africa and that where countries have been excluded from these reductions, this is largely due to geographical factors, i.e. – sheer

remoteness and poor access to roads. This contrasts with a huge body of critical analysis demonstrating how trade liberalisation exacerbated balance-of-payments problems across a raft of African countries and created widespread unemployment³ (Hobsbawm, 1994:431; Chossudovsky, 1999:51-2; Storey, 2000; Leftwich, 2000:49; Stiglitz, 2002:53-88;). As Leftwich puts it:

‘...no examples of good or sustained growth in the developing world have occurred under conditions of uncompromising economic liberalism, whether democratic or not’

Leftwich, 2000:133 (emphasis in the original)

Nineteen countries in Africa experienced absolute declines in their GDP in the period 1960-89, with agricultural production declining from 32 to 16 percent of GDP (Waters, 2001:45). Thirty countries in Africa and 18 in Latin America rely on primary commodity exports for more than half their export earnings – often on one single crop. For example, coffee accounts for 75 percent of earnings in Uganda and Ethiopia, and prices have collapsed since 1997, falling by more than 70 percent, at a cost of \$8 billion in export earnings to affected countries and immeasurable hardship for their already vulnerable populations (Held, 2004:40). These countries are highly vulnerable to fluctuations in commodity prices on the world market, constraining their growth and development (Gershman & Irwin, 2000). In contrast to Demery’s position, Nobel Laureate and former Chief Economist at the World Bank Joseph Stiglitz describes how after the recent Uruguay Round of trade negotiations, the US boasted of the gains it had made while a World Bank calculated that the income of Sub-Saharan Africa, the poorest region in the world, would decline by 2 percent as a result of the agreement (Stiglitz, 2002:61). In fact, Africa’s share of the global agricultural market

³ Although IMF ideology maintained that new jobs would be created as regulations were torn down and unproductive state monopolies replaced by profitable, private-sector businesses, in reality there was neither the capital for investment in new firms to create these jobs, nor the education needed to attract them. Local production wilted as protective tariffs were lifted and domestic production was replaced by cheap imports, and deluxe goods targeting the wealthy elites. Many Third World states in Africa had also become clients of the US arms industry as part of the Nixon Doctrine strategy of using increased arms sales to create demand for dollars either by direct sales to OPEC states or by encouraging governments to borrow during the petrodollar lending splurge. Consequently, access to new loans – albeit for restructuring – meant increased arms purchases, helping redress the massive US balance of payments deficit generated by US militarization during the ‘Second Cold War’ (Reifer & Sudler, 1996).

has halved since 1980, during which time the number of starving Africans has doubled⁴. Today food and agriculture exports account for 27 percent of the region's exports in spite of the fact that developed countries protectionist policies represent a tax on African agriculture of \$7.1 billion per annum, equivalent to 85 per cent of the bilateral aid it receives. The benefit to Africans of genuinely free trade is estimated at between three and fourteen times the total value of the development aid the continent currently receives (Herbst & Mills, 2003:69).

Contested Sovereignty

Sovereignty for many Sub-Saharan African countries was always qualified and the type of sovereignty enshrined in the Westphalian principle of *rex est imperator in regno suo*⁵ was never really bestowed upon them in the first place. The end of colonialism and then communism gave the IMF and the World Bank the opportunity to vastly extend their powers and become two of the dominant players in global governance with huge influence both over those countries in crisis and looking for Bank or IMF loans, but also over those seeking access to international capital markets who must also abide by their economic prescriptions. Thus the sovereignty of weak and failing states is increasingly eroded by the global institutions of governance on which they depend for a significant proportion of their budgets, and whose 'conditionalities' ensure that they will remain weak and unable to create the conditions in which life and livelihoods could prosper.

Whereas in 1970 only twelve Third World countries had foreign debts in excess of \$1 billion and none over \$10 billion; by 1990 twenty eight countries owed more than \$10 billion, with twenty four countries owing more than the total value of their annual GDP (Hobsbawm, 1994:423). In Sub-Saharan Africa in 1997, governments owed \$180 billion in long term debt, 70 percent to official creditors and almost half to the World Bank and the IMF (Gershman & Irwin, 2000:24). By 2003, the debt had increased to \$360 million, with debt servicing accounting for \$15 billion per year, more than enough to ensure basic social

⁴ Andrew McKay and David Lawson question some of the assertions about poverty trends by making a distinction between chronic poverty and transient poverty.

⁵ The king is emperor in his own realm

services for the populations of the entire developing world⁶ (Majavu, 2004). Desperate for financial assistance they are forced to accept 'free trade' agreements which result in lower prices for their exports relative to what they pay for their imports, required to open their markets to speculative short-term capital that destabilises their economies and deters long term investment, and prevented from producing generic versions of life-savings drugs needed to treat HIV/AIDS and other illnesses that they could otherwise not afford to address (Stiglitz, 2002:9).

Today macroeconomic policy for these countries is increasingly dictated by international institutions, who also determine welfare and social policy in concert with a host of UN agencies and NGOs (Duffield, 2000:50). This appropriation of state power and functions by insurgents and criminal gangs on the one hand, and IGOs and NGOs on the other has reduced the remit of the state and in some cases pared away what little legitimacy the postcolonial order had bestowed upon them.

Nowhere is the impact of contested sovereignty, economic collapse inequality and conflict more obvious than in health. Today in Sub-Saharan Africa we have examples of UN Security Council-mandated peacekeepers accused of promoting the rampant spread of HIV/AIDS in conflict-affected developing countries, where IMF-prescribed structural adjustment policies implemented by the World Bank bear a significant share of the blame for the dismantling of health services⁷, and anti-retroviral medicine are unaffordable because of the dictates of the WTO on intellectual property and patent rights (Stiglitz, 2002; Elbe, 2003). And while government intervention is essential, public sector expenditure on health is estimated to be less than half of what would be required to provide even basic curative services (World Bank, 1993; CMH, 2000). In 1998 in Africa, debtor

⁶ Meanwhile, new loans granted to pay back old debts contributed to the debt stock, increasing the debt-servicing ratio and further entrenching the government. The external debt stock of developing countries increased from \$616 billion in 1980 to \$2.2 trillion in 1997. At 34.9 per cent, the ratio of external debt to GNP was 50 percent higher in 1997 than in 1982 when the IMF and the Bank first intervened to address the Debt Crisis. However, in the early stages at least, the objectives of many of the private banks advancing these loans may well have been achieved: between 1983 and 1989 poor countries paid \$242 billion more to creditors than they received in new loans (Gershman & Irwin, 2000:24).

⁷ 'The IFIs proposed to trade "short-term pain for long-term gain". They failed to acknowledge that for already vulnerable populations short-term pain could mean devastating long term health consequences affecting future generations and that those least responsible for the crisis would be its primary victims.' Schoepf *et al*, 2000:100-1

governments spent an average of four times more on debt servicing to northern creditors than they did on health and education (Gershman & Irwin, 2000:25). In conflict-affected countries the situation is significantly worse with overwhelming reconstruction needs and the diversion of reduced government revenue to defence and security (Macrae and Zwi, 1995). Here, instead of promoting recovery and development, SAP-driven deregulation has frequently been exploited by political actors to support conflict-relationships. Funds from privatisation, dual-interest rate systems, and international trade have been used to create and sustain extensive and powerful patronage networks, obviating the need for inputs from, and thus accountability to, ordinary citizens. Consequently public-sector investment in health and other social services has declined, increasing inequity to unprecedented levels and fuelling competition and conflict over state resources (Reno, 1999).

Emergence of the Fourth World

Control over 'quasi-states' was contested, frequently as a result of repressive, elitist-minority, dictatorial and even genocidal regimes. State weakness followed as a result of these regimes' subsequent inability to service the often burgeoning instruments of coercion through which control had been maintained thanks to the military and development aid from the respective sponsoring power. Bereft of the economic means to maintain the required state apparatus for coercion and repression of these insurgency or independence movements, governments effectively privatize violence, manipulating ethnic consciousness by recruiting supporters and fighters along ethnic lines and promoting civil war. Frequently, fighters are underpaid or unpaid and are encouraged to derive income from attacks on opposition ethnic groups (Keen, 1998). The vulnerability of the dictatorial regime was compounded by public sector infrastructure decay as a consequence of years of low-level investment in health and safety systems, education and public services. Inevitably this vulnerability met with one or more hazards in the form of external sponsorship of insurgency movements, economic collapse, or natural disaster. The resulting crisis culminated in a major escalation of conflict between the regime and the insurgent movement (Keen, 1998; Duffield, 1994; Macrae & Zwi, 1994). Between 1989 and 1992, twenty-eight new civil wars broke out around the world bringing the total to fifty-two, all but three of which were civil wars (King, 1997). In 1996 an estimated 42 billion people around the world were directly threatened by internal conflict, and in 1997 all the major

wars were civil wars - ostensibly fought within states, not between them - though regional sponsorship of factions and belligerent parties continues to characterize many ongoing conflicts which could not otherwise be sustained (Keen, 1998; King, 1997). These conflicts were frequently characterized by the deliberate, systematic destruction of societal structures (Keen, 1998, 1999). In the extreme cases (Haiti, Somalia, the Democratic Republic of Congo, Liberia, Sierra Leone and Rwanda) countries experienced total collapse, while in others (Angola, Afghanistan, Burundi, Sudan, and Zimbabwe) varying degrees of weakness and failure have prevailed (Zartman, 1994; Milliken, 2003; Evans & Newnham, 1998).

What we have seen in the last decade of the 20th Century, is the emergence of a 'Fourth World' composed of the poorest, weakest countries who have been excluded from the benefits of economic globalization, refused the possibility to maintain the domestic market conditions that might allow manufacturing or services to be nurtured within their borders, and denied a fair price for the commodities on which they rely for the greater part of their export earnings (Stiglitz, 2002; Farmer, 2003, Duffield, 2001). Beginning in the 1970s, Fourth World governments built up massive, dollar-denominated debts as a result of collapsed commodity prices, oil prices running at 12 times pre-OPEC levels, huge increases in military spending, and the wider consequences of gross economic mismanagement and often spectacular levels of corruption (Wallerstein, 2003; Schoepf *et al*, 2003; Reifer & Sudler, 1997; Hobsbawm, 1994). The World Bank and the IMF imposed structural adjustment programs on 42 governments in Sub-Saharan Africa, and a host of other countries in the developing world as a condition for new loans and rescheduling of debt servicing. The financial prescriptions were often determined on the basis of dubious data and questionable analysis. In many cases, the impact of their economic 'shock tactics' provoked enormous hardships; in some they triggered conflict and even state collapse (Stiglitz, 2002; Leftwich, 2000; Doornboos, 2003; Yannis, 2003). Where governments are maintained in place and not allowed to subside into complete failure and state collapse, they are drip-fed international financial assistance which is conditional on the maintenance of fiscal conditions conducive to what some scholars maintain amounts to neo-colonial extraction, with their domestic policies determined by the IMF, the World Bank and the WTO on behalf of the wealthiest and most powerful commercial interests in the world (Farmer, 2003; Callinicos, 2002; Woods, 2002; Leftwich, 2000; Duffield, 2001;

Chossudovsky, 1997). Their mounting debts ensure their continued dependence on these institutions of global governance and the powerful political and economic interests that control them.

Indeed, globalization has few positive consequences for the Fourth World; Rosenau's (2002) notion of 'framegration' – fragmenting and integrating under the pressures of globalization – is only valid if countries are also subject to integration. This is clearly not the case for the Fourth World, where the technological advances and market liberalisation that characterise conventional interpretation of globalization have occurred even as the development achieved during the early years of independence has been unravelling and with it the improvements in health and welfare (Held, 2004; Rosenau, 2002; Wallerstein, 2003; Hirst & Thomson, 1999; Stiglitz, 2002; Duffield, 2001). In short, if you fall outside the three poles of regional production and trade, if you are deemed irrelevant to global development and excluded from the economic integration process, if you have fallen back in terms of human development, life expectancy, maternal, infant and child mortality rates, GDP per capita, exports and equality, and if you are crippled by conflict, AIDS and corruption, then you are only fragmenting - and fragmentation is the product of globalization in the Fourth World.

Structural Adjustment and Health

Throughout the Fourth World, the 1990s were marked by a sharp slowdown - and increasingly reversals - in the trend towards improved health status. The impact of structural adjustment on the health of the poor is well documented though frequently overlooked in health service recovery program planning (Arhin-Tenkorang, 2001; Kim *et al*, 2000; Kim *et al*, 2000a; Farmer 2002, 2003; Farmer & Bertrand, 2000; WHO, 1990, 1999; Creese & Kutzin, 1995; De Waal, 1997; Oxfam 1997; Diskett & Nickson, 1997; Simms *et al*, 1998, Bloom & Lucas, 1999; Chossudovsky, 1999; Chomsky, 1999; Turshen, 1999, 2000; Schuftan, 1999; Schoepf *et al*, 2000). The following section presents a brief overview of some of the impacts in terms of:

- Withdrawal of Government Funding for Health;
- Exchange Rate Devaluation;

- Liberalised Markets; and
- Access to Public Health.

Withdrawal of Government Funding for Health

Austerity programs cut government expenditures on health, resulting in closures of clinics and hospital departments and reducing access to care in the facilities that remained open. Pressed to cut public sector expenditure and increasingly threatened by opposition, governments sought to minimise the political risks associated with austerity measures by reducing services to the poorest, the marginalized, minorities and those living in rural areas where political mobilisation - hence power – was weak or nonexistent. As a result of structural adjustment, health budgets in most countries in Sub-Saharan Africa were reduced to around *2 percent* of GDP (World Bank, 1997), compared with the *12 percent* that the IMF estimates would be required to provide effective health coverage in low-income countries if they are to meet the Millennium Development Goals on infant mortality (IMF, 2001). At the insistence of the World Bank, governments introduced user fee systems at clinics and hospitals charging patients for services and presenting further obstacles to access (Arhin-Tenkorang, 2001; Schoepf *et al*, 2000; Simms *et al*, 2001). A 1998 evaluation of the Bamako approach to financing health services in Mali explains how the structural adjustment prescription imposed on Mali in the early 1990s had decimated the human resource base in the health sector, laying the foundation for future problems in attracting health professionals back into the public sector later in the decade:

‘The social sectors, including health, were negatively affected for several reasons. First, the reform program resulted in significant reductions in health and education staff, including at the primary levels, which were already understaffed. Second, the wage bill reduction target was met only in part by staff reductions, the rest came from real wage declines, which contributed to low morale among health workers. Finally, efforts to reduce the size of the central MOH administration resulted in the loss of experienced high-level staff, which undermined efforts to improve government's planning and management capacity in the sector.’

World Bank, 1998:28-9 (emphasis added)

Zambia, suffered a sharp, sustained rise (40 percent) in infant mortality during the 1980s and 1990s, from 15 percent in 1980 to 21 percent in the late 1990s. While part of the rise – particularly in the 1990s - has been blamed on HIV/AIDS and severe drought, it appears that reductions in government expenditure on health accounted for a large proportion of the increased mortality. Case fatality rates for inpatients rose indicating deterioration in the range and quality of hospital services. Severe cutbacks in non-personnel medical expenditure in rural areas also contributed to a reduction in the effectiveness of primary health care. The number of births attended by trained health personnel fell and infant mortality increased accordingly. The introduction of user fees compounded the vulnerability of poorer populations by further reducing access (Simms *et al*, 1999; Simms, 1999 quoted in Bloom & Lucas, 1999:18). These findings are supported by other research including a two-year study of children’s health in Lusaka, the capital of Zambia, which demonstrated the negative impact of SAPs on children’s nutrition and health between 1986 and 1988 (Schoepf *et al*, 2000:113).

Exchange Rate Devaluation

Exchange rate devaluation increased the prices of imported drugs and medical equipment, pushing some of them beyond the affordability of individuals and health budgets. Household incomes deteriorated in real terms as a result of various price rises – especially fuel - and resulted in less disposable income for medicines, user fees and transport costs to health facilities. Research on within-country differential mortality by income demonstrates a strong inverse correlation between household income and risk of infant or child death, attributed to confounding effects of mother’s education which is also highly correlated with household income. Immunisation coverage was also found to be closely linked to mother’s education, with coverage increasing by 40 percentage points for children whose mothers had completed primary school education (Bloom & Lucas, 1999:17).

Where services remained, devaluation pushed up the price of imported supplies, equipment and spare parts and thus the cost of maintaining health and sanitation structures and systems. Public health systems deteriorated as water supplies became contaminated, sanitation systems were not maintained and ceased to function, health facility buildings and equipment became run-down, stocks of drugs were not replenished and skilled staff left or

worked part-time, supplementing their declining salaries from alternative sources. Devaluation also reduced health workers' salaries and further undermined morale. Many health (and other social sector) professionals emigrated from countries where structural adjustment reduced salaries - or their real value - and increased workloads to unmanageable levels through pay cuts, hiring freezes, early retirement and firings. As noted, for example, in Ghana, where the number of doctors almost halved from 1,782 in 1985, to 965 in 1991 (Schoepf *et al*, 2000:110). For health staff that remained, morale was naturally devastated by the combined effects of real pay cuts, shortages of staff and medicine, impossible staff-patient ratios, increasing health problems related to poverty, malnutrition and deteriorating sanitation, lack of supervision, training and management support. The impact on quality of services provided, professionalism, and staff-patient relations was equally damaging, frequently discouraging the sick from attending facilities which might not be open anyway depending on whether staff were working privately to make up for lost income, or where fees would be charged, and medicine would be expensive or simply unavailable. Many people were forced to self-medicate or use traditional healers, both of which have been shown to have severe negative effects on the health of those who are seriously ill (Whitehead *et al*, 2001).

The combined effect of devaluation, market liberalization, and privatization on the availability of food was particularly detrimental. Liberalization opened the market to cheap, surplus wheat, rice and other staples displacing farmers from the domestic market. Devaluation exacerbated their plight by pushing up the costs of imported fertilizer and other farming inputs including fuel and driving local producers out of business. Privatization facilitated elite manipulation of land reform to create large plantations and agricultural estates for personal development or sale to multinational corporations, exploiting the displaced farmers and landless poor for labour. Since the 1970s both food production and rural incomes have declined in most of Sub-Saharan Africa as inequality increased (Chossudovsky, 1999; Schoepf *et al*, 2000).

Liberalised Markets

Liberalized markets resulted in increased food prices through removal of subsidies and also affected household incomes through increased unemployment as local industries were

closed. The price of imported food also increased in many countries as a result of devaluations, affecting household nutrition as well as disposable income. Nutrition may be the single most important determinant of health – malnutrition increases the likelihood of disease by lowering resistance, and disease reduces the utilization of nutrients, so the immune system requires more food intake to fight off infection (Schoepf et al, 2000:112-120). Food subsidies as such are a form of social expenditure on health. Since poor households in developing countries spend at least 55 percent of their income on food, food subsidies were instrumental in increasing the real incomes of the poor. As a corollary, studies show that food subsidies improve food consumption and calorie intake in poor households. There is also evidence of a positive link between children's weight for age and food subsidy programmes (Pinstrup-Andersen, 1985, 1987, 1988, quoted in WHO, 1990:16-20). So while there is evidence that adjustment policies in some cases resulted in farmers receiving fair prices for produce (De Waal, 1997:50), the same drastic increases in food prices also resulted in the poor going hungry (WHO, 1990).

Poorly fed mothers and their infant children experience increased risks of chronic illness and death. Even moderate malnutrition leads to a 50 percent increase in the risk of sickness, stunting, mental retardation and death in young children. Women who have been chronically malnourished during childhood often do not develop the bone structure required for safe childbirth, and tend to have underweight babies. Undernourished women also produce poor quality and insufficient breast milk (Schoepf et al, 2000:112).

A longitudinal study of the impact of structural adjustment on children's nutrition undertaken by UNICEF in 1995 showed a rise in acute malnutrition and stunting among children of the poor. Over time, as the impact of adjustment was increasingly felt, malnutrition rose, including among children of those considered non-poor. The proportion of low birth-weight babies almost doubled. One fifth of all mothers under the age of 18 were found to be suffering from malnutrition. The study concluded that the negative effects would continue through the next generation (Schoepf et al, 2000:113)

In Cote d'Ivoire, longitudinal studies of the impact of structural adjustment on rural and urban households between 1988 and 1993 showed sharp declines in nutritional status

among the rural poor with increases in child stunting as incomes declined, particularly in the north of the country. Overall poverty in the country increased from 18 percent in 1988 to 32 percent in 1993 and 37 percent in 1995 (Ibid.113, 454).

Access to Public Health

Average life expectancy in Sub-Saharan Africa increased significantly in the 1960s and 1970s. Whereas in 1970, only 40 percent of the population had life expectancy over 45, by 1990 this proportion had increased to 88 percent (Bloom & Lucas, 1999). A decade later average life expectancy across the continent had collapsed to 47 years, reversing 50 years of advance (UNDESA, 2001). Between 1980 and 1996, eighteen countries experienced a fall in life expectancy. Bloom and Lucas charted the availability of six widely available indicators against 1996 life expectancies. The indicators were selected to demonstrate the presence of functioning public health systems and included access indicators for health services, sanitation and safe water, together with immunisation against diphtheria, pertussis and typhoid, reduced child malnutrition, and births attended by health staff. Attended births, in particular, is understood to be a useful indicator of the presence of functioning health facilities. What the data strongly suggests is that populations that experienced higher levels of mortality tended to have reduced access to public health (Bloom & Lucas, 1999).

In Sub-Saharan Africa, the low-rate of health staff birth-attendance is a major contributing factor to high levels of maternal mortality. In the poorest countries between 60 and 80 percent of women give birth without the presence of a trained health worker. This is one of the main reasons why 1,600 out of 100,000 women die in childbirth or as a result of pregnancy-related conditions in countries like Somalia (UNICEF, 1999). Four groups are particularly high-risk: poor women; those under 20 years of age; women bearing children over the age of 34; and women who have had five children or more. In spite of studies showing that when maternity fees are increased women opt to give birth at home, unattended by a health worker, SAP prescriptions pushed governments to impose user fees for childbirth-related services in Sub-Saharan African countries for much of the 1980s and 1990s (Schoepf *et al*, 2000:108). Simms *et al*, (2001) have demonstrated that two of the key indicators of health system effectiveness have been deteriorating in many countries in Sub-Saharan Africa during the 1980s and 1990s: immunisation coverage rates levelled off

in 1990 and have been in decline since 1995, and the proportion of births attended by trained health staff declined in 15 countries (Simms *et al*, 2001:23-4).

Table 1.1: Life Expectancy by Access to Public Health

Life Expectancy 1996	Access per 1,000 population to			Malnutrition Children <5 % 1990-96	Births Attended by health staff % 90- 96	Immunisation Children <1 with DPT % 1995
	Safe water 1989-95	Sanitation 1989-95	Health services 1993			
30-49	44	30	51	32	28	45
50-54	60	44	67	29	51	63
55-59	52	39	46	21	61	61
60+	100	73	99	13	90	83
All	53	39	58	27	45	58

Source: Bloom & Lucas, 1999

The eighteen countries in Sub-Saharan Africa with the lowest life expectancy were all low income. All had life expectancy below 50 years compared with only 2 of the 11 countries in the higher income group.

Table 1.2: Life Expectancy by Income Group

Life Expectancy	Income Group		All
	Low	Middle	
35-39	1		1
40-44	5		5
45-49	12	2	14
50-54	12	2	14
55-59	7	2	9
60-64	1	1	2
65-69		1	1
70-74		2	2
75+		1	1
	38	11	49

Source: Bloom & Lucas, 1999

SAPs: Helping to Precipitate a Catastrophe

In summary, SAPs have affected health status directly and indirectly in a number of ways which combined to increase vulnerability through poverty and destitution, introduce new risks by destroying traditional coping mechanisms and forcing people into migration and

commercial sex work, and by eroding, weakening and ultimately dismantling the formal health systems that might have prevented their illness or restored their health when they became ill. In short, SAPs

‘helped to precipitate a catastrophe in which virtually all economic, social, educational and public health gains made in the 1960s and 1970s have been wiped out’

(Evans 1995, quoted in Schoepf *et al*, 2000:110)

Across Sub-Saharan Africa a number of countries saw sharp rises in infant mortality in the period 1980 to 1996, as the combined effects of economic recession, structural adjustment and – in most cases – violent conflict translated into widespread human suffering and deteriorating health systems (Bloom & Lucas, 1999:8). By the end of the century however, economic decline, structural adjustment and conflict had set the scene for the destruction of Fourth World populations by facilitating and – in some cases – accelerating the spread of the HIV/AIDS.

Structural Adjustment and HIV/AIDS

Economic decline in general, and structural adjustment in particular, have also been two of the most important factors promoting and accelerating the spread of HIV/AIDS in the Fourth World. In Sub-Saharan Africa this is particularly pertinent – the region has 13 percent of the world’s population and 66.5 percent of its HIV-infected people (UNAIDS, 2004).

Creating the Conditions for the Rapid Spread of AIDS

HIV/AIDS began its spread throughout Sub-Saharan Africa in the late 1970s at the same time that the region was descending into economic crisis and state failure as a result of falling revenue from commodity exports, rising oil prices and growing external debt (Schoepf *et al*, 2000). The social effects of poverty - multiplied and exacerbated by structural adjustment - accelerate the spread of the disease, increasing unemployment and hence dislocation which in turn increases contact with commercial sex-workers; destroying coping capacities within and between rural and urban areas; and forcing young girls and women into informal or formal sex-work (WHO, 2001). Moreover, dismantling of public

health systems all across the region as a direct consequence of fiscal austerity policies imposed on debtor government has further facilitated the transmission of the disease by closing or reducing the very services which could have provided education and protection from the diseases. Where facilities have been maintained, user fees have been imposed, usually at exactly the same time that currency devaluations were driving up the price of imported food, clothing, footwear and medicine, and austerity measures were cutting back public sector jobs and closing factories. As people lost their formal employment and prices soared, men were forced to migrate for work, often coming into contact with sex-workers infecting themselves and their wives, while female-headed households and young women were often pressured to have sex with men for food, money or some economic support for their families, or ended up as formal sex-workers.

Up to ten times more girls than boys in the 15-19 years age group are infected: many older girls and young women are pressured or otherwise forced into having sex with older men as a result of cultural and social pressures (UNAIDS, 2004). Women are also particularly vulnerable due to widespread cultural and social factors which specifically limit their ability to negotiate safe sex, either by refusing sex or by insisting on the use of a condom (Schoepf *et al*, 2000). Their vulnerability is exacerbated by the role of untreated Sexually Transmitted Infections (STIs) in facilitating the transmission of the HIV virus. In a region where 90 percent of HIV infections are transmitted during heterosexual intercourse, the lack of public health resources to treat STIs has contributed significantly to the spread of the disease. STIs facilitate transmission of the virus in a number of ways: (SACB, 2003):

- in HIV-positive individuals, STIs increase both the plasma viral load and viral shedding in both male and female genital secretions;
- in HIV negative individuals, inflammation of the genital surface caused by STIs increases the number of cells with receptors for HIV and thus the susceptibility to infection;
- inflammation makes the genital lining more vulnerable to disruptions;
- STIs are not readily diagnosed in women because there are usually few – if any – symptoms.

Nevertheless, only a quarter of Sub-Saharan African countries are successful in diagnosing, counselling and treating people suffering from STIs.

The Present Situation

Today the number of people around the world living with HIV/AIDS is estimated at 40 million, including 5 million people infected in 2003 alone, 85 percent were adults and 15 percent – almost three-quarters of a million – were children. During 2003, 3 million people died from AIDS, including half-a-million children. AIDS-related diseases are the leading cause of death in young adults and more African children die from AIDS than from any other disease including measles and malaria, which - when compounded by malnutrition - were the main child-killer diseases prior to the spread of HIV⁸. Ten per cent of deaths occur in infants and young children. Twenty percent of pregnant women in Southern Africa are HIV-positive. One of every three babies born to HIV-positive mothers becomes infected – either *in utero*, during birth, or through breast-feeding, leading in most cases to death within two years as a result of inadequate health care facilities or because their parents cannot find money to pay for care where it may be available.

By 1990, improvements in child health as a result of dedicated child survival programs began to be reversed and child mortality rates that had been declining between 1960 and 1980 were rising towards pre-1960 levels. It is possible to prevent vertical-transmission (from mother-to-child) using antiretroviral medicine which is becoming available in more and more countries. However the initially-poor development of public health systems in Sub-Saharan Africa and subsequent destruction of health networks as a result of economic recession and structural adjustment means that there is often insufficient public health system capacity even to undertake the community sensitization and counselling that are a prerequisite to testing, let alone to prescribe and monitor the use of ARV drugs. Consequently in 2003, 70 percent of countries still had almost no voluntary counselling and testing programmes or programmes to administer ARV therapy to pregnant women or newborns. In 2002, only 50,000 people in the region had access to ARV drugs (UNAIDS, 2003). The situation is further complicated by the tuberculosis (TB) pandemic. TB causes over 2 million deaths every year, largely through infection as a result of poverty,

⁸ This reality is frequently inadvertently de-emphasised when organisations refer to the six-main childhood killer diseases, meaning *vaccine-preventable* childhood killer diseases: measles, mumps, polio, pertussis, diphtheria and tetanus.

malnutrition and HIV, and is the leading cause of death worldwide in young women. One-third of TB deaths in Africa are AIDS-related (Schoepf *et al*, 2000).

HIV/AIDS and State Failure

Several processes occurring as a result of HIV/AIDS in some African states which have been affected by economic decline for several decades are contributing to state weakness and precipitating failure. These strategic implications of the AIDS pandemic in Sub-Saharan Africa are threefold:

- i) disproportionately high prevalence rates among security and military forces
- ii) social and economic devastation
- iii) HIV/AIDS among the political, administrative and bureaucratic cadres in the elite and middle classes, i.e. the civil service, business people and entrepreneurs, leading to political, economic and social instability in states with high prevalence rates.

Weakened Security and Military Forces

Recent studies have demonstrated that a number of armed forces in Africa and Asia have HIV/AIDS infection rates among their members that are significantly higher than their civilian populations (Elbe, 2003). In some armies in Southern Africa, rates as high as 40 to 60 percent have been recorded.

Table: 1.3: HIV Prevalence in Selected African Militaries

Country	% HIV+	Total Active Forces	No. HIV+
Angola	40-60	130,500	52,000-78,000
Congo Brazzaville	10-25	10,000	1,000-2,500
Ivory Coast	10-20	13,900	1,400-2,800
DRC	40-60	81,400	33,000-49,000
Eritrea	10	171,900	17,000
Nigeria	10-20	78,500	8,000-16,000
Tanzania	15-30	27,000	4,000-8,000

Source: Elbe, 2003

If there is a threat to national security such as that posed by an insurgent force or an aggressive neighbour, perhaps with regional ambitions, and capable of mounting an invasion, then high HIV/AIDS prevalence in the armed forces can indeed contribute to state weakening and even collapse. Elbe posits at least six key factors in identifying the extent of the impact of HIV on the armed forces:

- The level of HIV prevalence;
- The number of servicemen and women who actually have AIDS;
- Whether the armed forces are volunteer or conscript;
- The level of specialisation and technical proficiency required by the force;
- The size of the force relative to the overall civilian population;
- The level of leadership and resources available to address the problem.

While the impact on individual armed forces will vary, it is clear that the greater the threat to the integrity of a state from armed actors within and without its borders, the greater the chance that armed forces will need to be deployed to protect the state: militaries with high levels of HIV/AIDS will increasingly be compromised by the impact of the disease on force strength, combat readiness, resources, leadership and morale.

Social and Economic Devastation

The social and economic effects of AIDS can seriously prejudice development and even stability in a country with high prevalence rates, through the direct and indirect costs associated with lost years of health, life expectancy and reduced returns on business and economic investments. In a number of countries in Sub-Saharan Africa, life-expectancy has fallen by up to twenty years and more, reducing it to levels last experienced at the end of the nineteenth century.

Communities have lost the positive effects of the economic benefits associated with the earnings of their most productive members, often leaving only the elderly and the orphaned. The cumulative loss to countries with high prevalence rates is enormous amounting to hundreds of billions of dollars of annual earnings (WHO, 2001). Additionally, growth in these countries has declined by several percentage points as a result of the impact of AIDS on worker productivity and entire industries are being undermined by the disease. Some estimates put the losses in projected economic growth as high as 25 percent in the worst-

affected countries (Elbe, 2003:47). In Southern Africa mining has been severely affected by illness and death from related diseases:

‘...we have experienced reductions in staff resources in a counterpart government department in excess of fifty percent in less than twelve months in one central southern African country, and between 25 and 50 per cent in other countries’

(Crown Agents, quoted in Elbe, 2003)

Countries with prevalence rates around 20 percent can expect to experience reduction in annual GDP of 2.6 percent: this scale of loss cannot be absorbed by for very long and eventually brings significant structural pressure to bear on a national economy.

Table 1.4: Calculated Loss of Life Expectancy Due to HIV/AIDS

Country	Expected (with AIDS)	Hypothetical (without AIDS)	Years Lost
Namibia	41.5	67.7	26.3
Botswana	48.9	73.0	24.1
South Africa	47.2	67.4	20.1
Zimbabwe	50.4	69.8	19.4
Kenya	51	69.8	18.8
Mozambique	39.6	56.7	17.1
Zambia	51.5	63.7	12.3
Cameroon	55.3	66.2	10.9
Tanzania	52.4	63.2	10.8
Malawi	48.1	57.3	9.2
Lesotho	59.2	68.3	9.1
Ivory Coast	54.8	62.8	8
Nigeria	53.6	58.4	4.7

Source: UNDP, 1999, quoted in Elbe, 2003

Internal Political and Social Problems

There are a number of ways in which the AIDS pandemic is contributing to instability in states that are already weak, or becoming weak as a result of political and economic factors which could be exacerbated by the disease.

- *Competition for Resources:* Spending on treatment of people with HIV in high-prevalence countries is expected to significantly reduce public spending in other areas during the coming years, taking a similar toll to some of the austerity programmes imposed as a result of SAPs. In Rwanda for example in the mid-1990s, over two-thirds of the health budget went to HIV/AIDS. In Malawi, 70 percent of hospital beds are occupied by patients suffering with AIDS. Zimbabwe has imposed a 3 percent income and corporate tax to fund a trust for people living with HIV/AIDS. Additionally, access to medical treatment - particularly where treatment is available to elites and not to other classes who cannot afford to pay for such treatment - could result in tension and unrest.

- *Loss of Political and Administrative Human Resource Capacity:* While the combination of HIV and poverty are particularly lethal, the disease is also ravaging the political bourgeoisie and bureaucratic cadres in countries with high prevalence rates. For example, in Zimbabwe, three government ministers have died from AIDS and a further six were reported to be HIV-positive in 2001. The son of former Zambian president Kenneth Kaunde is also reported to have died from AIDS (Elbe, 2003). In 2005 the son of former President of South Africa Nelson Mandela died from AIDS (BBC, 2005).

- *Reduced Capacity to Maintain Law and Order:* Similarly, deaths among the police and the judiciary are also affecting the already reduced capacity of affected administrations to maintain law and order, undertake investigations, mount police patrols, make arrests and generally fight crime. For example, in Kenya, 75 percent of deaths recorded in the national police force between 1998 and 2000, were attributed to HIV/AIDS, and Zambia has reported similar problems in its police (Elbe, 2003).

In Fourth World countries, HIV/AIDS has spread so quickly and so widely partly because of structural adjustment. The destruction of livelihoods, coping capacities and public health services as a direct result of economic decline exacerbated by SAPs has left many of these countries without even the basic capacities with which to slow the disease. Of the 40 million people infected worldwide, 26.6 million live in Sub-Saharan Africa, and 3.2 million of the 5 million new infections in 2003 occurred there. AIDS killed 2.3 million Africans in

2003 (UNAIDS, 2004). Any strategy for post-conflict recovery of health services will need to consider how to address the emergence of this pandemic.

The Impact of Conflict on Health and Health Systems

The main targets in today's violent conflicts are civilians, driven out of their homes and villages or maimed and killed, often with impunity. They constitute between 60 and 90 percent of the victims of all conflicts today (ICRC, 1998). Their health and welfare are threatened not only by gunfire and bombardment, but also by lack of access to food, water, basic health services and disease control measures. Three main effects can be discerned:

- Increased health needs of the affected population;
- Reduced capacity of health services; and
- Distortion of the health system.

Increased Health Needs of the Conflict-Affected Population

During violent conflict and war, mortality, morbidity and disability can increase drastically as a result of fighting, displacement, hunger and disease. Battlefield injuries however, may represent only a small proportion of the health problems: war results in displacement, hunger, the erosion of coping capacities and the breakdown in community health systems. Major problems can arise from preventable infectious and parasitic diseases such as malaria, measles, tetanus, acute respiratory infections and diarrhea. The burden of these diseases falls disproportionately on children and women of reproductive age.

War Wounds, Disability and Mutilation

At least two-and-a-half million people were killed by conflicts occurring in the 1990s, while a further 31 million people were injured, displaced or otherwise affected (IFRC, 2001). Although war only takes third place behind epidemics and famines in causing deaths, it is the worst disaster for inflicting injuries (Barakat and Hoffman, 1995). War requires continuous, high level surgical capacity, often in the most adverse security conditions for medical staff. Injury through bombardment, landmines and unexploded ordnance such as cluster bombs frequently results in permanent disability. Over thirty million landmines were laid in Afghanistan in the 1980s: today four per cent of the

population is disabled and in Cambodia, 36,000 people have lost at least one limb as a result of landmines (WHO, 2002a; WHO, 2002b).

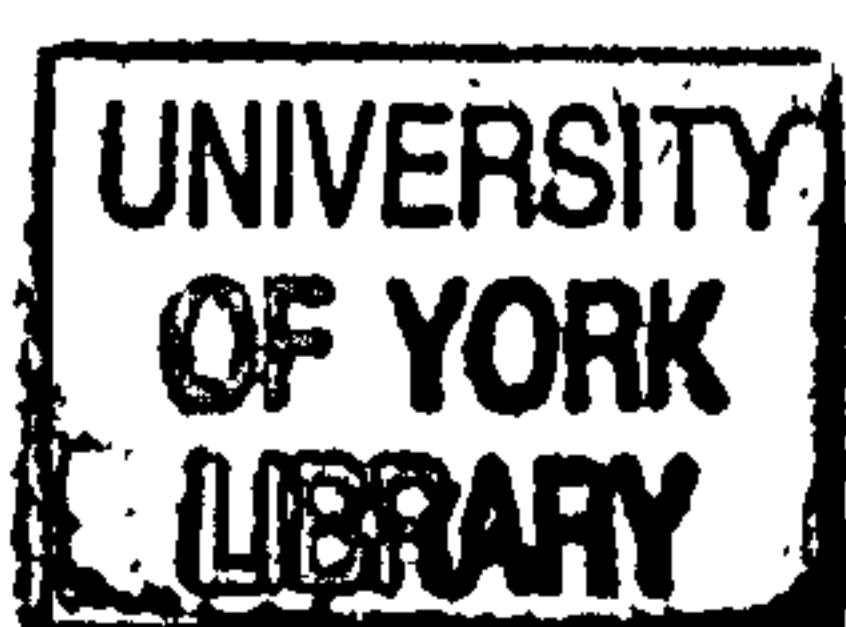
In some conflicts involving modern technologically-advanced weaponry, high levels of cancer have been reported – both among the local populations and among servicemen and women. Studies in Iraq report incidences of cancer in 40-48 percent of the population in some areas (Pilger, 2003). This has been attributed to the use of depleted uranium (DU) munitions: in the Gulf War more than 300 tons of DU munitions were fired, including tank shells containing up to 4.5 kg of uranium and hundreds of thousands of rounds of fighter aircraft ammunition made of solid uranium 238. These rounds disintegrate upon impact, with up to 30 percent turning to dust. Inhalation or inadvertent consumption when this dust makes its way into the food-chain result in cancer, birth deformities, high levels of miscarriage and other health problems (Pilger, 2003; HRW, 2000).

Mutilation has also been used deliberately as a weapon of war: in Mozambique people had their ears and lips cut off during the war; and in Sierra Leone, RUF fighters hacked off people's limbs during attacks on civilian areas (HRW, 2001; Pavignani & Colombo, 2001).

Communicable and Non-communicable Diseases

Secondary threats from waterborne, personal contact and vector-borne diseases increase as a result of overcrowding, damage to the infrastructure and inadequate clean water supply. For example, WHO estimates that there are 72,000 new cases of Tuberculosis and more than 15,000 deaths per year in Afghanistan, and over 15,400 new cases per year in Somalia (WHO, 2002b; WHO, 2001).

Threats from communicable diseases are worsened by the decline in immunization coverage, discontinuation of public health campaigns, and disruption of routine disease monitoring, prevention and control programs. Infant and child mortality increase as a result of vaccine-preventable diseases such as measles, tetanus and diphtheria. During the 1980s, infant mortality in conflict-affected areas of Uganda rose to 600 per 1000 (WHO, 2002a) and in 1992 in Somalia, child mortality rates between 500 and 750 per 1000 have been reported (Green, 1994).



Displacement, in particular, heightens exposure to health problems from communicable diseases, increasing the risks of measles, diarrhea and respiratory infections. During conflict and other disasters, refugees and displaced people experience ‘*massively raised mortality rates – at their worst, up to 60 times the expected rates during the acute phase of displacement*’ (WHO, 2002a). Lack of access to medical care also increases the incidence of mortality from non-communicable diseases such as heart-disease, and from other conditions like asthma and diabetes.

Women’s Health

Women’s health suffers disproportionately during conflict: maternal mortality in Afghanistan and Somalia (1,700 and 1,600 respectively per 100,000) are among the highest in the world (WHO, 2002b; UNICEF 1999). In Afghanistan the lack of basic health services was compounded by the shortage of female health personnel, gender segregation and restrictions placed on women and girls (WHO, 2002b). In Somalia restricted access to health services is exacerbated by the widespread practice of Female Genital Mutilation (Deely, 2001). Women are also particularly vulnerable to HIV and sexually transmitted disease during periods of conflict. In some African countries HIV prevalence among 15-to-24 year old women is up to six times higher than it is for men (UNDP, 2003).

HIV/AIDS and Sexually Transmitted Diseases

Risks from HIV/AIDS and sexually transmitted diseases also increase significantly during conflict, through prostitution, rape and the suspension of traditional cultural mores. In some Sub-Saharan African countries’ armies, more than half the soldiers are HIV positive (UNDP, 2003). Fighters from both insurgent and government forces frequently engage in forced or commercial sexual activities. Infection rates continue to increase as a function of fighters’ mobility, including during the post-conflict period when they return home after demobilization (WHO, 2002a). Refugee women in particular are more vulnerable to infection from HIV because of the lack of security in camps and host communities and because they are more likely to be forced into prostitution when they have been deprived of normal sources of income (*ibid*).

Mental Health

The psychological effects of conflict are widespread and profound. Frequent confrontation with death, proximity to bombardment, shelling and shooting, witnessing death or injury, loss of, or separation from family members, and the prolonged fear of invasion, capture, injury or abuse result in widespread post-traumatic-stress disorder (Maynard, 1997). Although many people manage to deal with the mental suffering and stress caused by exposure to violent conflict, it has been shown to produce increased rates of depression, substance abuse and suicide (WHO, 2002a). During the war Bosnia registered a high incidence of suicide among both young female victims of rape and sexual abuse, and elderly people who had given up hope as a result of the long siege of Sarajevo (Deely, 1998). In both Sri Lanka and El Salvador violent conflict is also credited with triggering sharp increases in suicide among the civilian population (WHO, 2002a).

Substance Abuse

Substance abuse increases dramatically as a function of depression and stress, and the increased access to drugs as a result of the breakdown of law and order. The production and supply of heroin, cocaine and *qat* have fuelled war economies sustaining conflicts in Afghanistan, Colombia, Kosovo, Somalia, Tajikistan, Myanmar, Peru and West Africa in recent years (UNODCCP, 2002). Heroin addiction among conflict-affected civilians is a major cause of ill-health. According to UNODCCP there are more than six million opiate users in Asia, mainly in and around Afghanistan and Myanmar (UNODCCP, 2002).

Aid workers and journalists have documented cases of parents and grandparents of Afghan refugees in Pakistani camps, taking opium and administering it to their children or grandchildren, to relieve stress and depression (TVE, 2003). In Somalia, *qat* addiction is a major social problem, directly affecting the health of hundreds of thousand of addicts throughout the country and indirectly affecting the health of family members by diverting scarce household income needed for food and health (Barakat & Deely, 2001).

Disrupted Access

The increased level of injury, disease and disability is compounded by the effect of the conflict in disrupting access to health care. Isolation from health services through damaged

infrastructure, reduced mobility, landmines, curfews, fear and insecurity, prevents people from seeking treatment for everyday or war-related conditions. For those who may be able to reach a nearby health facility, increased poverty at household level, due to loss of employment, decreased economic activity and high inflation, reduces access to increasingly privatized health care. Available treatment – if any – is further restricted by disrupted lines of access and referral within the health system as a result of fighting and territorial divisions (Macrae, 1995).

Diminished Capacity of Health Services

A number of factors combine to directly reduce the availability of health services: killings or displacement of health personnel, damage to facilities and equipment, and interrupted medical supplies. Indirectly, restrictions in local and central government budgets affect supervision, management and maintenance, while the lack of resources at national level weakens policy-making and planning.

Loss of Health Personnel

Attacks on health staff are an all too common feature of modern conflict. In Mozambique, health workers were systematically targeted, kidnapped and killed by RENAMO fighters (Pavignani & Colombo, 2001). In Uganda, half of the doctors and eighty per cent of qualified pharmacists fled the country between 1972 and 1985 (WHO, 2002a); in Rwanda over eighty per cent of the health care staff were killed or fled as a result of the genocide (Kumar, 1997); in East Timor most of the professional health staff were driven out during a three week rampage of violence and destruction in 1999: only 25 doctors remained (Tulloch et al, 2003). In the Occupied Territories ambulance drivers have been singled out and killed by snipers and regular Israeli forces during the current *Intifada* (PRCS, 2001).

Morale among surviving staff is further eroded by shortages of supplies, inability to deal effectively with patients' needs, and the devaluation or non-payment of salaries. In disputed or insecure areas, fear of being associated with one side or another and consequent persecution keeps staff away from public health facilities. Often rural facilities are abandoned completely as staff move to safer urban centers.

Damage to Infrastructure and Equipment

Clinics and hospitals are often systematically targeted during campaigns of violent conflict and war, as forces attempt to destroy the support base of their adversaries, displace perceived sympathetic populations, or terrify them into submission. Buildings are destroyed or seriously damaged, and vehicles, equipment and supplies are looted or stolen. For example, during the war in Somalia, eighty-five percent of the health infrastructure was destroyed or damaged beyond repair (Barakat and Deely, 2001). Following the referendum in East Timor in August 1999, pro-Indonesian forces demolished the Timorese health system, completely destroying thirty-five percent of the infrastructure and leaving only twenty-three buildings without major damage. Almost all medical supplies or equipment were looted or damaged beyond use and the central health administration was completely ruined (Tulloch et al, 2003).

Interruption of Supplies

Shortages and infrequent supplies of medicine cause increases in medically preventable conditions. This often leads to avoidable deaths from asthma, diabetes and a range of infectious diseases and is compounded by interruptions in cold chains for vaccines and maintenance of medical equipment for diagnosis and treatment. The imposition of sanctions exacerbates and prolongs this problem. Before the 1991 Gulf War health services in Iraq reached ninety percent of the population and children were routinely vaccinated against the major childhood diseases (WHO, 2002a). The sharp reduction in health system capacity as a result of damage and disruption during the war was compounded under the sanctions regime. Imports of cold-chain equipment, spare-parts and supplies needed to maintain medical equipment, including heart and lung machines, radiotherapy equipment, chemotherapy drugs and analgesics, were delayed or blocked completely by the Sanctions Committee (Sikora, 1999). As many as one million people are estimated to have died as a result of the combined affects of conflict and sanctions between 1990 and 1997 (UNICEF, 1998; Cortright and Lopez, 2001; Pilger, 2003).

Reduced Health Financing

Conflict-affected governments generally experience a reduction or redirection of resources away from health spending that jeopardizes their ability to maintain normal levels of public

health services and inform planning and policy. During war, the economy contracts as commercial activity declines and resources are diverted away from normal activities, leading to a shrinking of the government's tax base and the impoverishment of ordinary people. Collier (2000) estimates an average decline of 2.2 percent for each year the conflict continues. As conflict looms or escalates, public finances are diverted to military expenditures and central and local government health budgets are reduced. Typically inflation soars and the reduced health budgets are devalued further. This devaluation quickly translates into shortages of medical supplies, fuel for ambulances or other vehicles, spare-parts, and a general failure to maintain facilities and equipment. Public sector salaries fall below subsistence in real terms and staff increasingly resort to private practice to supplement or maintain incomes. Over time, services deteriorate further as staff performance is affected by diminished supervision and training (WHO, 2002a; Macrae, 1995, 1997).

Weakened Policy-making, Planning and Management Capacity

National capacity for policy-making, planning and management is dramatically reduced by the loss of senior health staff and the reduction in financial resources available for health. The exodus of senior health personnel often deprives post-conflict countries of their most experienced and capable professionals who seek safety and a future for themselves and their families in neighboring or third countries. Many of them never return (Macrae, 1995). Countries like Afghanistan, Somalia, Congo and Iraq which have been affected by conflict for years have been unable to participate fully in international debates about changes to health systems, for example to address the HIV/AIDS crisis, or the increased incidence of TB. For example, in Somaliland, a WHO study revealed that only 7 percent of registered private practitioners knew the correct TB regimens and only 13 percent apply direct observations (WHO, 2001). Because conflict-affected countries experience high levels of displacement and migration, they act like weak links in a chain, preventing the eradication of diseases like polio, and increasing the transmission of HIV/AIDS and TB. Inability to participate in international mechanisms for policy-making and planning also increases the risk that these countries – and as a corollary – their neighbors suffer major outbreaks. In Gulu, Uganda in 2000, an outbreak of Ebola hemorrhagic fever was linked to the return of troops who had been fighting in the Democratic Republic of Congo (WHO, 2002a).

Distortion of the Health System

As a result of the increased need and reduced public sector capacity, the structure, source and concentration of health services change dramatically during and after periods of conflict. The health system may undergo significant transformation or even fragmentation, and it is not uncommon for public services to be marginalized as a series of domestic and international actors take over the responsibility for the provision of services. Although they may provide a temporary solution, considerable problems are also associated with the proliferation of informal and unregulated services and the predominance of NGO relief health programs.

Diversion

As conflict escalates the focus of health services shifts away from primary to tertiary care. Increasingly resources are diverted to deal with war-related problems such as the treatment of battlefield injuries, malnutrition and disease. Preventive and promotive activities are reduced or suspended. Vector control and public health programs are compromised. Community-based activities in general are reduced or suspended and outreach services are cut back dramatically or halted completely due to lack of resources or insecurity. Disease control and surveillance programs are interrupted and health information systems are disrupted.

Privatization

The structure of health service provision can change dramatically during and after conflict as public health workers who are forced to leave their normal place of employment due to fear, destruction or the lack of remuneration, turn increasingly to private practice to earn a living (Macrae, 1995). As cutbacks and inflation drive government salaries below subsistence levels, workers either supplement their incomes by 'referring' clients for private consultations at their residence or in a local pharmacy, or they leave their public sector jobs and focus solely on private practice. In some countries, public health sector employees were allowed to divide their time between public and private practices. This was the case, for example, in Somalia during the Barre era, and the practice continues today

with many NGO health facility staff maintaining a private practice in a local pharmacy, or running a pharmacy themselves.

Informalization

In some cases, the *de facto* suspension of the regulatory role of the national health authority due to lack of resources effectively removes the requirements for health service providers, and the services and drugs they provide, to meet minimum professional requirements. An ‘informal’ health sector emerges as a result of the sharp rise in need, the collapse of public health services and the increased availability of drugs and medical supplies from aid operations. An increasing number of traditional healers, pharmacies and drug peddlers appear. In the Puntland state of Somalia, UNICEF estimates that as much as eighty percent of health service provision is provided by ‘informal’ or private providers. There are hundreds of unlicensed pharmacies in Bosasso, Galkayo and Garowe (Barakat & Deely, 2001). Far from improving the situation, this combination of ‘informalization’, deregulation and self-medication contributes to the worsening health status of the conflict-affected population. According to the WHO, in Somalia for example,

‘...anti-TB drugs have been prescribed in wrong regimens and are generally sold without prescriptions by the majority of pharmacies. This malpractice has taken place for many years and is contributing to the spreading of multi-drug resistance in the country’

WHO, 2001

Urbanization

Uncertainty and fighting generally force large numbers of people into urban areas in search of security, food and shelter. Health facilities become overwhelmed by the influx of displaced persons seeking care. Displaced health professionals and former public sector health staff may offer informal services or establish private facilities such as clinics or pharmacies. Meanwhile, under pressure from media-driven public and political interest, NGOs compete to set up relief health projects in urban centers with large populations. As health workers flee rural areas and outlying facilities are cut off due to insecurity or damage, the disparity in the availability and quality of services between rural and urban populations often becomes dramatic. In Angola in 1996, 90 percent of the health services in Huambo province were concentrated in Huambo city (Pavignani & Colombo, 2001). In

Somalia only 15 percent of the rural population has access to health services, compared with 50 per cent of the urban population (UNDP, 2001). In Afghanistan, Kabul currently has one physician for every 1,700 people, while in rural areas the ratio is one physician per 450,000 people. Half of the 8,333 hospital beds available in the country are located in facilities in Kabul, while the rest of the country has 0.34 beds per 1,000 people, compared with an average of 3 per 1000 in low-income countries (WHO, 2002b).

Internationalization

Short-term, high profile relief health programs by international NGOs often ignore government policy and guidelines, supposedly in the interest of time, or perceived neutrality, effectively sidelining the already weakened health administration. Usually operating outside the control of the Ministry of Health, many NGO activities are project driven with only token participation in co-ordination mechanisms. Bounded by project objectives, agency mandates and donor agendas instead of a national framework for health service delivery; relief aid further undermines national capacity for policy-making and planning. While they bring badly needed assistance, limited technical capacity and inflexible donor funding cycles can lock NGO into a short-term relief mode long after more developmental approaches could be employed (Macrae, 1995; Jackson & Deely, 2001).

Fragmentation

NGO health activities often constitute parallel health and welfare networks which fragment the public health service and divert resources from the government. During the complex political emergencies of the 1990s, responsibility for health service provision in affected countries was divided up between hundreds of different aid organizations, with certain NGOs or even donor countries assuming responsibility for specific zones. It was not uncommon to find different systems and even standards of health care being provided by different NGOs in neighboring provinces or districts. Designed with donor agendas and resources in mind, health services develop unevenly, even ad hoc, delaying rehabilitation and recovery of national health systems (Duffield, 1994; Stubbs, 1998). Aid agency initiatives also tend to favor vertical programs focusing on a single disease such as malaria or TB, or aiming for a single intervention such as malaria, with less integration across services (WHO, 2002a).

Lack of Accountability

Typically, NGOs are accountable to external donors for the effectiveness of their programs and the services they provide. There is little or no ‘downward’ accountability to people in the community or health authorities at local or national level. This lack of accountability obviates the need for consultation with or participation of beneficiaries. Local people - whose resources could be drawn on to sustain the health service in the long-term – often complain that their perceptions about their own health needs and wishes are ignored and that they have little meaningful involvement in decisions about the services provided. Intentionally or not, this often creates a ‘take-it-or-leave-it’ impression which alienates local people and reduces their prospective willingness to mobilize resources for the services when donor support is withdrawn.

The Challenge of Health Service Recovery

This gives some idea of the problems facing post-conflict states as they confront the challenge of health service recovery. Recovery requires a move away from relief-based programs towards the development of long term programs aimed at improving the overall health status of the population and establishing an effective health system. It implies a shift in focus from short-term projects to large scale rehabilitation and reconstruction programs. Any recovery strategy must respond to three specific challenges:

- Access large scale international support;
- Rapidly increase service delivery capacity; and
- Develop a strategy for sustaining services during the post-recovery period.

Accessing International Support

Given the lack of resources available to the post-conflict state, and the enormity of the task of rebuilding, significant sums of international assistance will be needed to meet the cost of recovery. Experience has shown that – even where the international community has intervened decisively to support large-scale reconstruction - it takes at least a decade to build the governance capacity, policies and institutions that are required to provide the

necessary support to the health service (Collier, 2003). And there are few cases of sustained international support. Recent studies have demonstrated that, even when large scale reconstruction aid is forthcoming, too much money is provided too early – during the first three years - when absorptive capacity is low, and resources are squandered. Then, just when absorptive capacity is increasing, the level of aid decreases (Collier and Hoeffler, 2002).

The theory suggests that in the past donor support for reconstruction and development assistance has been conditional on (a) a formal end to the conflict; and (b) international recognition of any new government. This is because the international aid system is based on relations between states and large scale reconstruction support cannot be granted in the absence of an internationally recognized government. Donors continue to bypass the *de facto* government and channel funding for health service rehabilitation projects through the NGO sector, even though experience has shown that when such projects are not implemented within a coherent national policy framework, resources are dissipated with little long term impact on recovery. Even with a recognized government in place, donors are reluctant to risk investing the levels of aid that would be required to deliver reconstruction and recovery without a formal end to the conflict, because renewed conflict remains possible or probable. The end of a conflict and formal recognition of the government, therefore, allow states to adopt positions on support to a post-conflict country, setting the wheels in motion for engagement by macro-level institutions like the World Bank to initiate the development of plans for reconstruction and development finance (Macrae, 1995).

In reality however, genuine post-conflict situations are few and far between and low intensity conflict can continue for years after a formal cease-fire. In the context of extreme instability that characterizes most Fourth World countries, conflicts often subside only to restart again within a few years (King, 1997). Even when there is a recognized government in place, these countries tend to have very weak institutions and high levels of corruption, and decades of development aid have failed to improve policies and institutions (WB, 2002). In some cases, they have made them worse (Leftwich, 2000; Gershman & Irwin, 2000). Donors are thus reluctant to risk investing the levels of aid that would be required

because previous efforts have failed. Regardless of legitimacy or post-conflict status, large scale assistance is unlikely to be forthcoming because donor strategies in these countries have not succeeded in producing recovery in the past (Collier, 2002).

Increasing Service Delivery Capacity

In the past, health sector rehabilitation typically focused on high-visibility reconstruction of urban-based secondary and tertiary facilities and increased vertical programs to tackle the main causes of disease. This type of approach centers mainly on NGO-led interventions at the micro-level and produces an expansion in services in the short term. Because they ignore long term considerations of capacity and sustainability they contribute relatively little to the overall process of reconstruction and recovery of the health system (Macrae, 1995). What is really needed is a twin strategy that can increase access to basic health care quickly and develop the capacities to maintain that access in the future. Emerging administrations must provide essential services quickly to improve health and ensure that recovery is not retarded or jeopardized. In the short-term, a scaling up of services is urgently needed to provide essential care and expand the health system to meet the needs of rural as well as urban residents and ensure services reach previously underserved or marginalized groups. For example, a survey carried out by WHO in Afghanistan in 2002, identified one basic health centre per 40,000 people in the central and eastern regions, and one per 200,000 people in the south. Nineteen districts had no health facilities whatsoever (Waldman & Hanif, 2002). In the long term, emerging authorities need to design and build a public health system that can identify, address and monitor the most common health problems, and guarantee the quality of both preventive and curative services. Long term recovery implies determining the character and content of the public health system and the channels through which the service will be delivered. Depending on the intensity and duration of the conflict, a range of activities may be required: rehabilitating and re-equipping damaged health infrastructure; developing a cadre of technically competent health staff; establishing an effective, practical health information system; developing and imposing a regulatory framework to guide the activities of a disparate collection of NGOs, private and informal service providers; and undertake a restructuring of services to provide an even distribution in rural and urban areas.

In theory, post-conflict countries require increased short-term funding for existing government facilities, while simultaneously deploying long term funding for investment in rebuilding the capacity of the public health system. However, even where an emergency provoked by an upsurge in violent conflict or a famine forces the international community to engage in relief and rehabilitation programming, experience has shown that government capacity – whether for health services or other functions – cannot be developed in the absence of a strategy for political reconstruction (Leftwich, 2000). Technician approaches to the development of government institutions and capacity in Fourth World countries have consistently failed and it is now widely acknowledged that without an overall strategy for political as well as economic recovery, accompanied by years of sustained investment to increase capacity, there is little prospect of a lasting increase in services. Unfortunately, in most Fourth World countries the political will to produce such a strategy is singularly absent. Consequently, these countries continue to suffer chronic failure of basic service provision.

Sustainability

Even if Fourth World countries manage to secure enough international support to rehabilitate a skeletal health system with the capacity to deliver essential services to some proportion of their population, these countries can only hope to make small improvements in their health condition if they can sustain essential services over a long period of time. This raises two major problems: first, Fourth World countries are generally very poor and simply lack the financial resources required to sustain even basic health services; and second, private expenditure on health tends to be out-of-pocket spending at the time of illness, rather than pre-paid, missing the opportunity to support community-based health delivery facilities (WHO, 2001).

In 1997, the average amount spent on health in the forty-eight least developed countries was \$11 per capita. No government in any of the forty-four low income countries with a per capita income of \$500 or less per year raised even \$20 per person per year for public outlays on health and no country with per capita income of less than \$600 per year spent four per cent of GNP in budgetary outlays for health (WHO, 2001). According to WHO, the minimum per capita outlay to scale up existing capacity to provide a set of essential

services in low income countries would be \$30 to \$45 per year – or \$10 to \$15 in purchasing power parity-adjusted terms (*Ibid.*). This would support a basic system capable of addressing the major communicable diseases and maternal and perinatal conditions that cause the majority of deaths in low income countries. But this would amount to between 10 and 15 per cent of GDP in Fourth World countries, much more than could be allocated from domestic resources - which in most cases rarely amounts to more than 10 percent of GDP - and far in excess of what would be available to any country struggling to rebuild after war. For example, in Uganda, the 1986 Ministry of Health budget was only 6.4 percent of its pre-war, 1970 level (Macrae, 1995). The Somaliland Ministry of Health and Labour budget in 2002 was \$500,000, or \$0.17 per person. In the Puntland State of Somalia in 2000, total public revenue was \$8.36 million, of which 2 percent - \$167,200 – was allocated to health. Even assuming the lowest population estimate of 850,000 persons, this amounts to \$0.19 per person (Barakat & Deely, 2001).

This inability is compounded by the inefficient use of private spending on health (WHO, 2001; Whitehead *et al*; 2001). Because of the poor state of public health service, private expenditure forms the main funding source for health care in low income countries, unlike established market economies, where public expenditure exceeds private spending by a ratio of 2.3 to 1 (Witter, 2002). The levels of private spending indicate that these out-of-pocket payments could make a significant contribution to sustaining community-based-health services if they were paid into a pre-payment scheme. Such schemes would also offer the benefit of risk-pooling, providing some form of insurance against future illness. Instead, households spend a significant proportion of their disposable income on out-of-pocket payments for services at the time of illness, often squandering the money on low quality or inappropriate treatment, or informal and traditional forms of health care with little - if any - positive impact on their health (Whitehead, 2001).

Post-conflict, post-SAP Recovery

In conclusion, recovery would need to deal not only with the relief-health needs of a conflict-affected population, but also to find ways of improving the overall health status of the population and come to terms with the need to establish an effective health system. The implied shift in focus from short-term projects to large scale rehabilitation and

reconstruction programs would require access to large scale international support, rapidly increased health service delivery capacity, and a solution to the major challenge confronting all public health systems in Fourth World countries: how to sustain essential health services to the population during the long term transition to recovery.

Conclusion

From the late 1980s onwards, the capacity of states in the Fourth World to protect the health and welfare of their populations declined sharply. The structural weaknesses inherited with the colonial state, political and economic mismanagement and exploitation, inequality and corruption, climaxed with the imposition of structural adjustment programmes that had devastating social consequences. Although neither the financial institutions nor their structural adjustment prescriptions were to blame for all that had taken place before their arrival on the scene, their impact on health was disastrous. Instead of the economic turn around the adjustment programs were ostensibly intended to produce, they precipitated the destruction of the social and economic fabric of whole societies, sharply increasing poverty and vulnerability and sparking unrest, violent conflict and – in some cases – state failure. The impact of structural adjustment on Fourth World countries also undermined their ability to resist the onset of HIV/AIDS. The erosion of family and community structures, traditional coping behaviours and the wholesale destruction of public health services as a direct result of structural adjustment programs paved the way for the rapid, unchecked spread of the virus.

By the late 1990s, the various effects of colonialism, Cold War Superpower sponsorship, militarization and disengagement, and structural adjustment were fuelling 52 civil conflicts around the world (Keen, 1998). HIV/AIDS had taken a firm hold in most of these countries and their health services were in ruins. The luckier ones were receiving some degree of international assistance to provide emergency health relief services to some proportion of their populations, but for the majority, health conditions continued to decline to pre-independence levels and beyond. Without any capacity to prevent or respond to the spread of AIDS, life expectancy in many of these countries is falling below 40 years.

Health service recovery would need to address not only the immediate effects of the conflict, but also the legacy of structural adjustment and ravages wrought by unchecked and inappropriate neoliberal prescriptions that systematically dismantled government services and replaced them with rhetoric about the free market. Access to international support is not easy to secure, depending on the nature of the transition from conflict, the potential for maintaining stability, and acceptance of the emerging administration's legitimacy. Even if they do receive assistance, experience suggests that these countries are unlikely to succeed in building the capacity needed to extend services throughout the country, and in the long run they simply don't have the resource base to maintain them anyway.

Prospects for recovery are therefore bleak. Clearly it is unrealistic (though perhaps not unreasonable) to expect that the wealthy countries of the international community will invest the political will and financial commitment to promote long term recovery in a raft of Fourth World countries. How then can health services be restored to people in these countries, plagued by poverty, inequity, debt and underdevelopment and ravaged by structural adjustment and conflict? How can they be sustained in the long term transition to recovery and development?

* * *

The next chapter will review current approaches to health financing and ask how these approaches apply to sustaining services and the long term transition to recovery in the particular context of the Fourth World.

2.

Financing Health Services: Between Theory and Practise

'Only through careful analysis of growing *transnational* inequalities we will understand the complex social processes that structure not only growing disparities of risk but also what stands between us and a future in which social and economic rights are guaranteed by states or other polities. This is especially poignant when one considers the concept of the right of the world's poor to modern medical care, because in the "neocolonial" era, the rich countries are even less likely to accept responsibility for better stewardship.'

Farmer, 2003:18

Introduction

Sustaining health service recovery raises important questions about financing and the limits of governments' abilities to allocate sufficient funding to health, and use these funds in the most efficient, equitable manner. In the aftermath of conflict and state failure, the twin challenges of securing international funding for reconstruction and scaling up to extend services to the wider population can be overcome, but post-conflict countries fail to sustain even a minimal public health system. This chapter will ask what makes an effective health financing system, examine standard systems for financing health in countries around the world and look at the value of such systems in the particular context of the Fourth World. The debate about financing in developing countries has frequently been dominated by the effectiveness of user fees, and the technical issues around key health indicators. In mainstream health service recovery programming circles, much less has been said about the alternatives to standard, western-models of general revenue, or the responsibility to make available cheaper and more effective treatments for diseases which are endemic in developing countries, but whose markets will not provide the levels of profit that can be made by focusing on diseases which dominate in the developed world. The final section suggests that concern with the actual financing mechanisms predominate, diverting users' attention and analysis away from the structure of government spending and options for enhancing health spending such as alternative taxing systems, more efficient pharmaceutical procurement and organization, and the development of more cost-effective treatments.

Objectives of Health Financing Systems

WHO summarizes the objectives of health financing systems as better health, equitable access for all, enhanced responsiveness to people's legitimate expectations, increased efficiency in the allocation and use of limited resources, protection against financial loss, and fairness in the financing and delivery of care. Health status can be improved by ensuring funding is available and allocated to the most effective measures to improve the overall health of the population. Equity is ensured when allocations address the most common threats to health and ensure that all individuals have access to health services. Health systems also need to respond to legitimate expectations of effective, accessible services to prevent and treat the causes of ill-health. Increasing efficiency requires financing systems to allocate a sufficient proportion of public spending to health and ensure these resources are employed in the most effective manner to meet health service objectives, and not squandered on a limited number of high-profile services or facilities that serve a small minority of the population as is so often the case in developing countries. Financing systems that spread risks and costs can help protect against the catastrophic cost of sudden and large-scale health costs that often force individuals, families and whole communities into debt and destitution. Effective financing systems ensure the poor are not penalised for sickness by paying a higher share of their income for services, and by providing equal access regardless of location or status (WHO, 1999:32-3).

Issues to be Considered

In the context of poverty, underdevelopment and limited life chances that characterises the Fourth World, financing systems need to give special consideration to certain issues:

Link between poverty and ill-health: Sickness and poverty are synergistic – the presence of one encourages the likelihood of the other. The conditions in which the poor are forced to live – especially in developing countries -mean that they are more likely to be sick; they are also less able to afford treatment (Farmer, 2003; Witter, 2002).

Need for protection against costs of sickness: Without the appropriate protection, sickness can create a poverty trap. Sickness prevents people from working and this prevents them earning the money to access health care which may result in them becoming sicker. This may also mean they cannot afford to buy the food they need to convalesce, and this in turn may aggravate the sickness. To break this cycle people are often forced to borrow, sell household assets or use business capital, all of which impair their future ability to function and progress.

Relative high cost: Health care can be very expensive, depending on the proximity of facilities, severity of the condition, the treatment needed, the type of drugs prescribed. For example, in Sierra Leone the cost of one consultation with a doctor or local hospital was estimated at 0.41 percent of the average annual income (Fabricant *et al*, 1999 quoted in Witter, 2002).

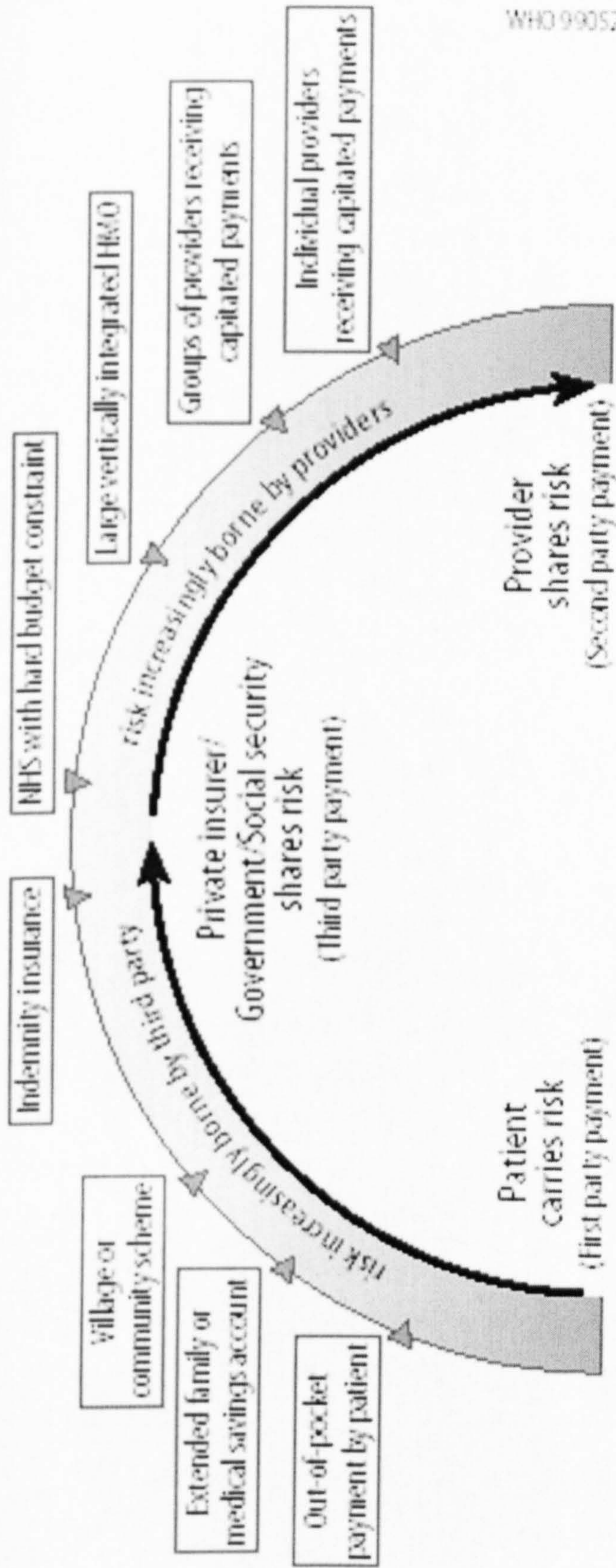
Randomness of need: The need for health care is sporadic and unpredictable. In developing countries people tend to face a range of health hazards and sources of disease and ill-health. Children in particular are prone to illness as their immune system develops, and vulnerability can be aggravated by sanitation, climate and socio-economic conditions ranging from humidity to overcrowding.

Criteria for Effective Health Financing Systems

Witter (2002:4) has advanced seven criteria for effective health financing systems which would ensure adequate, consistent flows of funds so that reasonable quality services can be planned, delivered and sustained.

- a. *Risk-spreading over time:* the financing system should allow the household to spread the risk of illness over a reasonable period of time relative to their income so it can plan for health care expenditure and avoid the necessity of paying out large sums of money.
- b. *Risk-pooling:* Serious or chronic illness would bankrupt most households. Effective finance schemes pool risk across entire communities so that the healthy subsidise those with poor health.

Figure 3: Who bears the risk of health care costs? The impact of different financing schemes and provider payment systems



Source: WHO, 1999

- c. *Universal access for maximum coverage*: Poor health poses a threat to all members of a community, for example through communicable diseases, interdependence. Schemes which actively discourage older people or those with a history of illness from joining by imposing high premiums or deductibles overlook this reality.
- d. *Equity*: Contributions should be set in accordance with income, or increasing with income levels. Fixed charges are regressive; equivalent to a higher – disproportionate - share of poorer people’s incomes, essentially presenting barriers to access for many households, or discouraging poor people from seeking treatment.
- e. *Simplicity*: financing systems should be relatively easy to operate; otherwise the costs associated with recruiting and training administrative staff may end up cancelling out the financial benefits, particularly in primary health care services with small staff levels, and peripheral or remote facilities.
- f. *Participation*: User involvement in the design, planning, operation and evaluation of the financing system is critical where the user is expected to pay towards the cost of the service.
- g. *Sustainability*: an effective financial system should generate adequate and consistent levels of funding to allow the facility or service to be maintained without risk of closure.

Health Financing Approaches

There are five general approaches to health financing (WHO, 2000:95; WHO, 1999:41; Witter, 2002; Witter *et al*, 2000):

- a) Universal Systems
- b) Private Insurance Schemes
- c) Voluntary Insurance Schemes
- d) Direct Payment
- e) External Aid

Universal Systems

Universal insurance schemes from general revenues (taxation) are by far the most desirable of these prepayments systems, allowing the entire population to benefit from services paid

for through progressive contributions made from regular incomes, usually deducted at the source of payment. Social insurance is a variation of this approach. Private health insurance works on the principal of pooling the health risks and financial contributions of as broad as possible a section of the population to cover hospital and other medical expenses for those who experience health problems specified in the insurance plan. Hospital care in particular is very expensive and without health insurance governments have to foot the bill for hospital services which serve a small section of the population to the detriment of the majority whose needs could be catered for at primary level with basic curative, preventive, and promotive services (Griffin & Shaw, 1995:143). Community based systems are a useful complementary mechanism for financing services for people who are not covered by social insurance.

In the developed countries it has been relatively easy to design effective health financing systems for households because (a) most people are in formal employment earning relatively reasonable incomes, and (b) their income is taxed at source, i.e. – prior to payment. In general, this transparency of income and the relative ease with which taxation and insurance premiums can be levied have resulted in the emergence of four main health financing instruments: general taxation, social insurance, private health insurance and out-of-pocket user charges (WHO, 1999:42; Preker *et al*, 2001).

▪ **General Public Revenues**

General taxation-based health financing systems are a function of the welfare state in which the responsibility for the provision of health services was assumed by government (see chapter 3).

‘Most equitable of all in terms of the way the health financing burden is shared, and in allowing equal access to care for people with comparable need, are risk pooling systems based on tax revenue financing such as in Canada, Cuba, Denmark, New Zealand, Norway, Spain, Sweden and the United Kingdom. The risk pool is the entire resident population, and the insurance function against the costs of health care is implemented by government, funded by taxes, which in a progressive system, take a larger share of income from the rich than from the poor.’

WHO, 1999:42

They are characterized by universal access; the inclusion of the entire population in the risk pool; the (generally) progressive nature of the contributions which are usually based on an increasing scale in proportion to income; and the vulnerability of the system to macro-level political and economic developments, such as competition from other sectors for larger allocations of the public purse. Taxes are levied directly on earned income, corporation tax, wealth and inheritance tax, and indirect taxes on sales, import-export duties and service (Pelizzon & Casparis, 1996; Witter, 2002; WHO, 1999).

▪ **Social Insurance**

Social insurance is often seen as a financing system that supplements or compensates for general taxation revenue. It is largely dependent on the existence of a formal employment sector such as a national civil service, and contributions are made through payroll-deductions. Entitlement to health services is based on contributions and there is usually a specified benefits package. It is often part of a wider social security system. Coverage depends on the number of people in formal employment making contributions. This can be an issue where social insurance only covers a small section of the population such as, for example, the civil service, leading to the exclusion of the majority of people who often have to make do with poor quality, fee-based services. Social insurance contributions are usually calculated on a fixed percentage basis which is obviously more progressive than applying a flat rate charge, and does allow for limited cross-subsidization between higher and lower paid staff. However, unlike general taxation levels which are banded, i.e. - taxation rates apply to salary ranges and increase for higher tax bands - social insurance rates remain constant regardless of tax bands.

Any country aiming to generate sufficient contributions to a social insurance scheme needs to consider whether there is an adequate formal employment base to ensure high coverage, and commitment from employers and businesses to make the payroll contributions. The system was particularly popular in post-Soviet states in the 1990s as governments sought to identify alternative sources for public health funding following the collapse of general taxation. However, results have been disappointing and most systems still depend on the general government budgets.

In Fourth World economies where a significant proportion of the activity is based on small-scale agriculture and informal employment, with low population densities and poorly developed transport, communication and administrative infrastructure, and subject to the volatility of primary commodity market dependence, social insurance is unlikely to generate adequate, sustainable revenues for the health sector (Witter, 2002).

Private Insurance Systems

Most of the countries where private insurance represents a large fraction of private spending are in the Americas or Europe. However there has been a powerful lobby composed of economists and corporate actors seeking to establish private insurance in developing countries. Private insurance takes two forms. The first is as the main form of health financing for a particular group (the wealthier strata or those for whom insurance is included in employment remuneration packages, as in for example South Africa and the US). Employer-paid schemes are most common in Brazil and the United States where they account for a large segment of financing. The second form is as a 'top-up' option to gain access to additional conditions or treatments not provided through public health services, e.g. - Canada and some European and Latin American countries (Musgrove & Zeramdini, 2001). This type of insurance accounts for a tiny proportion of health spending in the majority of countries, reaching 5% of private spending (equivalent to 1-2 percent of total health spending) in only 47 countries, five of which are in Africa (Musgrove & Zeramdini, 2001; WHO, 2000). Its luxury status is confirmed by the link between its increased importance and rising income (Witter, 2002; *Ibid.*).

Private insurance schemes can be run by for-profit companies, or by provident societies which re-distribute profits to members through lower premiums (Witter *et al*, 2000). Such schemes typically account for a small proportion of the health finances and tend to be used to supplement public health services rather than replace them. Members health risks are usually assessed and rated and premiums calculated according to the risk. This makes it possible to refuse high risk individuals, in favor of low risk members, a practice of 'risk-selection' which has been referred to as 'cherry-picking'. It also pools risk less. A more equitable approach is to tailor plans to different levels of coverage and charge more for higher coverage plans (Witter, 2002).

As such private insurance is something of a luxury and less than 1 percent of citizens in low-income countries are enrolled in such schemes. This ranged from 0.001 percent in Ethiopia to 11 percent in Kenya according to one study (Griffin & Shaw, 1995:147). Witter sees this as a reflection of a number of factors, such as expectations that health care should be free, and the view that health is a social good, or income: *'private insurance is often seen as a luxury good, giving access to high quality services, rather than low-cost access to basic health services'* (Witter, 2002:34). Griffin and Shaw (1995:146-7, 163) also note the link between the poverty that characterizes regions like Sub-Saharan Africa and the relative absence of private insurance schemes, but try to place more emphasis on factors such as *'preemptive presence of government in the provision of free hospital services'* or people's negative experience of poorly-planned insurance schemes which failed.

In essence, those who can afford to pay private insurance premiums do so to avoid waiting lists for treatment, or to secure preferential conditions in the event of childbirth, coronary illness or other conditions that require hospitalization. As such, insurance schemes tend to suffer from a number of related weaknesses such as adverse selection, moral hazard and cost escalation (Griffin & Shaw, 1995:145). Adverse selection occurs when those people with poor health are disproportionately represented in any given insurance plan. Moral hazard refers to superfluous use of services by members of an insurance scheme and occurs when members of a plan do not rationalize their use of the service as they feel that they have already paid for it. Insurance companies have instituted various mechanisms to deter this type of behavior such as no claims bonus, deductibles or excess payments levels, and co-payments. Cost escalation is common when health service providers' incomes are linked to the volume of services they deliver and a tendency to provide excessive, even unnecessary services and treatments arises in order to maximize income. Insurers have developed a number of mechanisms in an effort to control costs. In the US the *'health maintenance organization'* (HMO) became popular in the 1990s as a way to reduce ballooning health expenditures which had reached 14 per cent of GDP. These are companies that purchase all medical care for patients who register with them in return for fixed payments per patient per year. The fixed head-payment creates a strong incentive for them to limit payments, and acts as a counterbalance for providers' excess treatment. It

does however restrict patients' choice of provider. This type of control, also known as 'managed care' is associated with neoliberal reforms and has been heavily criticized for undermining physician-patient relations and for dismantling public health systems in Latin America (Farmer, 2003:309).

Community Based Insurance Schemes

The very low level of private health insurance is a function of its luxury status, i.e. – the positive income elasticity of demand, the availability of publicly-funded services, and the extent of formal employment in a given economy (Witter, 2002). In Fourth World countries the absence of a developed formal sector and related regular incomes is a major obstacle to any form of insurance, creating difficulties for payment schedules, and increasing administrative costs, billing and collection problems, and exacerbating trends towards adverse selection (Griffin & Shaw, 1995). As a consequence, most people in these countries have no possibility of being included in any type of prepayment scheme whether public or private. One way of dealing with this has been through community insurance schemes, which target most or all members of small – often rural communities. Community schemes tend to be promoted by development specialists and NGOs in an effort to pool risk and improve the sustainability of basic services in rural areas. The range of approaches, and the number of different countries and cultures in which they are adapted and applied means that there is no standard community-financing scheme model. Location often determines the profile of the scheme, as the type of community will influence the availability of services, the type of livelihood, the availability of money, the frequency of health service use, and so forth. For example in rural communities, schemes tend to cover low-cost, high frequency visit to the local village primary health centre, which is usually the only health care facility in the area. Benefits may include basic treatments for specific ailments common to the area as a result of geographic and seasonal conditions. In urban communities the scheme may be designed to help protect members against high-cost, low-frequency catastrophic events that may warrant hospitalization, implying longer treatment or recuperation periods and high user fees (Witter, 2004; Shaw, 1995).

Some models operate through the sale of pre-paid cards by the local clinic or shops, with the funds going into a community health fund which is managed by a community health

committee. Services are reimbursed from the fund, and the committee exercises a certain overview or governance of clinic activities. Other models use a one-off or seasonal payment system. A proportion of the running costs of the service are allocated for payment by the community in agreement with health authorities and external donors. This amount is collected as a lump sum payment for each household in the community or for member households at the time when the community has access to cash, such as the end of the harvesting period or after periodic sales of livestock. This facilitates both payment and collection, eliminates the need for billing and reimbursement, and requires no assessment of prepayment rates based on risk (Eklund & Stavem, 1995:216, Barakat & Deely, 2001, 2004).

Direct Payment Systems

Direct payment systems employ the payment of out-of-pocket charges or 'user fees' by the patient to the provider for services in the event of illness and at the time of treatment. The structure of fees varies depending on the aims and objectives of the provider, who may be a public health provider operating within the national health program, an NGO, or a for-profit private provider. Fees can be charged at each consultation and according to the type of treatment, or based on a flat-rate per visit. Alternatively, the structure may incorporate a risk-spreading and pooling function, and charge for a given period of treatment (Witter, 2002:5). Public services usually have some form of exemption system for the poor which is applied with varying degrees of utility depending on the availability of valid information about ability to pay, though in many Fourth World environments the administrative systems to provide or verify this type of data are largely absent. Depending on the type of scheme, the imposition of user fees can add significant administrative burdens to health facility workloads, particularly in small, community-based clinics which may have only one or two nursing staff. Also depending on the type and provenance of the scheme, the fees may be retained for use in the facility where they have been collected or they may be transferred to the district, regional or central health authority.

Fees are primarily intended as a means of mobilizing revenue for the facilities or service which would not otherwise be available. They were originally seen as particularly useful for recurrent expenditures such as drugs, utilities, salaries and general small-scale

maintenance. It has also been maintained that the range of fees imposed at different levels of the health system exercise an important role in promoting efficiency in the use of the referral system, with lower fee levels imposed for primary services, and concessional rates or even exemptions for secondary or tertiary care accessed upon referral (Nolan & Turbat, 1995; Shaw & Ainsworth, 1995; WB, 1987). Proponents argued that user fees would also improve equity by cross-subsidization from higher income groups who would pay fees to poor patients who would be exempted from payment (Shaw & Ainsworth, 1995). Initially it was expected by some that quality improvements made as a result of the additional revenue generated through fees would increase utilization and therefore improve access. By freeing up government resources for health, user fees were also expected to facilitate the expansion of the availability of services, enabling a network of primary care facilities to be created in a range of countries where economic recession and structural adjustment had produced a significant contraction in health services (WB, 2003; Nolan & Turbat, 1995; Griffin & Shaw, 1995; WB, 1993).

User fees have many and well documented drawbacks (Nolan & Turbat, 1995; Creese & Kutzin, 1995; Turshen, 1999; Kim *et al*, 2000; Waitzkin, 2000; Witter *et al*, 2000; WHO, 2001; Arhin-Tenkorang, 2001; Musgrove & Zeramdini, 2001; Gershman & Irwin, 2000; Farmer 2003). There is no pooling of risks between users and no opportunity to spread risk - and consequently payments - over time. Fees could be varied according to users' income but this would complicate and add to the administrative burden which they already impose and contribute to a situation where a large proportion of the revenue generated is spent on administering the scheme, as frequently happens in smaller facilities. Making facility income dependent on fees also has serious implications for preventive and promotive health services with important externalities. Studies have shown that public services relying on fees for revenue neglect preventive services, and private providers simply do not cater for public health services. However, the most important criticisms of user fee schemes in Fourth World countries relates to their impact on access by the poor, whose incomes are often so small that any episode of illness may produce a catastrophe in the context of fee-for-service health systems. Their earnings may amount to less than a dollar per day and fees for consultation, prescription and treatment may easily add up to a week's or month's earnings. Vicious circles of illness and indebtedness constitute a steep downward spiral for

these groups, who constitute a majority of the population in some of the poorest countries in the world. Exemption systems are all but impossible to operate in these contexts when almost everyone is poor or where nomadic or transient populations render means-testing impossible. For the most part, user fees have been found to generate no more than 5 percent of the running costs of services, yet exclusion remains a major problem.

External Aid

There are three general categories of aid: *bilateral*: assistance from one government to another, usually brokered by the donor government's development department, i.e. DfID, USAID; *multilateral*: which is essentially international assistance provided through intergovernmental organizations like the World Bank, the IMF and UN agencies; and *independent*: aid provided by NGOs such as Save the Children, CARE, Oxfam and so forth (Shakow & Irwin, 2000:50-1). Donor assistance (aid from private foundations; non-governmental organizations; government agencies; multilaterals such as the UN and the development banks) to health in 2000 amounted to \$5 billion, globally. Funding levels vary depending on political and economic trends, and to institutional and organizational priorities. The conditions that are attached to donor contributions are generally related to particular foreign policy interests and qualify the usefulness of such aid in addressing the health needs as experienced by ordinary people, and not always for the better. Dependence on aid for health financing is characterized by a number of important features.

Unpredictability: Only short-term planning can be undertaken with any degree of confidence. Although some donors are beginning to support multi-year projects and even enter into loose arrangements that allow some degree of confidence in planning, funds are typically committed for a maximum of one year, with an agreement in principle to provide support for a second or third year.

Reinforcing Inequitable Structures: In the past, donors have tended to favor high visibility projects and avoid commitments to recurrent cost. This has often reinforced inequitable allocations to tertiary facilities in recipient countries by building, rehabilitating or equipping hospitals and other tertiary care facilities. For example, after the 1999 earthquakes in Turkey, the International Federation of Red Cross and Red Crescent

Societies supported the reconstruction of a 120-bed hospital in Izmet to disburse relief funds as opposed to creating primary care networks which would have been dependent on external assistance to cover recurrent costs. In Albania in 1999, the Spanish government refused to allow aid funds to be used to support rehabilitation of primary health care facilities, preferring to spend the funds on rehabilitation of the regional hospital in Durres (SRCS, 2004).

Conflicting Interests: Project planning and designs are often dominated by donors whether through initial proposal processes or through technical advisors and representatives based in the recipient countries. Consequently, there is often only token participation of recipients or users of the end-product, and projects may not relate to perceived or actual needs in local communities. This has the added disadvantage of effectively canceling any potential for local inputs to sustain projects when donors pull out (Rifkin, 1999; Witter, 2002).

'Tied Aid': Restrictions on how aid is used may reduce its cost-effectiveness. Bilateral aid in particular is often subject to conditions that a certain proportion be spent in the donor country on technical expertise, equipment and supplies produced by the donor country (Witter, 2002). In 1990, tied aid accounted for 33 percent of global aid, though for infrastructure projects this ranged from 45 to 91 percent (Shakow & Irwin, 2000:51). Apart from the effect this may have on recipient country markets and human resources, it may not be the most appropriate use of the money (Witter, 2002). A 2003 study by the World Bank shows that tied aid is 25 percent less effective than untied aid. Some progress has been made in reducing the proportion of aid which is tied: it now accounts for only one-fifth of all aid. However, some donor governments resist this trend: it still accounts for more than half of non-technical assistance by Canada, Greece and Italy. Austria, Luxembourg, New Zealand and the US do not report on it (UNDP, 2003:148).

Burdensome Donor Requirements: As demands for successful implementation, accountability, and impact have increased, so has the amount of time and resources being spent by recipient governments on receiving donor missions, adhering to reporting requirements. *'Civil servants who should be designing policies and implementing programs are instead spending their time receiving donor missions and preparing donor reports'* (UNDP, 2003). Some prospects for improvement may yet emerge from the February 2003

Rome Declaration on Harmonization by heads of bilateral donor agencies and multilateral institutions, but it remains to be seen if these organizations can overcome their institutional rigidity to agree on and adhere to a common set of reporting requirements.

The Reality of Health Financing in the Fourth World

In the low-income developing countries of the Fourth World, total health spending is very low – less than 2 percent in some countries and rarely more than 4 percent in real terms (WHO, 1999; 2001). The absence or weakening of the formal sector as a consequence of colonial policies, economic decline and structural adjustment results in inadequate general revenue capacity and renders prepayment-type health financing systems ineffective. Over the past two decades, as public services have declined or collapsed, direct payment has become the main form of financing health services with widespread levying of informal charges by an underpaid public sector workforce, and the widespread *ad hoc* imposition of user fees by aid agencies, even as formal cost recovery strategies have become a condition of loans and aid from the World Bank and other international financial institutions. This trend is evidenced by the sharp divergence between developing and developed countries in out-of-pocket spending in general and spending on pharmaceuticals in particular. Spending on pharmaceuticals in developing countries accounts for between 30 and 50 percent of total expenditure on health care, as opposed to 15 percent or less in developed countries (Witter, 2002; Witter *et al*, 2000; Whitehead *et al*, 2001; WHO, 1999, 2000, 2001). Services have come to depend on three main sources of financing:

- Informal payments;
- Donor funding; and
- Cost recovery.

Informal Payments

Informal payments are defined as

‘Payments – both monetary and non-monetary – made by an individual to a health care worker that do not form part of the worker’s tax-deducted formal salary. These payments may be expected or unexpected and may be given for

services that are routinely carried out or for an augmented or additional service undertaken by the health care worker.'

Witter *et al*, 2000

Informal payments are particularly prevalent in low and middle-income countries where they have been found to make-up a significant proportion of spending on health care. For example, in Central Asia, they account for 30 percent of total public spending on health. In Bangladesh they are equivalent to 10 times official revenue from user fees in public hospitals, and in Poland almost half of all patients pay for services that are officially free. In Uganda informal payments account for up to one-third of primary health care workers' earnings in rural communities and more in urban areas (Witter *et al*, 2000:90). During structural adjustment in some developing countries, monthly salaries for civil servants were equivalent to the basic cost of living for between one and twelve days; obviously staff supplemented their income 'informally' to gain enough to sustain themselves and their families. Similarly, when staff members in hospitals, clinics and schools went unpaid for months at a time, they resorted to imposing informal payments to pay themselves (Witter, 2002; Schoepf *et al*, 2000; Jackson & Deely, 2001).

There are other reasons why people are willing to make informal payments: when there are pronounced disparities in the quality of personnel or services at a given facility, people who can afford to make additional unofficial payments are often willing to do so in order to ensure better treatment, or attendance by the most qualified staff. In Fourth World countries where budgets have been cut or transfers to primary health care and even secondary and tertiary facilities are not made, or made infrequently, it may be necessary for patients to pay towards the cost of medical supplies or drugs so that procedures can be carried out. Informal payments are also levied by health staff operating in remote areas in developing countries or in contexts where they effectively operate a monopoly on a given service or specialisation and use this privileged position to earn additional fees and income even though their formal salary is reasonable and adequate by comparison with market rates. This type of corruption is commonplace in Fourth World countries where the ratio of qualified doctors to population can be upwards of 1:100,000 (WHO, 2001b). In this case doctors, nurses and midwives charge for 'optional' extra services or attention, or 'moonlight' - attending the formal workplace for a couple of hours daily or less frequently,

and running private practices at a nearby location. While a large part of the problem can be addressed by ensuring that staff are paid adequately, this generally means increasing facility budgets significantly. Quality of service also needs to be considered so that patients do not feel obliged to pay bribes to receive the correct standard and range of treatments. Informal payment has become endemic in some cultures that are characterized by resource scarcity – e.g. Bangladesh where ‘gratuities’ have been virtually standardized and systematized at all levels in the health system – and professional regulation may need to be addressed (Witter, 2002).

Informal payments are one of the worst forms of health financing: they are completely unregulated and therefore offer no protection to the patient; like most other direct payment systems they have to be paid at the worst time, i.e. during periods of illness, which in the Fourth World generally mean periods of reduced or suspended income; they offer no risk sharing or risk-spreading mechanism, and there is rarely any possibility of an exemption scheme or safety net. This type of corrupt practice can destroy the public health system and undermine recovery initiatives during transition periods by effectively privatizing (‘bribitizing’) public health facilities. For example, a study in Uganda found that facilities operated as though they were private clinics, with the medical assistant monopolising most of the facility’s revenue generating capacity, selling the drugs as though they were private property and completely misappropriating 40 percent of stocks (Bennett *et al*, 1997 quoted in Witter, 2002:13).

Donor Funding

Donor funding accounts for around 20 percent of health spending in Sub-Saharan Africa as a whole (excluding South Africa), and more than 50 percent in several Fourth World countries (WHO, 2001).

Table 2.1: Donor Assistance to Health, 1997-1999

Country Groups	Per Capita Public Spending on Health (\$ 1997)	Total Per Capita Spending on Health (\$ 1997)	Per Capita Donor Assistance for Health (\$ 199-9)	Donor Assistance for Health (\$ millions, 1997-9)
Least Developed	6	11	2.29	1,473
Other Low Income	13	23	0.94	1,666
Lower Middle Income	51	93	0.61	1,300
Upper Middle Income	125	241	1.08	610
High Income	1,356	1,907	0.00	2
All Countries	-	-	0.85	5,052

Source: WHO, 2001

Recipient countries have limited influence over the amount of funding they receive and how it can be used (Witter, 2002). Assistance from multilateral institutions such as regional development banks, UNDP, UNICEF and IDA actually fell from \$872 million annually in 1996-1998 to \$673 million in 1999-2001 (UNDP, 2003). The least developed countries received an annual average of \$2.29 per person between 1997 and 1999, though much of this would have been spent on expatriate salaries, consultants, vehicles and equipment and other expenses which may or may not have been related to - but were almost invariably far removed from - the day-to-day health needs of poor people in these same countries (WHO, 2001).

Aid has always been used for political and economic purposes (Kim *et al*, 2000; Turshen, 1999; Riddell, 1997; Hobsbawm, 1994). In the new world order of globalized governance however, bilateral and multilateral donors increasingly tend to have their own analysis and objectives, dominating the discourse on how aid should be provided and used and supporting a specific set of policies which they seek to impose on recipient governments. These extend over a wide range depending on the donor; from political (e.g. - 'good governance') to economic (privatization of health services) to health policies (use of contraception). What is increasingly clear is that Fourth World states are dependent to such a great extent on aid to be able to provide some limited services for their populations, and subject to such a range of conditionalities for that aid, that their sovereignty is severely undermined in the process (Held, 2004; Wallerstein, 2003; Duffield, 2003, 2000; Held & McGrew, 2002; Turshen, 1999, Derlugian, 1996).

Fourth World health systems which are heavily dependent on donor aid are in very vulnerable positions (Witter, 2002). In theory, donor funding is provided as a supplement to government financing and for a fixed period of time, after which the national budget should assume responsibility. Some donors agree to support the rehabilitation of infrastructure or to provide transport or capital equipment and recipient governments need to budget for recurrent costs, such as salaries, maintenance and spare parts at some stage in the future. However, as noted already, governments in Fourth World countries simply do not have the tax base from which to sustain even a basic package of essential health services to their entire populations and many expensive projects have failed as buildings and equipment sit

unused or fall into disrepair for want of basic running costs, spare parts or money for fuel. Many donors have imposed user fees in an effort to generate some resources at local level to compensate for or justify gradual or sudden termination of funding support. This regularly occurs without any pre-planning, impact assessment or even broader understanding of the socio-economic impact of charges and is only loosely influenced by World Bank policies.

Cost Recovery

Cost recovery rose to prominence as a health financing model for developing countries in the 1980s context of economic recession, decreasing government revenue - and hence national health budgets - and declining health status. The idea of recovering the cost of service provision from the user was seen as an alternative to financing based on taxation and had the potential to increase resources for health, promote efficiency and improve equity (Nolan & Turbat, 1995). Its development was closely linked to the adoption of structural adjustment by the World Bank and the IMF as a strategy for reducing government expenditures and the launch of the World Bank's strategic policy proposal "Financing Health Services in Developing Countries: An Agenda for Reform" in which the Bank challenged the principle of free universal health care for all:

'The ... common approach to health care in developing countries has been to treat it as a right of citizenry and to attempt to provide free services for everyone. This approach does not usually work. It prevents the government health system from collecting revenues that many patients are both able and willing to pay.'

(WB, 1987)

The Bank argued that governments were unable to provide free health services and external donors could not be expected to fund them indefinitely, and therefore users of health services must be willing to pay for them. It presented a case for privatization of public health services through four main components (WB, 1987, 1993, 1997, 2003; Griffin & Ainsworth, 1995; Nolan & Turbat, 1995; Dunlop & Martins, 1995; UNDP, 2001, 2003; Shaw, 1995:8-21; Turshen, 1999:47; Kim *et al*, 2000:127-153; Farmer, 2003:299-300):

- a) User fees, especially for curative care and medicine. Critics argued that fees are also imposed on essential preventive care which produces major externalities, and that this is

responsible for the under-provision of preventive, public health services, and the low utilization of facilities.

- b) **Self-financing insurance:** the promoters of privatization promote a range of third party insurance schemes, sickness funds and social security systems. Critics argue that the imposition of user fees is not intended to provide adequate, sustainable local financing, but aims instead to force people to subscribe to insurance schemes to protect them against the cost of illness.
- c) Privatization strategies involved the provision of extensive funding to NGOs and charities to provide health services. Critics argued that the private voluntary sector was being co-opted into the privatization strategy by diverting donor funds away from state-run public health facilities into NGO, aid agency and missionary hospitals and clinics to improve the standard of care, while public facilities degenerate, reducing demand for free public care and conditioning people to pay for services in private facilities.
- d) The fourth component was decentralization of planning, budgeting, and procurement for public health services and the use of market led incentives to motivate staff and allocate resources. Promoters argued that this would improve responsiveness and local accountability, helping to tailor services to user needs and priorities. Critics argued that this was a cost-cutting measure, allowing central health authorities to shed expensive support roles and pushing responsibilities to the periphery without (adequate) investment in human and structural capacity development to ensure these new responsibilities could be met.

Shaw offers some of the most transparent explanations for the imposition of user fees in the 1995 World Bank publication '*Financing Health Services through User Fees and Insurance*', elaborating clearly the rationale behind the privatization strategy:

'Without a tradition of cost recovery in public facilities, households are unlikely to be predisposed to pay for private or public health insurance. When user fees become an established practice in the public sector, however, households begin to take interest in spreading the risk of substantial health expenditures over time and across a wider population. [...] User fees in public facilities can therefore help stimulate private insurance providers to rise to the challenge.'

Shaw, 1995:21

This privatization agenda was promoted as a component of structural adjustment during the 1990s and by 2000, at least 30 countries in Sub-Saharan Africa were operating some form of cost recovery scheme for health services (Gershman & Irwin, 2000:30).

Alternative Options

The main purpose of cost recovery is to mobilise funds for the health sector, particularly in the absence of adequate government funding for health as was the case in many developing countries in the 1980s. In this sense, the large-scale promotion of cost recovery may have diverted attention from the need for a broader strategy for increasing the health budget and freeing up resources that were either being squandered on corrupt and inefficient practices, or spent on non-essential products and activities (Brunet-Jailly, 1991; Nolan & Turbat, 1995; WB, 1998; Turshen, 1999; WHO, 1999, 2000, 2001; Arhin-Tenkorang, 2001). The following sections consider some of the alternative options that have been proposed to enhance health allocations and improve their applications in Fourth World countries.

The Impact of Globalization and Inequality

Three main strategies are frequently cited as having the potential to increase health ministries' spending power:

- Increased taxes
- Health budget efficiencies
- The development of cost effective treatments

In each case, the additional revenue that could be generated, the potential savings that could be made, and the potential solutions that could be provided, are opposed, obstructed or wilfully ignored by politicians, presidents of multinational corporations, and executives of international financial institutions.

Tax Collection

In the developed world, the post-war welfare state increased overall taxation revenue considerably to pay for the extension of its functions. For example, federal income tax was only introduced in 1913 in the USA. In 1887, federal receipts stemmed mainly from custom

tariffs and only amounted to 3 percent of GDP. By 1937, federal receipts had only risen by 2.5 points to 5.5 percent, but after 1945 it increased to almost 20 percent. Between 1955 and 1980, tax revenues in the developed countries grew significantly as a percentage of GDP, particularly in terms of income tax and social insurance contributions. Whereas taxation income had previously relied on excise, general consumption taxes and corporation and wealth taxes, there was a general trend towards large increases in individual income taxes and employers' social insurance contributions. During the same period, the average ratio of tax as a proportion of GDP grew from 24.7 percent to 36.6 percent. At 43%, the average ratio in the developed economies in the 1970s was almost 3 times that in the developing countries (Derlugian, 1996:156-162). Today, some middle and upper-income developed countries such as Argentina, France, Germany and Switzerland spend as much as than 9 percent of GDP on health. In the USA, the proportion has risen to 14 percent (WHO, 1999:34).

In the Fourth World, the large rural and informal sectors of the economy tend to impose severe limitations on governments' taxation capacities. Consequently, they mobilise a much smaller share of GDP in tax revenues or social insurance than middle or higher income countries: on average 14 percent and 1.1 percent respectively, compared with 31 percent and 8.8 percent in high income countries. Moreover, taxes tend to be disproportionately dependent on international trade. As was demonstrated in chapter 2, this renders developing countries highly vulnerable to the volatilities associated with dependence on one or two primary commodities, producing significant distortions in general revenue and limiting the possibilities to increase public spending (WHO, 2001:58).

Table 2.2: Taxation as a Percentage of GDP

Countries	Total Tax Revenue	Taxes on International Trade	Excises	General Sales Tax	Social Insurance
31 Low Income <\$760 per capita	14.0	4.5	1.6	2.7	1.1
36 Lower Middle Income \$761 to \$3,030 per capita	19.4	4.2	2.3	4.8	4.0
27 Upper Middle Income \$3,631 to \$9,360 per capita	22.3	3.7	2.0	5.7	5.6
23 High income >\$9,360 per capita	30.9	0.3	3.1	6.2	8.8

Source: WHO, 2001:59

Where only 10 percent of a country's GDP can be assessed for tax, 30 percent of the government's budget would need to be allocated to health to meet a health expenditure target of 3 percent of GDP. In most developing countries, spending fell in real terms in the 1980s and 1990s, and allocations for health rarely exceed 2 to 3 percent of GDP. In fact, not one country with an annual per capita income below \$600 allocated 4 percent of GDP to health in 1999 (*ibid.*:59). In Mali for example, government financing of basic and preventive health services is made very difficult by its limited ability to mobilize resources for health. With per capita GDP in 2001 averaging \$239, and a small formal economy, there is little prospect of generating the level of tax revenue that would be required to provide a comprehensive, free health service. In the past, the government has mobilized only about 10 percent of GDP in taxes. Increasing revenue without losing the small foreign direct investment base it has managed to build up in the 1990s would be difficult⁹. In 2001, government spending on health was 2.2 percent of national budget. At current levels of government revenue collection, to allocate the minimum recommended US\$9-12 per capita to provide an essential package of primary health care, would require the equivalent of 37 to 50 percent of government tax revenues (WB, 1998; WHO, 2001; UNDP, 2003).

This also makes pooling difficult in developing countries because it requires subsidization between the rich and the poor, the healthy and the sick, and the employed and unemployed. Where the informal economy accounts for a significant proportion of economic activity, tax evasion by the elites, the rich and middle-classes means that the public systems that pool risks and revenues cannot function effectively and most health financing is out-of-pocket expenditure (Preker *et al*, 2001:7).

During the 1980s, partly as a result of austerity programs and retrenchment, taxation '*nearly disappeared in several dozen Third World countries due to the lack of state enforcement of the tax and tariff policies and their own personnel's "endemic" corruption*' (Derlugian, 1996:162). Yet many of these countries have fabulous wealth due to their natural resources, oil and diamonds in Angola, diamonds in Sierra Leone and DRC, oil in Nigeria, Sudan, Equatorial Guinea, etc. These resources are exploited by elites and multinational corporations who benefit from a range of concessional taxation arrangement

⁹ FDI increased from 0.2 percent of GDP in 1990 to 3.9 percent in 2001 (HDR, 2003).

of sometimes questionable legality (Reno, 1999). The post 9/11 identification of financial practices by suspected international terrorist groups gives an indication of what can be done to track and block bank accounts, suggesting that wealthy elites and MNCs engaged in large-scale tax evasion can be detected, and taxes collected or accounts frozen. There have been public demands to collect tax from those who benefit from corruption and plunder:

‘...financial institutions should focus on how to tax rich rather than poor people – for example, by promotion of a tax on funds hidden in tax-free offshore accounts. If these off-shore deposits (estimated by the International Monetary Fund to be around \$8 trillion) earned income of around 5% per year, which was taxed at 40%, about US\$160 billion per year would be raised – estimated to be more than the cost of providing basic social services for developing countries.’

Whitehead *et al*, 2001:835

Health Budget Efficiencies

Allocative inefficiencies refer to wastage in government spending when large proportions of the health budget are spent injudiciously, as frequently happens in developing countries for a number of reasons, mainly related to political agendas, competence and corruption. This may range from excessive spending on expensive tertiary care to satisfy urban-based elites or supporters of the governing party, to official and illicit commissions paid to government officials by representatives of firms for purchasing brand-name pharmaceuticals, maintenance or other work, and to wastage on unproductive staff or the absent, dead or retired ‘ghost staff’ who were maintained on or added to payrolls and whose salaries were used to compensate for the low levels of pay, to fund other costs which were not covered by the budget, or simply siphoned off by corrupt officials¹⁰. The argument has important implications given the low levels of managerial and administrative competence and the extent of corruption and patronage in Fourth World countries. For example, in the early 1990s in Mali, the allocation of government health spending was described as neither efficient nor equitable (WB, 1998). The majority of the government's limited resources were spent on urban-based tertiary care and central administration. Almost 85 percent of private spending and a significant proportion of public spending were used to buy brand-name drugs that were five times more expensive than generic versions, and reorganization alone could have saved the government more than 40 percent of its expenditure on drugs

¹⁰ Jama, 2001, personal communication

(WB, 1998; Turshen, 1999). One study of the health sector there concluded: 'priority must be directed not to cost recovery but fairly and squarely to cost reduction' (Brunet-Jailly, 1991).

In fact, spending on pharmaceuticals, which accounted for over 50 percent of total health expenditures in developing countries in 1986, has long been recognized as an area where significant savings can be made (Brunet-Jailly, 1991; WB, 1993, 1997, 1998; Turshen, 1999; Kim *et al*, 2000). In this respect the development of a public drug sector was a major breakthrough for developing countries (Turshen, 1999:97-113). Turshen highlights four particular causes of increased costs of pharmaceuticals in the early 1990s (Turshen, 1999:97):

- High prices charged by multinational pharmaceutical companies for brand-name drugs and supplies.
- The 1994 GATT Agreements which resulted in further price increases and blocked developing countries from manufacturing cheap alternatives.
- Cuts imposed on government budgets by structural adjustment increased drug prices indirectly by destroying the concessional pricing and credit terms built up with foreign firms when health ministries defaulted on outstanding bills or made only partial or late payments.
- The devaluation of national currencies - a standard element of the structural adjustment prescription - created shortages of foreign currency which increased the cost of imported drugs. Governments' central pharmacies did not have the foreign currency to import drugs themselves and were forced to procure drugs from local providers instead, essentially adding one more layer of cost.

Before structural adjustment took hold in so many developing countries, the WHO had made important progress in introducing measures to help governments reduce their pharmaceutical costs. In 1978, WHO made three specific recommendations to governments in developing countries as part of a new essential drugs action program:

- i) centralize drug purchases at the national level;
- ii) limit procurement to a list of 200 essential drugs for specialised, hospital and primary care; and

- iii) take advantage of economies of scale accruing from their large orders and issue tenders for a limited list of generic items.

When patents expire and generics become available, prices fall sharply – by 45 percent within one year, and by 61 percent after two years. Many of the essential list drugs were no longer patent-protected and there was a range of generics available, making massive savings possible on national health expenditure. Prior to the WHO action and the adoption of new public sector policies, pharmaceutical companies were able to take advantage of limited – or as in the case of Mozambique nonexistent – regulation, to flood the national market with tens of thousands of different products, hiring sales representatives at local level to solicit orders from clinics, hospitals and GPs to order brand-name drugs. During the early 1970s in Mozambique, there were more than 13,000 pharmaceutical products being sold, without any regulation or control over need, cost, or effectiveness.

The essential drugs program helped produce savings in three main areas:

- Reorganization of the procurement and management of supplies, such as centralised, bulk purchasing on negotiated terms and often with tenders for large orders, restrictions in the range of supplies to be used, and the procurement of generics wherever possible;
- Improved storage, inventory procedures and distribution also helped realise major savings. For example in Guinea in 1984, 70 percent of the government's drug supply disappeared between central medical stores and health centres, and Cameroon lost one third of medicines in its central medical store as a result of poor conditions and expiration. Improved storage and security conditions produced significant savings.

The improvement of prescription practices and education of patients on the proper use and administration of drugs produced major savings. For example in Mali and Ghana, studies showed that between three and ten-times more drugs were prescribed than necessary. Meanwhile as many as a quarter of all patients waste drugs through non-adherence to instructions for use.

The essential drugs program was one of three global campaigns undertaken by WHO in the late 1970s espousing the cause of poor people throughout the world. The goal of 'Health for All by the Year 2000' outlined a primary health care service model consisting of a package of preventive and curative services to be delivered by auxiliary health personnel. In many ways this campaign also represented a direct challenge to the pharmaceutical industry, with its emphasis on preventive and promotive health care replacing the previous disease-oriented model which favoured the procurement and consumption of vast quantities of drugs. In 1981, WHO threw down a third challenge to the pharmaceutical corporations and their partners in the food industry, when it published a code of conduct that attempted to regulate the marketing and sale of manufactured infant formula, substitute breast-milk which contained none of the natural immunities and anti-bodies provided naturally when children are breast-fed by their mothers. All three campaigns were actively opposed by the multi-national pharmaceutical giants, and by the governments of their native countries. Germany, Japan, Switzerland, and the US, where many of the major firms are based, do not support the essential drugs program, and there is evidence to suggest that the US withheld its contribution to WHO in the 1980s as a result. In the prevailing unilateralist environment of the mid-1980s, WHO fell foul to the forces of neoliberalism, with the Reagan administration-sponsored Heritage Foundation arguing that the campaigns amounted to an attack on free enterprise and US commercial interests, and calling for US withdrawal from WHO. The administration supported a raft of proposals to reduce funding to the UN and WHO was targeted and effectively side-lined through a strategy of decreased funding and support for the World Bank's population, health and nutrition program. Within a few years, the Bank emerged as the largest and most powerful organisation funding health programs and dictating policy (Turshen, 1999:102, 120). Fourth World health budget efficiencies were effectively overruled by MNC profiteering.

Development of Cost Effective Treatment

The meagre resources that most Fourth World governments spend on treatment are often wasted on expensive patented treatments, or worse on treatments that are ineffective due to drug resistance or patients' difficulties with compliance. Yet modern biomedicine is more advanced than would have been dreamed possible a century ago. Why do people and governments in Fourth world countries have to devote so much of their income to treat

illnesses which in the majority of cases should have been eradicated years ago? The human suffering and social and economic destruction wrought by disease in Fourth World countries is enormous: in Sub-Saharan Africa, for example the economic value of lost life years as a result of HIV/AIDS was estimated at 72 million disability adjusted life years (DALYs) in 1999, valued at somewhere between 11.7 and 35.1 percent of the region's GNP. Leaving aside the enormous suffering for an instant, the cost of treatment, the loss of labour-market income from each episode of illness, the loss of adult earning power from episodes of disease in childhood, and the loss of future earnings from premature mortality, all add up to a substantial drain on a country's potential growth and development (WHO, 2001:30-2).

Public goods are goods and activities that are undersupplied by the market and consequently need to be supplemented by some level of public investment. Global Public Goods (GPGs) are *'public goods that are underprovided by local and national governments, since the benefits accrue beyond a country's borders'* (WHO, 2001:76). The global pandemic of HIV/AIDS spreading out across the globe, steadily increasing and infecting people in all countries and regions, is an example of the need for large-scale investment in GPGs – investments that extend beyond the resources or incentives of individual governments and deliver returns far in excess of the sum of the individual national-level programs (*ibid.*). Large-scale investment in research and development is essential if effective treatments - and even vaccines – are to be discovered and produced for a range of diseases including HIV/AIDS, TB, malaria and others that account for around 7 million deaths every year (UNAIDS, 2003; WHO, 2001). Balancing the need for - and entitlement to - access to new knowledge about treatments and vaccines with the involvement of profit-driven pharmaceutical corporations is not easy. Typically private firms seek to patent new applications of knowledge and monopolize production and marketing of treatments or vaccines created using that knowledge. Patent protection thus creates the incentive for private investment in R&D about the application of new knowledge through production and testing. Contrary to the claims and efforts of big business, patents should not be granted on basic scientific knowledge which benefits - and should belong to - society as a whole. In the US, public funding of \$20 billion per year is provided to National Institutes of Health for research that supports the efforts of private pharmaceutical firms to develop patent-

protected medicine (WHO, 2001). Public funding is therefore an essential element in the development of new knowledge and its protection from monopolization by private entities.

The problem with diseases that disproportionately or exclusively affect poor countries is that governments do not have the funds to support public investment in R&D, and household-level poverty means there is no market to be exploited, rendering patents meaningless in the economic sense. Consequently, MNCs and developed countries' governments all but ignore these diseases. Yet, the development of effective and efficient treatment for the main causes of morbidity and mortality is a global responsibility that should not be left to any single country or region even if the disease is overwhelmingly incident in that country or region.

WHO (2001) distinguishes between three types of disease. Type I diseases such as measles, hepatitis B and influenza¹¹ affect large numbers of vulnerable populations in both rich and poor countries. Public financing and patent protection provide incentives at both ends of the market for R&D in these diseases and products are developed. The issue for developing countries is *access*; although vaccines have been developed, they are not widely available because of high prices and patent protection. Type II diseases (also termed 'neglected diseases' in the context of R&D) affect both developed and developing countries but incidence is higher in the latter. Although the rich country markets provide some incentives for R&D, the markets are not considered profitable enough to warrant the level of R&D spending that would be justified by the scale of the suffering. For example 90 percent of HIV/AIDS and TB prevalence is in the developing world. The last new treatment for TB (a disease which kills 2 million people every year mainly in Third and Fourth World countries) was developed in the early 1970s. TB medicines have been categorized as 'orphan drugs' - defined by the US Orphan Drug Act as drugs which would not recoup development costs through domestic sales and affect fewer than two hundred thousand individuals in the US (Farmer, 2003:305). There is no commercial R&D investment in Type III diseases (termed 'very neglected diseases'); those that are predominantly or exclusively found in developing

¹¹ *Haemophilus influenzae* type b [Hib]

countries such as African sleeping sickness¹² and African river blindness¹³ (WHO, 2001:78).

It costs \$224 million to develop and produce a new drug, which according to private pharmaceutical firms renders unprofitable - and therefore highly unlikely - the process of developing new drugs to treat diseases endemic in developing countries (Farmer, 2003:305). Malaria kills between 1 and 2 million people annually and accounts for 3 percent of the global burden of disease, almost exclusively (i.e. - more than 99 percent) in the developing world (WHO, 2001). Private and public R&D investment for biomedical research sectors on malaria however, is barely one-twentieth of the average outlay for any given disease. The main thrust of efforts to develop a new treatment comes from the Malaria Medicines Venture, a public-private venture, which spends less than \$10 million per year (*Ibid.*). Given the cost of developing new treatments, the possibility of a breakthrough anytime soon seems somewhat remote. Yet even the economic value of lost life years as a result of malaria in Sub-Saharan Africa was equivalent to 17.4 percent of GNP in 1999, and the cost in human suffering, lives lost, shattered families, orphaned children and abandoned elderly is immeasurable (WHO, 2001:31).

Clearly, the benefits that might accrue in terms of public health spending in Fourth World countries are unlikely to be realized while short term profit, executive remuneration packages and shareholders' dividend payments remain the main determinants of the development and availability of effective treatment for so many life-threatening conditions.

Conclusion

Over the past two decades, public services in the Fourth World have deteriorated as a result of economic recession and state failure or have been destroyed by violent conflict. Total health spending has declined in real terms, rarely extending beyond 2 to 4 percent of GDP. The challenge of sustaining health services has been the focus of significant attention, but financing systems that support effective public health services in the developed world find

¹² Trypanosomiasis

¹³ Onchocerciasis

little useful application in the Fourth World, and general revenue limitations continue to prevent governments from funding even a minimal level of services. Meanwhile, underdevelopment, poverty and inequality exclude the poor majority from participation in prepayment systems and private, out-of-pocket spending continues to dominate, entrenching poor health conditions and spreading the burden of sickness and disease through a cycle of sickness, debt and poverty.

Yet revenue that could be raised by taxing individuals and corporations who benefit enormously from extraction of the natural wealth in Fourth World countries is not collected. Large scale economies that could be made on public health budgets through more efficient procurement of drugs and medical supplies are strenuously opposed and the efforts of WHO undermined by multinational corporations and their governments. And cost effective treatments that could reduce the burden of suffering and death in Fourth World countries are not developed because they are considered unprofitable by the same multinational corporations that receive billions of dollars annually in direct and indirect subsidies from public funds, and make profits that dwarf the health budgets of many Fourth World states.

What is emerging is a conflict of interest between the forces of free-market globalization - the free-market ideologists, multinational corporations, and the international financial institutions that support them – for whom health is a commodity to be privatized and traded for profit; and those who view health as a basic social entitlement.

‘In the face of momentous public health threats from global climate change, from an impending cycle of droughts and floods that threaten food security, and from emerging infectious diseases, the donor community – at the bidding of the G8 nations, the multinational corporations, and the international financial institutions – is diverting attention to private medical and pharmaceutical services and private insurance plans.

Turshen, 1999:128

Is health a commodity to be traded when the conditions of supply and demand are conducive to the generation of profit, and discarded when the terms of trade indicate there is no profit to be made? Or is it as an essential condition of human well-being, a moral prerequisite of peaceful co-existence, prosperity and progress, and a basic human right that

takes precedence over executive remuneration packages and shareholders' dividend payments?

These two perspectives have promoted two opposing approaches to sustaining health service during the long term transition conflict to recovery, decline to development, and poverty to prosperity in Third World countries. Over the last fifteen years, efforts have focused on health financing on one hand and health development on the other. One reflects the interests and agenda of global corporate capital, and addresses health services in terms of economics, i.e. - consumption, commoditization, pricing signals and supply-side versus demand-side strategies, and the other embraces a broader vision of health as the basis for human well-being, happiness and productivity, an essential element in development. These two approaches, the Bamako Initiative, and Community Involvement in Health will be reviewed in the next two chapters to determine their potential to help sustain basic health services in the transition from conflict to recovery in Fourth World countries.

The next chapter will examine the cost recovery approach and in particular the Bamako Initiative user fee model to identify lessons that could be used to develop a strategy for sustaining health services in the transition from conflict to recovery.

3.

Cost Recovery: Sustainability or Exclusion?

‘The well-being of poor people is the point of making services work. The value of public policy and expenditure is largely determined by the value the poor attach to it.’

World Bank, 2003:64

‘87% poorest group felt the levels [of user fees charged for primary health care services in public clinics in Benin] did not allow access by all.’

Gilson *et al*, quoted in World Bank, 2003a:18

Introduction

The previous chapter presented an analysis of the main types of financing systems used to fund health spending in countries around the world and the particular conditions in Fourth World countries that influence their almost exclusive reliance on direct payment methods. A dilemma emerged between the notions of health as a privatized commodity on the one hand, to be developed and traded based on profit, and health as a basic necessity for a normal life, a social entitlement or right. These opposing interpretations can be seen in the two approaches that have been deployed to extend access to basic health services in developing countries; cost recovery and community development. This chapter will examine the cost recovery approach and in particular the Bamako Initiative user fee model (which focuses on Sub-Saharan Africa, the region in which the vast majority of Fourth World countries are located) to identify lessons that could be used to develop a strategy for sustaining health services in the transition from conflict to recovery. The Initiative will be reviewed in some detail and the claims and counterclaims of proponents and critics analyzed to determine whether a similar model should be used to inform the development of a post-conflict recovery approach. A number of key questions will be addressed:

Competing Models of Cost Recovery

There are two main cost recovery models: a *standard* model which is associated with the Bank's 1987 'Financing Health Services in Developing Countries' report, and promotes the broader application of user fees in social sectors; and the *Bamako Initiative* model which was developed in response to concerns about the declining state of health care in Africa as public expenditure on health collapsed in the 1980s under the combined weight of economic recession and structural adjustment. Nolan and Turbat (1995) provide a comprehensive overview of the two models.

The Standard Model

The standard model imposes fees at all three levels of health care – primary, secondary and tertiary and promotes the use of the referral system through differential pricing and incentives. User fees are to be imposed first for hospital care and the intention is to cover the full cost of care through a combination of insurance and co-payment. The reasoning is that by cascading prices – i.e. using a sliding scale with the highest fees imposed for tertiary facilities and the lowest for community health centers and health posts - patients will be encouraged to adhere to the referral system, instead of clogging up hospital waiting rooms and courtyards regardless of the nature of their ailment. However, the assumption that this type of behavior can be deterred solely by pricing signals is contested, with some analysts arguing that greater attention to quality at the lower levels of the system would have more important effects (Kreese & Kutzin, 1995).

Fees are justified on the grounds that they increase resources and improve efficiency, and can incorporate exemption schemes or differential charges to protect the poor (WB, 1993; Shaw & Ainsworth, 1995; Nolan & Turbat, 1995). For many analysts, however, the economic theory overlooks a host of socio-political, cultural, and behavioral factors, and analytical propositions are not borne out by the reality on the ground in poor countries (Creese & Kutzin, 1995; Turshen, 1999; Waitzkin, 2000; Gershman & Irwin, 2000; Kim *et al.*, 2000; Farmer, 2003). The standard model promotes decentralization and focuses local

responsibility for planning and finance at the regional or district level. It is intended for developing countries generally and not only Africa.

The Bamako Model

The Bamako Initiative was launched at a regional WHO meeting in Bamako in 1987. The brainchild of the World Bank, UNICEF and WHO, it was designed to deliver universal access to primary health care in Africa through community level-financing and management (Nolan & Turbat, 1995). According to the World Bank, it has five main design features (WB, 2003):

- Change in the power relationship between service users and providers
- Reorganization of the delivery of primary professional care
- Procurement and supply of quality pharmaceuticals
- Cost sharing
- Participation of the community in management of the health system

The model focuses on the community level and the PHC Centre for planning and budgeting. Advocates were concerned with the lack of funding for PHC facilities – ‘the persistent and widespread under-resourcing of primary health care and consequent poor quality, particularly in terms of the drug supply’ (Nolan & Turbat, 1995). The Bamako model promotes user financing of primary health care through payment for essential drugs into a revolving drug fund which is managed at community level. Community participation was – theoretically at least – given a central role.

However, the World Bank and implementing governments admit to overestimating the capacities of district health officials and communities to participate in management activities, and also underestimating both the time and investment that would be needed to build capacity at local level to engage in genuinely participatory activities (WB, 1998:38). The model does not address concerns of secondary and tertiary-level care and does not promote the use of the referral system (Nolan & Turbat, 1995:4). Like the standard model, the Bamako model proposes to use exemption schemes to protect the poor, but in the context of the small and usually very poor communities in which the model is intended to

be applied, there has been little evidence to demonstrate that exemptions are designed or applied effectively (Nolan & Turbat, 1995:4; WB, 1998:32; Turshen, 1999, 49-50).

In Search of a Transitional Health Service Recovery Model

The two models differ in their assumptions about the structure and objectives of user charges in several ways (Nolan & Turbat, 1995:4). The Bamako model employs user fees principally to cover the cost of medicine and ensure the continued availability through a revolving drug fund that should in theory be managed at community level. The standard model relies on charges to subsidize the running costs of clinics and hospital and not only the pharmaceutical supplies. The standard model also uses an increasing scale of prices as the level of care increases, which in theory should promote rational use of services, where patients seek the lowest appropriate level of care instead of attending the nearest hospital for all ailments, and wasting resources (Gershman & Irwin, 2000:433). The models also differ in the control and use of revenue generated from fees. The standard model directs user fee revenue to the central health budget. Bamako promotes the retention of revenue at the community level and its use for ensuring drugs supplies and making perceptible improvements in the quality and range of service.

The Bamako model then, deals with community level services, purports to involve the community in service management and oversight, and focuses on Sub-Saharan Africa, the region in which the vast majority of Fourth World countries are located. For the purposes of this thesis, it is the most relevant and potentially the most useful approach to inform our search for a community health organization model to improve health conditions and sustain services in the transition from violent conflict and state failure to recovery.

The Bamako Approach to Health Service Financing

In September 1987, the World Bank, UNICEF and WHO launched a new strategy for financing primary health care services in developing countries at a meeting of the WHO Regional Committee in Bamako.

Aim and Objectives

The Bamako Initiative was designed around five main objectives:

▪ *Shifting the power relationships between providers and users of health services*

This involved a change in the direction of service providers' accountability to include accountability towards service users, by decentralizing decision-making and management from national level to local level, introducing cost sharing and community involvement in service management to increase the accountability of clinic staff to local users, and ensuring the availability of affordable medicines in a sustainable way, instead of the haphazard supply that characterized services dependent on irregular government transfers (particularly in the aftermath of structural adjustment) and fluctuating donor funding.

▪ *Reorganizing the delivery of primary professional care*

Primary health care centres serving populations of five thousand to fifteen thousand people were targeted for rehabilitation and expansion of service capacity. A service package was introduced to provide low marginal cost management of illnesses and professional public health interventions, with specific emphasis on childhood mortality and morbidity. Three basic service models were proposed: periodic campaigns focused on vaccination and ante-natal care; management of major causes of illness – malaria, acute respiratory infections (ARI), diarrhoea, and childbirth-related conditions; and family and community-based care using Oral Rehydration Therapy (ORT), exclusive breast-feeding and family-based treatment of malaria and ARI. Service provision focused on six main priorities:

- Increased availability of affordable drugs through the establishment of drug revolving funds;
- Revitalization of existing health centres and increased access through the provision of outreach services to surrounding areas within a 15 km radius;
- Community involvement to promote knowledge and use of immunization and ORT, and tracing defaulters from immunization programs;
- The imposition of user fees, supported by government and donor funding and cross-subsidization to maintain process lower than private-sector providers;
- Community participation in monitoring coverage and during biannual planning and budgeting of services;

- Standardized diagnostic and treatment algorithms, and training and supervision to improve quality.

- *Procurement and Supply of Quality Pharmaceuticals*

Essential drug policies were introduced in the three countries. Thirty to fifty of the most essential drugs were pre-packed in standard kits to supply health centres for a period of six months based on an assessment of the main causes of morbidity and standard treatment algorithms. Drug kits were provided to the health centres free of charge for the first three years, to help establish a capital fund and build up a reserve. Central Medical Stores were established in each country to provide a 'sustained procurement mechanism' for drugs and supplies. These were government-run in Mali and Guinea, but independent in Benin.

- *Cost Sharing*

The cost sharing approach at the centre of the Bamako Initiative was based on the imposition of charges for services at the point of delivery. Fixed fees were charged for patient registration, consultation and treatment, and low-cost drugs were sold for profit to generate revenue. Central medical stores secured preferential terms for bulk purchase of generic drugs which were sold at a 200 – 300 percent mark-up, income that was channelled into a facility health fund and used for local operating costs. Immunization and ORT were free-of-charge, and curative childcare, ANC and delivery were subsidized in rural areas. Government and donor funds were used to provide buildings, vehicles, training, drugs, vaccines and supervision. In Benin and Guinea, the government also paid all health staff, and the communities paid bonus incentives and salaries for additional staff. In Mali, only the supervisors were paid by the government; nursing staff were paid by the communities who consequently had the authority to recruit and sack them. According to the Bank (WB, 2003) this is a key distinction between the Bamako Initiative and other cost recovery systems: *revenue generated locally is retained by the community and used to increase access and quality of services*. Community committees were trained in the use of management systems and tools. Cost sharing also provided for the poor through exemption systems *'taking into account extended family networks that continue to be the backbone of the social security system in these countries'* (Knippenberg *et al*, 2003).

▪ *Engaging communities in the management of health services*

Communities were also involved in the co-management of the drug supplies and revolving funds. Community pharmacies could only be accessed in the presence of both the head nurse and a community representative and bank accounts for health funds required counter-signatures. There was a biannual monitoring and planning exercise in which community representatives participated.

Experience in West Africa

While it has been implemented in more than half of all Sub-Saharan African countries, its adoption in Mali, Guinea and Benin is used by the Bank to demonstrate its success and presented as an example of what might be achieved in other developing countries. The 2003 World Development Report provides an overview of the successful application of Bamako strategies in these three countries

‘During more than ten years of implementation in these three countries community-based services restored access to primary but also secondary professional health services for more than 20 million people, raised and sustained immunisation coverage, increased the use of services among children and women in the poorest quintile and led to a sharper decline of mortality in rural areas compared to urban areas in Guinea and Mali’

WB, 2003:76

According to the Bank, these countries were among the worst affected by the severe economic downturn of the early 1980s, and external debt and health conditions deteriorated as government spending declined. By the late 1980s immunization levels had fallen below 15 percent in all three countries, less than 10 percent of households were making more than one visit to health services in a given year, and self-medication was the main response to illness, with annual out-of-pocket expenditure at drug-peddlers amounting to \$5, on average, per household. In Benin the government’s health budget had fallen from \$3.31 per capita in 1981 to \$2.69 in 1986 (*ibid.*).

Successes: Expanding Services, Ensuring Drug Supplies

After 12 years implementing the Bamako Initiative in Benin and Guinea, and seven years in Mali, the Bank maintains that

'health indicators have improved quite significantly in terms of health outcomes and associated health services utilization, but also in terms of income protection as well as empowerment of communities over professional service providers'

WB, 2003a:10

To support this conclusion the Bank cites a selection of positive results including improvements in child mortality rates and immunization, improved physical access and increased facility income from user fees.

Efficiency: Improvements in Child Mortality and Immunization

According to the Bank, child mortality has been reduced significantly in all three countries. The reductions are greater, on average, among the poorest in Mali and Guinea (see Figure 3.1).

Figure 3.1: Benin, Guinea, Mali: Improvements in Child Mortality, 1980-2002

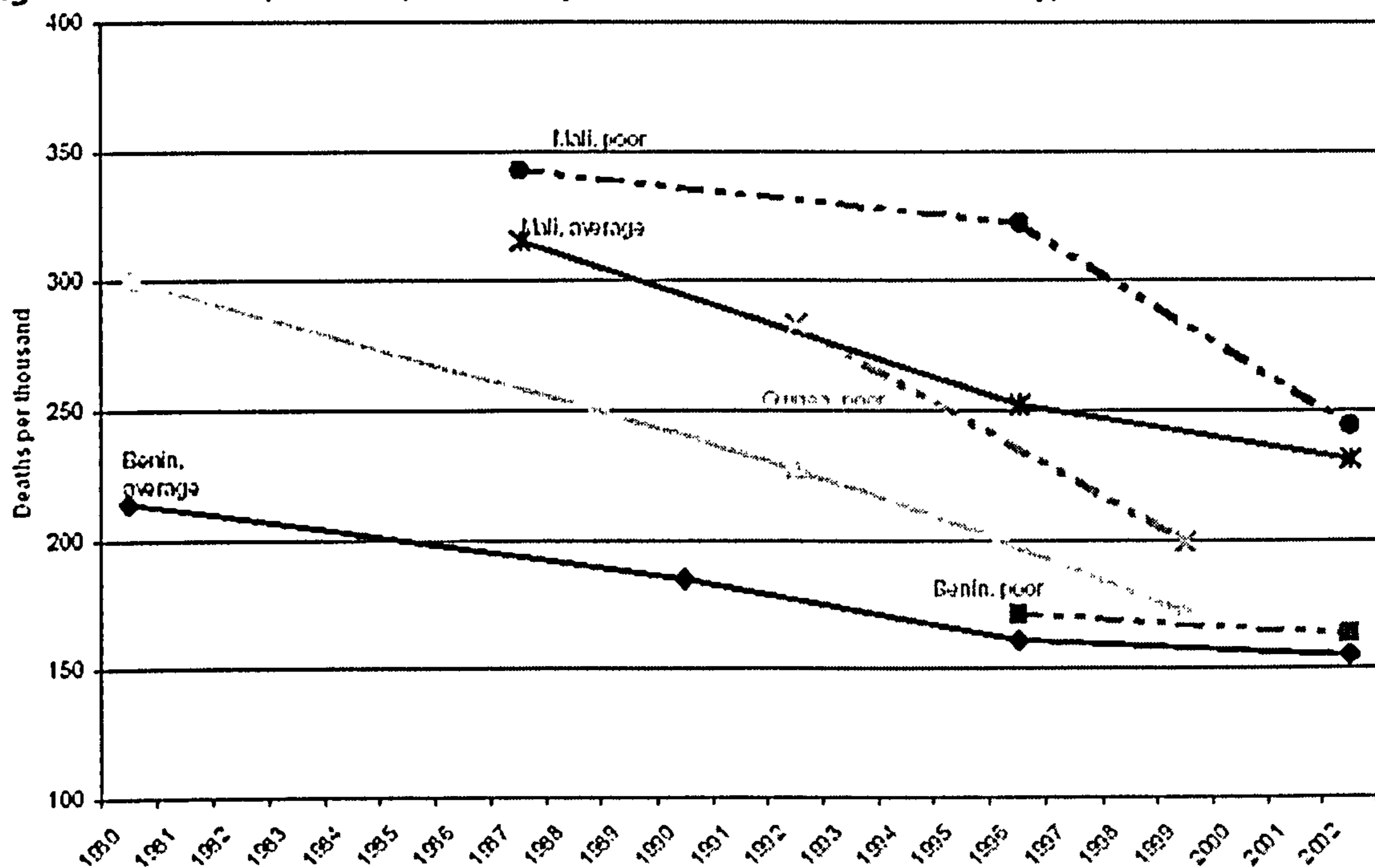


Figure sourced from World Bank, 2003

Immunization levels for DPT3 increased in all three countries and have been maintained at almost 80% in Benin over the past 10 years, one of highest levels in Sub-Saharan Africa. This has not been replicated in Guinea and Mali however, mainly due to problems of access (see Figure 5.3).

Figure 3.2: DPT3 Immunization Coverage in Benin, Guinea and Mali, 1988-1999

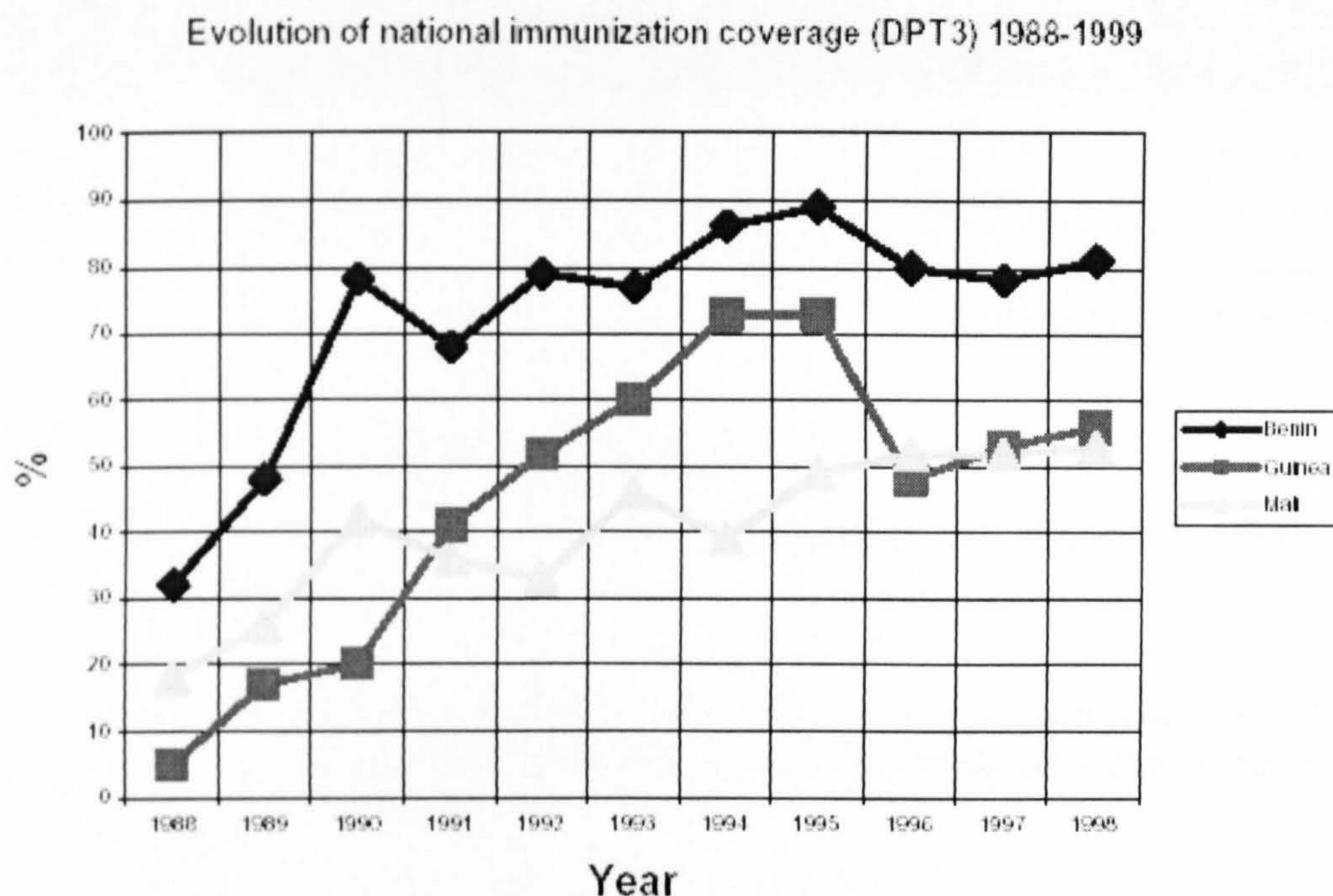


Figure sourced from World Bank, 2003

Improved Physical Access

The Bank review also describes increased coverage in other health interventions for all three countries. Utilization by children less than five years of age in Benin increased from less than 0.1 visits per year to more than one visit per year. In Mali rates of exclusive breastfeeding and utilization of professional services for antenatal care, deliveries and treatment of diarrhea and ARI have also improved.

The number of facilities was progressively scaled up in the three countries: from 44 health facilities in Benin in 1988 to 400 in 2002, from 18 in Guinea in 1989 to 367 in 2002, and from 1 in Mali in 1989 to 559 in 2002. According to the Bank, this raised the population with access to services within 5 km to 86 percent in Benin, 60 percent in Guinea, and 40 percent in Mali, covering more than 20 million people (*Ibid.*:20).

Table 3.1: Number of Primary Health Care Centres and Level of Access

Year	'88	'89	'90	1991	1992	1993	1997	Access <5km	2002	Access <5km
Benin	44	200	200	200	250	250	304	80%	400	86%
Guinea		18	98	164	214	256	346	42%	367	60%
Mali		1			4	11	363	25%	559	40%

Figure sourced from World Bank, 2003

Equity: Increased Income from User Fees

The Bank report states that 'relative affordability has improved' (WB, 2003a:17).

According to the review:

'Median household expenditures on curative care in a health center in 1989 was found to be US\$ 2, less than half the cost of private providers (US\$ 5) or a traditional healer (US\$ 6.7)'

(Ibid).

The report also claims that although more economically comfortable groups use the services, this utilization contributed to increased benefits in terms of preventive care for the poorest groups, and that cross-subsidization of preventive and promotive services has contributed to increased equity. Thus, the poor benefited largely from preventive services (WB, 2003a:17). The report also suggests that improved access to facilities and drugs led to decreased indirect costs linked to travel and that prices were set lower than alternative treatment sources. For example, antenatal care costs averaged US\$ 1.7 and charges were also made for immunization - US\$ 0.16 for the immunization card (*Ibid.*:17).

According to the report, the Bamako Initiative was able to use income generated by user fees to extend the range and improve the quality of services available to the poor by providing treatment and staff which would not otherwise be available. User fee revenue was used to procure essential drugs and basic medical supplies in clinics in all three countries. Surplus income generated by user fees was also used to pay additional staff or provide bonus payments to existing staff. The report does not say how poorer groups

without income to pay the fees overcame price barriers to access these services other than a passing reference to decisions on exemptions being left to the Community Management Committee, and a reference to the availability of services on credit in some cases.

Some Community Participation

One of the stated aims of the Bamako approach was to create a relationship of accountability between the users of the primary health care centre and the service providers who were normally answerable to a district or sub-national health office which typically had very limited capacity to monitor their adherence to standards and objectives, if any existed. This was to be done by decentralizing decision-making and management from national level to local level, introducing cost sharing and promoting community involvement in the management of the health centre.

Administrative and legal guidelines were created to regulate the status of community health committees, their composition and roles. Official policies on user fee charges, essential drugs and community participation were developed and adopted. Community committees were assigned responsibility for day-to-day maintenance and given the authority to use user fee revenue to carry out activities such as changing light bulbs, buying soaps and hiring temporary support staff. The review suggests that outreach activities were improved through committee oversight of drug stocks, vehicle fuel and mobility allowances. Community participation in decisions about incentive or bonus payments to facility staff also helped improve their performance. The review states that community representatives were also involved in the planning and monitoring of services, but does not provide many details.

Failures: Low-utilization, Exclusion, Token Participation

The Bank's claims about success are supported out by progress made on a select series of indicators presented in the 2003 World Development Report (WDR) overview of the Bamako Initiative in the three countries. However, analysis of a broader series of indicators taken from a number of Bank documents found on their website, including the review conducted to inform the WDR overview, and evaluations of the Initiative in 1998 and 1999,

together with a review of publications by critics of the Bamako Initiative, provide a less favourable picture.

Inefficiency: Compared with Increase in Number of Facilities

A closer look at child mortality trends, immunization levels, and the important distinction between increased physical access and actual utilization of services raises serious questions about the efficiency of the approach in improving health conditions, particularly given the level of investment made to expand access.

▪ Child Mortality

While it is true that under-five mortality has been reduced significantly in all three countries, it is also true that child mortality was declining in all three countries prior to the Bamako Initiative interventions, and that the rate of decline was not significantly increased by the interventions, even when the number of primary health care facilities was expanded significantly. Further analysis does not support the claims that the BI approach produced a significant reduction in child mortality, or even a reduction commensurate with the number of primary health care centers established, given the investment of resources made by external donors, technical experts and the governments of the three countries. For example, the rate of births attended by skilled health personnel is a widely recognized proxy for health service performance (Henry & Bloom, 2000; Simms, 1999). In 2001, the rate was 35 percent in Benin, 66 percent in Guinea and 24 percent in Mali. Sierra Leone, at the bottom of the Human Development Index, three places below Mali, sixteen below Benin, and eighteen below Guinea, had a rate of 42 per cent of births attended by skilled health personnel (UNDP, 2003:257).

▪ Immunization

The immunization rates quoted are for DPT3 only. In Benin there has been no significant improvement for almost a decade, and in Guinea, rates did climb to over 70 percent in the mid-1990s but then fell back to around 50 percent where they remain. In Mali, immunization rates have only increased slightly over the past seven years from 45 percent to just over 50 percent despite a massive expansion of the primary health care network and the huge investments made by donors and the government (WB, 2003a). Moreover,

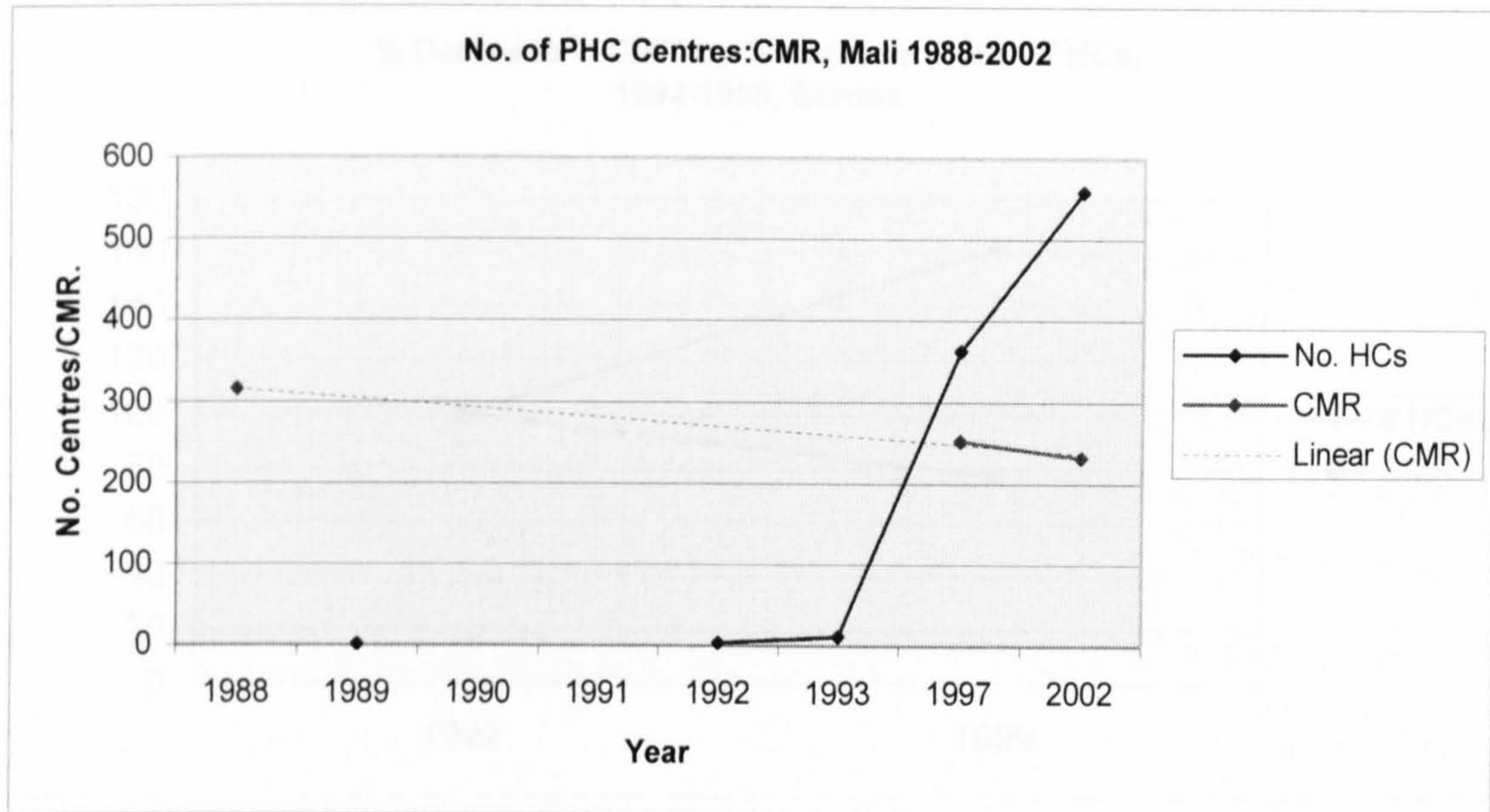
immunization against TB and measles paint a somewhat different picture of the capacity of the PHC system in these countries; in 2001 immunization levels for these two diseases were 71 and 52 percent in Benin, and 68 and 37 percent in Mali, well below the Sub-Saharan African averages of 73 and 58 percent (UNDP, 2003:257). Examples in the World Development Report 2003 and the supporting review of the Bamako Initiative do not seem to be supported by similar improvements in other aspects of health behavior. For example, use of oral rehydration therapy, a basic treatment for diarrhea, and one of the main priority activities promoted by the Bamako Initiative in all three countries, was 21 percent in Benin during the period 1994 to 2000, 18 percent in Guinea, and 22 percent in Mali. These rates are all well below the 28 percent rate found in bottom-of-the-table Sierra Leone (UNDP, 2003:257).

This raises important questions about the failure of the hugely expanded network of PHC centers to produce a greater impact on the health status of the population in spite of a massive increase in physical access. In fact, when one examines the evolution of child mortality in Benin and Mali the rate of decline appears to slow as the number of centres increases. In Mali, the rate of decline was clearly faster in the period immediately prior to the Bamako Initiative scale-up in 1997. For example in Mali, the number of health centres increased from 11 in 1993 to 559 in 2002, yet this expanded access to professional health services did not produce an equivalent decrease in child mortality (see Figure 5.2). In fact, the rate only declined from 251.7 in 1996 to 231.9 in 2000, a slower decline than that recorded for the period since 1987, when the rate was 315.3 (WB, 2003a:12).

This is further evidenced by the rate of DPT3 coverage compared with the increase in the number of health centres: although the number of PHC centres increased by 3,500 percent in the period 1993 to 1998, DPT3 coverage increased by barely 7 percent (see figure 5.3).

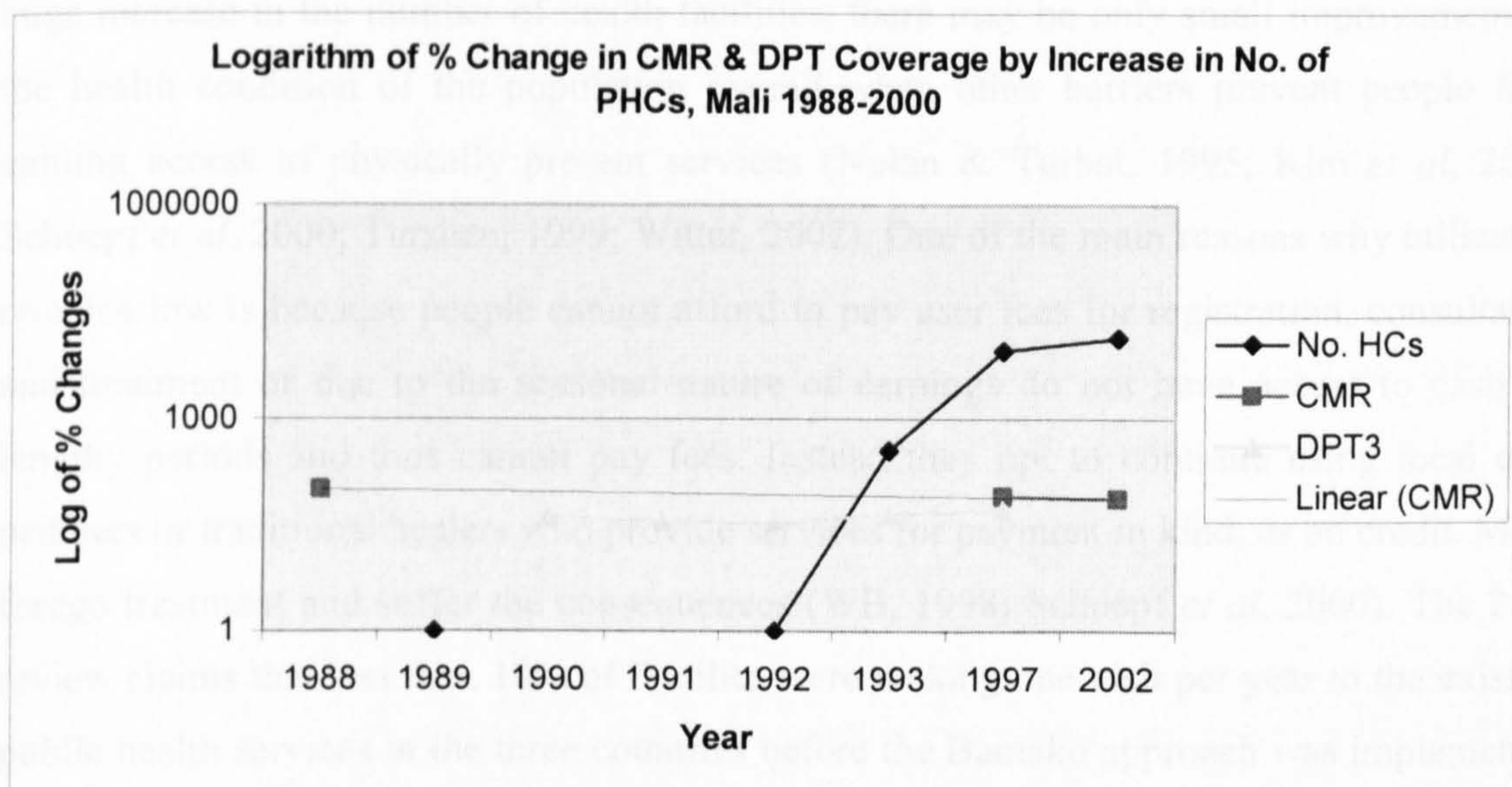
In Guinea, where the number of health centres rose from 18 in 1989 to 214 in 1992, to 367 in 2002, the rate of decline in under-five mortality barely changed. For example in the period 1992 to 1999, the number of PHC centres increased by 62 percent, yet the decline in CMR was only 22 percent (see figure 5.3).

Figure 3.3: Evolution of PHC Centres and CMR, Mali 1987 to 2002



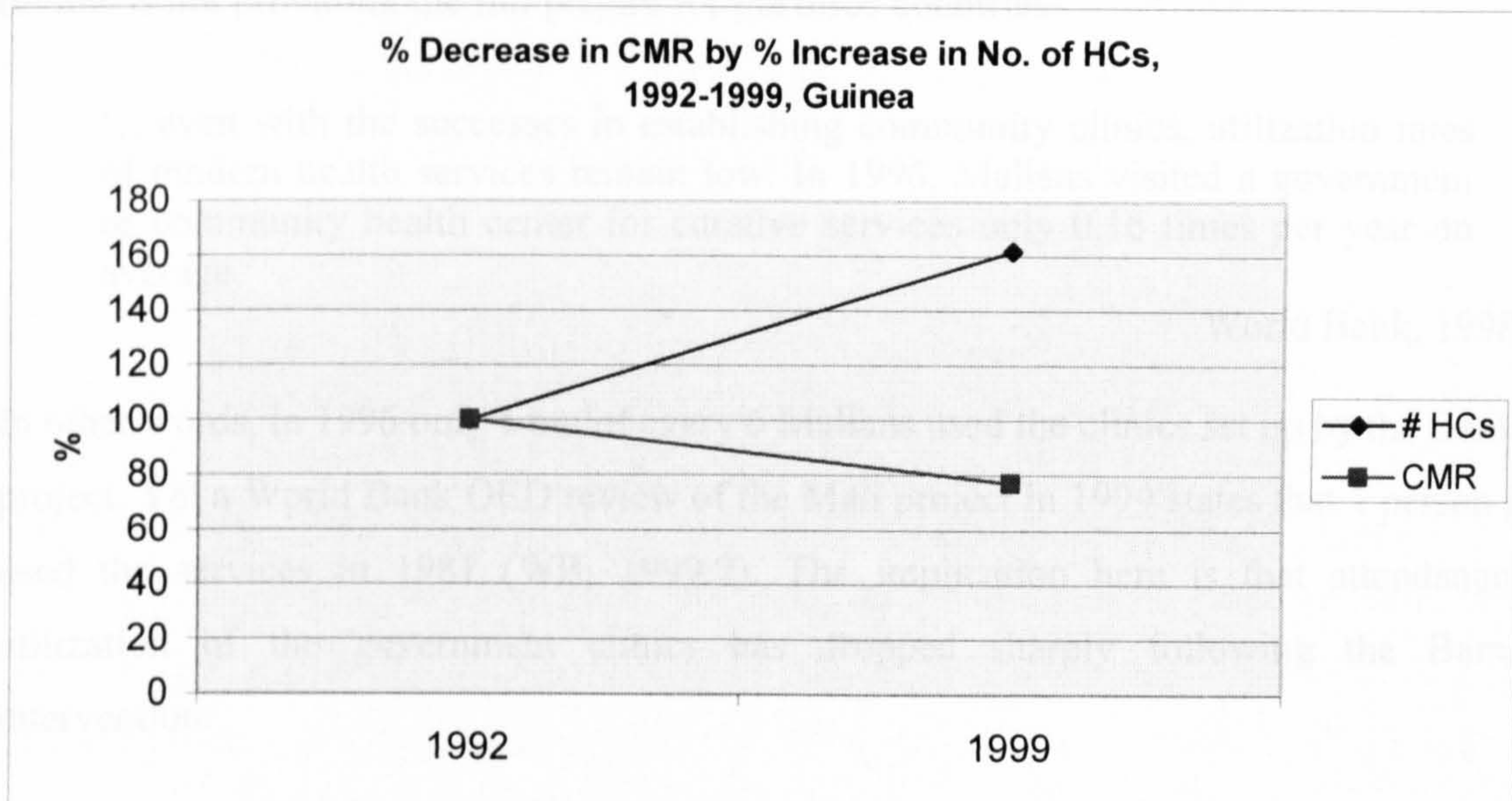
Data sourced from World Bank, 2003, 2003a

Figure 3.4: % change in CMR and DPT3 by number of PHC centres, Mali 1988-2000



Data sourced from World Bank, 2003, 2003a

Figure 3.5: % decrease in CMR by % Increase in Health Centres, Guinea, 1992-1999



Data sourced from World Bank, 2003, 2003a

Barriers to Access: Excluding the Majority

The 2003 review fails to make the important and well documented distinction between improved physical access to health services and increased service utilization. Even with a huge increase in the number of health facilities, there may be only small improvements in the health condition of the population overall when other barriers prevent people from gaining access to physically present services (Nolan & Turbat, 1995; Kim *et al*, 2000; Schoepf *et al*, 2000; Turshen, 1999; Witter, 2002). One of the main reasons why utilization remains low is because people cannot afford to pay user fees for registration, consultation and treatment or due to the seasonal nature of earnings do not have access to cash for lengthy periods and thus cannot pay fees. Instead they opt to continue using local drug peddlers or traditional healers who provide services for payment in kind, or on credit. Many forego treatment and suffer the consequences (WB, 1998; Schoepf *et al*, 2000). The 2003 review claims that less than 10% of families were making one visit per year to the existing public health services in the three countries before the Bamako approach was implemented and that utilization of health services by children under 5 years of age in Benin increased

from less than one visit per year for every ten children to more than one visit per year per child. However, the same claim is not made for Guinea or Mali, for example and re-reading the 1998 evaluation of the Bamako approach leaves one with the impression that the 2003 review is not providing the full picture for the three countries:

‘...even with the successes in establishing community clinics, utilization rates of modern health services remain low. In 1996, Malians visited a government or community health center for curative services only 0.16 times per year on average.’

World Bank, 1998:23

In other words, in 1996 only 1 out of every 6 Malians used the clinics set up by the Bamako project. Yet a World Bank OED review of the Mali project in 1999 states that 1 person in 2 used the services in 1981 (WB, 1999:2). The implication here is that attendance or utilization of the government clinics has dropped sharply following the Bamako intervention.

Equity: Inability to Pay

The impact of fees on poor people’s access to services is highly contentious, and deeper analysis of Bank reviews and evaluations reveals the extent of the exclusion suffered as a result of inability to afford user fees, and the failure of exemption schemes.

▪ Affordability

The Bank’s claim that relative affordability has improved is based on a comparison of average household expenditures on curative care obtained in health centres, private providers, and traditional healers, warrants further examination (WB, 2003a:17). First, this statement is based on data for 1989 and is used to support conclusions about the overall impact of 14 years of implementation. Yet in 1989, the Bamako Initiative has only just begun in Benin, and access to health centres had not yet been expanded to the majority of the population. Second, it ignores the widely acknowledged reality that almost all households use traditional healers – even when they are attending conventional practitioners (UNDP, 2001; Barakat & Deely, 2001; Farmer, 2001, 2003; WHO 2001). Thirdly, the provision by public health facility staff of private consultations outside official working hours at their own homes, or practices, or pharmacies is well documented (Witter, 2001; Turshen, 1999; UNDP, 2001, 2003; WB 1993, 2003). Where this is the case, the

imposition of user fees at public centres simply forces patients to pay the same nurse or doctor twice – once at the health centre and once at their private practice. Fourth, the introduction of user fees has been known to facilitate increases in prices by private practitioners, who often can refer patients from their public to their private practice, or can provide treatments or services that are not available at public facilities. And fifth, as Table 5.2 demonstrates, a very large proportion (85 percent) of private spending in these situations goes to procure medicines, something which changed little under the Bamako approach where medicines were charged for based on a 200 to 300 percent mark-up on cost.

In fact, these figures confirm what has been known for many years: the imposition of user fees in primary health care facilities means that poor people use them less frequently – or not at all. The fees serve to discourage patients from using the service as they either cannot afford them, or they do not have access to money to pay the fee at the time of illness. Instead patients are forced to use private ‘drug peddlers’ and traditional healers who provide consultations and treatments that can be paid for at a later stage, or in-kind, often with detrimental effects on their health (Whitehead *et al*, 2001:835).

Table 3.2 Private Health Expenditures, Mali, 1997 (FCFA billion)

	Amount	Percentage
Fees in public sector	0.9	3.1
Care in private or informal sector	1.5	5.1
Illicit private fees	1.0	3.4
Traditional medicine	1.0	3.4
Modern drugs	24.8	84.9
Total household health expenditures	29.2	100

Source: WB, 1998

The fees charged present a major barrier to the poor majority. Fixed prices were charged with no concessional prices offered to the poor or extremely poor (WB, 2003:18). This highly regressive practice clearly had an impact on attendance by the poor, with 87 percent of the poorest groups consulted in the 2003 review stating that the price levels did not allow access to all (WB, 2003a:18).

‘Despite sustained subsidies to supply the poorest regions, a significant proportion of the poor remains excluded from services and must rely on self medication, particularly for children illnesses.’

WB, 2003a:29

Under the socio-economic circumstances that prevail in most Sub-Saharan Africa countries, the majority of people simply cannot afford even minimum fees and Bamako approach clinics often end up serving only that small proportion of the population which can afford the fees (WB, 1998; Nolan & Turbat, 1995:11).

▪ **Exemption Schemes**

Although the standard defense offered is that exemptions will protect the poor, the 2003 review makes only a cursory reference to such exemption systems, without any explanations, statistics or analysis of the impact on the poor:

‘Decisions on exemption from payment for the poorest members of the community were left to the discretion of the Community Management Committees. They were assumed to best know who was actually unable to pay, taking into account extended family networks that continue to be the backbone of the social security system in these countries.’

WB, 2003a:8-9

The reason for this may be seen in the 1998 Mali evaluation and in an evaluation of the Bamako Initiative in all three countries, which explain that exemption systems may look good on paper, but in practice they seldom function. Clinic staff and health committees who depend on user fees for funds to procure drugs as well as their own incentive payments are often very reluctant to dispense costly exemptions:

‘In theory, when the very poor come to the health center for treatment, they are referred to the community association (or its representatives, the president or treasurer) for a determination of whether their costs will be covered by the association. Each health center had established a register for recording treatment provided to the very poor for whom the costs were covered by the association. Yet no center visited by the evaluation team for this study had any such treatment recorded in the register.’

WB, 1998:44

‘no country had developed an effective mechanism of protecting the poorest from payment and there were signs that the existing mechanisms benefited the non-poor’

Gilson, 2000

The conclusion – even by the World Bank - is that exemptions systems are not widely used: ‘communities do not appear to be widely providing exemptions’ (WB, 1998:32). The poor are excluded as both the 1998 evaluation and the 2003 review suggest:

‘...even though relative affordability improved, and preventive and curative child care services were heavily cross-subsidized, some of the poorest families were still excluded from curative and delivery care’.

WB, 2003a:17 (emphasis added)

Faced with the choice between generating and retaining enough revenue to maintain the service at the cost of excluding the poor, or granting exemptions and dispensing free drugs and foregoing the income, health committees and clinic staff frequently chose the former, often because they have no choice. Since facilities depend on the revenue from the fees, it is inevitable that pressure builds to give priority to users who can pay, and where clinic staff and health committee members’ salaries, bonus payments and other allowances are funded by revenue from fees, it is even more likely that paying patients will be preferred to those seeking exemptions (Whitehead *et al*, 2001:834).

Although the 1998 evaluation clearly identified this practice of ignoring provisions for exemptions to protect the poor, the Bank does not seem to be unduly concerned about the failure or the impact that this is having on the poor:

And a large proportion of the poor still do not use key health services in all three countries. In Benin and Guinea the health system allowed for exemptions, and most health centers had revenue that they could have used to subsidize the poorest, but almost none did. Management committees typically valued investment over redistribution.

WB, 2003:77

Although, the wider implications of this exclusion do not receive any attention in the Bank’s 1998 evaluation or the 2003 review, they are profound. The poor, who account for an overwhelming majority of the population in these countries, are forced to borrow, and where they cannot borrow, they frequently forego treatment, a practice which promotes the spread of diseases and ill-health in Sub-Saharan Africa:

‘A study in the Koulikoro region proposed that because of the embarrassment associated with being very poor, those without the resources to pay for

themselves prefer to ask a family member or friend to cover the costs or forego treatment rather than depend on the charity of the community association.'

WB, 1998:44

Although the 2003 review states that credit was offered to sick people who could not pay fees, there is no acknowledgement that credit still has to be repaid, nor any reference to the impact of indebtedness, entrenching poverty and spreading the burden of ill-health throughout the community through borrowing from extended families and deferred payment (Barakat & Deely, 2005; Deely, 2005; Farmer, 2003; Kim *et al*, 2001; Gershman & Irwin, 2001; UNDP, 2001; Whitehead *et al*, 2001; Cliffe, 2000; Turshen, 1999).

▪ Lack of Preventive Services

The claim that the Bamako approach contributed to increased equity in the provision of services is particularly disturbing because it misrepresents the facts as documented by the Bank in other reviews of the approach. Better-off minorities – referred to as 'more economically comfortable groups' - benefit disproportionately from the services provided through the Bamako approach, because they can afford to pay the fees, whereas the poor and the extremely poor cannot, or are forced to borrow or seek deferred payment. The 2003 report claims that utilization by relatively well-off community members contributed to increased benefits in terms of preventive care for the poorest groups, and that cross-subsidization of preventive and promotive services contributed to increased equity. Thus, according to the review 'the poor benefited largely from preventive services' (WB, 2003a:17). In fact, as the Bank reported in a 1998 evaluation of the Bamako approach in Mali, one of the fundamental weaknesses of the user fee approach is that the pronounced dependence on drug sales and curative services to generate income effectively constitutes a disincentive to the provision of preventive and promotive services:

'...the community-financing approach faces a fundamental problem with the provision of public goods, particularly preventive programs and health education. Since the community centers rely on drug sales to meet recurrent costs, they tend to under-provide health education services, which are among the interventions most critical for improving public health.'

World Bank, 1998:32

Consequently:

‘the clinics provide primarily curative health services, with little involvement in provision of family planning, promotion of clean water and sanitation, nutritional monitoring, or health and nutrition education and preventive activities.’

World Bank, 1998:7

Yet the 2003 review for the World Development Report manages to convert these conclusions into ‘the poor benefited largely from preventive services’ (WB, 2003a:17) without any reference to the findings from previous Bank assessments – a disturbing display of misrepresentation.

‘Top-Down Participation’

Community participation is notoriously difficult to engage and even harder to measure (Kahssay & Oakley, 1999). Curiously, the 2003 review describes only one of the main problems associated with community involvement – capture by dominant groups – but does not reflect on the other difficulties encountered during the process (WB, 2003a:19). Some of these can be found in the 1998 evaluation of the Bamako Initiative in Mali which describes how the process attracted the label "top-down participation" because of the manner and speed with it was imposed on locals (WB, 1998:39). This is inadvertently reflected in the 2003 review which describes how:

‘On several occasions, the central team came to villages to deliver a stock of drugs and refrigerators only to find that the conditions had not been fulfilled. After discussion with the local authorities, they left the village with the equipment that was then diverted to another health center. When the team returned to the first village one month later, the conditions had been fulfilled’.

WB, 2003:26

Here the Bank appears to overlook a key lesson in participatory community financing schemes:

‘On the basis of existing evidence the worst scheme is one that is conceptualized at the national level but is then given to (or forced on) local people to run and ensure that funds revolve. In this case there may not be the experience necessary to run the scheme effectively and when it runs into difficulties, little motivation to keep it going.’

Witter *et al*; 2000:84

The 1998 evaluation describes how the community organization process took significantly longer than planned and how the need to put some form of structure in place quickly prevented the development of consensus among the various villages to be represented. A survey undertaken in 1998 concluded that many health professionals viewed "participation" as patients paying for services, as district doctors failed to develop the skills to engage people in the service and often resisted the concept of community participation. The 1998 report also noted the problems of representativeness, with community authorities frequently appointing the committees instead of facilitating a popular process of selection. This resulted in a situation where people from surrounding communities did not know the community management structures. According to the 2003 review, problems with representation resulted in membership of most of the health committees being restricted to local elites who controlled health centers in agreement—and sometimes in collusion—with the health staff. This led to a range of problems including marginalization of the majority population and in some cases serious mismanagement. Although there were problems with accountability and corruption, the most common obstacles came from inadequate management skills, and consequent problems with financial planning, shortages of funds to cover administrative costs and drug purchases. These were all the more difficult to resolve because of the failure to engage genuine community involvement, and consequently the lack of motivation. Little was done to address the practice of male domination of committees and complaints from women that their concerns were not adequately represented were also reported (WB, 1998, 2003, 2003a; Witter, 2002).

Although the review reports some progress in addressing this issue, it notes that too little has been done to involve the poor and other underserved groups in the management committees. Oddly, perhaps, the Bank treats this as an oversight rather than an intentional component of an entrenched strategy of domination and control at the heart of national and local structures of inequality. While dominant elites may not necessarily have any specific agenda to exclude or otherwise victimize poor majorities or minorities, structures tend to be self-perpetuating, and when faced with decisions about allocating resources, controlling groups find it convenient to favour their own over the weak or those without political power (Kim *et al*, 2000; Schoepf *et al*; 2000; WB, 2003a)

‘Top-down organization of health committees in the community tends to perpetuate elitism, and the rest of the population can tend to feel marginalized by this process. Clearly most of the management committees have been initially colonized by the local elite including retirees and civil servants who often co-manage the centers in agreement—and sometimes in collusion—with the health personnel.’

WB, 2003a:19

And here we see an important example of how control and distribution of health and medical resources including access to life-saving treatment typically reflect and reinforce structures of oppression in society – a subject to which we shall return (Waitzkin, 2000:52-3).

Lessons from the Cost Recovery Approach

On the whole, the Bamako Initiative approach to financing primary health in Benin, Guinea and Mali appears to have been successful in two major aspects: establishing a functioning network of clinics throughout the three countries; and ensuring continuous supplies of essential drugs for treatments at these clinics. Given the extent of the devastation of the public health systems in these countries as a result of declining terms of trade, economic mismanagement and the effects of structural adjustment, this expansion of the primary network is an important success. Where the approach appears to have failed is in improving utilization of services, and improving sustainability of the public health system. According to the 1998 evaluation:

‘The community health strategy left unaddressed significant constraints to improved health for the majority rural population. Despite progress in expanding rural health services, overall utilization remains low.’

WB, 1998:5-6

Efficiency

The Bamako approach established primary health care networks with 400, 367 and 559 health centres in Benin, Guinea and Mali ensuring physical access rates of 86, 60 and 40 percent respectively, covering 20 million people. Why then do the 2003 review and the

1998 evaluation inform us that many people are not using these services? Why according to the 1998 evaluation did Malians only visit a government clinic once in every six-and-a-half years on average? Why is ORT use barely 20 percent in any of the three countries? Why are only 24 percent of births attended by skilled health personnel in Mali, and only 35 percent in Guinea? Why do up to 50 percent of the population in Mali and Guinea remain without access to affordable drugs? And why, in most cases, do child, infant and maternal mortality rates remain above or only slightly below the average for Sub-Saharan Africa?

Table 3.3: Health Indicators Mali, Benin, Guinea, Least Developed Countries, Sub-Saharan Africa

Country	% with Physical Access	ORT Use Rate	% Births attended by skilled personnel	% without access to affordable drugs	Infant Mortality Rate	Child Mortality Rate	Maternal Mortality Rate
Mali	40	22	24	21 - 50	141	231	630
Benin	86	18	66	21 - 50	94	158	880
Guinea	60	21	35	6 - 20	109	169	1200
LDCs	-	-	31	-	101	160	1000
SSA	-	-	38	-	107	172	1098

Source: UNDP, 2003

Table 3.4: Selected Wealth Indicators Mali, Benin, Guinea, Least Developed Countries, Sub-Saharan Africa

Country	HDI Rank (from 175)	GDP per capita US\$ 2001	Share of Income or Consumption		Public spending as % of GDP
			Poorest 20%	Richest 20%	
Mali	172	239	4.6%	56.2%	1.8
Benin	159	368	-	-	2.2
Guinea	157	394	6.4%	47.2%	1.9
LDCs	-	280	-	-	-
SSA	-	475	-	-	-

Source: UNDP, 2003

The answer would appear to lie in the level of poverty and consequently the inability of people living in these countries to pay the fees charged at the Bamako approach facilities. Although physical access to primary health care services was expanded enormously in all three countries utilization remained low and the impact on health behavior as evidenced by mortality, immunization coverage, ORT use, assisted births and other key indicators, has not been commensurate with the increase in access. The link between low utilization and the imposition of user fees is acknowledged in the 1998 World Bank evaluation and conceded in the 2003 World Development Report:

‘utilization rates remain low, apparently because of financial barriers to access’
WB, 1998:6

‘Poor people still saw price as a barrier. And a large proportion of the poor still do not use health services in all three countries.’
WB, 2003:77

The 2003 review does not emphasize the critical distinction between *physical* access and utilization, or the corollary that the expansion of the network of facilities will only lead to significant improvements in health status if the majority of the population uses the facilities appropriately. Mercedes Benz might establish a nationwide network of car dealers in Somalia tomorrow, but it does not automatically follow that a large number of people will be driving Mercedes Benz cars by the end of the year, or next year, or the decade. Utilization, as distinct from access, is a function of a number of conditions, ranging from topography to awareness among the population of the existence of the service, but one of the most important conditions is the ability to pay. This condition has been asserted by the proponents of the Bamako Initiative based on their analysis of private spending on health in Sub-Saharan Africa. In fact, one of the fundamental hypotheses of the user fee approach and of the Bamako Initiative is the principle that populations are able to pay for their own health services. This deeply controversial assertion can be found primarily in World Bank publications (WB 1987, 1993; Griffin & Ainsworth, 1995; Shaw, 1995).

Ability to Pay for Health Services

Shaw uses a number of examples from Sub-Saharan Africa countries to justify his argument that people are willing and able to pay for health services, noting that for example, they pay for traditional healers and medicine from drug peddlers (Shaw, 1995:22-24). To support this position, he refers to a table showing per capita household expenditures on health in five Sub-Saharan African countries ranging from 2.1 percent in Ivory Coast in 1985 to 5.9 percent in Senegal in 1991-1992. He argues that average household expenditure on health is significantly larger than central government expenditures and therefore:

‘These substantial differences between public and household expenditures further suggest the potential for cost-sharing and redirecting household expenditures in support of basic packages of care.’

Shaw, 1994:23

Table 3.5: Per Capita Household Expenditures on Health in Selected African Countries (US\$)

	Ivory Coast 1985	Guinea Bissau 1987/88	Ghana 1991	Nigeria 1985/86	Senegal 1991/92
Household Quintile					
Lowest	3.99	2.55	2.44	2.58	4.90
2 nd	6.59	4.25	3.88	5.88	10.27
3 rd	14.33	6.19	4.38	10.07	13.44
4 th	17.04	8.54	4.63	14.08	25.34
5 th	46.38	14.83	8.34	35.16	61.82
Average	18.88	7.27	4.74	15.05	23.14
PC Income	911.31	239.00	196.00	400.00	393.00
Expenditure as % PC Income	2.1	3.0	2.4	3.8	5.9

Note: Household expenditures include both traditional and modern health services and medicines.

Source: World Bank, 1994 quoted in Shaw, 1995:23.

What he fails to comment on is that in all five cases, around 80 percent of the population spend less than the average household expenditure, while the richest 20 percent spend between two and three times the average. The rich-poor divide is significant in all five countries; for example in Nigeria, the richest 20 percent of the population account for 55.7 percent of total income or consumption compared with the poorest quintile which accounts for only 4.4 percent (in Guinea Bissau the ratio is 53.4 to 5.2; in Ghana it is 46.6 to 5.6; in Senegal 48.2 to 6.4; and in Ivory Coast 44.3 to 7.1). In other words the vast majority of people are poor or very poor, far below 'average' incomes and any flat rate user fee schemes will risk excluding them from relevant services.

Apart from the geographical and urban-rural distortions which prevent pooling between rich minorities and the poor majorities, wealthy elites and urban populations also benefit disproportionately from tertiary facilities (Witter, 2001; WB, 1998; Turshen, 1999; WHO, 2001). Shaw's conclusion that because people pay for medicine and treatments, they must be willing and able to do so does not consider that the paltry sums spent by the majority of the poor explain exactly why mortality and morbidity rates are so high in these countries: there is no effectively functioning public health system and people cannot afford to spend the sums required to access private treatment.

Nor does he take into consideration the consequences for the majority populations who are forced into indebtedness, sex work, labour migration, and forfeiture of food, clothing, and education. As Turshen notes,

‘Another way to interpret the data is to ask whether there is a link between high private expenditures and the high levels of mortality and morbidity found in Africa.’

Turshen, 1999:51

Shaw’s argument makes no attempt to trace this link or to analyse the consequences for people who are forced to pay for health services. Yet, there are many studies showing that, for example, pregnant women give up antenatal visits when household budgets are tight (Turshen, 1999); those who cannot afford user fees often forego treatment (WB, 1998); women are forced into commercial sex work when children or male heads of household fall ill (Schoepf et al, 2000); households sell food stocks to pay for fees (Witter, 2001, Whitehead *et al*, 2001).

Per capita GDP in Benin averaged barely \$1 per day in 2001, and the richest 20 percent accounted for 47.2 percent of total income, or 7.3 times the income of the poorest 20 percent (UNDP, 2003:281). In other words, the vast majority of the population did not have anything like \$1 per day to live on. In Mali, where the richest 20 percent of the population owned more than 56 percent of the country’s income and the poorest quintile accounted for only 4.6 percent of income: 72.8 percent of the population had to survive on less than \$1 per day (UNDP, 2003:247, 285). In these contexts of widespread, entrenched, extreme poverty, claims that charges amounting to several days’ income for basic, life-saving health services were ‘negligible’ may appear inaccurate, disingenuous and even offensive. In the context of high maternal, infant and child mortality rates, poverty is the principle factor influencing a decision to seek care. Where earnings in a household are substantially less than \$1 per day, and infrequent or seasonal earnings mean that there is often no access whatsoever to money for weeks and months at a time, charges levied at \$1.70 or even \$0.16 present a significant obstacle to access for the poor.

In Mali, 73 percent of the population live in extreme poverty according to the Bank’s standard¹⁴. Therefore, according to the 2003 report, a large proportion of people accounting for more than three quarters of the population do not use the services provided by the Bamako Initiative approach. Clearly then, the policy of charging fees to the poor is

¹⁴ “Extreme poverty – defined as living on less than \$1 per day” (WB, 2002b:1)

preventing - or at least slowing – the improvement of the health status of the majority of people in these countries, something that has been asserted by many analysts during the 1990s (Creese & Kutzin, 1995; Turshen, 1999; Kim *et al*; 2000; Schoepf *et al*; 2000; Gershman & Irwin, 2000; Whitehead *et al*, 2001; WHO, 2001, Arhin-Tenkorang, 2001; Chossudovsky, 1999; Waitzkin, 2000; Farmer, 2003). Take for example, the conclusion of a 1988 WHO seminar on cost recovery:

‘...the poorer the patient, the less probable it is that he will be able to bear the full costs of the drugs he needs. In many countries more money is lost through poor management and handling of drugs than could ever be recovered through user charges. [...] It is inequitable to ask patients to pay for the inefficiencies of a system, especially if only a small group of people stand to benefit from the extra burden placed on the majority.’

WHO, 1988, quoted in Turshen, 1999

Why then do the World Bank, UNICEF, governments and other international actors persist in forcing user fees on these populations?

Sustainability

The 2003 review suggests World Bank and other proponents of the Bamako Initiative may consider the exclusion of the poor as a necessary price to pay to generate the revenue to ensure the continuation of the service, hoping that the question of inequity can be dealt with in the long run:

Building on their “Bamako Initiative foundations” which mainly strengthened the supply side of professional services, Benin, Mali and Guinea now face the challenge of similarly supporting the demand side through more emphasis on household behaviors, and the protection of the poorest and most vulnerable.

World Bank, 2003a:31

▪ The Sustainability-Exclusion Trade-off

The fundamental purpose of the Bamako Initiative – as with other cost recovery models – is to generate more resources for the health sector: the revenue raised by imposing fees at public clinics would allow basic services to be expanded and maintained (Nolan & Turbat, 1995; WB, 1999). The expansion of the primary health care network was made possible

through extensive external donor financing, mainly from the World Bank and UNICEF, with some funding from governments in the three countries:

“Governments and donors funded the investment in buildings, vehicles, training and drug stocks as well as vaccines, supervision, monitoring, and support systems. In Benin and Guinea, governments also paid the salaries of all staff, and in Mali, that of health supervisors.”

(WB, 2003a:8)

Sustaining the services would require the approach to generate enough income to pay recurrent costs, a situation which neither prevails nor is likely to prevail given the poverty of the people in these countries. Take Mali for example:

‘...although community financing can provide an important means to mobilize local resources, in the context of overall expenditures, the amount raised is currently only about 3 percent of total household expenditures, which translates into 1.5 percent of total sector expenditures.’

World Bank, 1998:44

The 2003 review does not provide figures or details of the sums of money being generated by the user fee system for any of the countries, preferring instead to note that

‘the revenue generated covered only a small fraction of the cost of running the health centers (less than 20 percent)...’

WB, 2003a:21

It is clear that the approach does not generate anywhere near enough revenue to allow services to be expanded or sustained. The significant donor and government financing that have been allocated to the project during the initial stages would need to be maintained in the future.

▪ **Increasing Dependence on External Financing**

However, the approach appears to have increased these countries’ dependence on external financing of health services. In Mali for example, donors increased their support to health to support the Bamako approach, and concentrated their resources on establishing a network of rural health centres. Apart from the problems this has generated in funding recurrent costs, with donor interventions displacing badly-needed government support for critical interventions, this appears to have encouraged a dependence on donor aid. Public

health expenditure in 2000 was only 1.8 percent of GDP in Benin, 1.9 percent in Guinea, and 2.2 percent in Mali: if anything the Bamako approach appears to have facilitated a decline in government health expenditures (UNDP, 2003). An even more disturbing development can be seen in Mali where primary health care and health education programs were entirely funded by donors in 1997. That same year the government provided barely a sixth of total resources for health, with more than half provided by households and a quarter by external aid (WB, 1998; Nolan & Turbat, 1995; Turshen; 1999).

The failure of the Bamako approach to mobilize even 20 percent of the overall costs of maintaining services, taken together with individual governments' inability to allocate funding to primary health care, raises serious questions about the ability of the Bamako approach to improve sustainability in the long run. Not only will donor funding be required for the long term, but it will be required to fund services which, according to Bank and other evaluations, are only used by a small proportion of the population of these countries, and typically by better-off groups. In other words, services which are unlikely to make a major impact on health status because they do not serve the poor, i.e. – the vast majority of the populations in these countries.

Neoliberal Globalization, Poverty and Ill-health

The Bamako approach emphasises strategies and tactics that support the export-oriented economic reforms at the heart of the neoliberal globalization paradigm: services for diseases that can be prevented or treated with immunizations and drugs, creating important markets for pharmaceutical and other multinational corporations. Supplies are purchased in hard currency provided by Bank loans perpetuating a cycle of borrowing, trade and consumption at the heart of the neoliberal paradigm (Turshen, 1999:121; Chossudovsky, 1999; Chomsky, 2000). But, Bank policies such as structural adjustment and health service privatization, including the Bamako approach, have failed to address the structural issues at the heart of poor health in these countries, and in many cases have compounded the conditions which have produced them (Turshen, 1999; Schuftan, 1999; Kim *et al*, 2000; Schoepf *et al*, 2000; Farmer, 2003). Studies in Sub-Saharan African countries suggest that the most important determinants of infant and child mortality include household income, the mother's education level, the nutritional status of the child, and the availability of basic

health services, particularly preventive prenatal care and child vaccination (WB, 1998). Despite being aware of these conditions, Bank policies were not directed to addressing them; in fact the Bank continued to pursue policies that aggravated them. In its 1998 evaluation of the Bamako initiative in Mali, the World Bank reported that household incomes had not increased over the past decades, female education remained low, and child malnutrition was increasing (World Bank, 1998). Per capita GDP in Mali is still below the level it attained in 1979 (UNDP, 2003). The same 1999 World Bank review of the Bamako approach in Mali that noted that ‘costs remain a deterrent for many’ reported that utilization of health services had declined to 0.16 visits per year, but shockingly failed to articulate the patent connection between the decline in utilization and the imposition of fees for services, despite noting that 40 percent of children were suffering from malnutrition and more than half of all deaths among children under five years of age could have been caused by lack of food (WB, 1999:2). If people cannot even afford to feed their children, it would seem reasonable to at least question whether user fees for basic primary health services might not act as a deterrent to utilization.

Similarly, the Bamako approach deals only with a small range of basic health services, and proposes the same prescription for a raft of Sub-Saharan African countries, despite the range of political, socio-economic conditions that prevail. Although the Bank revised its 1987 prescription in 1993 based on the lessons learned from six years of privatization, the main thrust remains the same – fees, private insurance, a reduced role for governments and an increased role for the private and voluntary sectors. There is no revision of the basic principle of government failure, despite an increasing awareness of the role played by structural adjustment in exacerbating the problems of public health systems, through fiscal austerity, deregulation and liberalisation without any safeguards for social sectors (Turshen, 1999:128).

Without an acknowledgement of the structural problems at the heart of failing health conditions in Fourth World countries, health financing approaches will continue to focus narrowly on issues of supply and demand, to the detriment of populations whose access to basic health services is a matter of life and death. Health status is determined by a wide range of conditions, and the provision of personal health services is only a small function of

a public health system. Yet the Bamako approach, with its focus on cost recovery reduces life-and-death questions about health conditions from an important debate about broad political choices, to narrow questions about how to pay for personal health care (Turshen, 1999).

Conclusion

The Bamako Initiative has provided the dominant approach to efforts to expand and sustain primary health services in Sub-Saharan Africa, the region where the vast majority of Fourth World states are located. It was designed as a community level-financing and management system to provide universal access to primary health care by combining five broad elements: accountability to service users, reorganization of the delivery of primary professional care; procurement and supply of quality pharmaceuticals; cost sharing through the imposition of user fees, and community participation. Today, at least 29 countries are implementing some variant of the approach. In countries where the Initiative has been correctly implemented its access to international funding has produced a significant expansion in the number of primary health care facilities and provided a consistent supply of drugs.

However, the neoliberal influences at the heart of the approach have prevented the Bank and UNICEF from acknowledging the failure of the 'self-financing' component of the approach, and the damage that this is causing in terms of low-utilization of services, and missed opportunities to produce significant improvements in health status. The imposition of user fees for both curative and preventive services has created fundamental problems of access for the poor, who constitute the vast majority of inhabitants in these countries. Meanwhile, better-off groups have benefited disproportionately from the government and donor investment in the approach, while preventive services have declined or been discontinued. Other drawbacks include: the lack of management capacity of district authorities and communities and the reluctance to allow time to develop these skills; the failure to engage genuine community participation; the inability to address allocative inefficiencies or promote use of the referral system; the creation of disincentives for preventive and other public health strategies; shortages of hard currency for the purchase of imported drugs; the incentives that arise for over-prescribing as a result of the link between

income and drug sales; the increased tendency towards self-medication and the consumption of drugs; discontinuation of treatment when users cannot afford repeat prescriptions promoting drug resistance, which, in turn, necessitate the purchase of ever-more expensive second and third generation drugs; and exacerbating inequalities within communities by penalising the poor who are sick more often and frequently excluding them altogether through price barriers.

The Bamako approach treats health service provision as a purely financial process, an expense which governments can no longer afford, and which must become 'self-financing'. The solution is increased revenue from users, hence user-fees. But sustainability in health cannot be addressed in isolation from political realities. Social inequities are invariably determined by political inequities, and the free-market forces at the heart of the Bamako approach have produced profound inequalities in Sub-Saharan African economies where the approach is being implemented. Only when health financing systems take these social and political inequalities into account will they be able to ensure the type of unobstructed access to health services that is needed to address the main causes of morbidity and mortality in Fourth World countries (Schuftan, 1999:612).

The dilemma to be resolved is one of sustainability versus exclusion: what is needed is an approach that empowers people to identify the causes of ill-health and to address these causes within the broader terms of the social and political context that determines their health status, to deal with the immediate causes of their illness, and to mobilize to address structural causes. This will be the subject of the next chapter.

4.

Community Recovery: Health as Development

‘Private medicine, especially biomedicine as practiced in the individualized Western tradition, robs people of the opportunity to identify the social origins of their illness – to find the source of occupational disease in the organization of the workplace, to attribute their children’s malnutrition to society’s failure to redistribute wealth. Public health projects that encourage community participation provide a setting in which individuals can communicate with one another about unhealthy conditions that affect everyone, in which they can make common cause, in which they can politicize health problems. Privatization plans divert attention from the question “How can people prevent illness?” to focus on “How can they pay for treatment?”’

Turshen, 1999:3

Introduction

Declining health conditions in Fourth World countries cannot be halted and reversed without an effective strategy to provide sustainable public health services. Chapter 2 outlined how financing systems that sustain health services in the developed world find little useful application in the context of general revenue limitations and weak public health infrastructure that characterizes the Fourth World. Chapter 3 reviewed the debate about the effectiveness of the Bamako Initiative and its application in West Africa and concluded that the privatization agenda at the heart of the approach is inconsistent with the reality of socio-economic conditions in Fourth World countries. For the vast majority of people in these countries, survival is determined by their ability to eke out a living on an income of less than one dollar per day. User fee schemes offer no protection from the disastrous consequences of ill-health, requiring payment at the time of illness when people usually are unable to generate any money, and there is no possibility to pool risk or income. Years of experience has demonstrated that there is neither the will nor the ability to make exemption schemes work in such contexts where everyone is poor and facility income – including salaries or incentives – depend on charges. The dilemma to be resolved is one of sustainability versus exclusion; what is needed is a system that locates health in the broader context of people’s living and working conditions and stresses that recovery and

development in any society are contingent on the wellbeing of the people that make up that society. Is it possible to create a system that reconciles the conflicting concepts of social justice and local-financing, to provide even minimal financing without excluding those who do not have the means to contribute to social insurance, or contract private insurance, or pay fees? This chapter will address that question, reviewing the evolution of development theory as a strategy to advance prosperity in post-colonial states, the emergence of participatory and empowerment approaches to development, and their application to promote better health.

Development Theory

Approaches to development have evolved considerably over the past fifty years, from an emphasis on macroeconomics and infrastructural projects, to human development and the satisfaction of basic needs, through the neo-Malthusian *laissez-faire* policies of the neoliberal doctrine.

Early Theories of Development

‘In the early days of development, donor agencies, both bilateral and multilateral, were organized and shaped by the understanding that their mission was to *deliver* development to poor countries. People hired by these institutions were trained in economics, engineering, or other, mostly technical, disciplines. They were expected to improve economic performance of developing countries, build roads, schools and hospitals, and provide expertise which would improve areas such as health and education.’

Long, 2001:5 (emphasis in the original)

Development as Growth

Some practitioners and theorists date the origins of development theory to the immediate post-war period and associate the concept with the Bretton Woods financial and trading regime and President Truman’s inauguration address announcing a program of development for the underdeveloped areas of the world (Eade, 2000:9; Leys, 1996:7; Stiglitz, 2002). In fact, early notions of development can be found in Hegel and Marx, but the theory that emerged in the 1950s chose to ignore this original body of work, whose

association with Marx rendered it 'contaminated' in the context of the Cold War, and too academic for the practical purposes of transforming the (already or soon to be) ex-colonies (Leys, 1996:5; Leftwich, 2000:69).

'It is not a great oversimplification to say that "development theory" was originally just a theory about the best way for colonial, and then ex-colonial, states to accelerate national economic growth in this international environment. The goal of development was growth; the agent of development was the state and the means of development were these macroeconomic policy instruments. These were taken-for-granted presuppositions of "development theory" as it evolved from the 1950s onwards.'

Leys, 1996:7

By the end of the 1950s the shortcomings of this predominantly economic conception of development had been exposed and modernization theorists posited a social and political science model for development drawing mainly on the work of Max Weber (*Ibid.*:9).

Modernization Theory

Modernization, it was claimed, would produce a transformation in the structure of developing societies, replacing traditional economic, social, legal, institutional, political, ideological and cultural spheres with modern, essentially Western structures, systems, norms and values (Leftwich, 200:33; Leys, 1996:10).

...producing an industrial or post-industrial order generating steadily increasing levels of material prosperity; a social structure based on the principles of individualism, equality and opportunity (whether of gender or ethnicity); a formally democratic political system of the representative kind (or at least one in which decision-makers are accountable through regular elections); a thoroughly secular political culture characterized by rational procedures for making decisions and one in which formal civil rights and liberties are entrenched in law; and a world view in which the role of reason and the application of scientific principles are said to predominate.

Leftwich, 2000:33

Some versions of this vision of development, such as that propounded by Walt Rostow, became equated with cultural invasion, the 'westernization' and ultimately domination and oppression of developing countries and a desire to turn developing countries into mass consumption societies (Leys, 1996:5-6; Haynes, 1996:7-9; Leftwich, 2000:35; Freire,

1974:133-4). Its revival in the early 1970s by Samuel Huntington was associated with US counter-revolutionary aims (Leys, 1996:64-79). Its more recent version has been presented as the universalization of Western liberal democracy (Fukuyama, 1992:51; Leftwich, 2000:36). But during the 1960s, modernization was in the ascendancy, and development was synonymous with growth plus change (Leftwich, 2000:40-1).

By the end of the 1960s, modernization was coming under sustained attack from scholars and theorists questioning the failure of development to redress inequality, particularly in Latin American countries. Dependency theorists such as Andre Gunnar Frank, Henrique Cardoso and Enzo Faletto built on earlier structuralist analysis by Raoul Prebisch and the United Nations Economic Commission for Latin America (Lievesley, 2003:145-6; Leys 11).

Dependency Theory

Structuralist theory posited that wealthy, developed states with dynamic economies, technological development, monopoly corporations and strong unions maintain high prices for manufactured goods, while poor, undeveloped states, with weak investment and no real labour movement, experience constant downward pressure on commodity prices and disincentives for industrial diversification. The result is a vicious circle of disparity between prices of manufactured goods and raw materials which blocks development. Dependency theory took this further and maintained that international capitalists deliberately use the allocation of capital to control the pattern of development in Third World states. These developing states served the purposes of supplying primary products (raw material for industry and energy, and food and agriculture) and an outlet for capital investment, mostly government loans and the infrastructures of transport, communications and construction, to facilitate the exploitation of the dependent countries. Thus, capitalism in the developed countries could not succeed without the suppression of indigenous development (Lievesley, 2003:145-6; Leys, 1996:100-118; Waters, 2000:113-114).

From Economic Development to Social Development

Essentially, there was a shift in thinking about what 'development' actually meant, as concern for social development grew. Four factors in particular are associated with the shift from development to social development (Leftwich, 2000:41-48):

- a) A changing political balance within the UN
- b) The political agenda of influential Third World leaders
- c) Evidence of the failure of development
- d) A looming economic crisis and consensus on the need to address inequality

Changing political balance within the UN

During the 1960s the membership of the UN General Assembly expanded significantly as former colonial states became independent. This shifted the political balance and gave rise to new debates, positions, policies and resolutions, setting the scene for the establishment of the United Nations Research Institute for Social Development (UNRISD) in 1963, and the United Nations Development Programme (UNDP). 'Social development' became the new focus – a qualification which implied improvement in education, health care, income distribution, socio-economic and gender equality, and rural welfare (*Ibid.*):

'But it also came to signify a much more radical and sweeping conception of development involving the nationalisation of major assets, the redistribution of wealth (as in land reform) and popular participation in political decision-making about both the means and the ends of development.'

Leftwich, 2000:41

Political Agenda of Influential Third World Leaders

With independence came the opportunity for Third World leaders to adopt national and international agendas that would deliver some of the long-promised progress to their populations (Hobsbawm, 1996:346-352; Leftwich, 2000:42). Charismatic figures such as Nyerere in Tanzania and Nkrumah in Ghana emerged, promising to address inequities and deliver progress, and insisting on development as social benefits for all. Growth and wealth would continue to be pursued, but only insofar as they served social development (Leftwich, 2000).

Evidence of the Failure of Development

In 1969 the findings of a UN meeting of Experts on Social Policy and Planning in National Development added to a growing body of evidence that development was failing to produce social and economic progress, and in some cases was actually creating poverty and

exacerbating inequality. Setting the agenda for the second UN Development Decade of the 1970s, the findings of the group called for 'radical social change, land reform, community development, the reduction of inequalities in income distribution and an increase in popular participation (especially of women) if development was to happen' (*Ibid.*:43).

Consensus on the Need to Address Inequality

Prebisch and the structuralists wanted fundamental change in the configuration and distribution of power – and they almost got it (Leys, 1996:113). The emergence of a group of newly wealthy oil-rich Third World states, added to the growing influence of the dependency theorists, the pressure from the UN General Assembly and the growing evidence of deepening inequality between the developed and developing world. Against the background of the first oil crisis and the emerging global slump, the 1974 UNCTAD Conference declared the need for a New International Economic Order (NIEO). Developed states essentially agreed to give more favourable terms of trade to developing countries and to adhere to a Charter of Economic Rights and Duties of States (Waters, 2001; Leftwich, 2000; Haynes, 1996).

Although the oil crises and global slump that characterized the 1970s wiped out much of the potential that emerged with the ideas about social development and the demands for a new order, the changes in the early 1970s focused the collective energies of the major intergovernmental organisations, research institutes and the academy on improving conditions for the poor and marginalised through a new approach to development: basic human needs.

Participatory Development, BHN, and 'Another Development'

The change in attitudes to development in the early 1970s was also strongly influenced by the writings of Brazilian teacher and political activist Paulo Freire, and in particular his theory of oppression and liberation (Leys, 1996; Leftwich, 2000; Long, 2000; Kahssay & Oakley, 1999). Freire argued that people's inability to improve their situation is a direct consequence of the structural violence visited on them by economic, social and political oppression. The ignorance and lethargy of the poor are not natural states. People are 'uncompleted beings' and if they are given the opportunity and tools they can come to

understand and change their lives and their world. Learning and participation become the basis for their development and 'liberation'.

'A deepened consciousness of their situation leads people to apprehend that situation as an historical reality susceptible of transformation. Resignation gives way to the drive for transformation and inquiry, over which men feel themselves to be in control. If people, as historical beings necessarily engaged with other people in a movement of enquiry, did not control that movement, it would be (and is) a violation of their humanity. Any situation in which some individuals prevent others from engaging in the process of inquiry is one of violence. The means used are not important; to alienate human beings from their own decision-making is to change them into objects.'

Freire, 1974:66

In 1974, under the stewardship of Robert McNamara, and the guidance of Harvard Professor Hollis Chenery, the World Bank produced a major study arguing that although average per capita income in the Third World had increased by half during the 1960s, a third of the population was excluded from the benefits of this growth. The study presented the case for government action to ensure equitable growth and emphasized the centrality of redistribution for equitable development (Stiglitz, 2002:13; Leftwich, 2000:45; Eade, 2000:9).

A year later, the Dag Hammarskjöld Foundation in Sweden published a report entitled 'Development and International Cooperation' calling for 'another development' based on the redistribution of wealth to ensure access to food, housing and health care. This report, which was delivered to the UN General Assembly's Seventh Special Session in September 1975, sought a fundamental shift in power in the UN and the World Bank and the freedom for developing countries to plan and manage their own political and economic development, through self-management (Oakley and Kahssay, 1999:3; Leftwich, 2000:44).

During the same period, the ILO, strongly influenced by Dudley Seers, began to highlight the role of employment in reducing poverty and producing development by providing the means with which people could meet their basic needs (Leys, 1996:110-118; Leftwich, 2000:46-7).

The work of the both the Bank and the ILO research teams was heavily influenced by dependency theory (Leys, 1996:112). It gave rise to the basic needs approach to development which set out to attain full physical, mental and social development of the individual, including 'self-determination, self-reliance, political freedom and security, participation in decision-making, national and cultural identity, and a sense of purpose in life and work' (Streeten, 1979 quoted in Leftwich, 2000:46). The official definition of basic human needs covered five main areas:

'Basic goods for family consumption (including food, clothing, housing); basic services (including primary and adult education, water, health care and transport); participation in decision-making; the fulfilment of basic human rights; and productive employment (to generate sufficient income for a family to meet its consumption needs).'

Leftwich, 2000:47

Both the Basic Human Needs and 'another development' approaches were predicated on the centrality of the state as the instrument of redistribution through whose institutions these needs would be met, assisted, of course, by the World Bank and various UN organisations. It was ironic therefore that just when the focus of development was shifting away from economic growth towards human welfare, the neoliberal right was beginning to rise. The state would be brushed aside, and with it, responsibility for development, as 'government-failure' was treated with 'free market forces'. Within a few short years, theories of redistribution and basic human needs disappeared down the 'memory-hole', to be replaced by the neoliberal supremacy of the free market, reversing the post-war consensus about the role of the state in development (Leys, 1996:24; Leftwich, 2000:49, 106; Stiglitz, 2002:15; Chomsky, 1999:20).

'It is hardly too much to say that by the end of the 1980s the only development policy that was officially approved was not to have one – to leave it to the markets to allocate resources, not the state.'

Leys, 1996:24

Nevertheless, the fundamental shift in development thinking in the 1970s and the focus on basic human needs and 'another development' helped produce a number of important development strategies, the need for which would be brought sharply into focus by the

deconstruction of Third World state infrastructures as a direct consequence of structural adjustment.

Democratic Governance and Civil Society

The end of the Cold War saw the emergence of 'good governance' as a key tenet of Western aid and development policy (Leftwich, 2000:109; OECD, 1995; Hintjens, 1999). Development policy in the 1980s was characterized by the imposition of a raft of economic stabilisation and adjustment requirements by the World Bank and the IMF as a condition for concessional lending. In the 1990s, two new requirements added a political dimension to these economic conditionalities for development assistance: recipient governments would now be required to institute changes to advance democratisation and ensure good governance. New concepts were minted and old ones like civil society resurrected as vehicles for democratic change, popular participation and accountability. Civil society is defined as:

'an intermediate associational realm between state and family, populated by organizations enjoying some autonomy in relation to the state and formed voluntarily by members of society to protect their interests or values.'

(White, 1994: 6)

Its origins can be traced through Plato, Aristotle and Cicero, through Hobbes, Locke, Rousseau, de Tocqueville, Montesquieu, Hegel and Marx (Ehrenberg, 1999:3-27; Kaldor, 2003:6-12; Harbeson, 1994:15-21). In the post-Cold War years it was popularized as an expression of the associational culture and liberty of Western, especially US, life (Kaldor, 2003:9). In liberal democratic political systems, it was credited with many positive functions (Naidoo & Tandon, 1999:1-16, WB, 1999:121-122; Financial Times, 21/4/98):

- Ensuring social stability, liberty and responsibility, legitimizing power, endorsing democratic processes and channeling grassroots sentiment and knowledge;
- Meeting human needs and aspirations through service delivery and the protection of heritage and culture;
- And creating opportunities and outlets for self-expression and development.

In short, civil society was embraced as a new panacea

“...a hitherto missing key to sustained political reform, legitimate states and governments, improved governance, viable state-society and state-economy relations...’

(Harbeson, 1994:2)

Taken together, the new development prescription of free markets, western-style democracy, and an efficient administrative apparatus was a blueprint for the neoliberal state that heralded the end of history and the ‘triumph’ of liberal democracy (Kaldor, 2003:9; Leftwich, 2000:110; Fukuyama, 1992:51).

‘...good governance is best understood as an intimate part of the emerging politics of the new world order. And, clearly, the barely submerged structural model and ideal of politics, economics and society on which all notions of good governance rests is nothing less than that of western liberal (or social) capitalist democracy – the focal concern and teleological terminus of much modernization theory.’

Leftwich, 2000:121

Leftwich (2000:109-116) suggests four main reasons for the West’s new found preoccupation with good governance and democracy:

- The failure of structural adjustment to overcome developmental stagnation;
- The dominance of neoliberalism;
- The collapse of official communist regimes;
- And the rise of pro-democracy movements in the developing world and Eastern Europe.

The Failure of Structural Adjustment

The Bank did not anticipate either the level of the resistance to structural adjustment or the distortion of its prescriptions to enrich and empower corrupt officials and their patronage networks (Reno, 1999). Many of those who stood to lose from adjustment, or to become wealthy through its misapplication - the bureaucrats, politicians, public sector workers and party officials – were part of the state apparatus and could use their positions to block or profit illegally from adjustment. As awareness increased, the Bank’s focus shifted to the

growing need for improved governance – albeit continuing to insist on a politically neutered, free market friendly form (Leftwich, 2000:110-2).

The Dominance of Neoliberalism

Submission to the neoliberal orthodoxy had already spawned the Bank's structural adjustment strategy and come to dominate development theory in the 1980s, but the political aspects of the doctrine also emphasise the need for democracy based on a thriving, independent civil society. According to neoliberal theorists, authoritarian regimes, poor governance and states with excessive political and economic involvement, were to blame for stalled growth and stagnation (Freedman, 1979). Imposing political conditionalities of good governance and democracy would help address this (Leftwich, 2000:114).

The Collapse of Official Communist Regimes

During the Cold War, the West considered 'good governance' and democracy as a poor second to strong links to its political and military allies in the developing world. Despotic rule; corruption, torture, even genocide, were all overlooked in the interests of Western security. With the fall of the Soviet Union, the West was no longer restricted by the fear of losing such ardent supporters as Mobutu Sese Seko, General Suharto, or for that matter, Manuel Noriega or Saddam Hussein (*Ibid.*:114; Chomsky, 1994:26-73). The failure of the soviet system also fuelled claims that the Western model was superior, and therefore neoliberal values and good governance were essential for growth and development (Fukuyama, 1992; Leftwich, 2000).

The Rise of Pro-democracy Movements

The 'Third Wave of Democracy' began in Portugal in 1975 and included Latin America, the Philippines and the former soviet countries of Eastern Europe (Huntington, 1991:21-26; Leftwich, 2000:115). A host of countries in Africa followed, as did several in Asia. Civil society was embraced as critical to the consolidation of these emerging democracies:

'It is in the institutions of civil society ... that the leadership of a democratic society is trained and recruited... Without a free and robust civil society, market capitalism must inevitably turn into mafia capitalism... Without civil society, democracy remains an empty shell'

(Ignatieff, 1995 quoted in Smillie, 1996:220)

This further encouraged the imposition of political conditionalities for development aid, whether in an effort to consolidate democracy and good governance for purely ideological reasons or in support of capitalist globalization (Leftwich, 2000:115)

While the focus on good governance has produced some positive results, not least in terms of reasserting the importance of competent administration - and therefore effective, functioning government - in developing countries, the technicist fallacy at the heart of the notion means that the enormous investment in time, human and financial resources is unlikely to produce any major successes in terms of development. As Leftwich notes:

‘Evacuated from the political context, no amount of institution-building or heavy doses of training, desirable and valuable as they may be in their own right, will induce a framework, let alone a regime, of good governance. Furthermore, no sophisticated institutional innovations nor the best trained or best motivated public service will be able to with stand the withering effects of corruption or resist the developmentally enervating pulls of special or favoured interests if the politics, autonomy and authority of the state do not sustain and protect them.’

Leftwich, 2000:124

Development as a Discourse of Domination

Freire argued that ‘development’ as it was conceived in the instrumental, structural-functional models of the 1950s and 1960s was part of a broader discourse of domination used by metropolitan or local elites to maintain a structure of oppression (Leftwich, 2000:64).

‘... the invaders are the authors of, and actors in, the process; those they invade are the objects. The invaders mold; those they invade are molded. The invaders choose; those they invade follow that choice – or are expected to follow it. The invaders act; those they invade have only the illusion of acting, through the action of the invaders. All domination involves invasion – at times physical and overt, at times camouflaged, with the invader assuming the role of a helping friend. In the last analysis, invasion is a form of economic and cultural domination.’

Freire, 1974:133-4

And although the revolutionary content of Freire's theories was itself the target of intense political repression in Latin America during the 1970s and 1980s, it continued to hold sway throughout the 1980s and 1990s amongst a small but influential group of development theorists and practitioners (Leftwich, 2000:65).

'...although underdevelopment is a very real historical formation, it has given rise to a series of practices (promoted by the discourses of the West) which constitute one of the most powerful mechanisms for insuring domination over the Third World today... . In this way, development will be seen, not as a matter of scientific knowledge, a body of theories and programmes concerned with the achievement of true progress, but rather as a series of political technologies intended to manage and give shape to the reality of the Third World.'

Escobar 1984, quoted in Leftwich, 2000:67

Empowerment of Whom?

More recently concerns have been expressed at the manner in which discourse control is used to disguise micro-level development interventions as participatory, empowering people with the abilities, tools, and strategies to take control over their lives and assert their influence over their socio-economic and political circumstances. Paul Farmer, a medical doctor and anthropologist who has worked extensively in Haiti, Mexico and Russia puts it plainly:

'In the global era, we often engage in fraudulent analyses of what bounds our "communities" and where they fit in larger social webs. If I were one of the Masters of the Universe, I'd try and get folks like us to adopt a motto such as "think globally, act locally."'

Farmer, 2003:172

The reality is that the *laissez-faire*, free market policies of the neoliberal orthodoxy are being imposed more ardently than ever at macro-level (Leys, 1996; Hintjens, 1999; Storey, 2000). Discourse control is an important tool in a strategy designed to maintain the illusion. Examples abound:

'Building on their "Bamako Initiative foundations" which mainly strengthened the supply side of professional services, Benin, Mali and Guinea now face the

challenge of similarly supporting the demand side through more emphasis on household behaviors, and the protection of the poorest and most vulnerable.'

World Bank, 2003a:31

Or as Leys (1996) refers to it, 'the World Bank's own ingenuous language':

'New ideas stress prices as signals; trade and competition as links to technical progress; and effective government as a scarce resource, to be employed sparingly and only where most needed.'

World Bank, 1991 quoted in Leys, 1996:24

In this respect, although 'participation' and 'empowerment' are embraced as the means through which development projects are implemented, they have increasingly been pressed into the service of the same 'free-market' paradigm which is credited with the reversal of development in the Third World during the 1980s and 1990s and has contributed so much to the emergence of the 'Fourth World' as explained in chapters 1 and 2.

Development and Health

Although it would seem logical that development in the sense of economic progress would be predicated on the health and wellbeing of the people who are expected to generate the wealth to promote this progress, it took some years before the links were explicitly articulated in a series of policies and strategies.

Participatory Development

Freire's work, in particular, contributed to the popularisation of participation as a people-centred approach to development. The idea that people would assume responsibility for improving the conditions that shaped their lives if they were given the opportunity and the tools to do so became the basis for participatory development. During the 1970s and 1980s many participatory processes and tools were created and 'participation' took on a variety of meanings and interpretations depending on the ideological agenda of the initiating agent (Kahssay & Oakley, 1999:5; Long, 2001:7).

The World Bank defines participation as:

'... a process through which stakeholders influence and share control over development initiatives, decisions and resources that affect them.'

World Bank, 2003c:3

While there are various 'ladders' demonstrating varying degrees of citizen and community of participation, and positing the authenticity of genuine community involvement (World Bank, 2003c), the following interpretations from Kahssay and Oakley (1999:5-8) are particularly relevant for the purposes of this thesis.

Participation as collaboration: This practice of limited involvement of local people in the implementation of a particular intervention is probably the most common interpretation of participation by aid organisation today. Local people's participation is required to ensure the success of the program or project, but their involvement is tangential, with little or no role in planning, prioritising or managing the process. For example, in annual 'National Immunization Days' where local people are immunized against various diseases and where local volunteers may be used to ensure as many people as possible attend. It is this process of collaboration which has spawned the notion of 'stakeholder' as those who may affect or be affected by the outcomes of the project.

Participation as Receiving a Share of the Benefits: In this interpretation, the aim is to involve previously uncovered groups by including them in the benefits of the project. However, this is harder to do in practice, and is often reduced to consultation during the assessment stage which is then used to inform the project plan, without any further involvement in the direction and implementation of the project (Kahssay & Oakley, 1999:6). It also risks provoking conflict unless conducted within the context of a thorough and complete analysis of the dynamics of inter-group relationships (Deely, 2003:22).

Participation as Empowerment: Participation as empowerment followed logically from its adoption as a form of 'liberation' and 'self-reliant' development and was seen as one of the most valuable attributes of the concept (Freire, 1974; Long, 2001:7; Kahssay & Oakley, 1999:6-7). Empowerment has been defined as 'strengthening the capacity of poor people to

affect decisions that have a bearing on their lives, and removing barriers that prevent them from engaging effectively in political, social and economic activities' (WB, 2000).

Empowerment has as wide a range of meanings, and is as ideologically tinted, as the term participation. In some cases it is used interchangeably with 'capacity building' to refer to the development of technical skills and abilities. In others, it has political connotations, giving people the possibility or means to decide upon and undertake their own development (Kahssay & Oakley, 1999:6). Four key elements have been identified as essential for empowerment (WB, 2002):

- Access to information;
- Inclusion/participation of poor people;
- Accountability;
- And local organizational capacity.

The notion of empowerment highlights the distinction between participation as a process through which some activities are carried out or objectives reached, and participation for its own sake, a transfer of both responsibility and means for the completion of the activities or achievement of the objectives. Participation as a means is undoubtedly the most common approach by aid organisations today, whether local or international NGOs, intergovernmental organisations or UN agencies. The reason for ensuring local people's co-operation or collaboration is to significantly enhance the prospects for successful implementation of an externally introduced development initiative. This is commonly referred to as 'participatory development'. The extent of the collaboration or co-operation can vary hugely, but such initiatives are characterised by the external design of the project, as opposed to the involvement of local people in the initial stages of the process, such as design, planning and prioritising (Kahssay & Oakley, 1999:7; Long, 2001:7-10).

Participation as an end inverts the priorities, and sets participation as the main goal in an effort to empower people by building their knowledge, attitudes, skills, and overall abilities to take control over some aspect of their development. Building directly on Freire's theory that '*A deepened consciousness of their situation leads people to apprehend that situation as an historical reality susceptible of transformation*' participation becomes an instrument

of change, helping people to take cognisance of their exclusion, marginalization or poverty, and to transform that reality through an active engagement in development activities (Freire, 1974:66; Kahssay & Oakley, 1999:7).

Participation in Health Development

At around the same time that 'Another Development' and Basic Human Needs were in the ascendancy in development thinking, there was a growing acknowledgement that the limitations of scientific or allopathic approaches to health care had been reached. During the post-war years medical and pharmaceutical innovation had achieved enormous successes in improving and prolonging the lives of millions of people around world (Hobsbawm, 1996:346; Hill, 1997:6-13; Oakley & Kahssay, 1999:1). Awareness of the limitations of allopathic medicine gradually increased with the emergence of drug resistant strains of certain illnesses, adverse reactions to particular medicines, and the failure of some conditions to respond (Hill, 1997). It was also acknowledged that this approach to medicine, with its emphasis on scientific knowledge, pharmacy, technological complexity and sophistication, excluded people from the management of their own health. Health became the exclusive responsibility of professional health staff, particularly medical practitioners. The traditional roles and responsibilities of family and other members of local communities were undermined and sidelined (Kahssay & Oakley, 1999:1; Hill, 1997:9).

In the 1970s, the resource implications of expanding effective health services to the majority of people, particularly in developing countries, caused a shift in the responsibility for health back towards the community. The Alma Ata Declaration in 1978 embraced primary health care (PHC) as a broad strategy to promote the conditions for a healthy life, by focusing on the social, economic and political aspects of health and disease. This more holistic approach emphasised inter-sectoral collaboration to promote healthy practices, prevent illness and not simply intervene after sickness or disease had struck. The strategy was founded on three main pillars: equity, participation, and intersectoral collaboration (Hill, 1997:13).

- *Equity*: requires that efforts are directed towards the poorest and most marginalized groups in society, i.e. - those who are most in need, in order to reduce any inequalities in the distribution of health resources.
- *Participation*: community involvement is sought in all aspects of health service provision, from planning and prioritising, to implementation, evaluation and management. Every individual is encouraged to participate to the greatest extent possible.
- *Intersectoral collaboration*: seeks to integrate the efforts of the different government agencies and NGOs to co-ordinate their collective efforts under one main strategy for improving the health of the population as a whole, avoiding, to the greatest extent possible, fragmentation, duplication and exclusion.

The PHC strategy was strongly influenced by the premises on which the 'another development' approach was based: the structural nature of poverty, and the centrality of people to development:

'...poverty is structural and has its roots in the economic and political conditions that influence people's livelihoods. Therefore, in order to tackle this poverty, it is important to develop people's ability to change these conditions. The second premise was that development programmes and projects have largely bypassed the vast majority of people; there is a need, therefore, to rethink development interventions in order to give the excluded majority a chance to benefit from development initiatives.'

(Kahssay & Oakley, 1999:3-4)

Participation, therefore, is central to the whole concept of primary health care.

'Poor people were seen as *excluded* and *marginalized* both from broader societal participation and from direct involvement in development initiatives. Simultaneously, development policy-makers and planners began to advocate societal political participation and to devise strategies to increase poor people's direct involvement in development efforts.'

Ibid: 4 - emphasis in the original

Rifkin (1996) distinguishes between two approaches to community participation in health. Building on the distinctions between participation as a means and an end in itself, she argues that one approach to participation in health is essentially 'target-oriented' and one explicitly seeks 'empowerment'.

Box 54 'Target-oriented' and 'Empowerment' Approaches to Participation

The target oriented framework sees community participation as:

- A way of mobilizing resources to supplement health services
- A means to an end
- Passive, responding to professional direction
- A product of a PHC program
- Best evaluated by quantitative methods

The empowerment framework sees community participation as:

- A means of giving people power over their health choices
- A means in itself
- Active and based on community initiatives
- A process whereby communities are strengthened in their capacity to control their own lives and make decisions without the direction of professionals and authorities
- Best evaluated by qualitative methods

(Rifkin, 1996 quoted in Kahssay & Oakley, 1999)

Community Involvement in Health Development

During the 1980s participation in the development of health services expanded with the adoption of PHC strategies in developing countries. Nevertheless, participation tended to be instrumental and was seen more as an additional component of health care delivery as opposed to a core strategy for increasing the effectiveness and accessibility of health care. In June 1985, WHO hosted a regional meeting in Brioni, at which community involvement was adopted as an essential principle of health development. Community Involvement in Health Development is defined as:

'A process by which partnership is established between the Government and local communities in the planning, implementation and utilization of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of primary health care.'

(Rifkin, 1990, quoted in Oakley & Kahssay, 1999:10)

Echoing Freire, the meeting endorsed involvement in the decisions and actions that affect their health as a basic right and responsibility of all people. Community involvement in health would prevent the type of dependence that health, and other forms of development work, create. Health programmes and projects would be more appropriate and therefore more successful in meeting the needs of local people if they were planned and managed with the support of local people. Within the context of severe scarcity of resources for health in developing countries, community involvement would lead to greater efficiency in the mobilisation and use of resources by increasing the responsiveness of services to people's needs, helping to extend the coverage and enhance the cost-effectiveness of services.

Community Involvement in Health Development was embraced as:

'A process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustained better health and in supporting the empowerment of communities for health development. CIH actively promotes people's involvement and encourages them to take an interest in, contribute to and take some responsibility for the provision of services to promote health'

Kahssay & Oakley, 1999:10

Partnership - based on consensus about the key issues and the solutions needed to address them - is a key element in CIH. Individuals, groups, organisations and health professionals all work together towards three main objectives: increased awareness and understanding among communities and health workers; improved health care; and shared management of resources with the objective of achieving efficiency, equity and empowerment in health development.

The potential benefits of Community Involvement in Health Development are summarized below.

Increased Utilization

People would make better use of existing health services and would ensure the sustainability of new services by being involved in decisions about their development. One

of the greatest problems with government health services in developing countries is the low level of utilization. Years of declining budgets, inadequate medical supplies and general neglect have reduced the range and quality of services, destroyed staff morale and undermined public confidence. By providing users and potential users with a real opportunity for genuine involvement, health authorities could demonstrate that services can be rehabilitated and rejuvenated to meet the perceived needs and priorities of communities (Chossudovsky, 1997; Whitehead *et al*, 2001; Schoepf *et al*, 2000; WHO, 2001).

Resources

People would be able to contribute resources of money, labour and materials to support the scarce resources allocated to health care. In developing countries, up to 50 per cent of health care expenditure goes on pharmaceutical drugs, compared with 15 per cent in developed countries. All too often this money is spent on inappropriate consultations and drugs which are ineffective at best and often detrimental. This money could be redirected towards community funds to maintain the local clinic if the facility provided the required service or treatment (Rifkin, 1996; Whitehead *et al*, 2001; WHO, 2001).

Education

People would change their poor health behaviour if they had been involved in exploring its consequences. Lack of awareness is often the sole reason why people practice certain behaviours that are detrimental to their health (UNAIDS, 2004). In some cases, people believe they are following a correct course of treatment when the reality of traditional healing and unregulated trade in pharmaceuticals in many developing countries means this is not the case. By raising people's awareness and knowledge about the consequences of poor health behaviour, CIH can empower them to improve their behaviour, and consequently, their health (WHO, 2001; Kahssay & Oakley, 1999; Whitehead *et al*, 2001).

Empowerment

People would gain experience and information which would help them to take control of their own lives and thus challenge the existing social, political and economic system which had deprived them of this control. Health is product of a combination of social, economic and political factors, not simply narrow medical conditions. Community projects that

involve people in learning about these broader conditions provide a platform from which they can formulate strategies to address them (Freire, 1974, Rifkin, 1996; Turshen, 1999; Farmer, 2003).

A number of constraints have also been identified (Oakley & Kahssay, 1999:11-12).

Political Commitment

Political commitment is required, particularly at local level to support the concept of people's involvement in the planning and oversight of services. Decisions about the mobilisation and use of resources for health are subject to the same conditions as decisions about all other resources, i.e. – politicisation and contestation. As Leftwich notes, '*when people change the way they use resources, they change their relations with each other*' (Kahssay & Oakley, 1999; Leftwich, 2000:110).

Structural Implications

There are important structural implications for a meaningful strategy of health development based on community involvement. The centralized and rigid structures of conventional health systems would need to be reformed to allow for decentralization and delegation of authority to the regional and district levels where it will be required to provide the support for community involvement. Similarly, the process requires the strengthening of district level structures to take on additional work to support, develop and service the local community structures (Kahssay & Oakley, 1999; Hill, 1997; Smillie, 2001)

Resources

The condition of the national economy and the level of resources that are allocated to health will determine the extent to which the Ministry of Health will be able to support a CIH strategy. Community involvement requires funding for staff, logistics, training and local health activities as identified by an engaged community. Given the poor economic condition of most developing countries, and the impact of structural adjustment on public health sectors, the allocation of adequate health resources is a critical constraint. External funding will be required if CIH is to have any chance of success (Sachs, 2005; WHO, 2001; Kahssay & Oakley, 1999; Macrae, 1997).

Capacity

The need for local structures, organizations and capacity to engage and sustain community involvement is a particularly difficult constraint to overcome. Community involvement, over and above the token consultation or user fee financing role, requires the development of organizational skills at community level. Planning, managing and budgeting skills, at least of a rudimentary level are required, as well as some knowledge of health (Kahssay & Oakley, 1999; WB, 1998, 2003, 2003a).

The Feasibility of Community Organization of Health Services

One of the major challenges for community involvement in health is to find a successful mechanism through which community participation can be achieved (Hill, 1997:10). In the 1990s the new development paradigm emphasised the role of civil society organisations in promoting participation in a wide range of activities, including health (Pearce, 1997). Consequently, strengthening civil society became an important and explicit activity for international development organizations and donors.

'The existence of an "active" civil society, manifested in nongovernmental organizations that claim to represent various groups in society but also claim to act with some public purpose, on behalf of an entire collectivity beyond family, provides international donors and their political backers with the nongovernmental counterparts they are looking for on the recipient side.'

Azarya, 1994:86

Civil society can be considered as three sets of components: a set of institutions, relationships and values. It is most commonly used to refer to a set of autonomous institutions, separate from family, class, locality and state, such as grassroots organizations, unions, universities, philanthropic foundations, NGOs, neighbourhood associations, and so forth. It is also used to refer to a theoretical sphere of relationships through which society acts both as a link to the state, and a buffer between itself and the state using mechanisms that safeguard separation. Finally, it is a system of civic values based on recognition of a common good through which others' rights and interests should be protected as well as one's own (Azarya, 1994:89; Smillie, 2001:179; WB, 1999).

All three components are relevant to the question of a successful mechanism through which communities can become involved in the recovery of their health services. First, in terms of institutions, it is the village health committees and similar community-based organizations that form the organizational base for community involvement in health. In theory, these associations tend to have a wide range of responsibilities including identifying local health needs, mobilizing resources, and supporting the implementation and evaluation of health projects. In practice, capacity and organizational constraints may restrict their actual involvement to periodic activities such as mobilizing support for health projects (Oakley *et al*, 1999). Second, in terms of a set of relationships, civil society institutions and associations already have partnerships built on established practices and traditions of internal regulation, mutual support and involvement in community affairs that can be built on to improve and expand community awareness of and participation in health development (Oakley *et al*, 1999:123). By expanding this set of relationships to include active, meaningful engagement with health authorities, NGOs and agencies providing health and other development services, and other communities, successful participation can be achieved. And finally, the system of values which is represented by civil society refers to a type of code of conduct that exists in many bounded communities for fellow members:

'It is an acknowledgement of consideration towards the "other" beyond one's family, a recognition of dignity derived from the individual's humanity or membership in a given community. It recognizes that all people have similar rights and obligations and hence implies a readiness to moderate particular individual or parochial interests in consideration of some common good, through which others' basic rights and interests would be protected as well as one's own.'

Azarya, 1994:90

It is this acceptance of a common or collective responsibility to the community and the positive attitude to activities that advance the common good which provides the foundation for a community's *willingness* to engage in participatory development projects. This component of civil society has also been equated with strong social capital – the informal values or norms shared among members of a group that makes it possible for them to cooperate with one another. When this is present, it also makes it possible to ensure some degree of adherence to the basic rules of a community scheme, because the community

itself deals with potential problems from adverse selection, free-riders, failure to contribute, and so forth.

'...If people know that they have to continue to live with one another in bounded communities in which continued co-operation will be rewarded, they develop an interest in their own reputations, as well as in the monitoring and punishment of those who violate community rules.'

Fukuyama, 2000:108

Constraints

Problems arise when NGOs fail to distinguish between participation as a means and as an end in itself, for example, by equating the different approaches with providing immediate access to the benefits of development on the one hand, and, securing long-term, sustainable development for poor people, on the other. The view that '*both purposes are of equal importance*' (Kahssay & Oakley, 1999:7) obscures the extent to which participation has been co-opted by intergovernmental and governmental agencies, and – wittingly or unwittingly, willingly or unwillingly - UN agencies and NGOs, to further the cause of neoliberal economics (Roy, 2004; Storey, 2000; Hintjens, 1999). The effective neutralisation of the distinction between participation as a means and as an end completely overlooks the origins of popular participation and Freire's contention that '*to alienate human beings from their own decision-making is to change them into objects*' (Freire, 1974:66).

There are also a number of drawbacks to the use of the civil society concept. First, although it has been the subject of many development programs during the past decade, it remains a largely theoretical concept (Bratton, 1994:58; Harbeson, 1994). Second, it has a wide range of interpretations, definitions and compositions (Azarya, 1994; Harvey, 1997; Smillie, 2001; Kaldor, 2003). It is thus a somewhat imprecise term which can lead to confusion, co-optation and even corruption (Eade, 2000). It also makes for less than rigorous approaches to very practical questions such as how to engage or organize community groups. In particular, the failure to distinguish between the use of civil society as a normative or empirical concept has contributed to a technical and depoliticizing approach to efforts to

strengthen civil society (Eade, 2000:34). Programs have frequently overlooked the negative dimensions of civil society, failing to consider the exact nature of the civil society structures that are being strengthened or how resources can be used for repressive purposes including rites, traditions and rituals which promote conflict, discriminate against women and exclude groups who are not, historically, members of a particular community (Azarya, 1994; Harvey, 1997; Fukuyama, 2000).

These concerns do not devalue the concept of civil society or delegitimize participation as a key agent of development, but they highlight how the original meaning and objective of participation can be neutered and how the concept can be co-opted to serve policies which are, in fact, antithetical to the whole notion of participation as control over one's own life and in Freire's sense - 'liberation'.

Community Financing of Health Services

In its landmark 2001 report, the Commission for Macroeconomics and Health expressed concern that the public proportion of health funding in developing countries was exceptionally low, and that private expenditure tends to be out-of-pocket, inefficient spending on brand-name drugs and unqualified practitioners, rather than pre-paid, and consequently with little or no risk-pooling. The Commission recommended the establishment of community financing schemes as a complementary mechanism to public financing to generate additional funds for cash-strapped government facilities (WHO, 2001:60).

Participatory Health Financing

The term 'community financing' has been used extensively since the 1980s to cover a wide range of local health financing arrangements including collective community health funds, micro-insurance, rural health insurance, mutual health schemes, revolving drugs funds, community involvement in user fee management and cost recovery in community facilities (Preker *et al*, 2001:7). However, the Commission provides a more specific definition:

'A scheme in which a community pools funds and shares risks, and that is constituted of payees and decision-makers/managers.'

WHO, 2001:188

Instead of squandering scarce financial resources on unnecessary or ineffective consultations and treatments at the time of illness (Whitehead *et al*, 2001:834), out-of-pocket expenditures should be channelled into community financing schemes to help cover the cost of community-based health delivery, mainly curative services other than the basic package of essential services which should be covered from public or donor funds (WHO, 2001:60).

'The local community would thereby be encouraged to pool its resources, and to provide some kind of community-based oversight of health service delivery. This method would offer a degree of risk spreading, so that households would not face financial catastrophe in the advent of an adverse health shock to household income.'

WHO, 2001:61

The report stressed that such schemes will not resolve the crisis in health financing in developing countries, but that they may well be a part of the overall solution, providing a flexible, locally-specific alternative to self-medication, or user fee schemes which have been shown to be regressive (*Ibid.*, Whitehead *et al*, 2001:833; Arhin-Tenkorang, 2001; Creese & Kutzin, 1995; Schoepf *et al*, 2000; Kim *et al*, 2000; Turshen, 1999; Farmer, 2003). The report specifically warns against any confusion with user fees, stressing the failings of this method of financing:

'User fees, as conventionally defined, are payments for health services at the time of illness (that is out-of-pocket expenditures), often levied on essential interventions. Experience has taught that user fees end up excluding the poor from essential health services, while at the same time recovering only a tiny fraction of the costs.'

WHO, 2001:61

Features of Community Financing Schemes

A working group set up by the Commission studied the evolution of community health financing over the past twenty years and found that most schemes have evolved in the context of extreme government failure: grossly inadequate public sector budgets, non-

existent social protection, and poor regulation of informal service providers. This explains many of the common features which distinguish them from broader general revenue approaches, user fee schemes and formal insurance plans.

- **Collective Community Action:** Such schemes exhibit a high level of collective participation in the raising and pooling of revenue, the allocation of funds for specific uses, and the oversight or management of health financing arrangements (Preker *et al*, 2001:7).
- **Socio-economic condition of participants:** Members of community financing schemes tend to be from communities that have no other financial protection or access to collective financing arrangement to cover the cost of health care (Preker *et al*, 2001).
- **Voluntary character:** These schemes are usually constituted on a voluntary basis, and are mainly found in cultures with a strong tradition of self-help and social mobilization, characteristics often associated with the poor in low-income countries (Preker *et al*, 2001; Arhin-Tenkorang, 2001; Farmer, 2003).
- **Prepayment:** Community financing contributions are pre-paid as opposed to out-of-pocket payments which penalise the sick at a time when they can least afford it. Prepayment thus allows some degree of risk pooling, an essential characteristic in any effective financing scheme (Witter, 2002; WHO, 2001).
- **Protection:** Contributions are not used to cover essential services; these are covered by public funds, whether from the government or donors. This implies that the provision of a minimal level of essential service is not dependent on the community's socio-economic circumstances, which is often subject to a wide range of unpredictable events (WHO, 2001; Preker *et al*, 2001).

The Feasibility of Community Financing Schemes

For many people in the world's poorest countries, life is characterised by extreme poverty, unpredictability and the absence of formal structures of support. Why then would community financing schemes succeed where general revenue, insurance and user fee systems have failed?

The working group study highlights three phenomena associated with the growth in these schemes (Preker *et al*, 2001:8-12):

- Communities' experience with micro-finance schemes in developing countries;
- The role of social capital in managing community finance schemes; and
- The link between community schemes and the overall welfare of society.

Micro-finance

Over the past two decades, the use of micro-finance in poverty alleviation for low-income groups has increased significantly. Both poor and non-poor households have to cope with the cost of a variety of predictable and unpredictable events ranging from marriage, childbirth, education, and death to less predictable events such as hydro-climatic disasters, conflict and sickness. While there are long-established traditions of family and community support for life-cycle events, poverty imposes severe restrictions on the type and range of coping mechanisms that individuals and communities can access in the event of unpredictable, catastrophic incidents. Risk-protection mechanisms were beyond the means of the poor, who - it was generally assumed - were neither willing nor able to save or contribute to insurance against the risks they faced. During the 1990s however, in recognition of the worsening situation of a majority of people in Sub-Saharan Africa, and elsewhere in the developing world, aid agencies began introducing micro-credit plans to poor communities. Consequently, many poor communities gained experience with micro-credit, suggesting that the poor can save, repay and provide regular contributions to collective schemes, and that community schemes can be a useful strategy to help poor people cope with both predictable and unpredictable costs (Preker *et al*, 2001; Hansch & Barcus, 2000). These schemes are also being extended to the health sector by aid agencies and development organizations in low-income countries (Preker *et al*, 2001).

Social Capital

The success of micro-finance organizations in engaging poor individuals and households is linked to the prevalence of social capital within and between communities (Preker *et al*, 2001). Social capital – an essential element in the creation of a health civil society – is defined as:

'...an instantiated set of informal values or norms shared among members of a group that permits them to co-operate with one another. If members of the group come to expect that others will behave reliably and honestly, then they will come to *trust* one another. Trust acts like a lubricant that makes any group or organization run more efficiently.'

Fukuyama, 2000:98

Preker *et al*, (2001) highlight four dimensions of social capital that impact – positively and negatively – on development:

- Community links through which people in small communities help each other, like extended families, local organizations, clubs, associations, and civic groups.
- Network links between similar communities (horizontal) and between different communities (vertical) such as ethnic groups, religious groups, class structures, gender etc.
- Institutional links such as communities' political, legal and cultural environment.
- Civil society links between governments and their citizens such as the level of collaboration between the public and private spheres, the legal framework that protects the rights of association, and community participation in public organizations.

The extent to which community financing schemes belong to and are controlled by the community is an important factor with low-income households likely to have more trust in community financing schemes that are linked to community organizations to which they already belong and feel they have some control over. Many people in developing countries have an ambivalent relationship with the state and national systems are often perceived to be distant and of little benefit to the great majority of inhabitants (Hobsbawm, 1996:352; Preker *et al*, 2001). In health, this view is reinforced when the public health system restricts provision to priorities that do not correspond to the needs of the poor as they perceive them.

Links to National Health System

Community-financing schemes—in addition to their links to micro-finance and social capital—benefit from links to the national health system, depending on the existing public financing system, social policy and the level of support from the district health office. Schemes that develop partnerships at an early stage are better able to evolve, expand in terms of membership, resources, the size of the risk pool, and the range of benefits they can cover. Their members

have more to gain as an integral part of the national system – regardless of how weak it may be – than as an isolated, independent project.

The case for public support for community financing schemes is strongly supported by evidence of the failure of the private sector and market forces alone to secure efficiency and equity in the health sector. In the case of *efficiency*, proponents of community financing refer to a growing body of evidence on market failure in the health sector: distorting or monopolistic market power, failure to provide public goods, increased costs of services, the absence of functioning markets in some areas; and the frequent occurrence of high transaction costs. With regard to *equity*, the evidence demonstrates how individuals and families often fail to seek treatment or protect themselves adequately against the risks of illness and disability on a voluntary basis (Preker *et al*, 2001; Whitehead *et al*, 2001)

Constraints

It has been observed that free market approaches to the provision of health services fail because health services are not typical consumer goods and the determinants of utilization are complex with economic factors representing only one consideration in people's consumption of health services (Creese & Kutzin, 1995). Similarly, the extension of micro-financing approaches to health care needs to take the complexity of the determinants of utilization into account. Health financing schemes in poor communities in developing countries must grapple with a number of unknown variables, including the range and severity of different illnesses, the range and scope of services provided, and the likely behavior of both patients and providers given past experience with moral hazard, adverse selection, and fraud. All societies and communities have some stock of social capital. But problems tend to crystallize around the range over which the social capital functions, what Fukuyama calls the 'radius of trust' (2000:99). These problems occur when the cooperative norms like honesty and reciprocity are extended to a very small community or even to some groups but not others within the same community or networks. Under these circumstances, communities can become isolated, parochial or even conflictive. Inter-community ties or bridges are needed to overcome this tendency and extend the radius of trust (Preker *et al*, 2001). Community-financing schemes that share risk only among the poor will deprive its members of much needed cross-subsides from higher income groups. Similarly, if they remain isolated and small, schemes deprive its members of the benefits of spreading risks across a broader population. Weak

social capital can also prevent the scheme from connecting with the formal health care system, including the district health structure, the referral system and NGO support networks, and thus deprive their members of the more comprehensive range of care available through the formal health care system.

Strengths of Community Financing Schemes

Strengths relate mainly to the degree of participation achieved through community involvement, their success in providing financial protection against illness, and – critically – the increase in access to health care by low income, rural and informal sector workers, a feature that distinguishes them from the standard and user fee or Bamako Initiative type schemes (Preker *et al*, 2001).

Technical Design Characteristics

▪ **Revenue Collection Mechanisms**

- Community financing schemes promote a change in local financing from out-of-pocket payment at the time of illness to pre-payment and risk-sharing.
- Schemes tend to collect a flat rate premium which facilitates revenue collection, reduces the scope for manipulation, and contributes to low transaction costs.
- Schemes were designed according to the local socio-economic context to accommodate contribution payments based on the income generating patterns of community households employed in agriculture and the informal sector, including seasonal, irregular, cash and kind contributions.
- There was a strong pro-poor orientation even at low income levels through exemptions of premiums and subsidies, despite flat contribution rates.
- Some schemes managed to build up reserves and develop links to formal financing schemes which provided some protection against external shocks.

▪ **Arrangements for Pooling Revenues and Sharing Risks**

- Pooling of revenues and sharing of risk within community groups allowed some transfers from rich to poor, healthy to sick and gainfully employed to inactive.

▪ **Purchasing and Resource Allocation**

- Most community schemes take a collective decision about who is covered through the scheme based on affiliation and direct family kinship.
- Many community schemes define the benefit package to be covered in advance (what to buy, in what form, and what to exclude).
- Some community schemes engage in collective negotiations about price and payment mechanisms.

Management

- Most community schemes are established and managed by community leaders. Community involvement in management allows social controls over the behaviour of members and providers that mitigates moral hazard, adverse selection, and induced demand.
- Many schemes seek external assistance in strengthening management capacity
- The management culture tends to be consensual, exhibiting a high degree of democratic participation.
- Most schemes have good access to local utilization and behaviour patterns.

Organizational Structure

- Most community schemes are distributed organizational configurations that reach deep into the rural and informal sectors.
- Incentive regimes includes:
 - extensive decision rights;
 - strong internal accountability arrangements to membership or parent community organization;
 - successful schemes are able to accumulate limited reserves but unsuccessful schemes often ask governments for bailouts;
 - mainly factor market exposure since few overlapping schemes compete with each other in the product market: and
 - some limited coverage of destitute populations through community or government subsidies
- Vertical integration may lead to increased efficiency and quality services. Schemes that have a durable partnership arrangement or contractual arrangement with providers are

able to negotiate preferential rates for their members. This in turn increases the attractiveness of the scheme to the population and contributes to sustainable membership levels.

- Better organized schemes use horizontal referral networks and vertical links to the formal sector.

Institutional Environment

- Stewardship function is almost always controlled by local community rather than central government or national health insurance system, thus schemes are more responsive to local contexts.
- Ownership and governance arrangements (management boards or committees) are almost always directly linked to parent community schemes, with free-standing health insurance schemes being extremely rare.
- There is little competition in the product market.
- Limited competition in factor markets and through consumer choice.

Weakness of Community Financing Schemes

A number of weaknesses of community financing schemes have been adapted from Preker *et al*, (2001) based on the past work of several authors (Carrin, Desmet and Basaza 2001; and Bennett *et al* 1998). These relate to the limited potential for generating revenue from poor communities, the frequent exclusion of the poorest of the poor unless there is funding for some form of subsidy, the small size of the risk pool, the limited management capacity that exists in most rural and low-income communities, and the limited nature of the benefits that such schemes can provide.

Technical Design Characteristics

- Revenue Collection Mechanisms
 - Without subsidies, resource mobilization is limited when everyone in the pool is poor;
 - Many of the poorest do not join since they cannot afford premiums;
 - Pro-poor orientation is undermined by the regressive flat rate contributions and when subsidies or premium exemption are not included this creates a financial barrier for the poor;

- Community based voluntary pre-payment schemes are prone to adverse selection;
 - Few schemes have re-insurance or other mechanisms to buffer against large external shocks.
- Arrangements for pooling revenues and sharing risks
 - The scope for transfers within very small pools is limited (often less than 1000 members in individual schemes).
- Purchasing and resource allocation
 - Without subsidies, the poorest are often left out;
 - The benefit package is often very restricted;
 - Providers can often exert monopoly power during price and payment negotiations.

Management

- Community leaders are as vulnerable to adverse incentives and corruption as national bureaucrats.
- Even with external assistance, absorptive capacity in management training is limited.
- Extensive community consultation is time consuming and can lead to conflicting advice.
- Most schemes do not use modern information management systems.

Organizational Structure

- Even very distributed organizational configurations may have difficulty to that reaching deep into the rural and informal sectors.
- There are often conflicting incentives, especially among high level of decision rights, soft budget constraints at time of deficits (bail outs by governments and external sources of funding such as NGOs), limited competitive pressures in the product markets and lack of financing to cover the poorest population groups.
- The less organized schemes are often cut off from formal sector networks.

Institutional Environment

- Government stewardship and oversight function is often very weak leading to a poor regulatory environment and lack of remedies in the case of fraud and abuse.

- Ownership and governance arrangements are often driven by non health and financial protection objectives.
- Choice in strategic purchasing is limited by small number of providers in rural areas.
- True consumer choice is often limited by lack of a full insurance and product market, leading to:
 - Adverse selection (signing on only the better-off, working age, and healthy);
 - Moral hazard (members making unnecessary claims because they have insurance coverage);
 - Free-rider effect (households waiting until they think they will be sick before joining); and
 - Information asymmetry (e.g., concealing pre-existing conditions).

Recommendations

The study made four recommendations for policy action that would strengthen and improve the effectiveness of community involvement in health care financing (Preker *et al*, 2001):

- a) Subsidies to pay for the premiums of low-income populations;
- b) Use of re-insurance and other mechanisms to enlarge the effective size of the risk pool;
- c) Assistance in strengthening the management capacity of community members involved in running the schemes; and
- d) Stronger linkages to the benefits of existing formal financing and provider networks.

Outcome: Increased Access and Affordability

Community financing schemes are thus an important mechanism for improving access to and affordability of health care. They should however, be regarded as supplementary to and not a substitute for government involvement in health care financing and risk management related to the cost of illness (Preker *et al*, 2001; WHO, 2001). The strengths identified in the working group study demonstrate significant advantages over out-of-pocket payment user fees schemes in terms of access, equity and willingness to pay.

Access: One of the main conclusions of the working group study was that:

‘...prepayment and risk sharing through community involvement in health care financing – no matter how small – increases access by poor populations to basic health services and protects them to a limited extent against the impoverishing effects of illness.’

Preker *et al*, 2001:34 (emphasis added)

Equity: In some regions, pooling of risks was shown to compensate for and even outweigh, the negative effect of overall income inequality, indicating that financial protection against the cost of illness may be a more effective poverty alleviation strategy than direct income support. The study also provided evidence that problems in reaching the poorest of the poor could be overcome with community financing schemes through well targeted design features and implementation arrangements.

Willingness to Pay: The study showed a positive correlation between willingness to contribute to community owned and run schemes, and guaranteed access to quality services that address communities’ perceived health priorities. This included the poorest of the poor who, if treatments are provided for their most common health problems, are often willing to contribute if their contributions are supplemented by a government subsidy.

Conclusion

In conflict-affected countries, the lack of health services needs to be seen in the broader context of state failure to provide for the basic needs of the population: chronic failure of health services is caused by the same factors that produce poverty, economic decline and conflict.

Community involvement in health emerged as a result of concerns that health services that are undertaken without the active participation of local people are less effective and, ultimately, unsustainable. It embraces the principle that people would make better use of their local health service, and be more inclined to contribute resources to ensure its sustainability, if they were given the opportunity to participate meaningfully in decisions about its organization and development. People who have some sense of ownership over their local health facility are more inclined to contribute to its upkeep. Furthermore, if the

service responded to people's perceptions of their health needs and priorities, they would have less need to use alternative providers and might be persuaded to redirect out-of-pocket expenditures into some form of community fund for the facility. If influential community members were actively engaged – at some level - in the planning, delivery and monitoring of services provided by their health facility, they might feel a responsibility towards the facility that would encourage them to mobilize community resources to support such a community health fund. Self-reliance is a key component of the approach. Local capacities to support health care provision are developed and local resources are mobilized to improve sustainability.

Community financing is a logical extension of increased local ownership and responsibility and represents a promising approach which can be adapted to local needs and resources. A consensus is emerging on the usefulness of schemes that channel out-of-pocket health expenditures on drugs, traditional healers and commercial provision into prepayment schemes to help cover the cost of community-based health delivery. Studies have demonstrated that people are willing to contribute to services that are owned and run by the community and provide services that correspond to local needs and priorities.

Critically, such schemes have the potential to address the fundamental weakness of user fee schemes by virtue of their prepayment and risk-pooling features, community financing on a collective basis increases access by poor populations to basic health services and provides them with some degree of protection against the impoverishing effects of illness.

This review suggests that a 'community recovery' approach would produce a significant increase in the quality and range of local health services. Such an approach would combine a broad initiative to build the structures, systems and capacities within a community that allows local people to become involved in the planning and management of their health services, with a community financing scheme based on collective contributions. By adopting such an approach, health services can be located within the broader context of local living conditions, economic circumstances, and linked to coping capacities and traditional protection mechanisms for vulnerable people. This would provide a sustainable basis for the long term recovery of health services in Fourth World countries.

* * *

The next chapter will set the scene for the field work phase of the research, generating and testing hypotheses based on the literature review and an initial phase of field-based research to be undertaken in a Fourth World country.

5.

Methodology

‘By common consensus, we do not yet appear to have achieved perfection, either on the large scale in the way that society is organized, or in the smaller-scale units with which we are centrally concerned in our professional and personal lives. I suggest, ultimately as an article of faith, but not perhaps as an unreasonable proposition, that systematic enquiry is a useful potential tool for those seeking improvement.’

(Robson, 1997:431)

Introduction

The previous chapters presented a range of arguments from current literature on the nation state and global transformation, conflict, recovery, development, health and health systems and posed a series of questions about the role of the state in health service provision and the dilemma of sustainable health service recovery following deterioration and destruction as a result of economic decline, structural adjustment and violent conflict.

The following section of the thesis will present the field research conducted in an effort to address this dilemma. This chapter will give some background to the research question and go on to review the traditional approaches to social science research, analysing their appropriateness to the research question before proposing a particular research methodology. Chapter 6 will report on the first phase of the field research conducted to explore the context of recovery in Puntland in northeast Somalia. Chapter 7 presents the particular research activities undertaken to produce baseline data on twelve communities in Puntland, and the findings from these activities. Finally, chapter 8 reports on the setting up of a field experiment in one community to test a participatory management approach developed with the representatives of these twelve villages.

This chapter attempts to provide the framework for the field research, addressing the following major questions:

- How did the research question arise?
- How was it treated initially?
- What are the traditional approaches to social science research and how relevant are they to enquiry in conflict-affected contexts given the specific constraints and limitation imposed by insecurity and destruction?
- What would be the most appropriate strategy to address the research question and how can it be reinforced to deal with the uncertainty and unpredictability inherent in states affected by conflict and collapse?
- What practical lessons have emerged to inform future fieldwork in this type of context?

Relatively little was known about the Puntland state of Somalia, in 2000 when the field research began, and there was a pressing need for objective, scientific enquiry into the health behaviours and conditions of the population there, and the socio-economic factors affecting them, in order to inform relevant, appropriate health service programming. The opportunity presented through the involvement of the International Federation of Red Cross and Red Crescent Societies, the Somali Red Crescent Society, and the World Bank, in the research was unique. Few research projects are so fortunate as to attract such interest and opportunities to engage the co-operation of these actors in a joint research effort are rare. It was essential therefore to develop a rigorous approach to the research. The following chapter provides the background to this joint engagement, explaining the opportunities to not only add to knowledge, but to improve practice and the situation in which the programming takes place. The chapter also questions the relevance of traditional methodologies to a real-world dilemma in conflict-affected Somalia and proposes a combined strategy to address the research question. The chapter finishes with some lessons from the experience of the author during three research missions to Somalia.

Research Considerations

The following section will describe the origins of the research question at the centre of this thesis and the advantages of combining the discipline of doctoral research with a real world

problem. It also questions whether research can, in practical terms, be expected to produce an improvement in practice. The feasibility of a problem-solving approach as opposed to a traditional approach to doctoral research is also questioned and precedents reviewed.

The Origins of the Research Question

The research question has its origins in the challenges faced by my former employer, the International Federation of Red Cross and Red Crescent Societies (the Federation) in a range of post-conflict countries where it strives to sustain basic services for communities without any alternative access to professional healthcare. In 1998, I completed an M.A. in Post War Recovery Studies. I had been working for the Federation in former-Yugoslavia and Congo-Burundi-Tanzania and wanted to address a specific question in my studies: How could the Federation, as an international humanitarian organisation with member national societies in 176 countries, support sustainable recovery in countries affected by violent conflict and collapse?

The previous decade has witnessed a significant increase in the Federation's post-war rehabilitation programming to a level which was unprecedented since the end of World War Two. By 1999, it was supporting National Red Cross and Red Crescent Societies (National Societies) with post-war rehabilitation activities in thirty countries. This increase had been recognized by the 1997 Seville Agreement between the components of the International Red Cross and Red Crescent Movement (the Movement), entrusting the role of lead agency in 'post-conflict' relief and rehabilitation programming to the Federation. However, the absence of any formally defined policy or intervention strategy to guide operations in this field was undermining the institution's response and dissipating its efforts. This was exacerbated by the delineation of the Federation's mandate on the basis of a 'post-conflict' transition period, a qualification which implies the complete cessation of hostilities, and is unrepresentative of the majority of post-war transitions where conflict may continue for years after a war has been deemed over. My M.A. dissertation drew on a number of approaches that had evolved or been developed during the 1990s to guide humanitarian operations in the aftermath of war. By analyzing the Federation's experience and adopting elements from these approaches it was possible to develop a series of recommendations for a strategic approach to post-war programming that reflected the

unique character of the International Federation and its member National Societies, and the constraints inherent in the current mandate. This approach was later integrated into the Federation's Post-Emergency Rehabilitation policy.

A key dilemma emerged during the research for the dissertation. One of the Federation's core activities is health. In the aftermath of conflict and war, this translates into the provision of health services – particularly community-based curative and preventive services for vulnerable groups such as women and children, and more generally community-based first aid, promotive and preventive services to communities. However, the continuation of quality, relevant services in the post-emergency period, following the decline of donor support, but in the ongoing absence of a formal public health system – or during its construction or reconstruction – poses a major problem. Either the resources are not available and the services are downgraded and eventually closed, or they are provided in such small quantities that the service is unable to provide the range and quality of services to attract local people to the service, and they revert to self-medication, traditional healers and pharmacies, often with serious negative consequences for their health (Whitehead *et al*, 2001; WHO; 2001; Schoepf *et al*, 2000)

The research question presented in the preamble highlights this dilemma:

Within the context of post-conflict recovery in the Fourth World, how can humanitarian organizations, working in partnership with local NGOs and emerging health authorities, harness the potential and resources of communities and empower them to participate meaningfully in the running and resourcing of their local health services?

Caught in the vacuum between donor disengagement and a grossly inadequate national health system, the challenge is to identify and harness resources that can help sustain the service at local level, while simultaneously integrating the service into an emerging national strategy for health service recovery supported by external organisations.

Central to this proposal was the belief that by studying the context in which the SRCS community health programming was taking place and the nature of the problem of sustainability of the service, it would be possible to validate hypotheses and design and test

solutions. By adopting a problem solving approach to the research question, studying and documenting the Federation's experience, specific technical guidelines for health service rehabilitation programming could be developed. This research and documentation activity might also provide a foundation for the formation of policy, strategy and best practice papers by the Federation.

Action Research: Promoting Understanding and Change

Adopting a problem-solving approach to a research question combines both academic and operational perspectives in a dual need for both understanding *and* the promotion of change. For example, it seeks to understand the role of the community in sustaining local health services and the approaches being used to engage communities in the organization and development of services *and* to promote change and improvement in these approaches to make these services more sustainable.

An Action Research Framework

If the findings from the research are to be applied in an effort to resolve the real-world problem, then it is important that a framework be created or adopted from the outset to determine how these findings will be used. Otherwise there is a risk that they will not be integrated into the experienced reality of day-to-day work.

‘The objective and generalizable knowledge embodied in social and behavioural research often is irrelevant to the conflicts that practitioners encounter or has little impact on the difficulties they face.’

Stringer (1999:6)

Stringer proposes an ‘action research’ approach to address this weakness inherent in conventional research. Action research considers the traditional research process of documenting particular phenomena and developing explanations as inadequate, seeking instead to apply these explanations to produce change and improvement through the involvement of research ‘subjects’ in the process. In its original form it was popularised by Kurt Lewin who coined the term and elaborated a formulation which involves a spiral of cycles of “planning, acting, observing and reflecting” (Robson, 1997; Hart and Bond, 1995; Stringer, 1999; Bowling, 2002).

It combines both exploratory and problem-solving approaches, beginning with a general objective of changing or improving practice in a specific area and initiating a series of cycles involving investigation, analysis, planning, acting and evaluating (Robson, 1997; Stringer, 1999). It revolves around the principle of engaging practitioners in the research process¹⁵ in order to produce change and improvement. In this case, the objective was to engage the practitioners in the Red Crescent health service program, i.e. - the programming staff – in the design, direction, conduct and use of the research and its findings to improve their understanding and bring about change and improvement in the way the program is implemented, specifically in relation to the sustainability of the health services.

Improvement of understanding

Improvement in understanding of the practice was sought through the combination of academic research - undertaking an extensive review of literature, programme plans, evaluations and reports - with original contributions from field-based research. The objective was to extend the boundaries of current knowledge by either developing new solutions or theories or testing existing ones in new contexts.

Promoting change and improvement

This objective involves three related processes: the improvement of practice; the improvement of understanding; and the improvement of the situation in which the programming is taking place (Robson, 1997).

- i) The improvement of the practice: In this case, the practice in question was the sustainable recovery of post-conflict community health services. The theory behind action research posits that the participation of the practitioners in the planning and conduct of the research improves the chances that any improvements and changes

¹⁵ A more recent variant 'community-based action research' seeks to engage all stakeholders (those whose lives are affected by the subject of the enquiry) in the processes of investigation and promotion of change and improvement. This variant will be proposed as a method to engage communities in the advanced stage of the research.

which are brought about during the process will be maintained thereafter. This is in contrast to the temporary improvements in practice often occurring as a result of a short-term intervention by an external consultant or staff from headquarters.

- ii)* The improvement of the understanding of the practice by its practitioners: By espousing an action research framework which specifically requires an active, whole-hearted engagement of practitioners in the design, conduct and use of the research, the process has the potential to produce an enablement of the practitioners to carry out their own enquiries into programmes and conditions, while availing of an external network of expertise as required.
- iii)* The improvement of the situation in which the programming takes place: The study and analysis of the Red Crescent health care programme are expected to promote the identification of better practices in programming and therefore an improvement in the overall health condition of the affected population. This quest for improvement provides a true test of the value of the research.

Traditional Research Methods and Application in Conflict Settings

Annex 1 presents a review of the three traditional research methods and their respective strengths and weaknesses according to the literature. Case studies, surveys and experiments all have their distinct advantages and disadvantages. They may also be combined to eliminate specific disadvantages and promote change. However, their appropriateness in conflict-affected situations has been the subject of much controversy in recent years (Barakat *et al*, 2002). It concludes that all three traditional strategies can – to some extent – be adapted for use in conflict-affected environments when certain critical conditions exist: in the case study, the critical condition is access; in the survey, the key issue is participation; and in conducting a field experiment the primary element is control. The participation of a major local organization such as a Red Crescent society may be the key to negotiating these conditions. As we have already secured the co-operation of the Somali Red Crescent in the research activities, we can move forward to address the main question about methodology: Which strategy is the most appropriate to address the research question?

The Research Strategy

This section presents criteria for the selection of the research strategy to be used to guide the fieldwork in the thesis. The research question is reviewed and the most appropriate strategy is selected. Further qualifications regarding the unknown character and unpredictability of the research context are noted and addressed.

Selecting a Research Strategy

According to Robson (1997:43-44) there is some truth in the suggestion of a hierarchical relationship between the three traditional strategies, and that while case studies are appropriate for exploratory work; surveys are more suitable for descriptive studies, and experiments are the appropriate strategy for explanatory studies. Yin questions this 'misconception' and gives examples of famous case studies which have been used for explanatory and descriptive purposes (Yin, 2003:3). Instead he contends that each of the traditional strategies can be used for all three purposes – exploratory, descriptive and explanatory, and that the selection of a particular strategy will be determined by three conditions, as illustrated in table 5.1 below:

- a) the type of research question posed;
- b) the extent of a researcher's control over actual events;
- c) the period of the enquiry – whether focused on current or historical events.

Table 5: Selecting a Research Strategy

Strategy	Form of Research Question	Requires Control of Behavioural Events	Focuses on Contemporary Events
Experiment	How? Why?	Yes	Yes
Survey	Who, what, where, how many, how much?	No	Yes
Case Study	How, why?	No	Yes

(Adapted from Yin, 2003:5; Robson, 1997:44)

The research question being posed in this thesis is:

In post-conflict countries, how can community health services be sustained in the absence of a stable government and a functioning public health system?

For the purposes of this thesis, the question was how to sustain community health services in post-conflict areas in the absence of a stable government and a functioning public health system, *with specific reference* to the Puntland State of Somalia. Experiments require control over behavioural advents – something which would be impossible in the particular context of recovery and health in Puntland and Somalia in the late 1990s. On the other hand, the case study offers the possibility to investigate this contemporary phenomenon (sustainability of community health services) in its real world setting where contextual conditions are of particular importance (post-conflict, absence of stable government and a functioning public health system) without requiring control of behavioural events. It has a distinct advantage in addressing questions such as the one in hand, when

‘a “how” or “why” question is being asked about a contemporary set of events, over which the investigator has little or no control.’

Yin, 2003:9

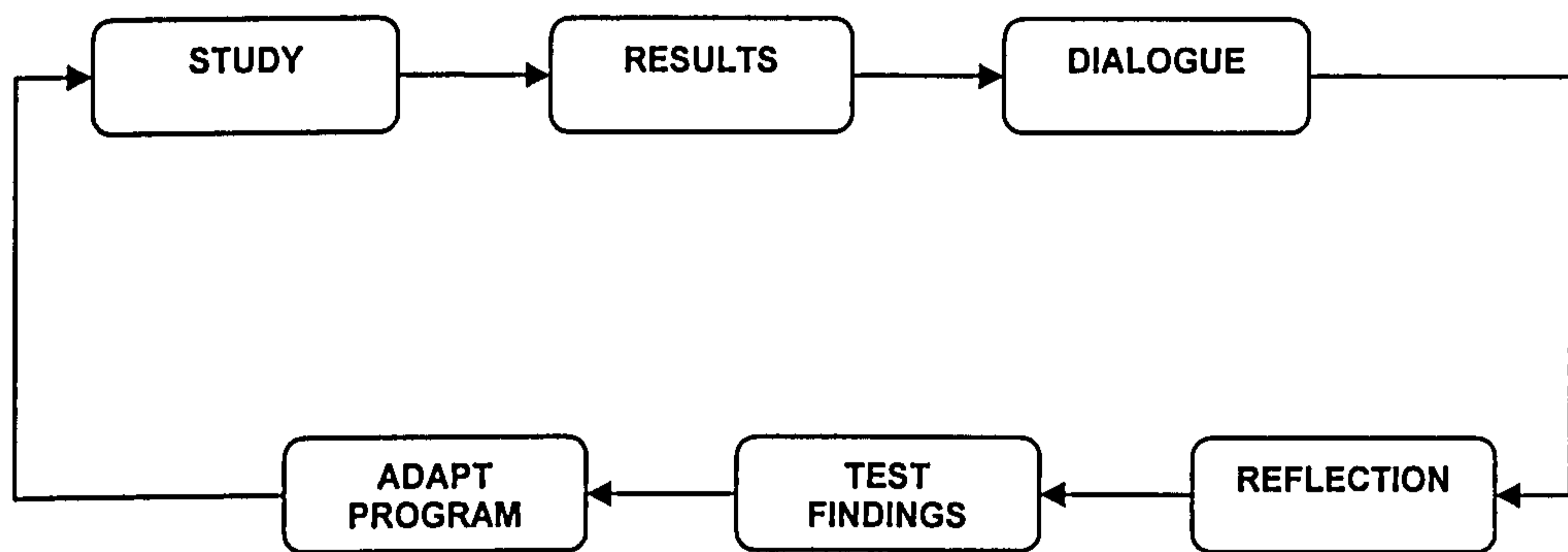
This would facilitate an investigation of the context of the recovery which is underway in Puntland and determine what – if any – capacities and resources exist to sustain basic community health services until formal recovery gets underway, and under what circumstances these capacities and resources might be mobilized and developed. In conclusion, it was clear that the central focus of the research strategy would be best provided by a case study.

Dealing With Uncertainty: What Kind of Case Study?

While the case study strategy is clearly the most appropriate approach, it incorporates many different tactics for gathering, validating and analysing information. Two considerations warrant attention in this respect: first, the research has specifically set out to develop and test solutions, and second, the context of protracted state collapse in Somalia is characterised by volatility which makes it difficult to predict what methods can be used to

gather information in different communities at any given time. These considerations were addressed through flexibility, the use of a combined strategy, and an initial pre-study to profile the context of recovery in Puntland. An action research mentality was adopted and maintained throughout the various stages of the field work. Conventional research is about describing, understanding and explaining – not about promoting change. Action research differs in that the knowledge and understanding generated is systematically applied and improvement is an integral part of the process (Robson, 1998). In addressing the central hypothesis, this study seeks to contribute to the understanding of health service recovery programming by international organisations, and to promote change and improvement in the design and implementation of such programs in the future.

Figure 5: The Traditional Action Research Cycle



Adapted from Robson, 1997

Participatory Action Research

For the purposes of this study the second variant of action research shall be referred to as ‘participatory action research’ as it is undertaken by participants in social situations – not only by practitioners. It is taken from Stringer who defines it as:

‘...a process through which people can collectively clarify their problems and formulate new ways of envisioning their situations. In doing so, each participant’s taken-for-granted cultural viewpoint is challenged and modified so that new systems of meaning emerge that can be incorporated in the texts – rules, regulations, practices, procedures and policies – that govern our professional and community experience. We come closer to the reality of other

people's experience and, in the process, increase the potential for creating truly effective services and programs that will enhance the lives of people we serve'.

Stringer, 1996, quoted in Bowling, 2002:411-412 (emphasis added)

Bowling (2002) notes that there has been a revival of interest in action research and that today the emphasis has moved away from rational social engineering to

'a method of community or organisational development through awareness raising, empowerment (an ability to influence decision making), and collaborative investigation between trained researchers professionals (nurses and doctors) and lay people with the help of designated mediators (facilitators)'.
(Bowling, 2002:410)

Local people are not treated as subjects: they become active participants, empowered by the process to make changes based on their own perspectives and interests. Bowling presents seven criteria to distinguish action research from other methods¹⁶.

Box 5: Participatory Action Research Criteria

Action research:

1. Is educative;
2. deals with individuals as members of social groups;
3. Is problem-focused, context-specific, and future oriented;
4. Involves a change intervention;
5. aims at improvement and involvement;
6. Involves a cyclic process in which research, action and evaluation are interlinked;
7. Is founded on a research relationship in which those involved are participants in the change process.

(Bowling, 2002, adapted from Hart and Bond, 1995)

It is a highly participatory and consensual approach towards investigating problems and taking action to deal with them. In the context of community health service provision, the central focus of this variant of action research is to promote change and improvement in the service through the enablement of service-users to identify, analyse, reflect upon, and take action to resolve problems with the service.

¹⁶ Participation is not an exclusively positive phenomenon. A growing body of literature testifies to the many negative experiences of participation by communities in the Fourth World, where it has all too often been introduced without sufficient attention to the local political history or socio-cultural context (Golooba-Mutebi, F. 2004)

The Different Stages of Participatory Action Research

There are four distinct phases in conducting participatory action research: setting the stage; looking, thinking and acting. (Stringer, 1999)

Setting the stage: A key element in this preliminary stage is stakeholder identification. If any groups or key individuals are omitted or excluded from the outset then the process will be seriously, even fatally, flawed. It is also essential to ensure common awareness of the objectives and dynamics of the process and to maintain people's commitment to participate actively in the exercise.

Looking: Here participants define and describe the context being studied and the problem being addressed. Information is gathered by working with different groups to develop a descriptive account of the context in relation to the problem. Multiple methods are used: observation, unstructured interviews, focus group discussions and document analysis.

Thinking: Meetings are organised to present the descriptive accounts and work with participants to enable them to understand and interpret them. Participants are organised into groups where they discuss issues and negotiate their perspectives. The next phase is planned.

Acting: A further process on internal group consultation takes place in the light of what was presented. Groups must agree on priorities before coming together in a plenary meeting to reach consensus on the way forward and develop a series of proposals for action based of these priorities.

The Role of 'Facilitator'

Because of its highly participatory nature, participatory action research requires the researcher to take on the role of neutral, objective facilitator in the process of uncovering people's perspectives of the context and the problem, mediating between different groups of stakeholders, and negotiating a proposed solution or set of solutions. The ability to gain

people's confidence without appearing to be too closely involved with any one group is essential for the facilitator, who must be – and be seen to be – neutral.¹⁷

Research Tactics

Multiple research tactics are used to gather information and data. In general they are qualitative methods which are accessible to all participants and promote a sense of ownership in the process through participation at every level: participant observation, focus group discussions, unstructured and depth interviews. Additionally, some surveying using structured or semi-structured questionnaires may be involved, and document analysis is a part of standard action research procedure to provide in-depth information on community profiles or specific characteristics such as disease burdens, frequency and nature of health facility usage, and so forth. Speed is essential in order to maintain participants' interest and confidence in the process and build momentum towards a solution-outcome. The overall approach to data gathering is often referred to as rapid appraisal

Rapid Appraisal

Bowling (2002) provides a helpful synopsis of the rapid appraisal as a qualitative technique for community assessment. Rapid appraisal is a useful way to conduct a quick assessment of local views and perceptions of problems, combining interviews with key people and group meetings. Used as part of an action research program it aims to gain insight into the community of interest and local people's perspectives of their own needs and interests with the intention of translating findings into proposals for action. Bowling notes that it can be used to 'establish the foundations for an ongoing relationship between service purchasers, providers and the public' (Bowling, 2002:414). Its validity is established through the use of triangulated research methods. Essentially it engages key local people as sources, conductors and facilitators of information, working in a larger enquiry process with a multi-disciplinary team of researchers. Initial meetings of the core research team explore the research questions, the methods of enquiry to be used, and the sources and likely respondents. Field work is punctuated with discussions at various levels including meetings

¹⁷ I would like to acknowledge and thank my supervisor Dr. Sultan Barakat, for accepting to take on the role of facilitator in the action research process in the community of Qarhis. His facilitation of the understanding by different social groups of the various stakeholder perspectives was invaluable to the process and the outcome of the case study.

of the core research team, feedback sessions with the key participants, and open meetings with the community. It concludes with workshops to present findings and work out concrete proposals for action to address the problem (Bowling, 2002).

Bowling also presents an example of the use of rapid appraisal techniques by Murray and Graham to assess the health needs of residents of a housing estate in Edinburgh. A team consisting of a medical doctor, a health visitor, two social workers and community education worker reviewed documents about the community, made direct observations and conducted interviews and focus group discussions with community leaders, residents selected to represent different age and social groups with different health problems and professionals working with the community. The local doctor's consultation records were analysed to provide a profile of health problems and behaviour, and a postal survey was carried out.

The rapid appraisal approach used in the community of Qarhis was a variation of the one developed by Ong and Humphris based on their experience of rapid appraisal carried out by health authorities and doctors within action research programs (Bowling, 2002). The following guide to participatory action research has been adapted from Ong and Humphris' seven steps for rapid appraisal exercises.

Box 5.1: Steps for Undertaking Participatory Action Research

Steps for Undertaking Participatory Action Research

1. Preparing the team to undertake the in-depth study
2. Choosing a target community, key questions based on information profiles, and identifying participants
3. Collecting, analysing and presenting information gathered from different participants
4. Identifying possible solutions and negotiating positions with different groups
5. Analysing responses and developing proposals
6. Presenting proposals in an open meeting of all participants
7. Formulating concrete plans of action

Adapted from Ong and Humphris, 1995

▪ Combined Strategies

The objective of this research is not only to contribute to knowledge and understanding, but also to promote change and improvement in the practice of post-conflict recovery of health services. A combined strategy or the use of multiple methods within a case study makes it possible to explore a situation and suggest some intervention or change (Robson, 1997:169; Yin, 2003:9). In real world research studies, and where some change in practice is being proposed, an experimental strategy may be an appropriate way to demonstrate change. Alternatively, a linked set of case studies, using multiple methods allows the introduction of 'experimental-like' features (Robson, 1997: 168-169).

Usually a small-scale study will be limited in resources and this may preclude the use of more than one strategy, such as for example, combining a survey to measure people's attitude to a hypothetical service, with a field experiment to make the service available to a sub-group within the survey in order to further explore the survey findings by observing and documenting their actual behaviour. Where feasible however, a combination of strategies has a number of distinct advantages.

For example, a case study may be used initially to explore the context and generate hypotheses, followed by a field experiment to test these hypotheses. Alternatively, an initial survey may identify representative communities which can be studied in more detail using a case study strategy to identify new approaches to – for example - delivering more relevant, appropriate services.

Surveys can also be combined usefully with case studies. When a survey is undertaken to substantiate a hypothesis or establish the existence of certain conditions, a case study can then be used to provide a more detailed and precise description of the processes at work. They can provide sampling frames to identify representative communities for case study research to provide a more in-depth analysis of the processes at work within local communities to test hypotheses (Hakim, 2000).

It may also be considered that in the case of research undertaken in conflict-affected contexts, without valid, reliable sources of data or sampling frames, and where access to

particular areas and communities may often be irregular or impossible, the use of a combination of strategies can increase the reliability and thus generalizability of the findings.

▪ The Composite Approach

Barakat *et al* (2002) favour a variant of the combined strategy which they call the 'composite approach' to overcome the obstacles confronted by research in conflict-affected areas (Barakat *et al*, 2002:996-1002). A case study is used to explore the context and generate hypotheses about the nature of the phenomenon under investigation. A thorough documentary review compensates for a lack of access to conflict-prone, high risk environments, perhaps through the detailed study of a wide range of agency program assessments and reports, government or local administration papers and development plans, and local NGO documents. Previous surveys (for example UNICEF Multiple Indicator Cluster Surveys), vulnerability and capacity analyses, case studies and focus group interviews can all provide valuable information on different aspects of the research question. There is a real risk of bias inherent in the compilation of information collected selectively to meet particular objectives, hence the need to offset this in analysing the literature or documentation. This provides the basis for the initial field research trip in two important respects: first, by generating a series of initial hypotheses which can be validated during the first field trip; and second, by clarifying the aim, objectives and profile of the first field intervention (*Ibid.*).

Because of the opportunity afforded to conduct an action research type enquiry, developing and testing solutions in an effort to improve practice and the situation in which the practice takes place, *as well as* contribute to knowledge and understanding, it was decided to incorporate both a survey and a field experiment into the case study. Not only does it allow for testing out of possible solutions, it also helps to deal with the uncertainty and unpredictability associated with research in volatile situations (Barakat *et al*, 2002).

Pre-studies

This type of approach equates broadly with the notion of a 'pre-study': a first phase of a research process undertaken when conducting evaluation of humanitarian assistance

programs in the context of complex emergencies to compensate for the complexity of the subject matter and need for a more accurate general profile of the case being evaluated than may normally be available in these situations (Hallam, 1998).

‘...a first phase or ‘pre-study’ to construct the narratives and baselines and identify the key issues on which to focus in the main phase of the study. Experience has shown that some of the main issues that emerge in humanitarian assistance evaluations are not apparent at the start of the process. Because of the need to interview key agency personnel and begin collecting key documentation, prestudies will probably involve visits to the site of operations.’

(Hallam, 1998:47-48)

Once this preliminary exploration is underway, and having established a clearer picture of the research subject *in situ* and the prevailing conditions, and with a greater awareness of the possibilities and constraints for using specific research methods, the researcher can then develop a more comprehensive research strategy for a further, more focused, phase of research. For example, a pre-study can facilitate the informed selection of a series of case studies to examine sub-units of the case, or the identification of a representative or otherwise desirable group to be surveyed in order to provide more detailed information on certain characteristics or conditions.

Alternatively a field-experiment may emerge as the most useful and feasible method to test hypotheses. The pre-study also allows for the identification of key informants, the selection of the most appropriate research tactics for the prevailing conditions – in terms of conflict, population movement, climate, physical access and so forth. The key is to use the first phase fieldwork as an opportunity to elaborate the most appropriate, detailed and comprehensive research design to address the hypotheses generated through initial literature reviews and discussions, and those subsequently emerging from the first phase of the research.

In conclusion, a case study strategy, using a combined or composite approach, and beginning with an initial field mission or pre-study, would be most appropriate to undertake the fieldwork stage of the research.

The Pre-study Design

Having identified the pre-study as the first phase of the research strategy, the first step was to develop a research design for the pre-study. In situations such as that prevailing in Puntland where so little was known about the context of the area to be researched, it would be easy to consider that every piece of information collected is relevant to the research, and the specific focus would be lost. The critical issue therefore was to ensure that the evidence collected addressed the research question. An appropriate research design was needed to help avoid this problem. Five main components of a research design are essential (Yin, 2003:19-56):

- a) The research question;
- b) The purpose of the study;
- c) Units of Analysis;
- d) Logic linking the data to the purpose;
- e) Criteria for interpreting the findings.

The following section presents the components of the Puntland pre-study research design.

The Research Question

The research question at the centre of the study asks how community health services in post-war countries can be sustained in the absence of a stable government and a functioning public health system. This dilemma exists or has existed in an increasing number of countries or territories since the early 1990s: for example, Afghanistan, Angola, Cambodia, East Timor, Haiti, Iraq, Kosovo, Liberia and Rwanda. Arguably, the most extreme case is Somalia; collapse has been total and fourteen formal international reconciliation initiatives at reconciliation and restoration of legitimate state authority have failed. It is here that the field research would be conducted. The assumption was that any new programming strategy or model which could produce an improvement in service provision in such an extreme case would find some application in a range of other less extreme situations.

Somalia is a classic example of a post-war country in protracted collapse, without either a stable government or a functioning public health system (Menkhaus, 2004; Doornbos, 2003; Weiss, 1999; Adam, 1995). The war that tore the country asunder in 1991 has long

since ended, and the northwest Somaliland and northeast Puntland regions enjoy different degrees of recovery (and - in the case of Somaliland – development). However, clan-based conflict continues between groups vying for control of different fiefdoms in the south and centre of the country, preventing the establishment of a nationally recognised government, and consequently, a legitimate state. Somaliland declared its independence from Somalia in 1991 and established a government, appointing, among others, a Minister for Health and Labour. The government has been successful in restoring law and order and stability, and consequently has managed to build confidence both within Somaliland and Somalia, and within the international community as a whole, in the durability of peace in the northwest. Although it has not been recognised by the international community, it has been making significant progress in post-war reconstruction and is considered a development context. While much remains to be done in terms of construction of the health sector, it has established the basic framework for reconstruction and recovery. In this respect it is significantly ahead of Puntland.

The Puntland state of Somalia, was created in 1998, a self-declared autonomous state within a future federalist Somalia. It represents a good example of post-war recovery, with an emerging administration trying to construct the basic framework and institutions of governance from scratch. There is no public health system and no functioning health administration to speak of, other than a Director General of Health within the Ministry of Social Affairs.

Puntland therefore, is a good illustration of the context referred to in the research question. It also has a number of other advantages as a real world laboratory for researching, designing and testing solutions for sustainable health service recovery:

- a) The concentration of twelve Red Crescent clinics and one referral hospital located in Puntland makes the Red Crescent the single biggest health service provider. How these services can be sustained and grafted onto an emerging public health structure is an important question for the emerging health authorities, the Red Crescent and their UN partners UNICEF and WHO.

- b) The participation of the emerging health administration and key UN agencies in the study can enhance the prospects that any emerging solutions will be integrated into future services and practices.
- c) Somaliland can provide useful lessons and experience, within the general Somali context for what may and may not be possible in Puntland, in terms of health service recovery.

Hypothesis

Most case studies articulate a series of propositions or hypotheses about the phenomenon being studied. The scope of the study can thus be narrowed considerably and attention directed towards the issues that should be examined in the search for relevant evidence. The pre-study was, in essence, an exploratory case study, seeking a more detailed, up to date profile of the situation in Puntland in order to identify the key issues of health service recovery in this particular post-war recovery context, and the direction and focus for the main phase of the research. By selecting the case of Puntland, the research question could be examined in a real world context and direction sought as to how services might be sustained. This direction would take the form of a number of working hypotheses which could then be tested through further field work.

The intention was to use the pre-study to generate a working hypothesis about the possible approaches to sustainable community health service recovery in Puntland, as a good example of the type of context referred to in the research question. This working hypothesis might either reflect the original thesis, or replace it entirely. The following preliminary hypothesis was based on an early version of the literature review undertaken in chapters 1 to 6, exploring the context of health service delivery and financing in conflict-affected, low income countries, including Somalia. It was initially articulated prior to the fieldwork phase of the research, during the preparation of the project proposal which was submitted to the World Bank¹⁸, and served to guide the focus and direction of the pre-study.

¹⁸ See for example Annex 2, personal correspondence to the World Bank dated 22nd February 2000, describing the opportunities presented by the project proposal, and the planned research activities.

Humanitarian organizations, working in partnership with local NGOs and emerging health authorities, can harness the potential and resources of communities and empower them to participate fully in the running and resourcing of their local health services, ensuring the appropriateness and sustainability of services and contributing to the recovery of an effective public health system.

Unit(s) of Analysis

The definition of the unit of analysis follows from the articulation of the research question, seeking to identify ways in which community health services in post-war areas can be sustained. In this particular case, the post-war area is the Somali state of Puntland. The unit of analysis for the pre-study therefore was the Puntland health service.

While the field research looked into the overall context and conditions of health service provision in Puntland, it should be noted that it was conducted with particular reference to the Red Crescent clinic services, partly in recognition of the major role they play there, and partly as a result of the access to these clinics for the purposes of the enquiry. Other services were also visited and studied.

The Pre-study research team also visited Somaliland and some of the Red Crescent health services in this area in order to compare and contrast facilities in this area, and determine if there were grounds for further research in Somaliland to inform the development of sustainable programming practices in Puntland. The time-scale for the pre-study was the three-week period from 18 April to 6 May, 2000.

Linking Data to the Hypothesis

Once the data has been collected in a case study, the investigator is faced with the challenge of analyzing it to answer the research question. There are few textbook formulae for how to do this, but investigators are strongly advised to develop an analytical approach in advance – as part of the case study protocol - clarifying how the data will be analyzed (Yin, 2003:110). The most common strategy in case study research is to follow the initial hypothesis that led to the case study in the first place. This type of analytical strategy can help to frame the enquiry process by providing a continuous link between the propositions and the overall research exercise, helping to distinguish between data which is directly

relevant and that which is peripheral, and thus ensuring the research question and propositions remain in focus throughout. It also provides the basis for the analysis of the data once it has been collected.

Prior to the commencement of the pre-study, an analytical framework was developed to guide data collection, recording and analysis in line with the study's thesis and hypotheses. The framework focuses on three main areas of analysis as depicted below on page 232:

a) *Context analysis* to assess the Threats and Opportunities for sustainable recovery to take place within the political, institutional and socio-economic conditions prevailing in Puntland at the time of the study.

b) *Sector analysis*: mapping the main health problems, current health behavior, service provision and financing, and policy and regulation, in order establish the Potential and Limitations of the health sector.

c) *Actor analysis* to establish the Advantages and Disadvantages of the Somali Red Crescent Society to support the development of sustainable local health services, focusing on the six prerequisites of any effective action: mission; competence; acceptance by the community; legitimacy to operate; knowledge; and availability of resources.

Criteria for Interpreting Findings

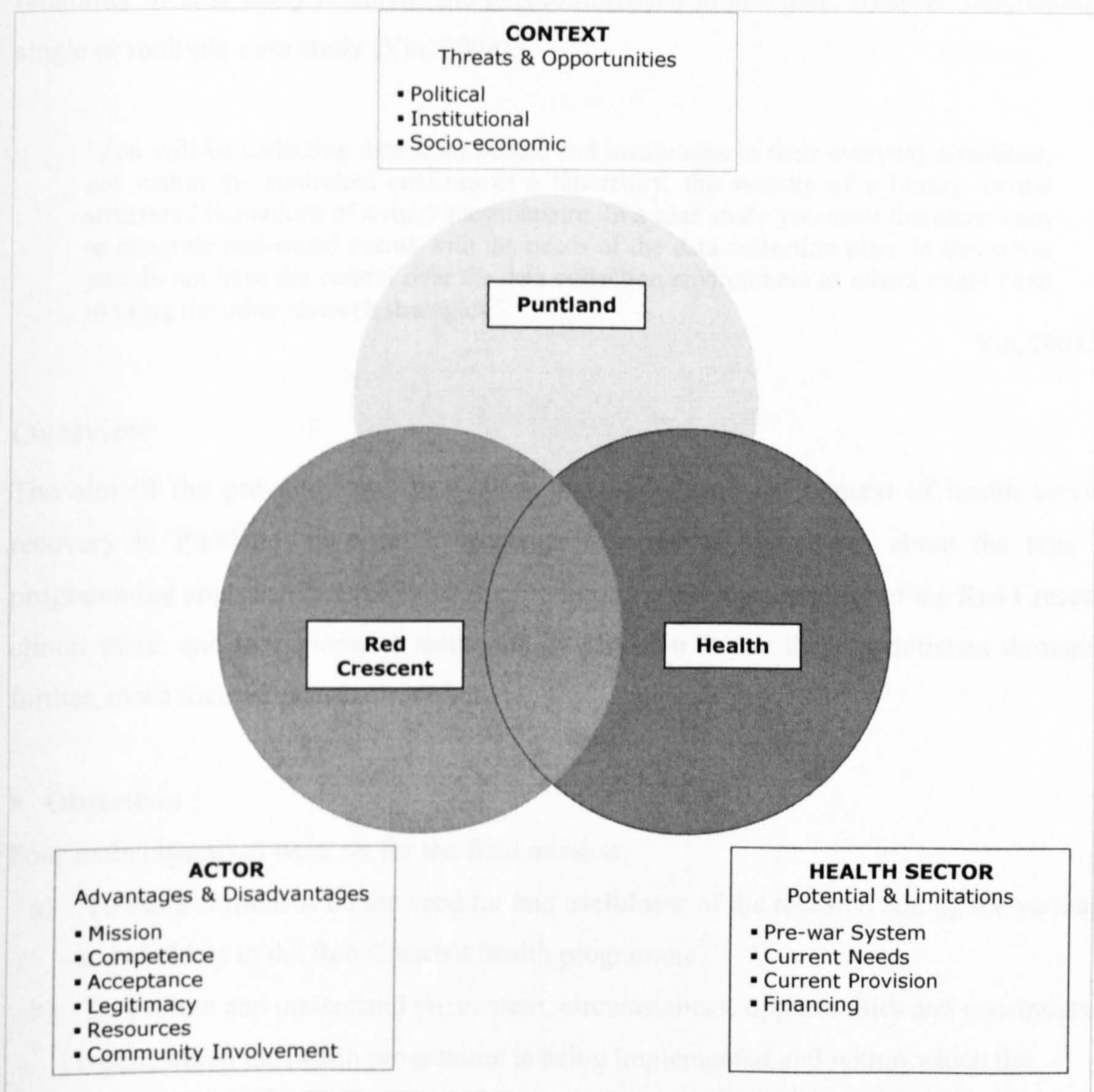
A variation of the 'explanation building' technique was used to interpret the findings from the Puntland pre-study. Explanation building is an analytical technique for interpreting findings from case study research that is normally used in explanatory case studies. A similar procedure has also been used for as part of a hypothesis-generating process to develop ideas for other studies (Yin, 2003). The process followed four main steps:

- The development of the initial thesis about the solution to sustaining community health services in post-war settings as set out in paragraph 1.2 above.
- Comparing the findings of the pre-study against the thesis.

- Revising the thesis based on the findings to generate a series of working hypotheses reflecting the findings from the real world setting.
- Comparing the other details of the case against the revisions.

This new set of working hypotheses about the specific context of Puntland would then be tested in a further phase of research, the results of which would be generalized back to theory, and serve as a basis for a generic approach to community health service recovery beyond the specific case of Puntland.

Figure 5: TOPLAD Analytical Strategy



The Pre-study Protocol

The protocol contains the data collection instrument, the procedures and general rules to be followed throughout the case. It keeps the investigator targeted on the subject of the case study and provides a critical guide to carrying out the data collection. Where more than one investigator is involved it helps to maintain clarity, coherence and consistency. Preparation of the protocol also requires the investigator to anticipate potential problems and to think through - in advance – the planned activities all the way through data collection to designing the case study report. The use of a protocol thus significantly increases the reliability of case study research, and is recommended in all cases, whether undertaking a single or multiple-case study (Yin, 2003).

‘You will be collecting data from people and institutions in their everyday situations, not within the controlled confines of a laboratory, the sanctity of a library, or the structured limitations of a rigid questionnaire. In a case study you must therefore learn to integrate real-world events with the needs of the data collection plan. In this sense you do not have the control over the data collection environment as others might have in using the other research strategies.’

Yin, 2003:72

Overview

The aim of the pre-study was to explore and understand the context of health service recovery in Puntland, in order to generate a series of hypotheses about the type of programming approach that might be used to improve the sustainability of the Red Crescent clinics there, and to elaborate a methodology and plan to test these hypotheses through a further, more focused phase of research.

▪ Objectives

Four main objectives were set for the field mission:

- a) To build consensus on the need for and usefulness of the research among the various stakeholders in the Red Crescent health programme.
- b) To explore and understand the context, circumstances, opportunities and constraints within which the health programme is being implemented and within which the research would take place.

- c) To draw out a number of assumptions and working hypotheses in relation to the health programme's achievements that could be tested in the research, and used to guide its activities.
- d) To develop an overall plan for the rest of the research.

The emphasis on consensus building in the first objective reflects the strategic aim of changing programming practice, one of the three main goals of the action research philosophy embraced as a key element of the research methodology. The program practitioners – in this case the Red Crescent and Federation health staff – also become researchers in the process of understanding and improving the practice under investigation. The other two goals of action research were the improvement of the understanding of the practice by its practitioners, and the improvement of the situation in which the programming takes place. This emphasis on consensus building and practitioner participation was reflected in a series of guiding principles elaborated for the pre-study.

Field Procedures

Somalia is a difficult environment in many respects, not least logistics. The organization of transport into and around a country with no functioning central government, no institutions of governance and no formal national laws and regulations, required a significant amount of advance planning and co-ordination.

▪ The Research Team

Conducting a case study of this magnitude was a major undertaking and the composition of a balanced, multi-disciplinary team was a critical step. The members selected for the research team reflected the need for expertise in specific disciplines. The selection also tried to take into account the potential difficulties and stresses associated with work in a stressful, insecure environment, continuous travel and long hours, often in spartan, if not downright uncomfortable, conditions. The team was composed as follows:

- A team-leader, with extensive experience in research and expertise in post war recovery to provide leadership and ensure the technical validity of the pre-study ¹⁹
- A medical expert, specializing in relief health to provide an in-depth assessment of the current health situation of the population and the existing services²⁰
- An economist specializing in post-war recovery of the social sector to help identify the opportunities and threats presented by the socio-economic circumstances²¹
- A senior representative of the SRCS to provide in-country leadership and credibility for the process²²
- A specialist in disaster policy and rehabilitation programming to assess the capacities and weaknesses of the SRCS integrated health care program and the potential and constraints faced by the staff and the organization²³.

A major disappointment was caused by the withdrawal of two female team members in the final days, one due to an alternative job offer, and one due to illness. This left us with a considerable gender imbalance, which – given the nature of the clinic services mother and child health – was a handicap we had to fight hard to address throughout the field trip.

¹⁹ Dr. Sultan Barakat, Director of the PRDU. Again, and in keeping with Robson (1997:450) and Phillips and Pugh (1987:52) I am grateful to Dr. Barakat for his support and participation throughout the project.

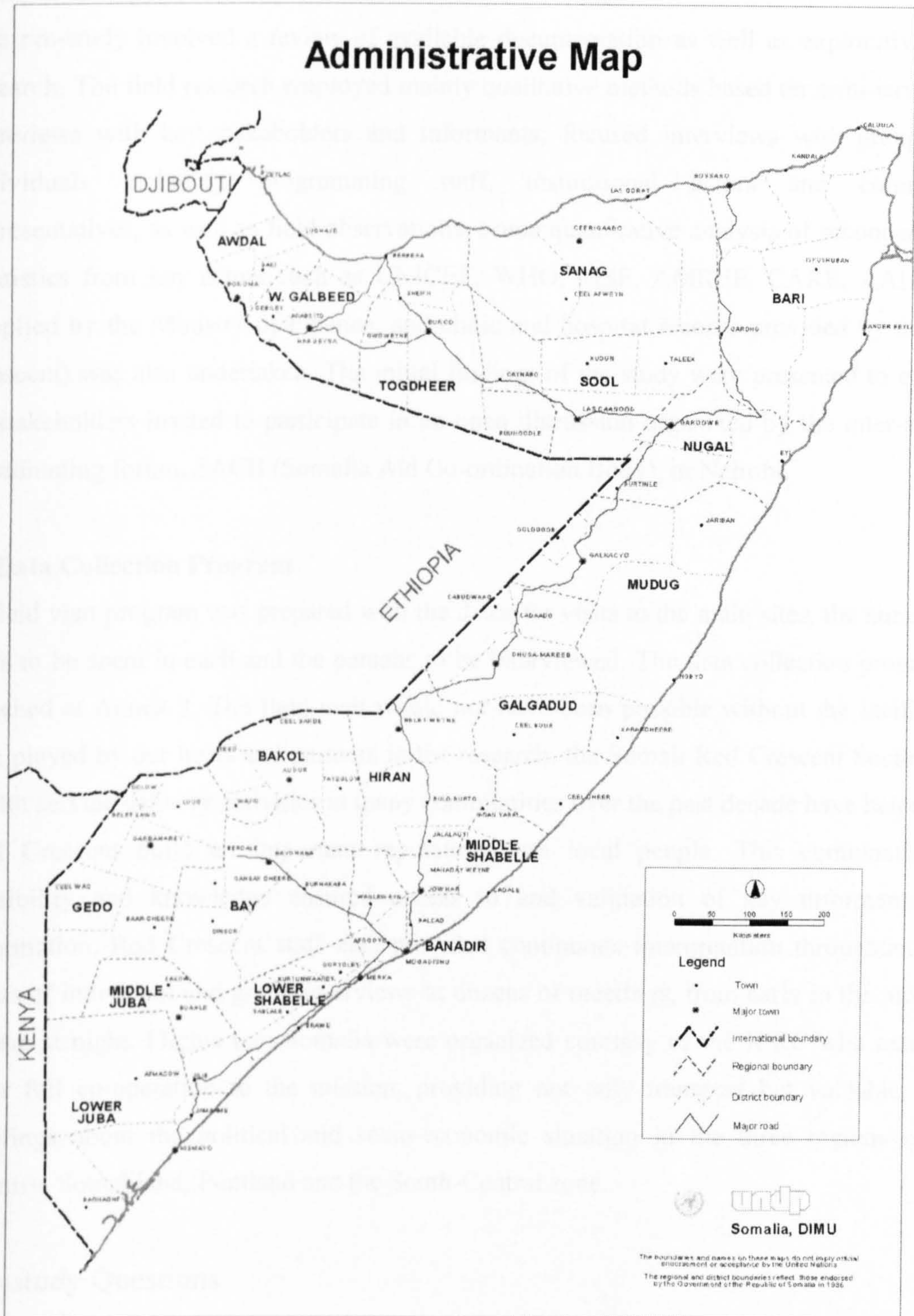
²⁰ Dr. Hakan Sandbladh, Head of Relief Health at the IFRC

²¹ Ray Martin, former World Bank economist

²² Dr. Ahmed Hassan Mohammed, former surgeon and President of the Red Crescent

²³ Myself, Senior Officer for Post Conflict Recovery

Map 1: Somalia, Regions and Districts



▪ **Methodology**

The pre-study involved a review of available documentation as well as explorative field research. The field research employed mainly qualitative methods based on semi-structured interviews with key stakeholders and informants; focused interviews with groups and individuals including programming staff, institutional actors and community representatives, as well as field observations. Some quantitative analysis of secondary data (statistics from key actors such as UNICEF, WHO, MSF, AMREF, CARE, AAH, data supplied by the Ministry of Finance, and clinic and hospital records provided by the Red Crescent) was also undertaken. The initial findings of the study were presented to a group of stakeholders invited to participate in an open discussion organized by the inter-agency coordinating forum, SACB (Somalia Aid Co-ordination Body), in Nairobi.

▪ **Data Collection Program**

A field visit program was prepared with the dates for visits to the main sites, the number of days to be spent in each and the persons to be interviewed. The data collection program is attached at Annex 2. The field visit would not have been possible without the facilitation role played by our hosts and partners in the research, the Somali Red Crescent Society. Its health service delivery activities in many communities over the past decade have helped the Red Crescent build an important reputation with local people. This combination of credibility and knowledge ensured access to and validation of key informants and information. Red Crescent staff also provided continuous interpretation throughout long hours of individual and group interviews at dozens of meetings, from early in the morning to late at night. Flights into Somalia were organized courtesy of the ICRC who extended their full co-operation to the mission, providing not only transport but valuable, open briefings about the political and socio-economic situation in the three regions of the country, Somaliland, Puntland and the South-Central zone.

Pre-study Questions

The Pre-study sought to find out how community health services could be sustained in the absence of a stable government and functioning public health system by constructing a profile of the Puntland region of Somalia with a particular focus on the community health

services being run by the Red Crescent in twelve communities there. Based on the literature review presented in chapters 2 to 4, answers were sought to the following questions about the context, the health sector, and its main actors, in an effort to determine the prospects for recovery, the structure and financing of existing services, and the resources available to contribute towards the recovery of health in Puntland.

▪ **Context**

1. What is Puntland's political status?
2. To what extent has Puntland been affected by state failure and conflict?
3. Is there a stable government and how is it organized?
4. Can the context be accurately described as post-conflict?
5. What are the state's main resources?
6. Who are the main population groups and what are their sources of livelihood?
7. What reconstruction activities are underway?

▪ **The Health Sector**

8. What has been the impact of conflict and state failure on health and health systems?
9. What are the main health problems?
10. What services currently exist?
11. How are they financed?
12. What is the government's role in health service provision?
13. What is its vision for the future public health service and how will it be financed?

▪ **The Actor: Red Crescent**

14. How does the Red Crescent clinic program fit into the overall scheme of health service provision in Puntland?
15. What is its relationship with the government and other providers?
16. What role might it play in the reconstruction of the public health system?
17. What role does the community play in the organization and delivery of Red Crescent health services?
18. Do communities have the resources to contribute to the upkeep of the Red Crescent clinics?

19. Are there traditions of collective participation in times of crisis or disaster?

Practical Lessons from Fieldwork

The experience of conducting research in conflict-affected areas with limited access, sometimes poor living conditions, insecurity and intense work-rates yielded a number of valuable lessons which are presented below under four main headings:

- Preparation;
- Security;
- Consideration;
- Effectiveness.

Preparation

Careful preparation of the field trip helps avoid unnecessary discomfort, tiredness, and sickness, and prevents a range of problems that might hamper or undermine the achievement of the trips objectives. Time after time during the field research missions, we had to strike a balance between conflicting demands and requirements. Luggage restrictions on ECHO flights into Somalia forced us to choose between and the bags and boxes of training materials, survey questionnaires, teaching materials etc. that we had prepared, and our clothes, hygiene articles and gifts we were bringing to our hosts.

▪ Well-being

Your own well-being is critical and finding out as much as possible in advance about the social, climatic and environmental conditions, the available travel and accommodation facilities, and the culture of the place being visited and consider how best to deal with the effects of tiredness, strange food, disorientation from malaria prophylaxis and vaccinations, poor hygiene conditions and overwork. For some members of one of the research teams, finding out – after take-off - that there was no toilet on the plane that was taking us on the four hour flight into Somalia proved to be a horrible experience, for others the taste of burnt camel meat will linger forever.

One essential element of preparation is planning for possible illness or accident, both in the event of a local hazard or a personal event such as a heart-attack, epileptic fit or other sudden condition. There may be a flying doctor service in operation and contact details and procedures should be sought prior to any field trips to areas where access is an issue. Some humanitarian organizations will include this in any security plan, but again caution is advised as the plan may be out of date. It is certainly advisable to carry a basic field medical kit, particularly in war torn areas where access to professional medical assistance may be restricted.

▪ **Research Materials**

Faced with luggage weight restriction on humanitarian flights to otherwise inaccessible places like Somalia, researchers may be tempted to jettison the tradition flipchart and the necessary rolls of paper for more modern group-work and appraisal techniques. These days, a combination of laptop computer and miniature data projector make it possible to carry out research workshops with only a small bag of material and props, dispensing with the flipcharts and reams of paper and the hours of preparation every day and allowing sophisticated graphics and high-resolution photographs to stimulate, motivate and inform participants. Questionnaires and other research tools can be modified and updated at the last minute based on dialogue and respondent participation. But it can all fall apart in the blink of an eye when the diesel runs out, the generator breaks down or any one of a hundred other faults develop. In war-torn developing countries researchers should also ensure there is a contingency for whatever methods are being used to undertake data gathering in the field research. Preparations should ensure at a minimum that flipcharts, markers, pencils, chalk, and post-its will be available. Similarly any photocopies that may be required (for example, for survey questionnaires, observation checklists, etc.) should to the greatest extent possible be prepared in advance. Where on-the-spot copying and printing is required local sourcing should be verified in advance and a contingency should be identified.

Security

Security in conflict-affected areas is always in question, even when it appears to be peaceful and calm, a life-threatening situation can develop in minutes. During one research trip we were invited by the President of Puntland to attend an 'Independence Day'

commemoration in Puntland together with the President of the Red Crescent. When it finished a crowd rushed forward to try and see the President and his entourage and we were separated from our SRCS hosts. A large group of mainly young people milled around us as we tried to make our way to a nearby restaurant where we knew the owner and could wait in safety for the Red Crescent President. One young man approached us and threatened in English to kidnap us, rallying the crowd against 'these Americans'. We managed to escape and continue to the restaurant where we met with our colleagues. On another occasion, an armed man threatened to kill us if we photographed the local Red Crescent branch office, despite the presence of the Branch Chairman.

▪ **Attitude and Awareness**

Researching in conflict-affected areas brings a whole range of physical threats which can be minimised or managed through a combination of awareness and attitude, yet is rarely mentioned in journal articles or essays about methodological approaches to research in the field. Nor does all danger come from military or weapons-related threats. As we learned from experience, crowds and mobs are notorious for turning violent without warning and present particular dangers for outsiders in conflict prone areas. In some places, bandits and thieves prey on relatively wealthy visiting aid workers and researchers while in others it may be safe to walk alone at night. By developing a good understanding of the environment in which you will be researching and learning about the specific threats that exist, a researcher can modify his or her behaviour to avoid taking unnecessary risks.

Almost all agencies and NGOs have developed situation-specific security guidelines for their operations and researchers should check that these have been updated recently and familiarise themselves with the threats, protocols and procedures. The ODI's *Operational Security Management in Violent Environments* (2000) focuses on knowing who you are and where you are, and provides useful guidance for practitioners and researchers in working in violence-prone situations (Brabant, 2000).

▪ **Local Travel**

Probably the single greatest cause of injury and death among humanitarian aid workers – except, perhaps, for HIV/AIDS – is driving accidents. On one field visit, the driver of the

vehicle which took us on a seven hour trip chewed the mildly narcotic *Qat* to stay awake. As a side-effect he drove very dangerously, and had to be requested several times by his superior to slow down.

Car-jacking and roadside robberies are another common danger in conflict-affected areas. A thorough appreciation of the local context is the only way to know which threats exist. It should be borne in mind that the excitement of travelling in war torn countries which may also be home to spectacular sights or historic landmarks, may cloud visitors' judgement: all travel plans should be weighed carefully against actual and potential threats to security, regardless of the 'prize' they seek to find.

Research in conflict-affected situations is a high risk activity: insurance – both for yourself and your belongings - should be contracted or if you have a policy – activated for the duration of the visit.

Consideration

The way that outsiders present and comport themselves can make the difference in the relationship between external researchers and local informants or participants in a research activity.

▪ Cultural and Religious Considerations

Cultural and religious considerations are particularly important. Getting full-scale co-operation from community representatives and local staff requires at a minimum a high degree of respect and tolerance for their religious and cultural practices. Workshop or group-work sessions had to build in time for prayers during the day and respect for Friday even though time in field may be limited and there was much work to be done. We didn't know in advance about local holidays, specific times for prayers or other requirements, but by asking and planning jointly with local participants we were able to reach compromises in some cases and plan in advance to rest or prepare working sessions during the time when they were not available. We learned early on that respect for local circumstances is another prerequisite for gaining the trust and building a solid relationship with local people. In an environment characterised by poverty, humility and scarcity, ostentatious displays and

lordly behaviour whether expressed in demands for better accommodation, different food, special treatment, places barriers between the researcher and the very people whose openness is most needed for the research – the men and women surviving in the conflict-affected area. A team member on one of the field trips who took on the character of a colonial emperor, became a barrier to local co-operation, and a bore to the rest of us. On two occasions our hosts confronted him openly in very humiliating ways and he learned to adopt a lower profile.

- **Resource-scarcity**

The use of the host's resources such as office materials, telephone and vehicles without proper compensation – or for personal purposes – particularly in a resource-scarce environment also signals a lack of consideration and respect and can cause resentment and even hostility among local people. Outside researchers may not even be aware that they are causing offence through their inadvertent misuse of things which are of little value in the developed world. I was approached by one of our hosts during a research trip in the dry season, with temperatures running up to 50 centigrade. He had become furious because several members of the research team, who had suffered from dysentery, were using bottled water to brush their teeth. It took some time and effort to persuade him that the delays and problems encountered as a result of a bout of diarrhoea suffered by members of the team the previous week could be best avoided by this practice.

Effectiveness

I learned a number of lessons about self-management and follow-up that helped to improve our effectiveness from one field trip to the next.

- **Self-management**

Tiredness - from long-distance travel, time in airports, planes and cars, hauling luggage around, navigating strange places, overcoming fear and dealing with insecurity, travelling and working for long-hours, adjusting to extreme heat – has a significant effect on the ability to function effectively, reducing concentration and productivity. It can also have a negative on a person's nerves, causing irritability, impatience and mood-swings. Strange food can produce a range of problems from discomfort to diarrhoea. For example, we were

treated to fried goat-liver and chillies for breakfast at 6am every day during one of the field trips - not everyone's idea of a great start to the day. Similarly a lack of variety in the diet or strange food can be hard on the stomach and the liver. The combined effect of malaria prophylaxis, Imodium and insecticide can also be debilitating and in some cases we found insect repellent to be as effective as prophylaxis and insecticide, and wiser eating to be immeasurably better than Imodium.

Poor hygiene can be hard to avoid in isolated areas where accommodation is scarce and running water unavailable. The combination of heat, dust and smoke in a house where the shower floor also accommodated the squat-toilet in the bathroom we shared between eight of us, was difficult at times.

Sleep tended to be a function of a combination of issues including the time we finished working in the night, the food we ate, the prophylaxis, the amount of mosquito spray in the room, the noise of the generator, the insects, the bedding, the quality of the mosquito net, the sense of security, and the exercise we did or didn't manage to get during the day.

▪ **Follow-up**

The field trip is usually the data collection phase and provides the basis for a major and often underestimated phase of the research: i.e. – the analysis of findings. This phase has none of the excitement of the field trip and consequently isn't always completed fully or satisfactorily. A week of research can generate six-weeks of follow-up work with data entry and recording, writing up, cross-verification and so forth. Unless there is a clear plan and time and resources allocated this can be postponed indefinitely or even left aside. Exhausted from the experience, there is a tendency to take a break, which may well amount to a lost opportunity to write up findings or clarify questions while memories are still fresh.

Pressure from other work can also be a problem particularly if you are researching part-time. My experience suggests that a two or three week field trip can result in a serious backlog waiting to be tackled in an environment where unimpressed colleagues categorise research activities under 'h' for holiday.

Conclusion

The approach used to inform the development of a research strategy was action research. This philosophy combines exploratory and problem-solving approaches, beginning with a general objective of changing or improving practice in a specific area and initiating a series of cycles involving investigation, analysis, planning, acting and evaluation. This would facilitate the engagement of Red Crescent health service program staff in the research and in the analysis of findings to improve program implementation.

A review of the traditional approaches to social science research examined their relevance in conflict-affected contexts and highlighted three main conditions for their application in these volatile, unpredictable and often dangerous environments: in the case study, the critical condition was access; in the survey, the key issue identified was participation; and in conducting a field experiment the primary determinant of success or failure was control. It was posited that the participation of an important local actor such as a Red Crescent society would be the key to negotiating these conditions.

The most appropriate strategy to address the research question was determined to be the case study strategy, using a composite approach, and beginning with an initial field mission or pre-study, would allow the most practical field research plan to be drawn up. The chapter elaborated a formal design for the pre-study and introduced the protocol used to guide the successful accomplishment of the first phase of the field research. The original questions used to guide the pre-study were also provided.

* * *

The following chapter presents the framework for and findings from the first phase of field research, the pre-study undertaken to produce a profile of the political, socio-economic and health conditions prevailing in Puntland in 2000.

6.

The Pre-study: Profiling Puntland

Introduction

In the previous chapter a review of research considerations and traditional research methodologies led to the selection of the case study as the most appropriate strategy to address the research question. Given the difficulty to predict what strategy and tactics it will be possible to use at any given time in a conflict-affected environment, and the prevalence of so many unknown variables, it was decided that a preliminary phase of research - or pre-study - would be undertaken, to provide a valid, up to date profile of the situation in Puntland and identify the key issues on which to focus the research effort.

This chapter presents the data collected through literature and documentary reviews, as well as key informant and focus group interviews, workshops and observation during the pre-study field visit which took place during three weeks in 2000. A number of key questions frame the research:

- What is the nature of the revival underway in Puntland today and to what extent is it conducive to the sustainable recovery of health services?
- What are the main health needs and priorities of the population and how are they currently being met?
- What policies are being adopted by the emerging health authorities and how are they informed and developed?
- What is the relationship of the Red Crescent to the Ministry of Health and more broadly to health service providers, where does the Red Crescent health program feature in overall health service provision, and what potential does it offer for the development of a sustainable health service provision strategy?

Analysis of the data collected about the current context of health service recovery in Puntland leads to the formulation of a working hypothesis and assumptions which form the basis for the research strategy and plan for the following stages of the field work.

The Data

Using the list of pre-study questions, a large amount of data was collected through literature and document reviews, key informant and focus group interviews, observation, and several workshops with Red Crescent and Federation staff in Puntland and Nairobi. Meetings were also held with a range of UN and NGO actors working in Somalia (see below the Data Collection Program).

The Somali State of Puntland

On August 1st, 1998 following a three-month consultation involving community elders and political leaders in the north-east of the country, the Puntland state of Somalia was declared. It was the first step on a long road to recovery after decades of repression, conflict and stagnation.

Background

On July 1st, 1960 the colony of Somalia gained its independence from Italy and united with neighboring Somaliland which had gained independence from Britain less than a week earlier. For almost a decade a democratic state with a recent history of colonial division and a complex and profoundly important clan structure and sub-structure strived to build the institutions of government amidst a post-colonial melee of 86 political parties, patronage and corruption²⁴.

Somalia under Siad Barre

As noted in chapter 1, most former Sub-Sahara African colonies were handicapped by a combination of inexperience, incompetence, corruption and ill-conceived macroeconomic and import-substitution models of development, producing little more than disappointment

²⁴ A rich base of literature on the anthropology of Somalia's clan structures has been created over the years including *inter alia* the writings of Ioan Lewis and Perouse de Montclos.

and disillusionment among ordinary people, and in many cases setting the scene for a military takeover. On October 15th, 1969 the democratically elected President Abdirashid Ali Sharmarke was assassinated and within a week Major-General Muhammad Siad Barre had installed a Supreme Revolutionary Council, of army and police officers, suspending the constitution and banning all political activities.

Somalia quickly became a soviet-style state, with powerful police and internal security networks. Barre declared Somalia a socialist country, applying "Scientific Socialism" under the patronage of the USSR, and introducing a written script for the Somali language in 1972, using a modified Roman alphabet. He then set out to unite the neighboring Ethiopian Ogaden region with Somalia²⁵. In July 1977, Somalia declared war on Ethiopia escalating an ongoing campaign of agitation by Somali-backed insurgents into all-out war. Four months later, Somalia expelled some 6,000 of Russian and Cuban fighters, and allied itself with the US. In response, the Soviet Union switched sides and allied itself with the Ethiopia. By March 1978 Somali troops had suffered a series of defeats and withdrew from the Ogaden. A month later, a group of disenchanted army officers attempted a coup to depose Barre. The coup was crushed and the organizers imprisoned or executed.²⁶. Barre undertook a purge, appointing relatives, and members of his sub-clan, the Darod-Marehan to key positions, along with members of the related Dulbahante and Ogadeni sub-clans.

A decade of brutality and repression followed, with arrests, torture and disappearance. The late 1980s were characterized by food crises, ballooning foreign debt and economic collapse. Somalia's strategic location in the Horn of Africa ensured it continued to receive significant quantities of aid, especially food aid. With the end of the Cold War, the level of aid declined significantly, setting the scene for a classic process of conflict and state collapse as described in chapter 2.

²⁵ The Ogaden was one of five areas claimed by Barre to be an integral part of a Greater Somalia; Djibouti, northern Kenya, Somaliland and the former Italian colony of Somalia being the other four.

²⁶ One of them, Colonel Abdullah Yusuf, escaped to Ethiopia where he formed the Somali Salvation Democratic Front, one of the first armed groups to wage a military campaign against Barre's regime. When civil war broke out he took control of north east Somalia and was elected President of Puntland in 1998. In 2004 he was elected President of the Transitional Federal Government (TFG) of Somalia. At the time of finalising this thesis, his government is awaiting the deployment of IGAD troops to Mogadishu to disarm local militias and render the city safe for the setting up of the TFG.

The withdrawal of foreign sponsorship produced an acute crisis for Barre, as opposition to his rule grew and armed resistance spread. In May 1988, following an agreement between Barre and the Ethiopian government to stop clandestine support to rebel groups on both sides, a rebellion was launched by the Somali National Movement (SNM) which had been based in the Ogaden, sponsored by the Ethiopians. General Morgan Hirsi, Barre's son-in-law was dispatched to crush the uprising, which he did by bombing the area indiscriminately, killing thousands of civilians and displacing hundreds of thousands more. Within two years however, armed resistance had spread and a manifesto signed by 144 public figures, (including politicians, religious leaders, professionals and business people) representing all Somali clans, was published in Mogadishu in May 1990, calling for an all inclusive national reconciliation convention to avert protracted civil war.

Fragmentation and Collapse

In December 1990 an armed uprising erupted in Mogadishu. The Hawiye-based United Somali Congress (USC) captured the city on 27 January 1991, expelling Siad Barre and loyal army units. The political wing of the USC appointed a civilian, Ali Mahdi Muhammad, as president. The military wing of USC, led by General Muhammad Farah Aydid, rejected the appointment and fighting broke out between the two factions. On March 3rd, a ceasefire was brokered, paving the way for a conference in Djibouti in July, in which Ali Mahdi was appointed interim president

In the northwest, Somaliland declared its independence on 18 May 1991, seceding from Somalia within the borders of the former British Protectorate. A year later, Muhammad Haji Ibrahim Egal - a former prime minister of Somalia - was elected president of the new state, following a three month constitutional conference in Borama.

In April 1992, the United Nations Operation in Somalia, UNOSOM I, began working in Somalia. UNITAF forces under American leadership took over in December. Efforts to reach a peaceful resolution of the ongoing conflict continued in the spring of 1993, with an Ethiopian initiative developing into a joint UN-Ethiopian sponsored reconciliation conference in Addis Ababa. Meanwhile, UNOSOM II succeeded UNITAF in May amidst escalating tension between Aydid's forces and international peacekeepers. On June 5th, 24

Pakistani peacekeepers were killed by Aydid's militia. A subsequent US effort to capture Aydid went badly wrong when marines killed over 50 unarmed Somalis holding a meeting in a private house in Mogadishu, increasing local hostility to the international intervention forces. On October 3rd, a US marine mission to capture Aydid's senior aides turned into a rout resulting in the death of 18 marines and hundreds of Somalis. TV news showing the body of a dead marine being dragged through the streets of Mogadishu led to major pressure for a US withdrawal, which took place in March, 1994. Aydid was killed in a battle against his former lieutenant, Osman Ali Atto three years later. He was succeeded by his son Hussein Muhammad Aydid, a former American marine who arrived with the UNITAF forces in December 1992. The withdrawal of US forces snuffed out any remaining hope of success for the UN mission in Somalia. UN forces quickly pulled back to Baidoa, Kismayo and North Mogadishu, and less than a year later, the final UNOSOM contingents left the country, leaving a collapsed state whose fragmented territory was controlled by a variety of factions, warlords and militias.

The Conflict Situation Today

Over the years, the conflict has mutated into a complex dynamic of chronic emergency of a varying degree depending on which of the three areas – South Central zone, Somaliland, or Puntland - is in question. In southern Somalia the continuing unwillingness of the multiplicity of faction leaders who control Mogadishu and the south prevents any negotiated solution to the conflict. The most recent attempt to reconcile clan factions ruling Mogadishu, a five-clan alliance maintains a precarious peace over the city despite opposition from two other faction leaders with artillery in range of both the port and the airport. Also in the southern regions, fighting between the Digil-Mirifle and Habar-Gedir sub-clans escalated in mid-1999, as warring Ethiopia and Eritrea injected new resources into the conflict.

In the north-west, Somaliland has sustained a long period of peace and stability since 1993-94 when internal fighting split the newly declared, though as yet unrecognized, republic. Nevertheless, a border dispute with Puntland over the northern territories of Sool and Sanaag remains to be resolved and could yet be the cause of another major conflict.

In the north east, Puntland emerged relatively unscathed from the war, experiencing little actual fighting other than a brief, albeit widespread, series of clashes in 1991 between the Al-Ittihad Islamic fundamentalists and militia loyal to the Somali Salvation Democratic Front (SSDF), led by Colonel Abdullah Yusuf Ahmed. Within a week, Yusuf had defeated the fundamentalists, restored relative stability and consolidated his control over a large part of Somalia, from Bosasso in the northeast to Galkayo in the centre, which was to become Puntland in 1998. Puntland has remained more or less peaceful since, with the exception of the area south of Galkayo where sporadic fighting continues to this day. The fact that Puntland is a relatively ethnically homogenous region, in which the majority of the population is Harti of the Darod sub-clan, may be a factor in explaining its success in avoiding the conflicts affecting the south. This relative security has allowed the development of a 'negative peace', and the gradual emergence of a post-conflict rehabilitation environment. People have started to prioritize their longer-term objectives for reconstruction and development. There is, however, a prevailing sense of emergency due to the ongoing conflict in the south of the country. For example, in an interview with MSF staff at the hospital in Galkayo, expatriates noted that stability has increased significantly since 1997-98, but they were still using armed guards at the hospital.

The latest peace initiative (the fourteenth to date) was under way while the pre-study was taking place. Somali clans were meeting in Arta some 30 km from Djibouti, debating who should take part in talks aimed at restoring a parliament and other organs of a central state in the country. However, the asymmetry that exists between north-west Somaliland and north-east Puntland, which have created their own constitutional frameworks based respectively on independent secessionist and federal autonomous goals, and representatives of the southern regions, which are still dominated by military faction leaders, presents significant obstacles to agreement in the near future.

The Puntland Government and Its Political Strategy

The civil war destroyed Somalia's post-colonial political framework and fragmented the state into clan-based territorial entities. Normal government functions, administration and service provision ceased. The pre-war administration in Somalia was largely focused on Mogadishu, with little development of systems and services in regional urban centres. The

north-east was relatively underdeveloped with small urban centres in Garowe, Galkayo and Bosasso. The creation of a Puntland state, and with it the formal institutions and machinery of government was intended to address this absence of formal governance, that had delayed Puntland's recovery and development during the post-war period. The new state claims to encompass a total of 23 districts covering the five regions of Mudug, Nugal, Bari, Sool and the eastern part of Sanaag. Its creation followed a long constitutional process similar to the Boroma Conference which formalized the creation of Somaliland. Unlike Somaliland, Puntland considers itself part of Somalia. The new government declared the region as a state within what they hoped would eventually become the Somalia nation made up of a federation of states.

Government

As in Boroma, the Puntland Constitutional Conference produced a three-year provisional charter and elected a political leadership, i.e., a president and an executive council. President Yusuf was elected from a list of four candidates. Efforts to construct government ministries are making progress. There are nine ministries: interior; social affairs (including health and education); finance; livestock and agriculture; trade and industry; religion and justice; information and culture; water and transport; and fishery and ports. However, public sector services are practically nonexistent, as the fledgling administration struggles with the mammoth task of building a government and nine ministries from scratch without external assistance.

Political Strategy

The government is operating under a preliminary 'charter', which - according to President Yusuf - is based on a complete rejection of the scientific socialism and tight state control of the Barre-era, and embraces a free-market, 'small state' philosophy.

The charter defines the primary role of government in the following terms:

- Assure security and establish appropriate policies;
- Institute democratic forms of government, including election of leaders;
- Encourage private initiative and free enterprise;

- Facilitate private sector ownership and control of major sectors such as banking, electricity and telecommunications;
- Shun state enterprises, although limited support is given to infrastructure development;
- Limit taxation, with the state budget primarily allocated to law and order and minimal public functions;
- Maintain a peaceful environment creating laws and conditions to promote foreign investment, and in general, minimal government; and
- Encourage the Somali diaspora to return and invest.

The strategy is clearly based on the model promoted by the World Bank in its 1991 report:

‘New ideas stress prices as signals; trade and competition as links to technical progress; and effective government as a scarce resource, to be employed sparingly and only where most needed.’

World Bank, 1991 quoted in Leys, 1996:24

Government Income

The Puntland government income depends on revenue from a restricted number of activities, with customs accounting for 80 to 85 per cent of total revenue. Some 70 per cent of this comes from Bosasso port, revealing a worrying vulnerability to the effective functioning of the port, and the level of export and imports. The remaining 30 per cent accrues from inland revenue. Roughly 15 to 20 per cent of total government revenue is raised through airport tax, licensing of motor vehicles and commercial business outlets such as restaurants, and minimal income through service charges. For example, the telecommunications firm, ‘Dialtone’, pays a 5% tax on declared profits. Overall revenue for the first quarter was estimated at 20.9 billion Somali Shillings (SS), the equivalent of US\$ 2.09 million, giving a total average income of SS 83.6 billion or US\$ 8.36 million in 2000 (source: Puntland Ministry of Finance).

Socio-economic Conditions

There seemed to be a high level of confidence in a peaceful future for Puntland which was reflected in large-scale investment with construction underway on almost every street in urban centres, and in most villages visited during the pre-study field trip.

Enterprise Economy: Construction, Utilities, Livestock

A thriving private service enterprise culture was evident throughout the visit to Puntland. In all the towns, Galkayo, Garowe and Bosasso, scores of construction projects were observed. In Bosasso, Garowe and Galkayo, various small enterprises compete to supply services such as telecommunications, electricity generation, water supply and banking. The Galkayo telecommunications group 'Dialtone' is licensed by both the Puntland and Somaliland governments and outlets in both entities. The group has built a telephone exchange that maintains more than 1,000 telephone lines in Galkayo, including international access, and have requests for a further 1,000 lines which they cannot meet because they do not have access to credit to finance the expansion. A massive generator was in evidence in the centre of Garowe, producing electricity which is sold to the surrounding neighbourhoods. Every street was littered with stalls, punctuated by the odd general store, pharmacies, and clothes shops. Reportedly, much of the investment is financed by earnings from abroad; both by Somalis who had returned home from a period overseas, and by expatriate Somalis remitting large sums of money to family members or local partners for the purchase of land, construction and investment in new businesses.

The rural economy is dominated by livestock rearing which engages the majority of the population. This activity was seriously affected by an 18-month ban on the import of Somali livestock by Saudi Arabia, following an outbreak of Rift Valley Fever in 1998. The ban affected not only the nomadic herdsman and those involved in spin-off services, but also the public sector revenue of Somaliland and Puntland, the majority of which is generated by customs levied on exports of livestock and imports of consumer goods purchased in the Gulf States with the proceeds of the sale of livestock. An increase in the flow of remittances helped to offset the impact of the livestock ban – apparently the volume of imports did not alter significantly as the increased volume of remittances was used to maintain spending on consumer goods and sustain trade.

Remittances as Foreign Direct Investment

Diaspora remittances are an important source of income for many people, amounting to as much as US\$ 5-6 million per month in Puntland, and US\$ 1.5 million per month being remitted through banks and money transfer offices in Garowe alone, according to one

unofficial report²⁷. The money is used to purchase basic consumer goods and with the improving stability, increasingly for investment and highlights the economic differences between the wealthier and less-well off sections of Somali society. It is mainly the urban, educated classes which have managed to finance the expensive business of sending family members abroad to be educated or develop skills, which in turn allows them to remit - often by Somali standards significant amount of - money on a regular basis. Sub-clans and groups currently in privileged positions, or those who constituted or were attached to the ruling elite under the Barre regime, and had or have better jobs and access to education, consequently tend to have a greater number of their family members in the diaspora. Poorer urban families and rural communities tend to have fewer relatives abroad and consequently less income from remittances. Internally displaced groups from poorer or urban backgrounds tend to reflect this disparity. One study of the impact of remittances on recovery in Somaliland found that only 5 percent of rural families received remittances, whereas a majority of households surveyed in Hargeisa were receiving money from relatives abroad (Ahmed, 2000). This structure of inequality tends to increase the historical economic differences between those groups who have relatives in the diaspora and those who do not (UNDP, 2001). Although tax has not yet been introduced by the government on such income, plans to levy a progressive charge were under preparation according to the Puntland Ministry of Finance. Amal and Barakat banks account for most of the transfers and the Minister spoke of applying a tax at the point of receipt of the remittances.

Qat: Conflict and Social Breakdown

Remittances are also used to purchase the mild narcotic Qat which is very popular in Somalia. While dozens of plane-loads reach Somaliland, Puntland and south central Somalia from Kenya everyday, there is also a thriving cross-border trade from northern Kenya and Ethiopia. Somaliland estimates that the country is spending \$100,000 per day on Qat brought in from Ethiopia²⁸. The addiction is draining resources in Puntland to the tune of US\$ 10,000 per day in Bosasso alone according to the Puntland Ministry of Finance, whose estimate is based on tax revenue generated by official sales of qat. Their customs statistics indicate that qat accounts for at least US\$ 45,000 of expenditure per day in

²⁷ This corresponds with estimates of \$500 million per year being remitted to families in Somaliland according to one recent study (Ahmed, 2000).

²⁸ Interview with Somaliland Director General of Health, Dr. Abdul Rahman, Hargeisa, April 29, 2000

Puntland. As this does not account for informal sector trade in qat, the figure is a conservative estimate to say the least. For example, Mohammed Haji the Garowe-based representative of the Swedish NGO Diakonia, who has been following the situation in Puntland since 1994, quoted studies claiming that \$70,000 per day, is spent on Qat in Puntland, bringing the annual consumption to more than \$2.5 million, or roughly fifteen times the Puntland public health budget.

Fuelling Conflict

There is no doubt that the import and trade of *Qat* is a major factor in the dynamics of conflict throughout Somalia. In Somaliland and Puntland the trade is firmly controlled by a small but wealthy and powerful cartel. In the south however, control of the trade is one of the major factors sparking conflict between a number of different groups. In Kismayo the trade is regulated with collusion among opposing clans to regulate imports and maintain the price – even to the point of attacking competitor sub-clans regardless of their affiliation in the conflict. At Wilson Airport in Nairobi – the provenance of a good deal of the Qat traded in Somalia – a burnt-out Cessna plane, which had been used to fly Qat into Somalia and was blown up by a rival trader, bears witness to the violence associated with the trade in qat. During the same period, the Kenyan government closed the northern border with Somalia following an attack by southern Somali militiamen on an army barracks to steal weapons. The volume of trade and profit being lost by Somalia warlords along the southern border was so great that they mounted a series of attacks to force the Kenyan government to re-open the border.

Social Consequences

The socio-economic implications are stark, affecting people's ability to work, and even function on a normal basis, presenting a significant obstacle to any prospect of a return to some form of normal social life in Somalia. Men traumatized by war, unemployed, and with little prospects for the future seek solace in qat chewing, which begins as early as 2 p.m., and can typically go on late into the night. As one informant - Mohammed Haji from the Garowe-based Swedish NGO 'Diakonia' put it: 'in one day people in this town chew the equivalent of your entire annual budget for one clinic'. Some donors, bent on down-scaling and withdrawal, conclude that if people have money for Qat, they can afford to pay

for health services. This however, does not stand up to more careful scrutiny. Qat chewing is an almost exclusively male phenomenon, and when men spend the money on Qat, they leave their families without money for food, clothing, education and health. Women have no control over household finances, but are forced to contend with the consequences. Meanwhile, the children - boys and girls - are forced to shepherd animals instead of attending school. Despite its social impact, the government has no plans to stop the trade – as one Minister commented ‘Siad Barre tried to stop the trade in Qat and that was what led to his downfall. We have no intention of making the same mistake.’

Displacement: Fuelling Growth - and Demand for Infrastructure and Services

A key trend driving the economic growth in Puntland has been the huge population increases in many of the towns and villages during the past 5 years. The population of Garowe, according to Mohammed Haji of Diakonia, was less than 3,000 in 1990, and is now estimated at 15,000. Similarly, the Governor of Bari Region informed us that the northern port of Bosasso has grown from 5,000 residents in 1990, to 20,000 in 1993 after the war, and between 200,000 and 250,000 today. In the village of Ba’adweyn, the head of the village committee pointed out that the population of the village was less than 3,000 in 1995 when the Red Crescent clinic was established and had almost doubled in five years to between 5,000 and 6,000 - 1,500 of whom were displaced families fleeing fighting in the south of the country.

Most of this increase was caused by an influx of internally-displaced persons, of Harte or Darod origin, driven out of Mogadishu or other parts of the country by opposing clans. Many had originally come from Puntland moved to Mogadishu or other parts to work, or still had relatives in Puntland with whom they could stay and have subsequently settled there. However, several hundred thousand are living in make-shift IDP camps, with no means of livelihood and without relatives or clan who can support them. President Yusuf quoted a figure of 320,000 IDPs requiring assistance on a day-to-day basis in Puntland²⁹. The good news is that more people are returning from abroad, bringing back their families after years in exile, and often bringing the skills and savings that can continue the growth and recovery

²⁹ In November 2004, a study by Norwegian Refugee Council’s Global IDP Project, estimated that there were an estimated 400,000 IDPs in Somalia as a whole, with approximately 70,000 of these in Puntland. The majority – some 250,00 – displaced in the south of the country.

in Puntland. President Yusuf noted that there are 411 Puntland doctors in the diaspora, and his aim is to bring as many back home as possible.

The increased population both fuels the dynamics of growth and recovery, and increases the demands on the state, its infrastructure and services. Essential services such as water, health and education were inadequate at the outset of the war a decade ago. Since then they have been destroyed by war, Electricity and telephone services were enjoyed by few. Today demand is fuelling the rapid growth of private services in all sectors. Regulation and quality is a major concern given the absence of standards, regulation and professional bodies. The gap is also widening between those who can afford to pay the costs, fees and charges demanded and those who cannot, rendering all the more urgent the construction of effective, adequate and appropriate public health and social services.

The Health Sector

Thus, the newly formed state government of Puntland is faced with the considerable challenge of establishing centrally administered health, education and judicial systems after almost 20 years of underinvestment, war and neglect. Health – the basis for a strong and prosperous population – should be a key priority

Pre-war Health System: Economic Collapse and SAPs

The Barre government's policy of scientific socialism was to provide free health services for all, but the distribution of the services was far from egalitarian. There was no effort to involve the community or the local authorities, and primary health care (PHC) services were almost non-existent. The system concentrated on Mogadishu, with 80 percent of health staff employed there. Its top-down, centralized and institution-based structure made it particularly vulnerable to destruction when conflict broke out, and rendered reconstruction in the absence of a centralized, national government all the more difficult.

But the seven-year absence of state functions that followed the destruction wrought by war was only the epilogue to the disintegration of the public health system that began in the 1980s with underinvestment, reduced public health budgets, and the shrinking of the state's role in public service provision as a result of a harsh structural adjustment program. Long

before the military and militia forces laid waste to health facilities in Somalia, the system had been decimated by the direct consequences of the structural adjustment prescriptions imposed by the IMF in return for preferential lending to facilitate Barre regime repayments to international creditors:

‘The economic reforms were marked by the disintegration of health and educational programs. By 1989, expenditure on health had declined by 78 per cent in relation to its 1975 level. According to World Bank figures the level of recurrent expenditure on education in 1989 was about \$4 per annum per primary school student – down from about \$82 in 1982. From 1981 to 1989, school enrolment declined by 41 per cent (despite a sizeable increase in the population of school age), textbooks and school materials disappeared from the classrooms, school buildings deteriorated and nearly a quarter of schools closed down. Teachers’ salaries declined to abysmally low levels.’

Chossudovsky, 1997:104

Privatization of social services began as a result of economic adjustment in the 1980s, with decentralization by the government of responsibility to the regional and district level. Public sector providers were encouraged to divide their time between public and private practice, with the payments for private services compensating for the lack of public finance to fund the public health system or pay adequate salaries (UNDP, 2001: 106).

Health Condition of the Population

The health status is very poor. This is reflected in some of the worst health statistics in evidence today outside the most isolated, rural areas of Afghanistan.

Infant, Child and Maternal Mortality

The infant mortality rate (IMR) is 175 per 1,000 live births, with child mortality (CMR) estimated at 211 per 1,000. The major health problems are infectious diseases like ARI (acute respiratory infections), diarrhea, measles and tuberculosis (TB). Four new cases of polio were registered during the period of the Pre-study. Immunization coverage was very low and none of the six EPI (expanded program of immunization) target diseases – TB, polio, measles, diphtheria, pertussis and tetanus – reach 50 per cent. A multiple indicator cluster survey carried out by UNICEF in 1997 revealed that 73 per cent of sick children were treated ‘privately’ (mainly at ‘pharmacies’, traditional healers, private clinics or

doctors). Only 20 per cent of babies were exclusively breastfed to the age of four months, depriving them of natural protection against a range of infectious diseases. The maternal mortality rate (MMR) is also very high 1,600 per 100,000 live births. Life expectancy is estimated at 47 years for men and women.

HIV/AIDS

HIV/AIDS prevalence is reported to be very low, mainly due to the strong influence of religious and social mores, but neighbouring Kenya, Ethiopia and Djibouti have some of the highest prevalence rates on the continent, and cross-border migration is a way of life in Somalia where up to 60 percent of the population is nomadic and work is very hard to come by. The analysis from the literature review presented in chapter 2 shows a strong correlation between unemployment and dislocation, and infection with STIs and HIV as a result of increased contact with commercial sex-workers. The incidence of sexually transmitted diseases is very high in Somalia and traditional practices such as Female Genital Mutilation³⁰ and scarification increase the risks further. As noted in chapter 2, vulnerability to AIDS is exacerbated by the role of untreated Sexually Transmitted Infections (STIs) and in facilitating the transmission of the HIV virus. In Galkayo hospital, MSF informed us that 20 percent of the blood screened for Hepatitis B tested positive.

Extreme Vulnerability of Nomadic Population

Health and socio-economic indicators show that the nomadic portion of the population, stated to be up to 60 per cent in some areas, is worse off than others. Neither Puntland's nor Somaliland's authorities have established clear strategies on how to handle this problem. In an interview for the Pre-study, the Governor of Bari region explained how he is supporting the development of a strategy for reaching this group, including how to train special health workers to serve them.

³⁰ In Somalia, more than 97 percent of girls are subjected to third degree or pharaonic circumcision, where the clitoris and labia are removed and the vagina sutured closed. This barbarity is usually conducted by a medically-unqualified Traditional Birth Attendant often using razor blades or rudimentary tools as scalpels are generally not available. As a consequence, safe childbirth requires a dual episiotomy - a surgical procedure applying both lateral and vertical incisions to open the birth canal during childbirth to allow the child to be born. But many women, living in remote areas or from nomadic clans do not have access to even a TBA. The implications are apparent in the highest maternal mortality rates to be found anywhere in the world, other than – perhaps – remote regions of Afghanistan (Deely, 2001)

Health Services Today

This disease-burdened population, estimated to number somewhere between 850,000³¹ and 2.5 million³², is served by a loose network of NGO health service providers, a vast plethora of up to 1,000 drug peddlers passing themselves off as pharmacies and an increasing number of private clinics and general practitioners. According to a recent inventory, there are 63 qualified doctors registered in Puntland, 12 hospitals (five in operation), three health centres, 25 MCH/OPDs, and 62 health posts (many of them not functioning). The main donors are the European Union and USAID with UN agencies and up to 130 aid organizations currently operating in Somalia. In Puntland, the Red Crescent is the main public sector health service provider with 12 primary health care clinics and a referral hospital in Garowe.

Co-ordination

Communication and co-ordination between agencies is weak. In a fragmented country with no central government, no organs of state, no ongoing dialogue between the different controlling parties and no agreement about the future structure of any emerging political entity, aid coordination and management is a difficult business. Few international organizations maintain a permanent expatriate presence in Somalia, and headquarters are almost exclusively located in Nairobi. Apart from security considerations, communications with the different regions cannot be assured from any one internal location. Decisions about where offices should be established are further complicated by issues of legitimization. Reconciling security and logistical demands with the principles of community participation and consultation, involvement and ownership of projects espoused by aid organizations will be difficult. Nairobi-based coordination is perceived as management by 'remote control' from Nairobi and was strenuously denounced by the government. According to the DG for health, Abdul Rahman Said:

'If the SACB is the Kenya Aid Co-ordination Body, let them meet in Nairobi as they do. If they are coordinating for Somalia, why do they not meet in Bosasso, Hargeisa, Garowe or Mogadishu? I cannot get a visa for Kenya so easily, how can I attend regular meetings in Nairobi.'

³¹ United Nations Development Program

³² The Puntland government

The Puntland Directorate of Health

Hence, according to Dr. Said, the Puntland Directorate of Health has three official partners: UNICEF (which has been working directly with the DG to develop a framework for services, and has its Somalia HQ in Hargeisa), WHO (currently setting up offices in Garowe which according to informants will include facilities for the DG) and the Red Crescent, as the most consistent, local and co-operative actor. Dr. Said's capacity is limited however, since he has neither staff nor a proper office. In this respect, the Directorate of Health was described as 'virtual' by one key informant. MoSA's major health care management strategies encompass decentralization, privatization, cost-recovery systems and community participation. The DG has co-operated with UNICEF to develop a national health policy framework for the future public health service in Puntland. This provided the basis for the regulations contained in Law Number 14, governing the provision of health services in Puntland, which was voted through the Puntland Assembly on December 21st, 1999. The neoliberal World Bank prescriptions stressing '*effective government as a scarce resource, to be employed sparingly and only where most needed*' (World Bank, 1991 quoted in Leys, 1996:24) have already been adopted by a government keen to retain the support of UNICEF and to attract desperately needed support from the Bank, as evidenced by provisions such as:

'...every able Puntlander with an income will contribute towards his/her health'.

Puntland Ministry of Social Affairs, 1999

However, the absence of a functioning health authority to impose this regulatory framework and monitor adherence raises important questions about the responsibility for rehabilitating and rebuilding the health system, not to mention the appropriateness and standard of medical services being provided by the informal sector.

Health Service Financing

Under the previous public health system, services were – in principle - provided free of charge, although this principle was perhaps not widely practiced. Nevertheless many people have had some experience of NGO health service during the emergency years, consolidating the traditional belief that health services should be free. Today, the

government of Puntland is attempting to create a totally new system with a new health care management strategy, based on cost recovery and privatization.

Government Financing of Health

The Ministry of Social Affairs' health division enjoys minimal financial support (around 2 percent) in the budget. Based on the 2000 budget forecast shared with us by the Minister of Finance, government spending on health this year will amount to USD 167,200, which is equivalent to USD 0.19 or USD 0.06 per person (depending on which of the two population estimates – 850,000 or 2.5 million – you subscribe to). Either way, Puntland is probably at least a generation away from the WHO recommended annual per capita spending for an essential health package: \$10-15; which is roughly what the official recommendation of \$30-45 comes to after purchasing power parity adjustment for least-developed countries, (WHO, 2001). It seems highly unlikely that the current government would adopt these recommendations even if it could afford to: President Yusuf made it very clear during an interview for the Pre-study that the government does not intend to finance health services – period. All services will be paid for by the users, whether out-of-pocket, or - at a later stage – through some form of health insurance. When I questioned him about services for the poor and those who are vulnerable by way of age, chronic illness, disaster or conflict, he replied that NGOs like the Red Crescent would be mandated to take care of them. He could not elaborate further.

However, in a number of facilities visited we were told that the government does contribute to running costs; for example paying some of the staff salaries at Galkayo referral hospital, a 60 bed facility with an average of 700 OPD cases and 500 emergency cases per month. The salaries of four nurses at Qardho hospital are also paid by the DoH.

Community Financing

The government's policy of privatization is supported by some Nairobi-based aid agency informants who claimed that communities can afford to pay for services, citing the high numbers of pharmacies and private practitioners. According to one UNICEF survey, as many as three out of every four families rely on private consultations to meet their health needs. Little is known about the quality of drugs and services on offer, whether patients get

value for money, are prescribed the correct treatment, and so on³³. From the Pre-study observations, it appeared that the reality of payment for private services is more likely to be a reflection on the scarcity of public facilities and supplies, leaving people with little choice but to pay for services – if they can find the money. Donor-funded drug support to hospitals and clinics is diminishing and their pharmacies are often empty. This forces doctors to “refer” their patients to private pharmacies or drug-peddlers whose severe shortcomings in terms of quality, reliability and safety harbour very real dangers for public health. Those that cannot are forced to borrow, which favors the drug peddlers who offer drugs on credit. In Galkayo alone, MSF calculated that there are more than 150 ‘pharmacies’.

Standards, Quality and Regulation

Before the war, pharmacies run outside the actual health care system, were subject to licensing, strict regulations and regular government quality control. Today, there is no meaningful regulation of private pharmacies, so it is likely that many of the “pharmacists” have few or no qualifications. The appropriateness and quality of drugs offered for sale are also open to question. The pharmacies we visited were stalls or shacks without electricity or paraffin fridges to maintain a cold chain of drugs or vaccines. Some medicines were expired and the ‘pharmacists’ we spoke with had no formal training and exhibited no medical or pharmaceutical knowledge other than an ability to read the leaflets enclosed with the particular product. In an interview for the Pre-study, WHO noted that drugs - including antibiotics - have been prescribed incorrectly and sold in the wrong regimens for years in Somalia, increasing vulnerability to illness and contributing to the development of drug-resistant strains of TB and other diseases. Pharmacies and private services are also concentrated mainly in urban areas, with 50 percent of the urban population having access to services compared with only 15 percent of rural households. In rural areas, the most vulnerable – those who can’t borrow, have no access to credit or don’t have access to services or drug peddlers – are forced to live with chronic illness. Many use traditional healers but this is unlikely to result in recovery. The vast majority of traditional healers

³³ Anecdotal evidence from Red Crescent clinic staff suggests a disturbing level of incompetence and a lack of concern for patients’ welfare. One nurse told how she presented a blood sample taken from a goat to a new private clinic offering laboratory tests for various conditions, pretending it was from a patient suspected of having some sexually transmitted disease, and asking for confirmation. The sample was tested and diagnosis was that the patient did have the suspected disease.

have no medical training, and treatment often consists of administering cuts using razor blades and less sophisticated instruments, or when there is fever burning the sick-persons skin at point of pain. The outcome can be particularly tragic when children are involved. During a visit to Qardho hospital, one handicapped child was observed with burn marks on almost every part of his legs and abdomen, inflicted – over a period of months - by a traditional healer attempting to cure him. His family's lack of money to pay user fees to access professional medical treatment caused him to be handicapped for life.

Nevertheless, the Directorate of Health and many NGOs have introduced user fee cost recovery schemes in all hospitals and some primary health care facilities.

User Fee - Cost Recovery

In the thriving port city of Bosasso, the administrators of the regional hospital were very enthusiastic about privatization. They had recently introduced a user fee - cost recovery policy which was supported by staff because it would guarantee their regular salary payments and also provide for periodic bonus payments. OPD patients are charged SSh 5.000 (or around \$0.50) for registration, X-rays cost Ssh 40,000 (\$4) and ultra-sounds are charged at Ssh 100,000 (\$10). Surgery is a major source of income for the hospital, with charges for procedures varying from \$5 and \$100. Operations are performed on a contract basis by surgeons who receive 50 percent of the fee – the other 50 percent goes to the hospital. The scheme was producing \$1,000 per month - enough money to cover 80-90 per cent of the costs of running the hospital³⁴. The DG informed us that the cost recovery scheme in Las Anod regional hospital in Sool covers 70 percent of the running costs.

³⁴ Hargeisa hospital has a similar cost recovery system, but the income only covers 10 per cent of the cost of running the hospital, reflecting the more relationship of responsibility and accountability that exists between the Hargeisa electorate and the government authorities, a relationship that has yet to be built in Puntland. It may also be a sign of the more stagnant economic situation prevailing in Somaliland, unlike the Puntland economy which is dynamic and thriving, fuelled by optimism, remittances, reconstruction and trade in goods imported through the port of Bosasso. In Boroma hospital in Somaliland we were told frankly about how cost recovery had failed at the hospital, causing a huge falloff in utilization and raising little money. Unfortunately the failure seemed to have been blamed entirely on the staff, their lack of management systems and procedures and lack of experience.

User fees are also charged in Qardho District hospital, at a rate of Ssh 5,000 per consultation (about \$0.50). The hospital claimed to attend to around thirty outpatients per day, of which twenty are fee-paying and ten exempted because they are judged to be too poor to pay. The government pays the salaries of four nurses at the hospital, around \$130 each. In Galkayo hospital, MSF confirmed that nominal user fees were being charged for services; around \$0.15 for admission, lab tests, and a \$0.30 charge for outpatient services.³⁵ User fees were introduced in Garowe hospital in 1997, initially with a registration fee, then adding fees for OPD, laboratory and x-ray services. The revenue is used to supplement salaries and cover some of the running costs.

Community Participation

The Centre for Education, Peace and Development in Galkayo, provides educational training for women and young girls and is funded partly by the local population and partly through donations from the diaspora. The building was donated by government, who also granted the Centre a legal status that includes tax exemption and the right to raise funds. It has 252 members in Galkayo who pay a regular monthly contribution,. The Centre has five full classes for primary education and six older women run an outreach program for 20 younger women dealing with FGM, child spacing, prenatal training, and child marriage.

UNESCO's educational program employs 12 staff in Puntland looking after 14 schools. The village schools program is operated in partnership with UNICEF which provides school books and materials, UNHCR and UNDP who allocate small grants to construct or rehabilitate classrooms, and WFP which supports a food-for-work project to engage teachers. UNESCO provides an initial subsidy in cash to help pay salaries and costs, decreasing on a sliding scale in six month periods. For example, UNESCO initially pays \$1.80 per child, and the parents pay \$1, after six months the subsidy is reduced to \$0.90 and fee increases to \$1.50, and so forth. An income generating project begins at same time as the subsidy and builds up a fund which is used initially to compensate for any fall-off between the subsidy decrease and parents' contributions, and eventually to allow the complete withdrawal of the subsidy. Teachers are paid per pupil, and only for those that attend. A community education committee collects fees, pays teachers. According to the

³⁵ US\$1 was worth roughly 10.000 Somali shillings on May 22nd, 2000 in Garowe market

Program Manager, the strategy includes plans to form a District Educational Committee and then a Regional Education Committee.

Potential and Limitations for the Research

All of the above will affect potential and limitation for the development of a sustainability approach to service provision at the Red Crescent community clinics.

The Somali Red Crescent Society

The International Red Cross and Red Crescent Movement has been one of the most consistent humanitarian actors throughout the past decade. From the massive food relief program implemented by ICRC and the Red Crescent in 1991-92, to the current integrated health care program (IHC) operating in the three zones with support from the ICRC and the Federation, and a number of Red Cross Societies. Operating through 32 Mother and Child Health clinics, a referral hospital in Garowe and 12 health posts, the health program serve the needs of 840,000 beneficiaries.

Mission

The Red Crescent was established in 1963, initially as a disaster response organization to respond to drought-induced hunger. The Integrated Health Care programme dates from 1993, in response to the deterioration and destruction of the pre-war health service and the overwhelming need for Mother-and Child health services. With support from the International Federation, the ICRC, the Norwegian Red Cross Society and other National Societies, the Red Crescent stepped into the breach and to a considerable extent assumed the role that the government would typically play in offering a public health service.

Competence

In both Galkayo and Garowe, the Red Crescent has been filling a critical vacuum in health service provision for those in the community who cannot afford to consult private physicians and commercial “pharmacies”. The twelve clinics in Puntland are staffed by a nurse, a midwife and an auxiliary nurse. The Red Crescent manages the system, pays staff, trains personnel and provides essential drugs and equipment. It has a radio communications system that links with all its facilities and a health information system that gathers basic

data on services provided. Services include simple outpatient, curative care, pre-natal consultations for pregnant women, deliveries, vaccinations and other well-baby growth monitoring and care. Some health education is provided. Since many deliveries are attended by traditional birth attendants, Red Crescent trains them. Clinic staff consult with Field Health Officers at the branches in Garowe and Galkayo and refer difficult patients to hospitals. However, with so few hospitals, often at great distance, and little public transportation, the referral system does not work well. Long-term sustainability is a major concern and there has been no previous attempt to develop a strategy to reduce dependence on outside donor support. Cost recovery and user fee systems had not been introduced in Red Crescent facilities at the time of the Pre-study. During the past decade some Red Crescent strengths have been reinforced as a result of the experience gained (assistance to victims of conflict and natural disaster; establishment of branches; development of branch capacity; etc.), while others have been lost or eroded mainly as a result of the conflict (blood donor mobilization; logistical capacity; etc.).

Acceptance

It has been noted many times that the National Society's key advantage is its ability to operate across clan divides and political boundaries. Nevertheless it was striking to note the level of support on the ground for the Red Crescent and its recognition by the variety of beneficiaries, community members, authorities and elders in the four areas visited (Galkayo Garowe, Bosasso and Hargeisa). Today, the Red Crescent is the main public sector health service provider in both Puntland and Somaliland. This was acknowledged by the Directorate of Health in Puntland and the Ministry of Health and Labour in Somaliland. Given the absence of any other recognized national institution the Red Crescent is in a unique position to inform and support a systematic approach to health service delivery and recovery throughout the country.

Box 6: Key Events in the development of the Somalia Red Crescent Society

1963 Establishment of the Somali Red Crescent Society
1968 Drought response programme: major mobilization of volunteers
1972 Cholera response programme; Hiran floods
1974-75 Drought relief programme
1976 Red Crescent assigned national role in natural disaster response coordination
1977 Ogaden war: 6,000 volunteers mobilized, Garowe, and Lugh branches established .
1980 General assembly; Red Crescent assigned role in blood provision service, supported by Finnish Red Cross Society
1982 Establishment of rehabilitation centre in Mogadishu, supported by Norwegian Red Cross Society
1985 Drought operation
1988 SNM uprising in Hargeisa. Establishment of Hargeisa branch; ICRC war-surgery Hospital in Berbera
1990 General Assembly
1991 Civil war; ICRC assisted relief operation assisting 900,000 beneficiaries; ICRC-Red Crescent war-surgery hospital and Kitchen programme established in Mogadishu
1992-3 Establishment of Garowe hospital; Establishment of first MCH in Sinujiif; Establishment of International Federation delegation
1994 Establishment of Swiss RC delegation in Galcaio
1995 Bosasso cholera outbreak
1996 Closing of International Federation delegation
1998 Red Crescent meeting in Djibouti
1999 Flood response operation; Drought operation in Puntland; distribution of water trucks; Allocation of branch premises in Garowe and Galcaio
2000 All-Inclusive Red Crescent Meeting in Djibouti

Source: SRCS Garowe, April 21, 2000

Legitimacy

While the society's performance in this function has been highly praised, the formation of the new health administration in Puntland presents a significant challenge to the Red Crescent and will require a substantial injection of resources and support to its existing structures in the state to ensure they respond effectively to the emerging opportunities. In particular, Puntland's Director of Health made it clear that the Red Crescent is the directorate's main operating partner and features prominently in its planning for the future health service there. In this respect, there appear to be limitations in the organizational

structure of the Society with regard to separation of strategic and tactical functions, which places the regional offices in the difficult position of responding to questions about ‘national’ – i.e. Puntland-level – priorities which are determined by the Red Crescent HQ in Nairobi.

Resources

The changing circumstances also warrant the development of a strategy to reinforce Red Crescent personnel in Puntland. While existing staff have provided commendable service over the past years, the formidable challenges presented by the emerging health administration will require strategic planning, management systems and training, and the introduction or development of specific skills to ensure the Red Crescent can play a major role in the new health sector, at least until such time as the administration is in a position to assume responsibility.

The twelve clinics are coordinated by Red Crescent branches in Garowe and Galkayo. Support includes delivery of medical supplies, processing of weekly and monthly reporting, supervision and monitoring, on the job training, assistance with complicated cases, personnel management, payment of salaries and co-ordination with partner agencies. Most of the clinics are in remote areas, where access is limited or difficult. Garowe is responsible for seven clinics, some of which are up to seven hours-drive away from the branch. The health team is limited to one field officer. It would seem that the provision of effective support for seven clinics would require an expansion of the current level to allow for an increased level of engagement with clinic staff, community committees and local authorities. On the other hand, the branch maintains two relief staff an administrator, and a radio-operator, in addition to the Chairman, though there has been no relief program there for years. This substantial additional cost which has to be borne by the health program although most of it is unrelated – would need to be reviewed in the event that a community financing approach was introduced to increase the health program sustainability.

Community Involvement

The extent of genuine community participation in the clinics was investigated through a one day visit to the Red Crescent clinic at Dangoroyo, comprising interviews with the staff,

clinic users and the local authorities. The clinic is situated on the main road between Garowe and Bosasso, linking the north and south of the state. It is also an important junction for those wishing to travel to the main coastal town of Eyl. The clinic serves the village of Dangoroyo and the surrounding area. During the dry season the population increases significantly as semi-nomadic families settle near an important water source at Dangoroyo, and nomadic herders stop regularly to water their herds.

The visit to the clinic and interviews with staff left a positive impression of a successful service, well managed with committed and competent staff. A meeting was held with the District Officer in charge of Dangoroyo district. There was clearly no working relationship or regular communication between the staff of the clinic, the Red Crescent and the local authority, revealing the absence of any strategy to involve either the authorities or the community in the running and resourcing of the clinic. Red Crescent and Federation staff admitted that the concept of 'participation' had been raised when funding for the clinics was being reduced and there was a need to cut costs; this was done by eliminating the staff positions of cleaner and security guard, and these tasks were assigned to the community. No terms of reference had been developed for the communities' participation and no training or guidelines provided to local people.

Conclusion

Over the years, new weaknesses have emerged in the Red Crescent and historical ones have been compounded by the impact of war (instrumentalisation; reduced access to local resources; destruction of the volunteer base). Other weaknesses such as the concentration of the society's resources in Mogadishu, or poor record keeping have been reversed to some degree as a result of fragmentation of the society and dependence on an external HQ and international donor support.

In addressing some of these operational issues, the experience of the Somaliland Red Crescent may be useful. There appears to be a well-developed, coherent, coordinated organizational structure at regional level. The projects visited in Hargeisa, Boroma and Boon indicated an encouraging level of community mobilization and involvement.

Analysis and Outcomes

Reviewing the data collected - examining the threats and opportunities in the context, the potential and limitations for health service recovery systems, and the advantages and disadvantages of the Red Crescent as a vehicle for health service delivery - produced a number of conclusions that facilitated the generation of hypotheses about the possible direction, form and content of a strategy for sustainable recovery of community health services.

Analysis

Despite the relatively peaceful conditions since 1995 and the favourable environment for development (including the creation of the Puntland state of Somalia and the effective combination of government and traditional authorities), longer-term potentials have not been systematically identified, let alone harnessed by donor countries and implementing agencies. This is particularly true in the case of health provision. The research exercise presents a unique opportunity to develop a programming approach for sustainable local health services based on the longer-term developmental potential and participate in the current transition and to a stable and peaceful Somalia, as well as a sustainable health sector.

The Context

The evidence pointed to some major threats to and opportunities for efforts to develop a new programming approach for community health services.

Threats

- a. **Security:** Although there is a growing stability in Puntland which will be difficult to reverse permanently, there are ongoing security threats which could affect the vibrant pattern of growth in Puntland and jeopardise a formal recovery program. The dispute with Somaliland over the regions of Sool and Sanaag is an important one. Somaliland's secession from Somalia increases the possibility that this will lead to violent conflict between the two sides at some stage in the future. There are also threats from the inter-clan fighting south of Galkayo which could affect Galkayo, one of the most important

towns in Puntland. The knock-on effects from the continuous fighting in the south of the country have a broader destabilising effect on both Puntland and Somaliland, resulting in frequent population displacement and causing the entire country to be classed as an emergency, or conflict-zone. This will continue to inhibit international engagement and investment in recovery.

- b. Continuous absence of a recognized central government: This means that there is no overall framework for recovery and presents a major obstacle, even greater than the security situation, in that there is no counterpart at national level with which the international community can engage. This in turn prevents the creation of national strategies for recovery. The policy followed by the UN in the past, which was to encourage the establishment of sub-national administrations, has not been adequately articulated and –as a consequence - provides insufficient support to emerging institutions, whose capacity is extremely limited, as illustrated by the ‘virtual’ nature of the Puntland Directorate of Health. There seems to be some reluctance to engage with ‘self-declared’ administrations behind the lack of co-ordinated support by the international organisations working in the area, who – instead of building the capacity of the newly emerging Directorate of Health to supervise, regulate and provide the necessary support to sustain the service - are sitting on the fence, waiting to see if the administration will last.
- c. The Livestock Ban: The ban imposed by the Gulf States over suspected Rift Valley fever has the potential to seriously retard growth and undermine recovery. The longer the ban continues, the greater the likelihood that Australia or Europe will have permanently cornered the market that Somali herdsman previously supplied, as happened in 1984 when Somali cattle exports to Saudi Arabia were discontinued and Saudi beef imports were redirected to Australia and Europe. Livestock production is the heart of the formal economy and an ongoing ban will destroy the economic viability of a Somali state or federation of states. The Puntland administration depends on export and import tariffs for 85 percent of its budget, so the ban will directly affect the Administration ability to provide even the most basic services like law and order, never mind contribute to health and education. Disenchantment on the part of ordinary people

in the government's inability to provide these services might well lead to destabilization and renewed conflict.

- d. Extreme Poverty: A significant section of the population – mainly internally displaced people - lives in extreme poverty, without any of the traditional support systems or coping mechanisms. Many have fled – or been driven from – the South, or neighbouring Somaliland. In total, there may well be more than 300,000 such people in Puntland, a huge burden on the economy of such a small and poor state. Providing the basic levels of water, nutrition, shelter, sanitation, health and education poses a major dilemma for the Puntland administration. Studies have shown that poverty or extreme poverty are the single greatest threat to development and recovery; people cannot save, the government cannot raise taxes, and cannot afford to provide the infrastructural and other services required to attract the foreign investment needed to create employment. Nor can the government afford to invest in health and education, which means the potential labour force is sick or low-skilled, compounding the infrastructural disincentives to business development. This is further compounded by brain-drain as the most productive members of the population emigrate to seek opportunities elsewhere. Ultimately, these deprived, marginalized populations provide fertile breeding grounds for violent conflict.
- e. Qat addiction: This is a major drain on the resources – both physical and financial – that are badly needed for recovery. If half the money that is spent everyday in Puntland to buy Qat could be redirected into essential service such as health and education, services could be strengthened, expanded and sustained. Instead, hard earned money is squandered, along with a substantial part of diaspora remittances, even to the point where milk and livestock are bartered for Qat, adding to the widespread poverty and vulnerability of the population.

Opportunities

- a. Relative Stability: However, constraints such as the above should neither detract from the need for, nor negate the concept of investing in the historic opportunity created by the current status of transition, to gear up activities towards a more developmental

outcome. Puntland has enjoyed years of relative stability without any major conflict and the homogenous ethnic character of the population – the vast majority are Harti from the Darod sub-clan – reduces the risks of state fragmentation along ethnic fault-lines or the use of ethnicity in any competition for power. The main problems of the past few years have been related to banditry or intra-sub-clan feuding over grazing rights or domestic affairs and do not pose a threat to the emerging administration or their control over the territory.

- b. Establishment of Puntland Administration: The creation of a formal administration – as encouraged by the UN – its consolidation through the 1998 constitutional conference, and the endorsement of the new government by the leaders of civil society highlight the historical opportunity that exists to build a regional administration that can create and maintain an environment in which reconstruction can take place.
- c. Vibrant Dynamic of Recovery: The confidence exhibited in every town and village, and the pace of physical construction is evidence of the huge potential for recovery at large in Puntland today. This impression was reinforced by the massive growth of the private and informal sectors in every sector, and in particular by the advances made in telecommunications and electrical power supply. We encountered Somalia-style internet cafés, international telephone access at a fraction of the price we had been paying in Nairobi, and vibrant, thriving markets in both villages and towns we visited.
- d. Relative Wealth: The quantity and variety of foodstuffs, goods and services available for purchase and the volume and pace of trade in the local markets suggested that a relatively prosperous ‘middle-class’ is developing. Although their economic situation must be extremely fragile, the small business sector, i.e. - utilities and service provision, construction work, livestock, fruit merchants, trucking and haulage, fishing, and qat – seems to be reasonably robust. It was also interesting to note the type and purpose of buildings being constructed – guest-houses and larger hotels, restaurants, and family homes of all sizes.

- e. External Investment and Returning Diaspora: Professionals returning from the diaspora and setting up businesses, or those still in the diaspora who are sending home money for investment in land and business are further signs of the dynamics of recovery in Puntland today. The economy is clearly benefiting from the constant and significant volume of remittances which are sent home by emigrant Somalis working abroad, it funds the investment in construction and businesses which create the jobs, which fuel the demand for food and domestic goods, services and utilities. This income is likely to continue to increase in the future, providing a very important buffer for the economy in times of crisis.

- f. Desire for Peace and Recovery: The cumulative effect of a weariness with insecurity – in the broader sense – and isolation, and the absence of a functioning government to provide basic services, together with a widespread recognition of the opportunities for recovery promoted by diaspora investment, private service provision and an expanding population, all contribute to a palpable desire for peace and recovery. To the extent that businesses are functioning very successfully there is no doubt that a powerful and wealthy business cadre are supporting the Yusuf Administration’s efforts to restore a functioning government in Puntland.

The Health Sector

The explosive growth of the private and informal provision and the emergence of an embryonic health administration are two aspects which present both potential and limitations to the development of a recovery strategy.

Potential

- a. Influencing Policy: The research is timely in that it presents a valuable opportunity to draw lessons from health service provision in Puntland over the past decade that can be integrated into the emerging policies and priorities of the central government and more specifically the Directorate of Health. Financing is an issue which has not been studied properly and there was broad acknowledgement of the need for new approaches to community financing based on community participation. The DoH and the implementing agencies are trapped between the short term need to cut costs as a result of declining donor support, and the long term quest for sustainability. It is critical

therefore, that the aim to share the cost should be driven by the need for long-term sustainability and not by a requirement to reduce budgets.

- b. Building Partnerships: The key issue then is neither cost recovery nor cost sharing: but building genuine and workable partnerships with the community. The research has the potential to contribute to an improvement in collaboration, communication and co-ordination between the main actors in health service provision in Puntland; a research project addressing a question which is of interest to all major parties has the catalytic power to bring people together in the search for a common solution. The interest expressed by implementing partners and NGOs and their expressed willingness to participate in the research are valuable assets.
- c. An Integrated Approach: Currently health is seen in isolation from all the other needs and priorities of the people of Puntland, and not explicitly related to socio-economic conditions and livelihood in general. The research has the potential to place health needs and priorities within the wider socio-economic aspects of recovery and service provision, with particular reference to people's livelihoods. Such integration could take place at the various local, regional and central levels, while keeping in mind the differences between urban and rural constituencies, as well as between settled and nomadic populations.
- d. Foster Genuine Community Participation: Up to now, community participation has been little more than a programming token in Puntland. But it is widely acknowledged that meaningful community participation ensures more effective management and relevance of the services provided. One of the aims of the research should be to harness the potential that exists to empower the communities to own, manage and support their services, and communities should be recognized as the main partners in service rehabilitation projects.
- e. Building Capacity: Participation as an enabling or empowering concept is neither understood nor attempted by the Red Crescent in its community health program. Local and regional health committees being set up without the necessary systems, tools or

training or without any real vision of the potential role of the community in managing its own services, or at least playing a key role in planning and organising the service. Often committee members do not really understand what is expected from them. Both Red Crescent staff and community members would benefit from training on the potential for genuine participation and how it can be realised. By developing and testing new approaches to service provision that involve programming and clinic staff and community representatives; the research has the potential to build the capacity of local actors to address the sustainability dilemma.

Limitations

The Puntland government has a massive task ahead, upgrading the health service's geographical coverage, quality and capacity. It will take a generation of stability and a massive and sustained investment by the international community to build the basic institutional infrastructure needed to begin to create an effective public health system.

- a. A Neoliberal State?: The adoption of a free-market approach to social services by President Yusuf's administration is antithetical to the development of the type of public health system that would be required to improve the health condition of the Puntland population. His position, during an interview for the Pre-study, reflected the notion that health services are delivered to those who have the money to pay for them by private, commercial providers, with the voluntary sector providing a minimal service for those who cannot afford to pay. The role of the government is to provide an appropriate regulatory environment in which this can take place. This is the same neoliberal doctrine which has failed to deliver even a minimal level of basic services in the West African test-cases of the Bamako Initiative, countries largely unaffected by conflict and state collapse, as experienced by Somalia. If this approach cannot succeed in a stable, conflict free environment with a functioning government, what chance does it have in post-Westphalian Somalia? The dilemma is all the more acute given the total destruction of the health infrastructure throughout Somalia and the complete absence of the systems and capacities required to provide an effective service.

- b. Absent Structures and Systems: Most of the health care institutions visited during the Pre-study were poorly maintained, lacking resources, inadequately managed, and technical, professional knowledge needed upgrading. Services are almost exclusively facility based and - to a significant extent - curative. Vaccinations levels are low, and resources for health education are almost non-existent. There is no coherent system; health facilities do not have clear reporting lines or management responsibilities. Planning and management skills are - at best - weak, and discussions with doctors and other health care providers suggest that there is a very poor understanding of broad, population-based approaches to health care needs analysis and treatment using epidemiologically effective strategies. To improve the major health indicators in Puntland, a huge investment in preventive and promotive health activities will be required. Some of the major challenges relate to upgrading the quality of services and ethical standards amongst health professionals, to creating laws and guidelines required to regulate the health care sector, in particular providing the necessary framework for the best use and control of the informal/private sector, and to instituting the monitoring systems needed to ensure full compliance. Health care management training including the creation of a reliable health information system (HIS) is absolutely essential for monitoring and appropriate planning. Yet, with no functioning central health administration and no overall framework, it will impossible to coordinate the activities of NGOs, private doctors, traditional healers, pharmacies and drug peddlers, let alone maintain consistent standards or ensure geographical coverage.
- c. Privatization - User Fees: It was clear from the timing and rationale behind the introduction of user fees in all these facilities that they are motivated by reduced donor support – either as a result of cutbacks, or as a consequence of failure to mobilize donor support for newly rehabilitated facilities or services. Structured cost-recovery systems with appropriate financial management are yet to be established. Current attempts are focused on charging fees for x-rays, ultrasound and laboratory tests, as well as a nominal admittance fee. Income generated is used to supplement doctors' and surgeons' income and contribute to some running costs, such as fuel, water and electricity. The apparent absence of any separation of executive and governing functions in Bosasso hospital also raises questions about rationalisation, standards and accessibility of these

services to the significant vulnerable and displaced populations in the area. None of the schemes observed or learned about during the Pre-study had been developed based on any formal assessment of communities' resources or people's ability to pay. In many cases the schemes have been introduced too quickly without support systems or structures; for example in Garowe hospital entitlement to exemption is decided arbitrarily:

‘We know most of the people in the town and whether they can afford to pay or not. If we don't know the person, we ask for the fee before allowing them to see the doctor. If they say they cannot afford to pay, we send them away telling them to get the money. Most people either borrow it or sell something. If they are still waiting in the courtyard after four days and haven't managed to get the money, we accept that they are destitute and exempt them’.

Khalif Abdullahi, Administrator, Garowe Hospital

As was demonstrated in chapter 4, this type of cost recovery effectively denies access to the poorest in society – those who have no money, no relatives who have money and no access to credit, the IDPs, nomadic families and the destitute. Who knows how many people don't come back a second or third or fourth day? It also spreads the burden of disease and ill-health throughout the community, forcing people to borrow from clan and neighbors, often for drugs or services that will not cure them anyway. As suggested by the analysis of the literature review in chapters 4 and 5, there is no objective way to distinguish between the poor and the non-poor in Puntland where the vast majority is without formal employment or business assets. No valid demographic data are available and the last census was in 1990, before the major population displacements that followed the war.

It was also difficult in smaller facilities to see how user fee schemes could be justified in cost-benefit terms. The amount of money raised is small, yet the administration of the schemes impose a significant additional burden on staff, generally occupying the time of at least one person, and adding to the responsibilities of supervising staff. The conclusion on user fees in the current context of vulnerability and marginalization in Puntland is that they imply a trade off between sustainability and vulnerability that is simply not acceptable when the services involved are essential primary health care.

- d. Regulation, Standards and Quality: The development of the health sector in Puntland today and the absence of any enforced regulatory framework, or professional ethical bodies, is a matter of some concern. Given the administration's vision for health which does not envisage a direct service provision role for the government, together with the external emphasis on privatization of health services, the internal drive towards privatization of curative services, and the uncontrolled expansion of the informal sector, there is a clear need for advocacy on behalf of the vulnerable in the community who do not have the means or the voice to ensure they receive minimal health care services. The potential role of the Red Crescent - as a widely accepted, highly trusted, institution with an acquired competence in the field of health - to fill this vacuum could be addressed by further research and testing of alternative approaches.
- e. Verifiable Data: One of the major limitations to the development of a sustainable programming approach is the lack of verifiable data: There are no up to date records about the socio-economic conditions of the population and the data that is collected about health condition is severely limited in scope and representativeness. Agency and government staff lack research and data gathering skills and while settled communities are dispersed over huge areas with poor access, up to 60 percent of the population is nomadic. Another major limitation is presented by the lack of coordination and cooperation among some of the main actors. Another concern is the urgent need for the application of regulatory and incentive measures to improve the quality of service. Clarification of roles and responsibilities together with coordinated action among the various stakeholders and service providers is crucial for a successful transition (formal sector, informal sector, Red Crescent, NGOs and UN as well as communities and their traditional leaders). It is essential that actors agree on a shared vision and that projects are implemented in close partnership. The need is enormous and the responsibilities can be divided according to geographical regions.
- f. Community Involvement and Participation: There is very little genuine community participation, and even less understanding of the dynamics of communities' internal make-up and relationships on which to base any initiatives. The attitudes, wishes and

capacities of local people are neither well researched nor understood and are often underestimated. This lack of appreciation of these capacities and the priorities is a major constraint to the development of an approach to provide sustainable services. Meaningfully community participation will also require a change in the pre-war attitude and expectations that public services should be provided free of charge.

The Somali Red Crescent Society

The Red Crescent has been supporting the people of Puntland and Somalia throughout the conflict and since, and has developed a reputation for disaster assistance and health service provision but there are also serious weaknesses in its Puntland set-up. These advantages and disadvantages are discussed in the following section.

Advantages

- a. Leadership: The experience of the President and his role in the commission and committee of the Red Cross and Red Crescent Movement at international level have helped maintain the profile and the cause of the Red Crescent, and thus ensured continuing access to donors in the post-emergency phase. This is widely appreciated in Somalia and in even more so in Puntland because of his clan affiliation. His involvement in the research represents a distinct advantage. The Red Crescent's reputation for assistance to victims of disaster and conflict through its relief, health, tracing and dissemination programs over the year is also a strong basis for any initiative to develop and test new approaches to health service programming.
- b. Relationship with the government: The traditional role of the national red cross or red crescent society as auxiliary to the government in the fields of health and disaster relief is an important advantage. The existing partnership and close co-operation between the DoH and the Red Crescent will help engage communities and their authorities in the research and build a broad consensus on any new programming or service delivery approaches developed for testing through the research..
- c. National Presence: Critically, the fact that the Red Crescent has clinics in all three zones, means that any new system which is developed in Puntland may also be tested and replicated in either or both of the other two zones (Somaliland or south central

zone) after adjustment to take into account the different conditions. Critical advantage can also be drawn from the successes of a well-staffed, well-managed and well-supported operation in Somaliland which presents lessons and examples for the Puntland operation. Things which have gone wrong as well as things which have succeeded should be studied and the lessons transferred to help speed the transition for the Puntland branches.

- d. Expertise: The well-trained staff base of the Red Crescent is another important advantage for the conduct of the research. From the outset, the intention has been to undertake action research based on the full participation of the Red Crescent programming and clinic staff; the fact that they are experienced and well-trained will make this all the more feasible.
- e. Legitimacy: The legitimacy of the Red Crescent is a function of the extent to which it has been able to respond to the needs of local communities over the past decade. While the society cannot be all things to all people it had managed to mount a number of important relief programs and maintain basic health services in 50 communities. However, it also has to contend with often unrealistic expectations from both the Puntland administration and the communities. A new investment to improve the sustainability of the Red Crescent health facilities and capitalize on the opportunities presented by the recovery which is clearly underway in Puntland, would serve to enhance this legitimacy and strengthen the Red Crescent further in the eyes of local people.

Disadvantages

- a. Fragmentation: One of the main disadvantages arises from the fragmented nature of the National Society. The two branches in Puntland are geographically isolated from one another, and operate completely independently of Somaliland and SCZ. To make matters worse, they have been literally cut-off from the outside world for almost a decade. Unlike Somaliland and SCZ, there is no co-ordination office in Puntland, and instructions – when they come – are from senior management in Nairobi.

- b. External Management: The location of the society's HQ outside the country makes coordination difficult and has sapped the motivation and interest of the staff working there. The society's operations suffer as a result - particularly in Puntland. Although Somaliland - considered a development context - and SCZ – as an emergency context - receive frequent visits from donors and programming staff, Puntland which fits into neither category, has received much less attention or interest from outside. In one sense there is no Puntland Red Crescent – even as a sub-division of the Red Crescent, and this means that there is no coordinated management on a day-to-day, week-to-week basis, and no sense of direction or urgency about implementation of plans and strategies.
- c. Poor Planning: A consequence of this is the lack of strategic planning at sub-national level. Existing plans seem to be a carbon copy of those which have been in place for the past five years, and the staff structures are simply a pared down version of those that were created during the emergency phase. Hence there has been no meaningful attempt to re-organize the Puntland set-up to reflect the new political reality of Puntland, nor to seize the opportunities it presents. Unless this is done there is little prospect of introducing any new programming system, even if it can be developed.
- d. Lack of Community Participation: The lack of any real community participation in the clinics program is also a source of concern. Although the Red Crescent supports the concept of local participation and did create health committees in recent years it seems that this was driven by the need to reduce staff and operating costs and that genuine community involvement is very low. The creation of the health committees for most clinics involved the informal appointment of people to a committee which was responsible for the cleaning, maintenance and security of the clinic on a voluntary basis, compensating for the discontinuation of funding for these staff positions. According to the clinic staff, these tasks are rarely carried out by committee members or volunteers, but by the clinic staff themselves. No formal agreement was made with the community to govern the roles and responsibility of the health committee, and no Terms of Reference or guidelines were drawn up and no training provided. It would seem that community participation is little more than a token affair to satisfy program descriptions and occasional donor questions, and to reduce costs.

If the branches had developed close relations with the communities systematically over the years, then engaging local people in an initiative to identify sustainable recovery strategies through increased community involvement would be a less daunting task. As it stands, communities have grown used to the existence of the clinic services without any contribution or consideration from them: securing it now will be all the more difficult.

Elaborating the Working Hypotheses

Based on the initial literature review the pre-study took the following thesis as its starting point:

In the context of post-conflict recovery in Puntland, the Somali Red Crescent, working with communities and emerging health authorities, can build the necessary capacities and systems within communities to enable them to play a central role in the running and resourcing of their health services, and in doing so, increase the sustainability of community health facilities and contribute to the creation of an effective public health system.

Building on the conclusions drawn from the extensive literature review carried out in chapters 1 to 4, and following careful examination of the context of Puntland, facilitated by the *TOPLAD* analysis, the next stages of the field research will address the following four hypotheses:

Hypothesis 1: In the context of post-conflict health sector recovery, community involvement in planning and management can lead to significant improvements in the quality, appropriateness and sustainability of local services.

In support of this hypothesis, the research set out to test the following assumptions:

A.1.1: Conflict-affected communities would make better use of their local health service, and be more concerned about ensuring its sustainability, if they were given the opportunity to participate meaningfully in its organization and development.

A.1.2: Programming approaches that are based on locally-appropriate solutions – instead of standardized, ‘one-size-fits-all’ kits – and are informed by the expressed needs, priorities and concerns of local residents, and the socio-economic circumstances of individual communities, can engage the involvement of local people in the provision of sustainable health services.

A.1.3: If the range and quality of services and treatments responded to local people’s priorities, they would have less need to use alternative providers and could be persuaded to redirect out-of-pocket expenditures into some form of community fund for the facility.

Hypothesis 2: In conflict-affected contexts, collective financing schemes that accommodate communities’ seasonal income and asset realization cycles can provide a significant proportion of the direct costs of basic health services.

In support of this hypothesis, the research will test the following assumptions:

A.2.1: Collective community financing schemes that are based on an appropriate assessment of people’s willingness and ability to pay can maximize local contributions by facilitating households’ participation while helping protect household asset bases and contribute to long term recovery.

A.2.2: Communities are willing and able to contribute to financing schemes that are based on an appreciation of their income from livestock-trading, migratory and seasonal work patterns, and remittances linked to religious celebrations.

A.2.3: Community financing schemes based on local traditions and mechanisms to take care of the poor and the vulnerable, can overcome the inequities inherent in user fee and cost recovery systems that exclude the poor from health services, force people to borrow money for fees, increase indebtedness and spread the burden of ill-health throughout the community.

Hypothesis 3: The Somali Red Crescent can provide an institutional platform for the post-conflict rehabilitation of local health services, channelling the efforts of a wide range of actors and donors into a community-owned strategy for sustainable recovery.

A.3.1: Coordinated action among the various public and private stakeholders involved in health service provision, based on a shared vision and strengthened partnership, can contribute significantly to the creation of an effective public health system in Puntland.

A.3.2: The traditional mandate of the Somali Red Crescent as auxiliary to the government in the field of health and disaster response, and its unique position as the de facto public health service in Puntland confer a unique authority to inform the development of policy by the Directorate of Health.

A.3.3: Programmes which recognize – and where possible include – other local service providers, both formal and informal, have a better chance of long term success than those which ignore the potential winners and losers from changes in the structure and provision of health services in a community.

Hypothesis 4: The Somali Red Crescent is uniquely positioned to harness the driving potential of communities in the recovery process and empower local people to take control of their health services. Given the appropriate investment, the Red Crescent can build the institutional and individual capacities to enable communities to take responsibility for their health.

In support of this hypothesis, the research set out to test the following assumptions:

A.4.1: Token community participation paying lip-service to donor requirements ignores the skills, talents and capacities that exist in local communities for planning, organizing and managing services, and the role of traditional leadership and institutions in meeting community needs.

A.4.2: A strategic investment in the operational capacities of the Somali Red Crescent could produce a shift in its role from direct service provider to facilitator and supporter of communities in co-management of the health services.

A.4.3: The Red Crescent can develop the structures, systems and capacities at local level to enable local people play central role in the running and resourcing of their health service.

It was proposed to test these hypotheses and assumptions through a further phase of field research involving the Somali Red Crescent, local communities in Puntland, and their health authorities.

The Research Strategy and Plan

The thesis and hypotheses suggest that development of a programming approach for sustainable community health services in Puntland could be advanced through the following course of action:

- The elaboration of an in-depth understanding of the socio-economic conditions within local communities, their traditional and contemporary coping capacities and strategies;
- Agreement on a strategy for community involvement in the organization and part-financing of the services based on an appreciation of these conditions; and
- The development of a system and tools to promote local enablement of communities to participate meaningfully in the running and resourcing of their health services.

Combining a Survey with a Case Study - Field Experiment

To inform an understanding of the socio-economic conditions and coping capacities within local communities and develop a participatory model for health service provision to be tested in an action-research project, a research strategy was designed to combine a household survey with a case study - field experiment. The survey would explore the health priorities, socio-economic circumstances and traditions of participation in communities being served by Red Crescent clinics, and provide baseline data to be used to inform the design of the participatory model for health service provision. This approach would then be tested using a rigorous case study to achieve conditions of experimental isolation in a

carefully selected community. The results would be used to inform the development of a new programming strategy.

The Household Survey

There is a general lack of basic data and whatever data are available have been questioned by a number of sources (e.g., demographic information, levels and sources of income, the informal sector, etc.). Therefore, it is important for the research to undertake a quantitative survey in order to validate the available data and highlight gaps in knowledge. The clinics within each community would be used as the focus for the survey which would be undertaken by clinic and Red Crescent staff together with community members. In order to establish individual communities' willingness and ability to participate in the running and resourcing of their health service, the survey would seek to assess a range of community attribute, opinions and practices, as well as mapping assets and assessing potential to contribute to the service in the future. The survey would examine the following:

- health profile
- social coping mechanisms such as internal clan support systems
- livestock, water and pasture
- employment, business and trading
- diaspora remittances

The Field Experiment

An action research case study would then be used to conduct a field experiment in a community to be selected after the initial analysis of findings from the household surveys of the 12 communities. The community would be selected to give the most representative reflection of socio-economic conditions prevailing in Puntland. The aim of this in-depth study was to test the hypothesis in a manner that allowed the full participation of the community, to determine the community's capacity and willingness to contribute to the running, maintenance, sustainability and ownership of the clinics.

The in-depth studies would incorporate participatory action research workshops in which the communities were to be given the chance to:

- articulate their willingness to contribute to the sustainability of the health facilities;

- identify strategies for service improvement;
- make proposals for sustaining the services in the future, according to their priorities.

Action Research Strategy

The next three chapters describe the process to develop such a programming approach:

- The next chapter explains how participatory surveying was used to involve the communities and Red Crescent clinic and health program staff, in the design, planning and conduct of a participatory household survey to gather baseline data on the socio-economic conditions of the twelve communities and determine their willingness and ability to participate in the running and resourcing of their health services;
- Chapter 8 describes an action research exercise used to engage a selected community in designing a more sustainable programming model through awareness raising, empowerment, collaborative investigation and planning, and the elaboration of a field experiment to test the model.
- Chapter 9 evaluates the field experiment and draws on the experience to identify the key elements for a generic programming model to provide community health services in the transition to long term recovery.

The Red Crescent staff were engaged in each of these activities, together with community representatives, clinic users and non-users from the twelve communities. The aim was to maximize the benefit of the study for Red Crescent by allowing its staff and community members the opportunity to actively participate in, and own, the process.

Conclusion

The pre-study analysis reveals a dynamic Puntland, as opposed to the static, stagnant and debilitated image so often conjured up by post-conflict Sub-Saharan African analyses. The study found an expanding population, a thriving economy, a secure environment and a consistent supply of diaspora remittances to spur investment and growth. The complete destruction of the public health system after years of economic mismanagement, harsh structural adjustment, and the impact of the conflict presents a formidable challenge to the emerging health authorities. Engaging the Somali Red Crescent and the Puntland

Directorate of Health to identify and test new approaches to sustainable recovery of health services has real potential to inform policy and help build individual and institutional capacities at a crucial time in the post-conflict revival. At the same time a number of limitations are evident. The total destruction of the physical and institutional infrastructure of the health sector and the chaotic growth of informal services renders all the more urgent the need for a coherent and progressive public health system if recovery is to be steady and sustainable. The Puntland government's adherence to a market-based approach to health is unlikely to produce the expansion in public health services that will be necessary to improve the appalling health conditions of the population. A major obstacle to the development of more sensitive mechanisms for local financing is the lack of verifiable data about communities' socio-economic conditions and the demographic distribution of poverty and vulnerability. Progressive financing systems cannot be developed in the absence of information about the wealthier groups in society, particularly in a context where so many people are poor. This is exacerbated by the failure of agencies and authorities to promote and facilitate genuine community involvement in the planning and management of services.

The Red Crescent has important and unique advantages in the context of health service recovery. As the only organisation with national presence spread over the three zones, it has an important influence. It has a highly respected leadership and a widespread reputation and legitimacy through many years of health programming and disaster response operations. Nevertheless, the society suffers from a number of disadvantages which undermine its potential as a vehicle for health service recovery, e.g. - fragmentation of the society along political lines, a weak resource base, and a lack of genuine participation.

Based on an analysis of the findings, the pre-study produced a series of working hypothesis and assumptions and elaborated a research strategy and plan to test these through the development of baseline data about communities' socio-economic and health conditions and the setting up of an in-depth case study-cum-field experiment. By sharing the responsibility for the development of a participatory management approach with the clinic users and staff, the field work would attempt to answer the critical question: can

community involvement lead to more equitable, efficient and – ultimately – sustainable local health services?

* * *

The next chapter will present the first step in this process: a participatory household survey to provide baseline data on the socio-economic conditions of the relevant communities and identify a representative community for the field experiment.

7. Measuring Communities' Willingness and Ability to Participate

Introduction

The previous chapter identified – as a prerequisite for the development of a programming approach for sustainable community health services in Puntland. – the elaboration of an in-depth understanding of the socio-economic conditions within local communities, and their traditional and contemporary coping capacities and strategies in order to determine – among other things – their willingness and ability to participate in the running and resourcing of their health services.

This chapter explains how participatory surveying was used to develop this understanding providing baseline data on the socio-economic conditions of the twelve communities where the Red Crescent clinics are located in order to determine local people's willingness and ability and subsequently identify a representative example of a community which could be used to test the hypotheses in a real life setting. Having determined how to adapt the traditional surveying method to develop a more participatory tool, the chapter goes on to describe how the Puntland participatory survey was planned, organized and executed in three distinct stages: planning and organization, preparation and administration; and results, feedback and validation. The key findings are then presented in three sections: lifestyle, health service usage, and committee participation. The chapter goes on to describe the validation of the findings and the trends and conclusions drawn from the data - a process which was undertaken with community members and Red Crescent programme and clinic staff. Finally there is an overview of the discussions and criteria for the selection of the test community to participate in the field experiment.

Enabling Local People to Take Responsibility

Annex 1 also notes some criticisms of the use of standard questionnaire surveys in conflict-affected or developmental contexts without adaptation or alteration. Robert Chambers in particular describes how surveys produce distortion in three specific stages of research (Chambers, 1999:93-7):

i) Constructing the questionnaire: the questionnaire topics and questions are thought up in some distant, central office far from the reality of life where the problems have to be dealt with on a daily basis. They are, therefore, flawed from the start, incorporating the biases of the people who know least about the problem, and excluding the participation of those at local level who know it best.

ii) Administering the questionnaire: The questionnaire depersonalizes the respondent, assigning them little value other than as indicators of the appropriate check-boxes on the pre-set list. The often intimidating appearance of the interviewer confirms the hierarchical relationship between the surveying organization and the respondent, serving to confirm the conservative bias of the status quo: in this case, the victim and the service provider. This in turn leads to caution on the part of the respondents as they provide answers based less on reality and more on what they intuitively feel the interviewer would like to be told. Interviewers themselves reinforce this bias by erring on the side of what they know their superiors would like the questionnaire answers to confirm. Finally the temptation of convenience provides additional distortions, again in favor of what the superior would like to see, with little use of the 'other' category which would require additional explanations, long text, or complicating exceptions that might invalidate the questionnaire, or the question, or the entire survey.

iii) Analyzing the data: The process of self-deception continues during the analysis stage, as the external researcher and higher officials collude in the selection and even manipulation of data which reinforces their pre-cast response to a problem or phenomenon they have never been open to understanding in the first place. According to Chambers, this final stage allows the production of results which are selective, simplifying, overfavourable and reconfirming.

Selective: The greater the volume of data, the more the analysts are forced to select, to choose what to present, what to focus on. This according to Chambers '*necessarily reflects their priorities and predispositions, which are then reinforced*'. Moreover, in a structured questionnaire, data is strictly limited to what was asked: the original selection of questions in a questionnaire prepared by the external researchers as suggested above, means that the data collected does not extend beyond the limited perspective of the external researcher and therefore does not challenge their preconceived notions about the problem and, or its solutions. '*What is not asked about is not found out about and cannot be part of the analysis*' (Chambers, 1999:95).

Simplifying: Questionnaires require precise responses to closed questions – producing multiple-choice simplifications of often complex phenomena, and usually excluding even simple combinations or permutations of circumstances such as multiple sources of income or complex mixes of crops grown by farmers.

Overfavourable: The generation of overfavourable responses already begun during the interview stage through respondent caution and interviewer deference, continues during the analysis stage. Interpretation by officials at higher levels becomes manipulation and even misrepresentation in a pre-determined conclusion in order to substantiate their preconceived notions of the problem and their prescription solution.

Reconfirming: Because questionnaires are often highly structured and require an action-reaction type response, they usually only serve to reconfirm the limited knowledge that the external researcher had in the first place. Missing valuable opportunities to learn from people who might be able to provide a much richer, informative, detailed, broader picture of complex local circumstances, they are unlikely to correct misconceptions, introduce new ideas, or construct new hypotheses to replace wrong ones. Hence, to paraphrase Chambers, they do not inform, they only reconfirm, and they often reconfirm partial or incorrect solutions.

Can these weaknesses in the survey as a research method be overcome? And if so how? Chambers' criticism contrasts starkly with Hakim's analysis of the advantages of ad hoc surveys presented in Annex 1, particularly her assertion that the survey provides data and results which are transparent, accountable, credible, democratic and progressive (Hakim, 2000:76-79). Chambers proposes alternative participatory methods to surveys for what he states are their four main purposes (Chambers, 1999:122-125):

- i) *To gain insights, including for project formulation:* mapping, seasonal calendars, trend and change analysis, well-being ranking matrix scoring, Venn-diagramming and linking-diagramming have all enabled local people to express their knowledge, engaging their commitment and enabling the expression of their diverse and complex realities and to give insights to their values, needs and priorities in a way that can also motivate participatory action;
- ii) *To identify social and economic differences:* Mapping is the participatory tool which has been used as an alternative to surveying for identifying target groups;
- iii) *To provide baselines and means for monitoring and evaluation:* Rejecting questionnaire surveys as 'virtually useless for impact assessments' Chambers reports that participatory mapping of population groups and service utilization, and causal linkage diagramming of observed phenomena, have been used to enable local people to evaluate impact, identify their own indicators, producing their own baselines, monitoring change and establishing causality; and
- iv) *To generate statistics:* Participatory methods such as mapping, listing and counting are suggested as an alternative to surveying.

Feasibility of Participatory Methods

Our objective is to determine to what extent the conditions of willingness and ability are present in twelve communities across Puntland. For the purposes of our research, we are dealing with twelve communities across Puntland whose populations are diverse in their make-up ranging from nomadic livestock herding to farming, fishing and trading; widely dispersed over an area the size of England and Scotland; varied in their health needs and

uses of Red Crescent clinics; and as complex as they are different in their attitudes, beliefs and values.

The questionnaire survey offers a method which, when properly used, provides data that can be generalized to the broader survey population. The challenge is how it can be done without the weaknesses and biases elaborated by Chambers. His thesis is that such distortions arise as a result of the exclusion of local people from the processes of constructing the questionnaire, interviewing, and analyzing the data. However, rather than engaging local people meaningfully in the surveying process, he suggests the use of qualitative methods to produce data that is representative of a smaller population. Chambers argues that

‘participatory mapping and listing avoids laborious sampling and sampling errors, since all people are included; sampling focuses on the choices of communities, not choice within them; (ii) comparability can be sought through protocols or schedules [...] with a visual interactive questionnaire’

Chambers, 1999:124

The total number of inhabitants in the twelve communities is estimated at 144,000 people. It is simply not feasible - in terms of time or cost - to suggest that participatory methods be used to engage every sub-group in each and every community in mapping, charting and visual or other analyses, before the hypothesis in question has even been substantiated. If, the hypothesis is substantiated using a more time- and cost-effective method, then it may make sense to conduct further, more in-depth studies, in individual communities, that will allow the development of a detailed profile of these communities. Initially, however, our concern is to substantiate the hypothesis by establishing the existence of the pre-conditions stated above.

The question therefore is: how can the surveying process be adapted to include – to the fullest extent possible – local people in:

- The preparation of the survey questionnaire;
- The interviewing of other local people as respondents; and
- The analysis of the data to produce survey results.

This raises the question of the extent to which the community should be involved in the process of information gathering and research in the context of post-war recovery.

Participatory Surveying – The Concept

As noted above, surveys are typically used to seek information about a respondent's own characteristics and circumstances, their behavior and practices, and their values, beliefs and attitudes. The household survey in particular has specific advantages for conducting research on questions relating to socio-economic status and lifestyle, addressing issues of shared responsibility or common concern. (Robson, 1997; Hakim, 2000; Bowling 2002)

Ad hoc surveying using structured questionnaires has been used extensively to gather information in conflict-affected contexts and provide reliable and valuable information about the circumstances, opinions, beliefs, attitudes and practices of people in conflict-affected contexts. Local people can be surveyed on a range of questions about their communities, their livelihoods, health behavior and traditions of participation, education, training and professions. Examples include: the *Somalia Multiple Indicator Cluster Survey* (UNICEF, 2000); the household survey on *Remittances and Their Impact in Post-war Somaliland* (Ahmed, 2000); and the *Household Survey of Vaccination Coverage in Grozny* (Drysdale, 2000) for Merlin.

Surveys can also be used to identify representative communities which can be studied more closely using the case study research method. This will provide a more in-depth analysis of the processes at work within local communities to substantiate the study hypothesis. As noted above, case studies can achieve *experimental isolation* of selected social factors or processes in order to test an idea or explanation (Hakim, 2000). Surveys provide excellent sampling frames for follow-up case studies that examine particular situations, groups or processes in greater depth.

On the one hand, if the survey is being undertaken purely for academic purposes, (in this case to collect data to substantiate a hypothesis that communities have the willingness, resources and abilities to co-manage their health facilities) then it can be argued that the collection of that data only requires a token involvement of the community – effectively

their consent to the exercise. This represents the notion of participation as a means to an end, Rifkin's 'target oriented' approach as reviewed in chapter 6. It is arguably the norm for many aid organizations conducting assessments in disaster-affected communities – a responsible person or institution may be requested to allow the exercise to take place, but national or expatriate agency staff then undertake the information gathering exercise. It is not uncommon for external consultants to be employed to conduct missions to post-conflict areas, characterized by what Chambers calls 'rural development tourism, the phenomenon of the brief rural visit by the urban-based professional' (Chambers, 1983). At a very minimum this approach eschews the wealth of knowledge that community members have of their own circumstances, and leads to a range of biases distorting the findings.

On the other hand, if the objectives of the exercise include improving practice and improving the situation in which the programming takes place, as intended in our adoption of the action research strategy, genuine participation of the community may be seen as an end in itself, as described in Rifkin's 'empowerment-oriented' framework in chapter 6. Where such participation is engaged, the validity, relevance and usefulness of the information gathering exercise can be significantly enhanced (Long, 2001; WHO, 2000; Chambers, 1999; Rifkin 1996; Weil et al, 1990). If anything, the process of engagement which takes place when ordinary people become convinced that they can influence and control the services provided should be recognized as an outcome in its own right (WHO, 2000).

In reviewing the concepts of participation, community involvement in health, and empowerment, in chapter 6, it was suggested that projects which seek to promote people's involvement in health must be flexible and willing to experiment, and not governed exclusively by 'deliverables' such as objectives and outputs (WHO, 2000). The organization of the Puntland survey presented a choice between the target-oriented and empowerment-oriented approaches outlined in chapter 6. If the intention is to improve the situation in which the programming takes place then the empowerment approach is most appropriate for the purposes of our study. It is also clear that the community would benefit significantly more in the long term from this empowerment approach.

Potential of Participatory Surveying

The following section provides an overview of the potential and constraints of participatory surveying (Freire, 1974; Kahssay & Oakley, 1999; Chambers, 1983, 1999; Barakat & Deely, 2001; WB, 2002).

- **Empowerment:** Community participation in surveying about health conditions has the potential to demystify the issues around community health behaviour and build confidence to confront health needs and associated problems
- **Sharing Knowledge:** about health needs, problems and treatments, living conditions, available resources, and a host of other individual, household and community characteristics - between community members, clinic staff, district health officials, local authorities, agencies' staff
- **Developing Capacity:** of community members and clinic staff engaged in the survey to communicate, plan, design, map, rank, interview, report, and manage. To conduct similar information gathering exercises for other needs.
- **Building relationships:** between community representatives and clinic staff, between staff and the users of the clinic, the community at large, district health officials and other health care providers;
- **Changing the mentality** built up through years of relief health that services are planned and delivered by an external party - usually an aid agency, with little or no involvement or responsibility on the part of ordinary community members
- **Promoting the use of the clinic** by publicizing the services it provides during face-to-face contact with households/respondents
- **Raising awareness** about health problems through promotion of health messages with different households and gathering feedback during the interview process
- **Building consensus** on priority problem areas through discussions with household heads, community members, and through the involvement of community members and clinic staff in the process of collecting and analyzing data.
- **Generating ideas** for solutions to tackle problems through consultation with community members, clinic staff, district health officials, local authorities, agencies' staff

- Improving access to households and increasing response rates for questionnaires as a result of replacing outsiders with trusted local community members to undertake the survey.

Constraints of Participatory Surveying

There are also drawbacks or constraints, mainly related to the limitation imposed by lack of control over the selection and control over the people who conduct the survey which, to a large extent, is imposed on the researcher by the circumstances of the individual community (Chambers, 1999; Kahssay & Oakley, 1999; Robson, 1997)

- **Feasibility:** The participatory survey requires significantly more organization, and assumes the availability of a local partner to assist with preparation and planning. It may be limited by community members' reluctance to participate, and by lack of prior knowledge of their abilities.
- **Facilitation and training expertise:** the transfer of complex concepts to local people with limited education, whose culture may be predominantly oral and whose concepts of information-gathering or research may differ significantly from the standard academic research methods, is a challenge which is generally underestimated and usually poorly met.
- **Conflict:** It may revive or provoke conflict between clinic staff and community members or representatives over control or responsibility for the management of health activities including the community health facility.
- **Time:** Initial consultation and agreement, and subsequent preparation, planning, training and support can require significantly more time than, say, the selection of a group of students or people from nearby urban areas who have some experience as surveyors with government or an aid agency.
- **Validity:** the use of local people brings its own biases, including those arising from reluctance on the part of respondents to disclose certain information to people they know; to manipulation by local interviewers to produce an outcome which coincides with their interest; and avoidance of certain areas or households known to be inhabited by minority groups.

- **Raised expectations:** an unavoidable consequence of empowerment is that people's expectations have to be raised in order for them to become engaged. When the survey is being designed, consideration needs to be given to the possible outcomes of empowerment and how they will need to be supported.

Empowering local people - including clinic users, health workers and community elders - to conduct or participate actively in the planning, design and conduct of surveys in their own communities has the potential to address many of the weaknesses of the traditional questionnaire survey: community members have a better understanding of the local context, know culturally-appropriate ways to seek information – particularly about sensitive issues - and can gain access more easily to households (Chambers 1983, 1999; Barakat 1992; Anderson 1999; Barakat and Deely 2001). It also has the potential to produce an active mobilization of community members to resolve a problem that they know more about, understand better, are no longer intimidated by, and feel mandated to confront (Barakat et al, 2002; Barakat & Deely, 2001; Long, 2001; WHO, 2000; Chambers, 1999; Rifkin, 1996). At a minimum, their involvement can extend, enrich, interpret and validate results from the responses to the survey.

The Puntland Participatory Survey

How then can a traditional ad hoc survey be adapted to produce a genuinely participatory process, empowering people in its own right, encouraging community initiative, giving people power over their health choices and the capacity to make independent decisions?

The strategy used the Puntland participatory survey combined participatory methods with traditional surveying methods to enable local people and health workers to undertake an enquiry into the health and socio-economic conditions of their own communities. The process of enablement took place through the active participation of local people representing their communities, and clinic staff in six major activities:

- i. Consultation about the need for baseline data to help improve the running and resourcing of the clinics and the decision about how this data should be collected;

- ii. Training on a range of research and data collection techniques to enable community representatives and clinic staff participate in the planning and conduct of the household survey;
- iii. Preparation of the survey questionnaire;
- iv. Undertaking the survey;
- v. Analysis of the raw data to identify and validate trends, patterns and conclusions emerging from the survey; and
- vi. Decision-making about how the results should be used to improve the provision and sustainability of services in their communities.

The methods used to enable this participation were participatory mapping of communities, catchment areas, populations, sub-groups and services; well-being and wealth ranking; seasonal calendars describing variations in climate, population, health service utilization, water resources, labour patterns and migration; listing; role-playing; observation; simulation and real-life practice.

The survey was designed, organized and carried out with the active participation of community members, their representatives and health facility staff, supported by the SRCS. The approach used to prepare the survey was adapted from Robson's method for mounting small scale surveys (Robson, 1998; pp. 133-145):

- 1) Sort out the general purpose and specific information requirements:
- 2) Determine the population and the sample to be selected
- 3) Construct the questionnaire.
- 4) Testing and final preparations
- 5) Finalize plan of action and conduct the survey

Each step involved the full, active and at times, highly animated participation of the representatives of the twelve communities. A detailed description of the workshop is attached at Annex 3. A Survey Preparation Checklist is attached at Annex 4, and a copy of the survey questionnaire can be found at Annex 5.

The Survey: Key Findings

The household survey was carried out over a three week period between the 20th August and the 10th September 2000, by teams made up of at least one community member and one clinic staff. The completed questionnaires were collected and the responses were translated and tabulated at the Red Crescent offices in Garowe and Galkayo.

The following section presents the key findings of the household survey in relation to lifestyle, health service usage, committee participation:

Lifestyle

The population serviced by the clinics is predominantly nomadic and rural in character. Across the sampled population clinic users were predominantly nomadic (44%) and settled rural dwellers (23%) with the remainder divided between settled urban dwellers (14%) and IDPs (10%). Household size ranged from 5 to 16 persons with an average 9 members across the 12 communities. Female-headed households accounted for 18.5%, while 77% of those sampled were headed by men.

Fifteen percent received some form of remittance from overseas. Given the nomadic and rural structure of the sample population, this statistic correlates with the results of previous studies which suggest that remittances are a predominantly urban phenomenon, with only 5% of rural families receiving regular transfers (Ahmed, 2000). Almost half of all households claim to own livestock (49%), while seasonal employment was a source of income for 37% of the sample population. Eighteen percent of those questioned relied on agricultural production. Female-headed households earned most income from seasonal and part-time employment (28% and 27% respectively). 23% trade livestock while other forms of business accounted for 23% of earnings.

Impact of illness on household finances

Of the 49% of households claiming to own livestock, 98% own goats, 72 % own camels, and 83% sheep. The decision to sell livestock rests with the head of the household (Father 75%, Mother 9%), with 10% of those questioned stating that there is some form of

consultation in taking this decision. Proceeds from the sale of livestock are used to meet the cost of purchasing food in 94% of households surveyed, to fund loan repayment (89%), pay for health (87%), purchase clothing (86%), and meet the cost of education (46%). Only 14% claimed to sell livestock to engage in business. This would seem to indicate that for the majority of people, livestock is a fluid asset equivalent to savings in developed countries.

The fact that the vast majority of households surveyed use the proceeds from the sale of livestock for the purchase of food and health services gives some idea of the impact of sickness on household finances. Payments of user fees for health services clearly reduce the amount of money that would be available for food, as well as clothing and education. Only 25% of households surveyed own other fluid assets such as land, fishing equipment, water reservoirs or *birkad*, and domiciles, underlining the fact at least 75% of the population have to sacrifice food and other basic household necessities to pay for health services.

Utilization of Health Facilities

It appears that all households surveyed were Red Crescent clinic users. Fifty-four percent also consult Traditional Healers, 37% seek treatment from private service providers, while 35% procure medicines in pharmacies.

Borrowing: Spreading the Burden of Ill-health

Almost three-quarters of those consulted stated they borrow to meet health needs. The major exception is Galkayo with only 19% claiming to have borrowed for health needs. This may be an urban phenomenon: people have more regular access to money than the rural communities where access to cash equates with sale of livestock, which takes place seasonally. It may also occur as a result of the higher than average socio-economic conditions prevailing in Galkayo, a relatively large town with dynamic construction and business sectors. Among those who have to borrow to pay for health services 69% of those surveyed stated that the amount they are in a position to borrow precludes the use of some health facilities

The choice of which health facility to use was determined by three key factors: first, accessibility; then severity of illness; and finally, the perceived quality of service. The importance of accessibility reflects the reality of life for a highly dispersed and nomadic population in the mainly rural communities served by the SRCS clinics. Again the decision-maker was mainly the male head of household (73% of those questioned), reflecting the financial implications of health facility usage. Perceived severity of illness alone was given as the most important factor in determining use of the hospital, a finding which challenges the pro-cost recovery 'rational use of services' argument reviewed in chapter 5³⁶. Once a decision to use the hospital has been taken, access ceases to be an issue. Among those surveyed, mothers and sons within the household were the main users of hospital services - approximately twice as frequently as fathers and daughters.

Consequences of cost recovery: Exclusion and Indebtedness

Over the past 7 years 71% of households surveyed had used the hospital. Of these, 65% stated that their use has declined during this period. The main reason given for declining use of hospital services is declining income. While this may be the reality for households relying on sale of livestock and therefore seriously affected by the livestock ban, it is also linked to the introduction of cost recovery schemes: 65% of respondents state they use the hospital less since the introduction of cost recovery.

50.5% of households surveyed had not used the hospital in the past year. 64.5% of households using the hospital have had to borrow to pay for the treatment. This ranges from 70% in Eyl and 98% in Qarhis to only 19% Balibusle. Two households in five (40%) had no need for hospital services. One household in eight, or 12.5% of those needing hospital services, stated they did not use the facility, as they could not find money to meet the cost.

Community Participation

The survey found well-established and supported mechanisms and practices of participation, with a wide variance across the twelve communities.

³⁶ The standard cost recovery model uses an increasing scale of prices as the level of care increases, which in theory should promote rational use of services, where patients seek the lowest appropriate level of care instead of attending the nearest hospital for all ailments, and wasting resources (Gershman & Irwin, 2000:433).

One out of every five households surveyed has at least one member belonging to formally organized committees supporting a community service. This was notably lower in some localities e.g. Qarhis 8% and Harfo 8% and higher in Jeriban (47%) and Dangoroyo (37%). One third of households surveyed had at least one member involved in community based welfare projects, ranging from four fifths in Dangoroyo, and Jeriban to less than one tenth in Harfo, Balibusle and Kalabayr. In Qarhis 58% of households surveyed had at least one member participating in a community project or activity.

Analysis of the types of committees and projects in which people participate suggest an inclination to engage in essential service provision; e.g. water and education, and to a lesser extent security and production activities. 50% contribute labour, while 28% engage in decision making, and 26% contribute financially.

Systematic Exclusion of Women

The male household head is likely to be the active participant in both committees and community projects, regardless of location or lifestyle (80%). The proportion of women participating broadly correlates with the proportion of female headed households (15%). This trend is also reflected in data about who in the house makes decisions on participation and specifically financial contributions to projects or activities. The correlation between the very high infant mortality rates found in rural areas of Puntland as reported by UNICEF (1999) and the institutionalized exclusion of women - including from access to and control over resources – supports the findings reported by Bloom & Lucas (1999) as presented in the literature review in chapter 3.

Social Capital and Willingness to Contribute

Willingness to make financial contributions is a function of: access (50%), i.e. - not being able to access the same service from another source; quality (41%) - the supported service meets needs better than other alternatives; and community pressure (29%). The fact that one third of households surveyed gave money because of pressure from the community highlights the traditional influence of community elders, relatives and neighbours and

supports the claims made in the literature review in chapter 6 about the important role of social capital in regulating community participation.

Lack of formal participation mechanisms

When asked about the timing of contributions made, households replied:

1. "when asked" (46%)
2. "monthly" (26%)
3. "seasonally" (11%)

The predominance of *ad hoc* contributions reflects the general lack of formal participation mechanisms and the needs-driven context of financial donations.

Across the sampled population, lack of time was the main reasons given for non-participation by the household in community committees or activities. Not being asked to participate was the main reason for 25% of those questioned, indicating the untapped potential of a society accustomed to family and community-based approaches to resolving problems of every type. In only 10% of cases were financial requirements the cause of non-participation.

Validation of the Findings

A workshop was conducted in February, 2001 to present the survey findings to the community members and clinic staff who had conducted the survey. The workshop was held in Garowe and attended by staff from the Red Crescent offices in Garowe and Galkayo and the twelve Puntland clinics, and by elders from the associated communities. It was also attended by the Director of Health in the Ministry of Social Affairs, and representatives of UNESCO and UNDP in the Puntland State of Somalia. The main objective was to validate the socio-economic data provided by the survey and the trends and conclusions drawn from the said data, in order to provide a legitimate baseline for the development of solutions to sustainable community health services in Puntland. As noted above, Chambers' criticism of the analysis of data generated by traditional surveys:

'the realities portrayed in the final analysis can be expected to be: selective..., simplified..., overfavourable...[and] reconfirming'.

Chambers, 1999:95

With this in mind the data generated by responses from the twelve communities to each question was prepared for presentation and validation or rejection. A list of queries was drawn up seeking explanations from the broader group of community members and clinic staff for trends and conclusions emerging from the data. Questions were focused around four key issues:

- i) Health Behaviour**
- ii) Ability to contribute materially and financially to the running of the clinics**
- iii) Willingness to participate more actively in the health service**
- iv) Meeting Community Expectations**

Health Behaviour

Approximately 35% of households surveyed use private pharmacies, ranging from no use at all in Jeriban and Sinujiif where there are no pharmacies, to 55 per cent and 75 per cent in Galkayo and Eyl (both urban centres), all the way to 98 per cent in Qarhis.

Community representatives were asked:

If Red Crescent clinics in the twelve communities provide free, professional health services for all community members, why do so many people still pay for services and medicine from unregulated 'pharmacies' run by largely unqualified people?

Participants explained that the use of pharmacies in communities with Red Crescent clinics is related to the non-availability of drugs in the clinics. In some cases, the administration of injections and the availability of rudimentary lab-services in pharmacies add to the perception that they provide better or more effective services. There is also an element of

access in that pharmacies' opening hours are longer, extending into the afternoon and late evening while clinics are only open during the morning and early afternoon.

Red Crescent health officers added that in some communities, staff from the clinics also maintain a private practice in the pharmacy, or may even own a pharmacy and maintain both public (i.e. Red Crescent clinic) and private practices.

Some pharmacies charge a consultation fee, others do not. They are regarded as cheaper than private doctors. Almost all pharmacies provide services and medicine to regular customers or people they know in the community. The participants did not know of any pharmacies with refrigerators for storing perishable medicines or vaccines.

If the Red Crescent clinics are run by professional staff using modern, proven methods with good recovery rates, why do so many people still use Traditional Healers with no formal medical training and no access to effective modern treatments?

According to the survey, of those households surveyed, 54% still consult traditional healers. This finding was rejected by the community representatives who insisted that out that the real rate is more like 100 per cent, as everyone uses the Traditional Healer. They gave two explanations for this:

- a) Most people use both healers and professional services such as clinics or hospitals – it is not an either/or situation. There is a widespread belief in Healers and such beliefs are strongly held within the rural communities. The President of the Red Crescent, a surgeon and former director of the National Hospital in Mogadishu, noted that one of the main problems when treating patients in the hospital was that they would 'disappear' for a couple of hours every day or during the night, leaving the hospital to go and see the Traditional Healer. The men among the group showed the burn marks from traditional healers' standard treatment – burning the body at the point of pain to prevent it from spreading.

- b) In most cases, especially rural or nomadic areas, people will seek assistance from the community healer before making a journey to the nearest clinic. The correlation between use of Healers and the presence of sizeable nomadic community is undoubtedly a reflection of accessibility, particularly during the wet seasons when nomadic families remain in the bush for weeks, or months, at a time.

The 'healing' tradition appears to run in families with training being passed down from one generation to the next. Participants said that some healers are not paid and appear to practice traditional healing as a 'calling' or duty. Traditional Healers are particularly associated with re-setting fractures. Most are paid in cash or kind, usually based on 'results'. In the past the practice was a legitimate feature of the Somali health system. During the Barre regime there was a department dealing with Traditional Healing within the Ministry of Health. This legitimacy continues in spite of the absence of any system for regulation or control. For instance, participants from Muduug noted that local Traditional Healers give consultations at Galkayo hospital.

Why do mothers and sons use health facilities twice as much as fathers and daughter?

Within households surveyed, mothers and sons were the largest users of hospitals and clinics. Clinic staff and elders related this to childbirth and related care, and the family practice of leaving daughters at home to take care of the household in their mother's absence, while the son would accompany his mother to carry things or provide other help. It was noted that mothers are among the most vulnerable in society, related to issues of pregnancy and related conditions. Sons also have more exposure to the environment outside the home; consequently they are more prone to illness and accidents and thus require treatment more frequently. Sons also accompany their mothers for security or out of tradition, while daughters are more likely to remain at home shepherding livestock. Elders commented that sons are traditionally given a higher value or status than daughters and families are more likely to invest time and finance in the health and education of their sons.

Ability to Participate

An important indicator of people's ability to contribute to the running of the clinics is their ability to pay for other formal health services. The community representatives were asked to give feedback on the results of the survey with reference to existing cost recovery schemes in the referral hospitals.

The Impact of User Fee and Cost Recovery Systems on Access

Although there is a high use of health services such as traditional healers and pharmacies that are not free; two thirds of those surveyed said their use of the referral hospitals had declined since the introduction of user fees. The main reason given by them is that they have less income: two thirds of households using the hospital said they had to borrow to pay for the treatment. A significant fraction of those needing hospital treatments (12.5%) did not use the facility, as they could not afford the cost.

Community representatives and clinic staff were asked:

Have respondents' use of hospital services really declined since the introduction of cost recovery charges? Or are people continuing to use services as much as before the introduction of cost recovery and giving negative responses in the hope that the use of charges will be discontinued?

Experience among the participants verified the lower hospital usage due to the practice of charging user fees as cited by 65% of respondents. They emphasized that nomads and rural communities depending on the livestock trade have been particularly affected by the livestock export ban and for the most part do not have access to cash to pay user fees. Even if they have camels or other livestock, they may not be able to or agreeable to their sale depending on the conditions of a saturated local market, and often prefer to put off hospital treatment indefinitely until their economic situation improves, rather than sell assets and face the future with even less security.

Staff from the Garowe hospital added that 1 in every 5 hospital patients are treated free of charge, but currently there is no clear criteria in place for determining access to free care/treatment.

Borrowing money to pay for Health Care

The survey revealed that two thirds of the households who had used a hospital during the past year had borrowed the money to pay for the service. People's choice of services is clearly dependent on their ability to borrow: sixty-nine per cent of those surveyed indicated that the amount they can borrow precludes the use of some health services. Survey responses also indicated a significant factor in the sale of livestock is the need to repay loans. This raised further concerns about the consequences of imposing an obligation on households to participate in the costs of running the clinics. Community elders and clinic staff were asked:

Would the imposition of charges for some clinic services exacerbate poverty by adding to the burden of unsustainable indebtedness?

Participants described how borrowing was one of the few local coping mechanisms to respond to the imposition of charges and how this perpetuated the cycle of poverty for many families. Most people do not have regular incomes and where unforeseen expenses are incurred, money is borrowed locally. Businessmen, shopkeepers and those in the community who are relatively well-off are expected to lend money to those with genuine needs. People lend without any need of guarantees at village level. The reasons for this were that it maintains good relations within sub-clans and communities and between neighbours, It is also important for generating business and maintaining customers' loyalty. Small businesses, shops and pharmacies take only cash, not kind, and will usually supply goods such as medicine on credit, on an agreed repayment basis. In urban areas, repayment is usually monthly; in rural areas, it is seasonal, linked to the sale of milk, ghee, livestock, and to the rains.

Willingness to Participate

There are considerable levels of participation both in projects and in committees as well as financial involvement, amongst households surveyed. One in every three households indicated some form of involvement in community based welfare projects. The participants confirmed the positive trends emerging from the survey of people's general willingness to

participate in projects and services that meet communal needs such as water and education. The conclusion that half of those participating financially said they gave money because they had to: i.e. – there was no alternative service that they could access was a reflection of the reality of life in a country with no functioning public services. Participants noted that Somalis are a proud people and there is a general willingness to contribute financially for a higher quality service.

Reluctance to Participate

Participants were not surprised that half of those questioned gave ‘lack of time’ as the primary reason for not participating: even if formally unemployed, most people have extensive commitments ranging from informal work with livestock herding, to domestic activities and attending to relatives needs. Nor were they surprised that one household in four had not been asked to participate, implying that participation needs a specific focus, planning and implementation. This was supported by community elders’ concerns that participatory initiatives such as projects and committees face a range of difficulties, including:

- Social pressure to ensure clans or sub-clans are represented on committees, regardless of ability or qualifications
- Pressure from politically ambitious individuals for committee inclusion, in spite of having no qualifications
- Pressure/influence on committee decision by powerful local vested interests

From their own experience they gave examples of pressure they faced from local people in relation to employment decisions and problems arising from the occupation of land around a local clinic. They also spoke of the difficulties associated with responsibility for building maintenance in resource-poor communities. Nevertheless, Committee membership is perceived to confer status and command respect, and indicate standing in the local community. This was linked to practices in the previous government when people were organized in committees at various levels.

Timing of financial contributions

Timing of financial contributions is an important factor in the design of any system to engage people's participation in the running costs of the clinic. The survey results indicated that voluntary contributions were made:

- "when asked" (46%)
- "monthly" (26%)
- "seasonally" (11%)

Participants were asked to validate and explain these responses. Community elders pointed out that in rural areas where most of the clinics are located commercial activity doesn't revolve around the receipt of a weekly or monthly pay cheque or salary. A significant proportion of earned income is realized on a seasonal basis through the sale of livestock or other seasonal activity such as fishing. Payments are arranged accordingly. The "when asked" responses highlighted the lack of structured participation mechanisms and the needs-driven context of financial donations.

In Search of a Community Financing Model

In order to inform the design of a field experiment to test the hypotheses and assumption elaborated after the pre-study, community representatives and clinic staff were asked to help identify what improvements could be made to clinic services to encourage local people to contribute financially to the running of their clinics.

i) Community Health Committee Representatives were asked:

- *What services would the community be willing to pay for?*

The responses were given as follows:

- Basic laboratory Services: 8/12 communities (would be willing to pay)
- Additional/more comprehensive provision of drugs: 4/12 communities
- Improved quality: 3/12 communities
- Simple in-patient services: 3/12 communities
- Staff training: 3/12 communities
- Transport for emergencies: 2/12 communities

- Staff incentives/salaries: 2/12 communities
- Additional staff resources: 2/12 communities
- Fridge for medicine and vaccines: 1/12 communities

ii) Clinic staff were then asked:

- *What additional clinic services are most commonly requested by the community?*

The responses from the clinic staff:

- Additional/more comprehensive provision of drugs: (proposed by) 12 clinics
- Basic laboratory Services: 9 clinics
- Maternity Services (e.g. in-patient facilities): 5 clinics
- Snake-bite serum: 4 clinics
- Qualified doctors: 4 clinics
- Fridge for medicine and vaccines: 3 clinics
- New equipment: 3 clinics
- Equipment maintenance: 3 clinics

These two groups of preferences were the subject of a lengthy and detailed plenary discussion which led to a consensus on the three main upgrades required for the clinics to meet communities' needs, and engage their willingness to participate in the running and resourcing of the service:

1. Improvements in the range, quality and supply of drugs
2. Basic diagnostic laboratory services (obviating the need for inconvenient, expensive journeys to district hospitals or private facilities in Garowe and Galkayo for tests)
3. Refrigeration - cold chain facilities, enabling more comprehensive vaccination coverage.

Selection of a 'Test' Case

The participants were then presented with the idea of conducting a field experiment in one of the twelve communities to test the hypotheses drawn from the literature review and the

pre-study and develop a more sustainable, locally appropriate service. The objective was explained as identifying ways to sustain the Red Crescent clinic through the participation of the community - i.e. clinic users, community elders, local associations, district health authorities and local government - in the management of the clinics, and the mobilization of resources at local level.

A Representative Community

The overall goal was to identify a system of participation that contributes to the sustainability of the clinics. This system therefore should be applicable to as broad a range of clinics as possible. Participants reviewed key aspects of the socio-economic data derived from the Household Survey, in order to ensure that: (1) the selected community would be representative of the average lifestyle as illustrated by the survey. This implied a roughly even nomadic-settled population ratio, (49% overall according to the survey); and a good degree of isolation in the chosen community as faced by most of the Red Crescent clinic communities (on average, 2-3 hours away from the nearest alternative health facility). The test community therefore should be representative of the other 11 communities in four key characteristics:

1. Lifestyle
2. Participation
3. Income
4. Borrowing for health

From the household survey data, four clinics were identified as being largely representative of the broader population:

1. Qarhis
2. Harfo
3. Hasbahale; and
4. Balibusle.

Qarhis was determined to be the most representative community across the four key characteristics. Representativeness in terms of the average level of community participation

was used as a deciding factor. The process of selecting a field experiment community continued by group discussion on existing patterns of participation and community performance in key areas such as the provision of security, cleaning, maintenance.

Table 7.1: Community participation in clinic support

	Cleaning	Security	Maintenance
Qarhis	Yes	Yes	Yes
Harfo	No	Yes	No
Balibusle	No	Yes	No
Hasbahale	No	Yes	Yes

After further discussion, mainly centred on the extent of community health committee involvement in the running of the clinics, and the state of staff-community relationships Qarhis was determined to be the most representative of the twelve communities and was duly selected as the site for the field experiment

Towards a Participatory Management Model

An in-depth study of the community of Qarhis will therefore be undertaken to provide the basis for the development of a field experiment to design a model for community involvement in the running and resourcing of the local health service and test the four hypotheses and their assumptions. The conclusions from chapter 5 are particularly pertinent: successful expansion of health services can only be sustained by an approach that locates health in the broader context of people's living and working conditions and takes into consideration the reality of social inequities. The chapter concluded that the dilemma to be resolved is one of sustainability versus exclusion. Any requirement for participation by users in the running costs of local health services in Puntland will need to consider that at least half of the population is nomadic, and access to cash is restricted for the majority of people to once or twice a year when livestock are sold. In this context the administration of any formal exemption system will be highly problematic and perhaps even impossible: most people do not have regular incomes and where unforeseen expenses are incurred, money is borrowed locally. Risk and vulnerability are thus spread around the community by the practice of borrowing. Furthermore, a financing system based on service charges and user fees is likely to increase borrowing and exacerbate indebtedness and vulnerability across the community as a whole.

The hallmark of an effective financing system will therefore be seen in its ability to contribute to sustainability while protecting access. The key to this dilemma lies in an appreciation of the distribution, sources and frequency of access to income among the population as a basis for the elaboration of a financing scheme. The system would reflect the following criteria – affordability: the level of the participation; frequency (i.e. - weekly, monthly or seasonal contribution); structure: collective or individual payment; and equity: the existence of functioning and effective traditional safety nets to protect the poor and the vulnerable.

Conclusion

Empowering local people to conduct or participate actively in the planning, design and conduct of surveys in their own communities has the potential to address many of the weaknesses of the traditional questionnaire survey and produce an active mobilization of community members to resolve a problem that they know more about, understand better, are no longer intimidated by, and feel mandated to confront.

Results from the survey which were validated by community members and clinic staff show a significant degree of willingness and ability to participate in the running and resourcing of local health services. However, the assertion that everyone in the communities has the ability to contribute financially to the running costs of their health facilities was challenged by the trend emerging from the survey that people use hospitals less since the introduction of a user fee. The impact of user fee and cost recovery systems is particularly pernicious given that restricted access to clinics and hospitals is one of the main causes of record infant, child and maternal mortality.

The survey confirmed people's general willingness to participate in projects and services that meet communal needs such as water and education, with one third of households contributing to community based welfare projects. Reflecting the reality of life in a post-war country with no functioning public services, half of those participating financially said they gave money because there was no alternative service available to them. In most

communities there is a strong tradition of participation with considerable levels of engagement both in projects and in committees.

However, people's willingness to participate in community health and contribute their resources to support the running of the clinic cannot be taken for granted. The conclusions of the survey and the analysis with community representatives are clear: the current externally-driven approach delivering standardized clinic services is no longer appropriate in the context of an emerging recovery, competition and the widespread sense of entitlement to a reasonable range and standard of service. Investment in additional clinic services designed to add value, improve quality and meet peoples' perceived needs is a prerequisite to meaningful participation and enhanced clinic sustainability. In this sense, the conclusions from chapter 5 are particularly pertinent: successful expansion of health services can only be sustained by an approach that locates health in the broader context of people's living and working conditions and takes into consideration the reality of structural inequities.

* * *

The next chapter will present the theory behind the use of the case study as field-experiment and its application in the community of Qarhis to identify ways to sustain the local health service through the involvement of community actors in the management of the clinics, and the mobilisation of resources at local level.

8. Qarhis: The Field Experiment

Introduction

The participatory surveying process presented in chapter 7 established a valid profile of the twelve Puntland communities' ability and willingness to contribute to the running and resourcing of their local clinics. The trends and conclusions that emerged from the survey were validated and elaborated further by the community representatives and clinic staff during a participatory validation workshop, providing a preliminary substantiation for the hypotheses advanced in chapter 8 and the assumptions on which they were based.

The next step is to design a field experiment to fully test the hypotheses and the assumptions on which they were based by identifying a participatory management model to sustain the local health service through the involvement of community actors - i.e. clinic users, community elders, local associations, district health authorities and local government - in the running of the clinics and the mobilisation of resources. In order to be able to do this, an in-depth study was carried out in one of the twelve communities serviced by the Red Crescent clinics: the community of Qarhis.

This chapter takes as its starting point the Annex 1 review of participatory action research as a methodology for enlisting local people's participation in the study of social situations to improve their understanding and engage their commitment to improve them. An in-depth study of Qarhis was undertaken using this methodology. The following questions frame the study:

- What are the main demographic features of the community?
- What formal or traditional administrative structures exist and how might they be engaged to support health service recovery?

- What collective activities are undertaken to meet the main communal needs of the population?
- What are the specific health needs of the community and what role do private sector providers play in meeting them?
- What services are provided by the Red Crescent clinic, and how well does it function?
- Is there a willingness to participate in community health, as evidenced by a tradition of collective community efforts to confront potential or actual disaster?
- Do people in the community really have the ability to participate, i.e. - sufficient resources such as assets and income to be able to contribute financially or materially to the running cost of the clinic?

The findings were used as a basis to reach agreement with the community and the main health service actors on a programming model to increase community involvement in the running and resourcing of the service, and to set up a field experiment undertaking significant changes in the planning, management and resourcing of health services in the community of Qarhis.

The Case Study as a Field Experiment

In chapter 5 the case study was selected as the most appropriate methodology for in-depth study of the context in which community health services are delivered, and the issues of participation and sustainability. The case study was defined as

‘...a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence’

Robson, 1997:52

The case study was described as an intensive, in-depth exploration of past or current events, using a combination of observation, interview and documentary analysis which could be used for the rigorous testing of a well-defined thesis undertaken when an intellectually rigorous approach achieves experimental isolation of selected social factors in their natural setting. In this sense, the case studies can become a field experiment to investigate or confirm causal processes behind observed patterns or correlations (Hakim, 2000:60;

Bowling, 2002: 403-406). Descriptive case studies could also be exploratory if relatively little previous research has been conducted or could be used to develop a detailed profile of social features or patterns which are held to be representative of other cases. When a survey is undertaken to substantiate a hypothesis or establish the existence of certain conditions, a case study can then be used to provide a more detailed and precise description of the processes at work (Hakim, 2000:63-75).

Community Studies are studies of a local community, village or town to describe and analyse the main aspects of community life such as its political and religious activities, family life, work and pastimes. Such studies usually provide a detailed profile of the particular community and the pattern of social life, but they can also be used to address specific questions and issues (Hakim, 2000; Robson, 1998). The type of case study used to conduct the in-depth study in Qarhis community was a variation on the community study, seeking a more detailed profile of the community in relation to its health behaviour and its ability and willingness to participate in the running and resourcing of the Red Crescent clinic. An *action research* approach was used to conduct the study. Preparations centred on selecting and briefing the core research team, identifying participants and key questions, and preparing a data collection plan.

The Research Team

A multidisciplinary team was selected with professional expertise in medicine, public health, education, economics and planning. To ensure commitment from the main stakeholders in health service provision, the team included staff from the Red Crescent offices in Galkayo and Garowe, the Puntland Directorate of Health and the Federation Somalia Delegation. Training on research methods was given and the team developed observation checklists, semi-structured interview questionnaires for clinic exit interviews, structured questionnaires for a mini-household survey, maps for transect walks and key probes to guide the data collection process.

Participants

The selection of the target community had already been made by community members and clinic staff from the twelve communities during the household survey validation workshop.

Community representatives and clinic staff facilitated the identification of key individual and social group participants. This was cross-checked with the Garowe Red Crescent office and participants were listed for involvement in the study. The list included a cross section of community members including clinic users, local traditional leaders, and community elders, clinic staff, private health service providers such as pharmacists and Traditional Healers; and staff from local government offices, the Red Crescent and UNICEF.

Key Questions

The overall aim was to engage these participants in an action research exercise about the community's willingness and ability to support their health facility, in order to facilitate the identification by participants of proposals for changes to the running and resourcing of the clinic service to make it more sustainable.

Specific areas of study were identified based on the information provided by the household survey and seven main questions were developed:

- i) What are the main demographic features of Qarhis community?
- ii) What governance systems operate in Qarhis and what suitable community governance mechanisms exist to support health?
- iii) What are the community's main health problems and the facilities they use to address them, and why;
- iv) How are other communal needs such as water, education and communication met?
- v) How does the Red Crescent clinic function and to what extent does it really meet the needs of the community
- vi) Do people in the community really have sufficient resources such as assets and income to be able to contribute financially or materially to the cost of the clinic?
- vii) Are people really willing to participate actively in the running and resourcing of the Red Crescent clinic?

Data Collection Plan

The research team planned to spend three days in Qarhis conducting the study. Working in teams of two, the plan was to conduct in-depth research into various aspects of life in

Qarhis, the surrounding villages and the nomadic community using a variety of data collection methods:

- Meetings with people from the community, including elders, health committee members, representatives of women and youth groups,
- Randomly sampled household interviews (both settled and nomadic),
- Visits to local pharmacies and traders,
- Analysis of clinic records
- Exit interviews with clinic patients
- Depth interviews with clinic staff
- Focus group interviews
- General observation of community life and clinical practice, using observation checklists.

The Case Study of Qarhis

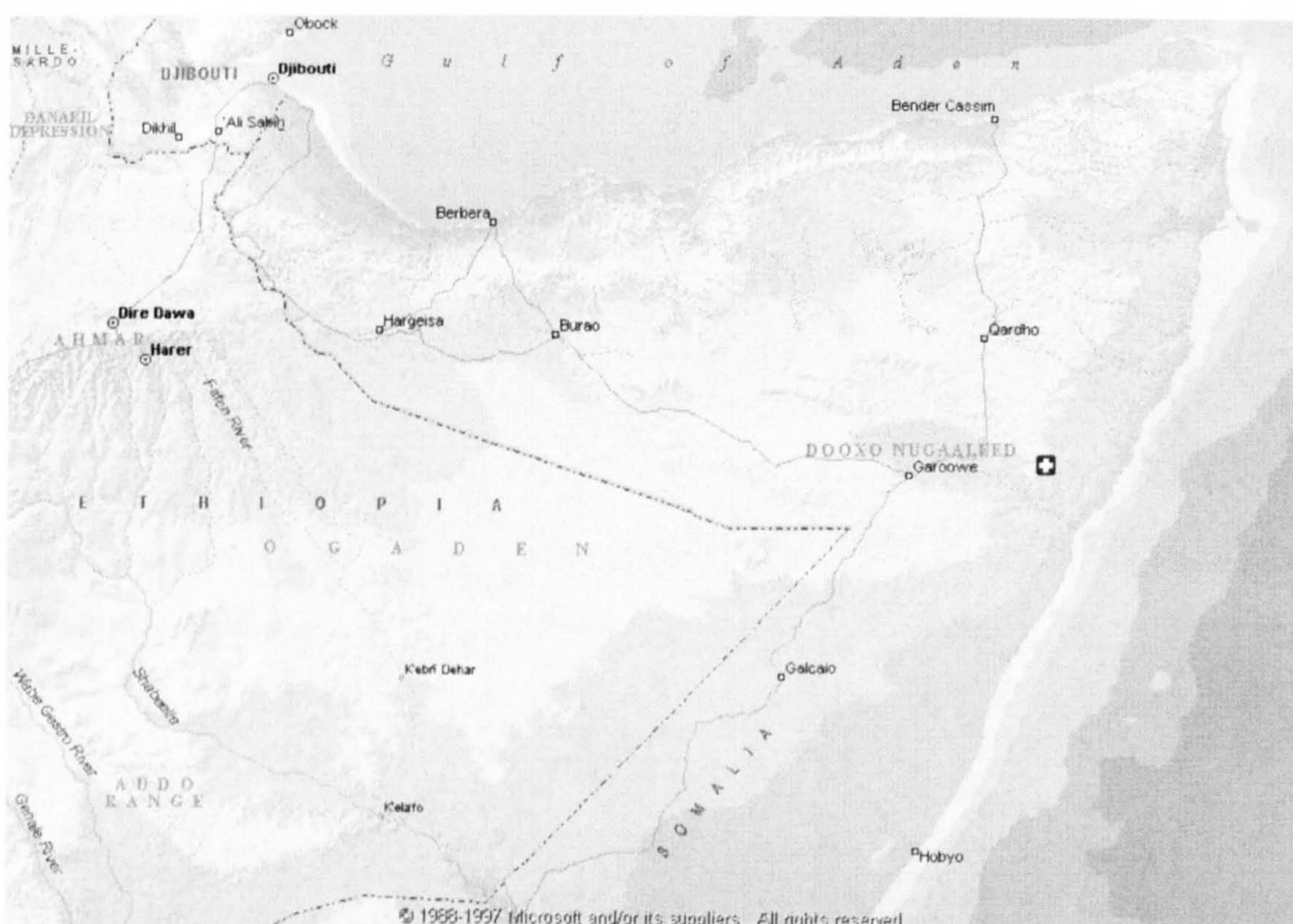
The main findings from the action research exercise in Qarhis are presented in the following paragraphs. They fall under seven headings:

- i) Demographic features
- ii) Governance systems
- iii) Main health problems and facilities
- iv) Communal needs
- v) The Red Crescent Clinic
- vi) Ability to Participate
- vii) Willingness to Participate

Demographic Features

Qarhis is a village situated approximately 135 km to the north-east of Garowe on an old trade route joining the main north-south road between Garowe and Bosasso with the coastal town of Eyl. Its population is estimated at around 5,500.

Map 2: Qarhis



The household survey data pertaining to Qarhis indicates a rural community reliant on livestock production for its survival. Lifestyle among the sampled population was estimated at 53 per cent nomadic and 30 per cent rural. A further 10 per cent is engaged in fishing, while 3 per cent of those interviewed have an urban lifestyle and 3 per cent are displaced. Interviews with households selected randomly during the case study broadly reflected this data. Although five years ago, there were no stone-built houses, the village is now made up of 463 houses, the majority of which are made of stone, reflecting a dynamic, permanent settlement with a relatively high level of income which has been sustained over a period of years.

It appears that many people moved to the area after fleeing from Mogadishu during the war. Of the 12 households interviewed during the case study, six had suffered displacement as a result of the war. Most had been living in Mogadishu and were forced to leave after family members were killed in the fighting. They moved to Qarhis because they were born there, or had relatives in the area that helped them resettle.

General observation suggested a healthy, well-off, well-dressed population. The majority of the houses appeared to be well constructed and maintained. There were a several wattle and daub constructions adjacent to stone-build houses, which were reportedly used to house elderly, settled nomadic relatives. All the houses observed had external, stone-built latrines, and some had stone-built goat pens. During home visits for interviewing it was noted that houses were clean and well maintained.

Governance Systems

Qarhis falls under the jurisdiction of the district of Eyl about 3 hours drive to the south-east. There are no formal administrative structures in the village and the community adheres to the traditional Somali governing system of village councils or committees composed of clan or sub-clan leaders.

✦ Clan Systems

The Qarhis catchment area is inhabited by seventeen sub-clans. The elders of the sub-clan come together to elect a 'Village Elder: Hassan Mahmoud Adde. The elders also nominate a Village Committee, which, along with the Village Elder are the highest governance structure within the community of Qarhis. It comprises seven members. Sub-clan representation is important at the Village Committee level. The seventeen sub-clan elders also elect one elder to head the Village Committee.

It is then the responsibility of the Village Committee to constitute other service committees depending on needs and opportunities. There are two service committees supporting health and education. Qarhis also has established Women and Youth Organisations. Some committee members are more active than others: four of the village committee members are represented in one or more of the service committees (Mohammed Haji Musa, Abdullah Ahmed Abu Musa, Haji Abdul-Said and Halima Moalem).

Membership of the committees is voluntary. It requires the commitment of a great deal of time and goodwill on the part of the members. All members claimed that they gain no

direct benefit as a result of their membership. They are often left with the difficult job of implementing schemes and accounting to the community. With the exception of a three members of the education committee, neither group of committee members have received formal training for their roles, and none have been given terms of reference.

✧ **The Health Committee**

The representatives acknowledged that a verbal agreement had been made between the community and Red Crescent, in which the community committed itself to meet the needs of the clinic in terms of providing cleaning, maintenance and security. The agreement was made at the behest of the Red Crescent after it reduced the numbers of clinic employees from twelve to three in order to cut costs when donor interest in the program started to flag back in 1997. The representatives claimed that in those early days the concept of 'community participation' was very new to them. They were not able to organise themselves properly and failed to live up to their agreement with Red Crescent. Clinic staff said they have had to employ a guard and pay his wages from their own pockets. However, this changed in 1999. Today the community contributes to the clinic activities in a number of ways, some of which were not in the original agreement:

- **Security:** They claimed that the community collectively ensures that someone is sleeping at the clinic every night as a precaution against break-ins. Apparently this became necessary after the clinic was burgled.
- **Cleaning:** The community cleans the surroundings of the clinic on a regular basis and whenever asked to do so by the clinic staff, who clean within the clinic.
- **Water:** The community provides water free of charge for the use of the clinic on a monthly basis. It is the Committee's responsibility to ask for the water from various local donors. Occasionally, when donors were not willing to donate the water, the committee has had to raise the money to pay for it. Clinic staff added that the supply of water was a source of frequent problems.
- **Mobilisation:** The Committee is active in the mobilisation of the community to help ensure maximum attendance during vaccination campaigns.
- **Transport:** Transport of seriously ill people to and from the clinic to the referral hospital in Garowe is organized by the committee if the family has no access to any means

of transport. The committee claimed they have to deal with as many as six cases every month.

- **Accommodation:** The committee also arranges with the community to provide overnight accommodation for patients who travel long distances to attend the clinic, or for emergency cases.

Communal Needs

Research was conducted in how the community meets the main communal needs of the population other than health. Participants provided the following information about water, education and communication.

✧ Water

Water is drawn from the 41 barkads in the immediate surroundings of the village. A barkad is a water reservoir dug into the ground and lined with concrete to capture and retain precipitation and surface water. It resembles a crudely built swimming pool, with a concrete rim surrounded by the mounds of earth excavated to make the hole, and covered with a tensile supported web of fishing nets, cloth and dry branches to prevent evaporation. This is critical as temperatures can reach 45 degrees in the dry season. Typically, there is a concrete platform at either end of the barkad with a manhole type opening from which water is drawn using a bucket or 40-litre plastic container attached to a rope. The container is emptied into a type of water trough fashioned by cutting a fuel drum in half to make two cradle-like “troughs”. Animals are led into the barkad enclosure and queued up to water.

There are thirty-three large barkads containing 10,000 barrels each and 8 smaller ones containing around 2,000 barrels of water each. The smaller barkads are for domestic use – not for animal consumption. Of the thirty-three only three (owned by Islam Mohamed) are for exclusively commercial use – the other 30 are owned by families who have large herds of livestock which they water from their barkad. They sell the water to nomadic herdsmen when there is a surplus. During the dry season nomads bring their livestock to be watered on a weekly basis. This task also provides them with the opportunity to visit the clinic and seek advice and medicine for any ailments. Basic food and hygiene supplies are also

procured. In the wet seasons they come less frequently and usually for more urgent treatment.

Box 8: Excerpt from an interview with Shire Elmi Yusuf

Shire Elmi Yusuf owns one the biggest *barkads* in the village. It was built in 1985 and serves the needs of his family's herd of livestock consisting of 50 camels, 1,000 goats and sheep and 20 cattle, and those of the village more generally. His family is over 40 persons who help to look after the herds – shepherding and milking. The water in the barkad is now running low and will probably be exhausted in one month. Rain is expected before the end of March.

✻ **Education**

There are two schools in Qarhis – a basic two-room Islamic school or *Kuttab* for children aged from five to fourteen, and a primary school. In the *Kuttab* the old Islamic system of preparing text from the Koran on rectangular wood boards, called *Loox* is used. The text is written using black ink made from charcoal mixed with water. The ink is fixed using goat milk. The primary school was established in 1971 when a two-room school-house was built for the residents of Qarhis. In September 1997 three rooms were added under a UNOPS sponsored health sector rehabilitation programme. In December 1998 UNICEF provided funding for the construction of a latrine and a water tank. The two original schoolrooms were renovated as part of the UNESCO Peer programme in June 2000. There are plans to build a sixth room in the coming months and stones have already been delivered by the community.

Table 8: Qarhis primary school

Grade	Total	Girls	Boys
1	24	10	14
2	28	9	19
3	16	6	10
4	18	10	8
Total	86	35	51

The school director is Mohammed Haji Musi who is also the chairman of Qarhis Village Committee. There are three other teachers. A seven-member education committee chaired by Abdullahi Ahmed Musi provides governance support.

Education is not free. The school is run on a user-fee basis whereby parents pay SS 15.000 (approx. USD 1.25) per month for each child attending school, up to a maximum of two children. The money is used to pay part of the teachers' salaries and a small amount is set aside for costs related to upkeep and maintenance. Labour, cleaning and water are contributed by the community. This income is supplemented by an income-generating project sponsored by UNESCO Peer. A solar-powered HF radio station provides access to communication for the otherwise isolated members of Qarhis community and its extensive nomadic constituency. The average amount generated by the radio service is around USD 50 per month. Together with school fees income amounts to around USD 150 per month

✳ Communication

The nearest telephone exchange is two hours drive away in Garowe. Communication is made possible by this HF radio connection. Radio communications are charged at SSh 1,000 per minute, and international calls cost USD 1 per minute. Contact can be made with Somali communities in many parts of the world. To demonstrate this Mr. Musi spoke with Dubai, Nairobi, Bosasso and Balibusle. He then demonstrated how the radio serves as an international telephone service for the village. Using the HF radio, he contacted *Puntel* Telephone Company in Bosasso some six hours drive from Qarhis and gave them he telephone number for a subscriber in Jordan. While the rest of the research team listened, one member spoke with his father in Amman. The service is used by nomads to check the condition of the livestock market, the prices for different animals and even to trade with livestock exporters. There is also frequent communication between parents in the village and their sons or daughters who are working seasonally in Eyl. The service provides a valuable link between the Red Crescent branch in Garowe and the clinic in Qarhis. It is used regularly to request additional drugs, and provide situation reports. Although it generates up to USD 50 per month, the fragile nature of such projects became clear when participants informed the team that competition was expected soon from a seasonal fisherman who had procured another HF radio and would be setting up a rival service at the end of the season.

Health Needs and Service Providers

In-depth interviews with staff, analysis of clinic records, and patient exit interviews were used to prepare a descriptive account of health needs and private sector health service provision.

✘ Health Needs

The major health problems encountered in Qarhis are infectious diseases like ARI (acute respiratory infections), diarrhoea, measles and tuberculosis (TB) and malaria. The most common complaints treated at the clinic were diarrhoea and cough, mostly in children, malaria, skin diseases, ear and eye problems, and pregnancy related issues, wound (injuries) etc. The clinic also services patients with chronic illnesses such as asthma. More complex illnesses are referred to Garowe hospital for treatment, as are cases requiring surgery such as, for example Caesarean section, appendicitis, etc. Whooping cough was common among under-fives, and the midwife reported two infants had died due to neonatal tetanus.

Tuberculosis (TB) is on the increase throughout Somalia and Qarhis is no exception. In Qarhis TB is commonly found among the nomadic population and patients were being referred to Garowe hospital, for testing, and treatment with can be given. Intestinal parasites are also common, frequently leading to anaemia. Incidence of malaria is also high, as mosquito larvae breed in the village *barkads*.

The registers showed that urinary tract infection (UTI) and Sexually Transmitted Diseases (STD), e.g. syphilis and gonorrhoea, were common occurrences. Patients with UTI were being treated in the clinic; others were referred to hospital for management.

The high rate of Sexually Transmitted Disease and TB both point to high risks of an HIV/AIDS epidemic in the near future. Moreover, a number of factors specifically promote the spread of the disease among women of child bearing age:

- Lack of awareness and education, particularly among girls and young women
- High prevalence of STDs
- The widespread practice of Female Genital Mutilation

-Traditional surgical practices such as scarification and episiotomy by Traditional Birth Attendants.

✧ **Physical Access to Services**

A majority of clinic users interviewed were from Qarhis village, with a significant number of users from the nomadic population (29%). The rest were from the neighbouring villages. Patients from the nomadic areas and neighbouring villages walk between one and six hours to seek treatment in the clinic. Walking is the most common means of transport for clinic visits, but for severe cases the Health Committee may arrange motorised transport. The Committee also arranges accommodation in the village if needed.

✧ **Health Service Providers**

During group discussion with community members and clinic staff five different categories of private health service provider were noted:

- i) General Practitioners;
- ii) Pharmacies;
- iii) Traditional Healers;
- iv) Traditional Birth Attendants;
- v) The Red Crescent Clinic

A more detailed profile of each was obtained through participant interviews and observation.

General Practitioners

Clinic staff informed us that there were no private doctors in Qarhis, but further enquiries revealed that the Clinic Head Nurse maintains a private practice at a local pharmacy during the afternoon, and the auxiliary nurse provides dental consultations and sets fractures outside of clinic opening hours.

Pharmacies

Pharmacy usage was common, depending on the time medication was being sought and the amount of money patients had, thus indicating a tendency to obtain only partial/incomplete courses of treatment. There are two “pharmacies” in Qarhis. Neither is run by a qualified pharmacist or medically trained person. The oldest “pharmacy” is owned and run by Mohammed Haji Musa, School Director. Essentially a limited general store, a variety of

clothing, cosmetic and medical products was for sale. Sales were mainly on credit and one entry in the ledger noted a loan of SS 220,000 that had been provided recently to a regular customer and subsequently repaid. Mr Musa is a teacher by profession with no training or background in health, although he claims that before the clinic was opened he used to perform a range of health procedures, including giving injections, setting up infusion and applying sutures when the need arose. The shop has a limited range of syrups, tablets/capsules, quinine injections and some infusions, acquired from Bosasso. Expiry dates were difficult to determine. Haji Musa says he sees about five or six people daily during the low season, and between fifteen and twenty-five a day between May and August. Drugs for sale cost SS 300 and SS 500 per tablet (e.g.: Panadol SS 300, Ampicillin Capsules SS 500), while syrups were from SS 10,000 to SS 20,000.

Box 8.2 Interview with a Traditional Healer

Munina Osman, 63 years of age, is a traditional healer. Her grandfather was a well-known traditional healer in the Qarhis area. Her mother also was a traditional healer. She learned what she knows about healing from them and has picked up a lot of knowledge since she started practising as a traditional healer at the age of 20. She also runs a small shop selling very basic items such as razor blades, shampoo, soap and matches. She spoke about two main complaints that she treats: intestinal – kidney infections, liver and stomach ailments; and orthopaedic (osteoporosis, dislocations). She said she always burns her patients and sometimes she will make small incisions or cuts, both at the point of the pain. She also gives herbal preparations and mentioned specifically mixing certain herbs and sheep lard to make a potion that she prescribes to people with bone disease. She emphasized that burns are superficial and care is taken not to do damage to veins or lower epidermal layers. She said that she must burn otherwise the illness will spread and there will be long-term damage. She sees 5-10 people per week for intestinal/abdominal complaints and 3-5 people per week for orthopaedic problems apparently related to TB (chest deformity). Her diagnosis is based – in the first instance – on pain. Intestinal problems are diagnosed by identifying the source of the pain, and then checking for any fever, diarrhoea or vomiting. For skeletal problems, she will ask the person to stand up and check their posture, and question them about the source and range of the pain. She noted that pains in the feet or legs could also indicate back and chest problems. Her relationship with the clinic is tenuous. On one occasion recently a woman's jaws became locked when she was yawning and the head nurse at the clinic could not solve the problem and referred her to the hospital in Garowe. Her family and neighbours organised a car to take her there. While they were awaiting the car Munina was called upon to look at the woman. She managed to reverse the dislocated jaw. She said she doesn't charge anything for her services though this was contradicted by every other participant asked about traditional healers.

Excerpt from an interview with Munina Osman

Traditional Healers

As noted in chapter 8, the use of traditional healers is widespread throughout Somalia. Most have no formal training and use crude instruments and primitive techniques. According to the Household survey, 50% of households in Qarhis use Traditional Healers. However, the clinic is still preferred to Traditional Healers. One patient with back-pain commented: "I am tired of the burning treatment from the Traditional Healer, as it was not solving my problem but just leaving me with terrible scars." Sums charged by the Traditional Healer ranged from free-service, to SS 1,000,000 (US\$ 77), and "not more than one camel." Qarhis has two traditional healers. A depth interview was conducted with one of them.

Traditional Birth Attendants

Three trained Traditional Birth Attendants (TBA's) work in the village in close co-operation with the clinic. The TBA's conduct deliveries at home and the midwife is often consulted for complicated cases. They are not paid by the Red Crescent but do receive payment from families for assistance with the delivery of a child. The payment is generally made in kind, usually in the form of a goat or a sheep, and was reported to be conditional on the birth of a live, healthy child. The relationship between the TBA's and the clinic staff, especially the midwife, is very good. Reporting on deliveries by TBA's is regular, immediately after each delivery, and they are regarded as effective community mobilisers, especially during immunisation.

The Red Crescent Clinic

Qarhis clinic is the only health facility in the area, serving a total population of approximately 6,000 people and offering free medical consultation and drugs. The clinic was established in 1996 with a mission to provide essential basic health care for the population of Qarhis, targeting the most vulnerable groups, such as mothers and children. A detailed profile is presented in the following section

The Red Crescent Clinic

The clinic provides a range of curative, preventive and promotive services aimed at improving the health status of the population of Qarhis and the outlying area:

- Mother and child health care
- Out-patient consultation, prescription and medication
- Outreach services to improve health service coverage in the village catchment area
- Information, education, communication (IEC) campaigns to promote community health awareness and action
- Training for health personnel including community's own resource persons (CORP's), traditional birth attendants (TBA) to improve their efficiency.

✧ Clinic Services

Clinic registers were reviewed for a period of six months (July to December 2000). This included all clinic registers, mother and child, delivery and outpatient register. It was observed that 80% of clinic users come for curative services, including pregnant women. Clinic staff use the visit to offer all services required by the patient. In the MCH section, about 200 to 250 patients were seen monthly, including mothers and children. In the OPD, records indicated between 200 and 250 patients a month were being seen. The busiest period is from May to August, coinciding with the *Haga'a* dry season which brings a major inflow of nomads in search of water, and also with the return of seasonal fishermen from the coast.

Patients were treated for a range of common diseases, vaccinations were administered, and antenatal and other postnatal care was provided. Although deliveries do not usually take place at the clinic, the midwife does provide assistance to TBAs with difficult deliveries, and refers complicated cases to the hospital in Garowe.

Health education about personal hygiene, sanitation, and nutrition and vaccination is given routinely during clinic visits. There are also periodic health education and sanitation campaigns and occasional presentations to school classes and youth and women's groups.

UNICEF organises annual vaccination drives as part of its program for expanded immunisation (EPI). However, this has less impact on the nomadic community who are difficult to reach and frequently default on vaccination schedules. Missed opportunities for immunisation were a major problem, despite staff efforts to use curative services as a

vehicle for preventive services. Vaccine supply was reported to be irregular, as the clinic does not have a fridge or freezer and has to rely on the Garowe Red Crescent branch Cold Chain.

✘ Supplies

Supplies are delivered to the clinic on a monthly basis by the Red Crescent Health Office in Garowe. The clinic receives one kit of essential drugs every month, and supplies of vaccines for the main six childhood diseases: polio, TB, measles, whooping cough, diphtheria and tetanus. Staff reported that drug supplies arrive regularly, but are usually insufficient, and that, during the dry seasons when attendance is high, supplies of certain drugs, particularly antibiotics, are exhausted before the end of the month. It was noted that the drug 'kit' and the type and quantities of medicine supplied do not vary from one month to the next, even though health problems differ and attendance at the clinic varies significantly during the dry and wet seasons. For example, while malaria may increase tenfold during the wet season, conjunctivitis is a very common complaint during the dry season.

Critically, the clinic does not have a fridge or other equipment needed to preserve the vaccines, and immunizations can only be carried out for a couple of days each month while the cool-box maintains the antigens at the prescribed temperature. During the rest of the month, people requiring vaccines – essentially children and pregnant women – either forego vaccination, exposing them to a range of life-threatening conditions, or they must travel to the nearest alternative facility in Garowe, an expensive and time-consuming process which is rarely undertaken.

Although treatment protocols for all drugs were available in the clinic, observation of patient visits revealed some inappropriate prescribing, and analysis of patient records indicated irrational use of drugs – or over-prescription. It is very common for one family member to travel to the clinic and request – and be prescribed – drugs on behalf of several members.

✦ Staff

The clinic employs three staff: a head nurse, a midwife and an auxiliary (or trainee) nurse. Salaries are paid on a monthly basis – the head nurse receives USD 120, the midwife USD90 per month and the auxiliary USD 60.

Interviews were conducted with all three staff. The mission of the clinic was understood as being concerned with both promotive/preventive and curative health care in the community. Two staff had been provided with job descriptions. The staff explained the role of the clinic in providing basic curative and preventive care within the health program run by the Red Crescent. They described their place in a health system that depended on the Red Crescent branch and was supported by UNICEF and to a lesser extent the WHO.

Supervision and training

Supervisory visits by the Red Crescent Health officer in Garowe take place once a month for monitoring and problem solving. Written reports of attendance and clinic activities are made once per month. There was a discrepancy in understanding of working hours, with three different times (1.00 pm, 2.00 pm and 2.30 pm) being given as the closing time. A staff meeting is held weekly and problems are raised and advice given by the Head Nurse. Additional training is received through ad hoc attendance at workshops, although staff described these as infrequent and insufficient to maintain professional development.

Relationships with the community

Relationships between staff and the community were described as good and mutually supportive. The Health Committee reportedly meets every month, and members occasionally visit the clinic. Relationships with Traditional Birth Attendants were also described in constructive and positive terms. There has been less contact with Traditional Healers, although occasionally they refer cases for fracture setting.

Staff try to respond to requests for home visits to remote areas but this depends on the distance and severity of the case in question. Complicated cases, which fall outside the clinical competence of staff, occur at least two or three times a month.

Ability to Participate

To determine whether people in the community really have sufficient resources such as assets and income to be able to contribute financially or materially to the cost of the clinic, the case study sought to explore in more details ownership of assets, sources of income and access to credit.

✦ Assets

The economic mainstay of the village continues to be livestock. According to the Puntland survey, 52 per cent of the population own livestock – on average 13 camels, 76 goats and 40 sheep per household. Distribution is not even however, and the structure of ownership in Qarhis is such that a few families own as many as 150 camels, 2,000 sheep and goats and even some cattle, while other households maintain a few goats for milk and for sale when cash is needed for living expenses. In the Puntland survey, ninety four per cent of those polled in Qarhis said health costs as one of the main reasons for selling livestock.

Traditionally, Somalia has exported a large amount of livestock to Saudi Arabia and the Gulf and is the largest exporter of camels in the world. However, since September 2000 there has been a ban on the import of livestock from East Africa, imposed by Saudi Arabia and the Gulf States. This is due to suspected incidence of Rift Valley Fever among livestock from the region.

✦ Income

The main sources of income for people in Qarhis community are generated in relation to livestock production, and include trade in live animals and products such as skins, milk and veterinary supplies. Eighty per cent of the population interviewed in the Puntland survey cited livestock sale or production as their main source of income. Income is derived from a much wide range of livestock-related activities.

Sale of water

During the dry season when water is scarce, the owners of Barkads sell water to nomads for watering their animals. Camels are watered at SS500 per head on average, depending

sometimes on camel size. Goat and sheep are charged by *tiro* or each one hundred head – every 2 *tiro* costs one goat on average depending on the market price of the goat.

Payment for water depends on the source from which it is drawn:

- borehole water is always charged for as there is the cost of maintaining the borehole, running the generator and pump;
- *barkad* water is charged at the discretion of the owner;
- hand-dug well water is usually free of charge.

Fishing

Seasonal work was a main source of income for 46 per cent of households surveyed in the participatory survey. During the fishing season – September to May - young people and male heads of families from almost half of the households, migrate to the Eyl and other villages on the coast (around 75 km). There they join other migrant workers from as far away as Kismayo, Mombassa and Ethiopia, to work with a number of big firms that fish up and down the coast and transport sizable quantities of lobster on a large scale to Bosasso for export. Depth interviews with Village Elders revealed that there are fifteen six-tonne refrigerated trucks operating in the district of Eyl, transporting lobster to Bosasso where it fetches \$20- to-\$24 per kilo before export to Dubai. This leaves the village with a population of around 2,200 during this period, but generates significant earning which are sent back to the village regularly or brought back by returning workers at the end of the season.

Remittances

Only eight per cent of the population interviewed in the household survey received income from remittances, and this was confirmed during the in-depth study. Remittance income is a mainly urban phenomenon with few rural families having the education or income required to secure opportunities to send a family member abroad.

Small trade

Among the surveyed population, 10 per cent were involved in small trade or business and this was evidenced by the number of petty commercial enterprises in the village. Shortage

of disposable income and cash to import was clearly evident by the absence of any real economic activity, however. There were three small shops with very limited stocks of razor blades, matches, shampoo and clothing shirts (the in-depth study was conducted during the religious festival of *Eid* when, traditionally, new clothes are purchased). A small amount of frankincense was available at SS 12,000 (USD 1) per kilo. None of the shops had any customers while we were visiting. A butcher's stall exhibited two camel hindquarters, but again, no customers were visible during the two-hour observation session. A fourth "shop" – a room divided into living quarters and a small store - sold flour and pulses from six USAID marked bags leaning against the wall. WFP food is sold in the market. During the visit, a refrigerated truck was parked in the centre of the village and a punctured tyre was under repair. Nearby a couple of piles of goatskins were parcelled up waiting to be collected. Untreated goat and sheep skins apparently fetch around SS10, 000 (USD 0.87) a piece.

Two huts with a handful of very basic products (matches, key rings) were open. Camel and goat milk was also being sold there, not far from the one teashop in evidence where tea and milk were also available. Typically a glass or aluminium beaker of camel milk costs SS 2,000, while goat milk - more popular, particularly for feeding children – sells at SS 2,500 per glass. The school director, who also owns one of the two pharmacies, runs a 'cinema' in a large room behind the pharmacy. This consists of a video player/TV set and patrons are charged SS 2,200 for entry.

✎ Credit

The livestock ban is causing considerable economic hardship. When asked if they ever borrowed money to pay for livelihood activities, all respondents in the Puntland survey answered yes. During depth interviews with community members it was made clear that the ban has resulted in a high level of borrowing for the population of Qarhis, some eighty per cent of whom depend on livestock-related activities for their living. Even for the relatively affluent within the community there is a cash flow problem, with people unable to realise capital from their livestock assets. Many people live on credit, keeping an account they will pay when they can sell their animals. This is particularly true for health care related costs, with ninety-five per cent of Qarhis population surveyed in the Puntland survey

claiming that they had to borrow money to pay health costs. Indebtedness is adding to the overall level of vulnerability in the community and restricting access for some people who need to procure medicines which are not available at the clinic or who need to pay for transport to Garowe for treatment.

The settled, urban community reported the highest satisfaction concerning their present situation as well as optimism for the future. Those interviewed stressed that life was not easy but by comparison with 7 or even 5 years ago, things had definitely improved.

✧ **Vulnerability**

A mini-survey of households in the community indicated that the most vulnerable members of the community are the nomadic households, who have been the most severely affected by the livestock ban. In two cases, the hardship was slightly eased by remittances from relatives working overseas, however the sums involved are small and irregular. Additional earning capacities exist for those nomadic households with particular skills (tinsmiths, mechanics etc.) able to do occasional work in the village or urban centres. Access to education, uptake on vaccinations, and knowledge and use of the Red Crescent clinic is also lowest among this group. One household reported the death of a child in the previous year due to diarrhoea. The economic and health status of this sector of the community appears to be extremely precarious.

Willingness to Participate

The critical area of willingness to participate was investigated through an examination of traditions of collective community efforts to address common problems or confront potential or actual disaster together. The existence and depth of such burden-sharing strategies and communal coping mechanisms were taken as indicators of the potential for collective engagement to improve and sustain community health. The second indicator examined was the level of satisfaction with the service provided, a clear sign of the value that the community would assign to the service, and a useful gauge of its willingness to act to save or sustain the service.

✧ Traditions of support and coping mechanisms

There are long-standing traditions of entitlement and duty which govern individual and community life in Somalia. Key probes solicited information on three particular practices relating to grazing rights, water shortages and compensation in the event of death.

Grazing

From north of Galkayo as far as Sanaag and Las Anod in Sool, livestock herders are free to graze their animals wherever they want. There are specific agreements called 'Her' with other sub-clans according to which watering rights are granted and communities either agree that you have access based on future exchange, or they quote a price. If the water is from a hand dug well you only need to agree the time when your herd can draw water.

Coping with water shortage and drought

When the water in the barkad runs out there is no alternative source in the area. Livestock herders drive the strong herds to Dangoroyo, Sinujiif, Libaaho (41km in direction of Sinujiif) and other areas where there is borehole water. The weaker animals are kept in Qarhis and water is brought in by truck and stored in the Barkad. Those in the community who have the means, pool their resources, hire a truck with barrels (from Garowe, Dangoroyo or Sinujiif) and buy water at the boreholes in Dangoroyo (currently the pump is not functioning), Sinujiif or Libaaho. In the dry season these boreholes do not supply enough water for people from these areas. There are also hand-dug wells near the coast in Eelmodobe (60km), Biyo Ado (55km). In times of drought not only the livestock, but also entire families will move to other villages where there is water. While the community will take care of those who have no water, no money to contribute to its purchase and no relatives to whom they can move in other villages, there are limits to the community's capacity. During the 1997/98 drought thousands of head of livestock were lost. There was no water in the village and truckloads were brought in from Dangoroyo, Sinujiif and Garowe. At one point the price rose to SS 20.000 (\$3) per 200 litre drum.

Compensation for loss of life

In Somali tradition, a family must receive compensation for the accidental or intentional killing of one of its members. This compensation is paid by the family of the person who is

responsible for the death. It can amount to thousands of dollars and few families have access to such an amount of money. The tradition of *dia* or blood-money requires that the money be collected from all the male adult members of the sub-clan of the person who caused the death. This payment of *dia* or blood money is a pertinent example of the traditional 'insurance' schemes that exist in Somali tradition to this day.

✦ User-Satisfaction

Twenty-one patient exit interviews were conducted to determine users' satisfaction with the services provided and to gather information on health problems, needs and expectations of the clinic users. Clinic records were analysed to produce a more complete profile of the community's health behaviour. Patients were also questioned about access – i.e. the distance they had travelled to seek treatment, clinic utilisation by different lifestyle groups, and levels of satisfaction with service provided, medication prescribed and dispensed, staff response to patient's needs, and waiting time before receiving attention. Exit interviews were spread over three days, giving the opportunity to interview as many patients as possible and so reduce bias.

The clinic as their first choice for health care, although a significant number (45%) may opt to use Traditional Healers. Appreciation for and use of the SRCS clinic is strongest among the settled, urban community with responses indicating a high uptake for vaccinations and maternity services. Patronage of private pharmacies is also highest among this sector of the community, particularly when the clinic has run out of the required drugs. Overall, participants were clear that the clinic was appreciated as an important and convenient community asset with users typically making two to three clinic visits a month.

When asked about what improvements or changes should be made to the clinic service so that it would respond better to the needs of the community, the following suggestions were made:

- Forty eight percent of patients polled in exit interviews expressed a preference for syrups for treating children, stating that it was difficult to get children to take tablets. Syrups are not provided by the clinic as tablets are cheaper and easier to transport, store and package.

- Fifty-seven per cent recommended a wider range of drugs, including the provision of injections. The range of drugs supplied in the clinic drug kit is narrow and not always appropriate or adequate, compelling some patients use the pharmacy on occasions. This was a major source of dissatisfaction as 38 per cent said they
- A number of participants expressed a desire to extend the clinic opening hours. It is officially open from 08:00 to 14:00, but when clinic staff were interviewed they differed in their understanding of working hours, with three different times (1.00 pm, 2.00 pm and 2.30 pm) being given as the closing time, which suggested some irregularities in clinic opening hours.
- Other participants recommended extension of the building with the provision of laboratory services, in order to cut out the cost of travelling to Garowe for tests/treatment. The clinic's lack of basic laboratory facilities means that patients needing lab tests must spend considerable time and money on journeys to and from Garowe hospital, in addition to test, consultation and medication charges incurred. Providing primary health-care laboratory tests through the Red Crescent clinic would ensure tests are done, save patients' time and money, and enhance the value of the clinic to the community. Lab tests are charged for at the Garowe hospital, and elsewhere in Puntland and the community has indicated a willingness to pay for these services, if they were made available at Qarhis.

Presentation of the Findings

The findings were presented to a meeting of all the stakeholders including the village council, staff from the clinic, the Garowe Red Crescent health office, the Directorate of Health and the International Federation Somalia delegation.

Conclusions of the Study

The study concluded that, taken collectively, the community has the assets, the ability and the willingness to participate in the resourcing and running of local health services.

- Qarhis has a sound socio-economic base, centred on livestock production, lobster fishing and the sale of water to nomads. This diversification income provides a safety net, at the community level, against the consequences of drought.

- The livestock ban is a source of economic hardship and instability, but seasonal employment in coastal fishing firms is a major source of income and as many as half of the households in Qarhis benefit from this.
- Sub-clan coping mechanisms and traditions of participation in burden-sharing respond well to requests for assistance and support for vulnerable people.
- A significant proportion of the community pays for health consultations - from the clinic head nurse at his private practice in one of the pharmacies and from traditional healers. People also pay for medications at the two local pharmacies, and for tests and consultations in Garowe Community Hospital.
- There is a general level of satisfaction with the Red Crescent clinic service, with most users citing free medication, trained staff, and good recovery levels as reasons for their satisfaction.
- Clinic users - although in principle willing to participate more actively in the running and resourcing of the clinic - clearly expressed their desire to see an improvement in the quality and range of services provided. The study revealed that staff practice was not always satisfactory, highlighting the need for training and supervision to improve the quality of clinic services.
- However it was also noted that the capacities of the Red Crescent office in Garowe to provide supervision to Qarhis and six other rural clinics were limited and given the distances to be travelled, the absence of asphalt roads and the shortage of vehicles, there is an important role for the community in monitoring standards of performance and services at the clinic and supporting community health programming through increased participation at every level.
- The community health committee acts as a conductor for community participation in some areas of support to the clinic and the service, but it was clear that these are ad hoc and almost always in response to arising needs and not as part of a systematic or regular participation. It also provides a limited degree of governance support but again this seemed limited to at most three of the nine members of the committee and was neither formalised nor structured.
- The low immunization coverage due to the absence of a cold-chain in the clinic was a major cause for concern shared by all participants. Given the poor state of the 'road' from Garowe to Qarhis, the lack of transport and staff capacity at the Red

Crescent office in Garowe and the irregularity of attendance at the clinic, particularly by nomadic users, the only solution would be to establish a cold chain in Qarhis clinic with a fridge and freezer and other equipment.

- The standardized approach to clinic drug supply produced frequent shortages of drugs which resulted in patients having to go without, or pay to procure them at the pharmacy, or request them from a pharmacy in Garowe.
- Irregularities with clinic opening hours were also a cause of some dissatisfaction.
- The clinic's lack of basic laboratory facilities were a source of dissatisfaction to many users and upgrading the service with a primary health care laboratory would provide the clinic with an additional means to improve the community's health status.

Participants' Positions

The participants were asked to provide general feedback as they saw fit and specific feedback on a number of key questions:

- Is sustaining the clinic a priority for the community of Qarhis, the clinic staff, the Red Crescent, the Directorate of Health and the International Federation?
- If it is, on what basis would they be willing to participate more actively in the running and resourcing of the clinic?

All the participants agreed that sustaining the Red Crescent clinic was a top priority for them. Community elders and health committee members expressed clearly their willingness to participate actively in the maintenance of the clinic. They agreed that the first priority was the need to sustain the services offered by the clinic. Moreover, they made it clear that the community is in a position to contribute and support such an essential service. When asked how they would provide for the community's health if external funding was discontinued, members of the Village Committee replied that the research team should not concern itself with this – the clinic had been built by the community and it would be sustained by the community, ideally with external support, but if not, then without.

The President of the Red Crescent explained that the Red Crescent had brought the clinic to Qarhis and supported it for six years and that sustaining it was a priority for the Red

Crescent and the International Federation. However, donor funding was limited and increasingly hard to access. The world's media had moved on from Somalia to other countries facing difficulties and emergency relief funds for Somalia programs were limited, but development funds could not be accessed unless some level of recovery could be demonstrated. In the case of the Red Crescent community health program, recovery could be shown through an ability and willingness of communities to participate in the running and resourcing of their own clinics. This would help to persuade the international donors that there are prospects for recovery of health services in Somalia and that services are not wholly dependent on external funding. Participation by the newly-created Puntland health administration – however limited - would also help.

It was also pointed out that increased community involvement in the clinic would induce improvements in the quality and range of the services provided. Participation would be based on joint ownership and imply joint control. Community members would be able to ensure that services and - within the limits imposed by availability of resources – the range of medication and treatments were appropriate to their needs.

Developing Proposals for Action

The participants were then asked to retire and consult internally on the following specific questions:

- What specific changes to clinic services would be required by the community, in order for the clinic to respond better to their perceived health needs?
- What changes would the Red Crescent and the Federation be willing and able to make?
- On what basis should the clinic running costs be shared between the Directorate of Health, the Red Crescent/Federation and the community collectively?
- How much would the community be willing to contribute in cash?
- Would the community be willing to increase its participation in the governance of the clinic through the Community Health Committee?
- Would this be acceptable to the Red Crescent and the clinic staff?

The meeting was adjourned and the participants were given two days to reflect on the findings, consult within and between individual sub-clans and social groups, Directorate officials, Red Crescent and Federation staff, and discuss their positions on the various issues raised and their priorities in terms of needs from the clinic and financial contributions to the clinic running costs.

Over the next two days, village elders in Qarhis consulted extensively with community members, health committee members and heads of the seventeen sub-clans in an effort to work out the extent and nature of their participation and the service upgrades they would request for the clinic.

Meanwhile, back in Garowe, detailed discussions were held within the research team and with Red Crescent and Federation representatives to determine an acceptable level of community participation in the clinic running costs, which would not adversely affect the community or impact negatively on the most vulnerable members of the community. Local staff from the Red Crescent were able to provide valuable insights on specific abilities and mechanisms for contributions to be made. A second meeting was held between the research team and representatives of the Directorate of Health, UNICEF and WHO to consider possible models for joint community, Red Crescent and Directorate of Health cooperation, and to work out the details of possible service upgrades.

Agreeing a Community Health Management Plan

Two days later, an open village meeting was held at the primary school. It was attended by the community at a meeting convoked by the head of the Village Council and attended by all seventeen heads of sub-clan, the Community Health Committee, representatives of the Qarhis Women's Association and the local Youth Association, the director general of the Puntland Directorate of Health, the District Officer for the region, the UNICEF representative for Puntland, the members of the research team, and a broad section of the population who stood around the classroom, in the hallway and listened and watched outside the windows.

Participant Engagement

The Director General of Health endorsed the process and encouraged the community to engage more actively in support of the clinic. He informed the meeting that he had discussed the Qarhis community and the action research project with the President of Puntland who approved of the process and although the Puntland administration has very little financial resources, agreed to participate in the running costs of the clinic. The Director General committed five per cent of the running costs for the first year of the project, stating that this would be increased to ten per cent after one year if the field experiment was successful and could increase further in subsequent years.

In response to the questions posed during the previous meeting community elders responded that the only condition for them to participate more actively would be for the Red Crescent to upgrade the services offered at the clinic so that they can meet the actual needs of the community. They specifically requested better drug management, regular vaccine supply and the establishment of primary health care laboratory at the clinic.

- They also stated their willingness to pay a charge for the laboratory services (they already do for tests in Garowe).
- Health Committee members would be willing to increase their activity to provide governance and monitoring for the clinic and ensure more active community participation, but they would need a formal mandate, guidelines and training.
- They were concerned about the most vulnerable community members, who may not be in a position to pay a charge on health service and rejected earlier ideas about imposing using fees or service charges. Instead they proposed the possibility of creating some form of community health fund which would be used to raise money for their participation in the running costs of the clinic.
- However, they had not been able to reach an agreement on the amount of the community's contribution to this fund.

The President of the Red Crescent informed the meeting that consultations had been held with clinic staff, UNICEF and WHO to mobilize additional support and resources to

improve the quality of range of services at the clinic, and that he was in a position to agree to the following upgrade of the services:

- Improved clinic service monitoring by the Garowe Red Crescent health office;
- Improved staff performance through training and supervision;
- Provision of a cold chain facility at the clinic
- Establishment of a primary health care laboratory for Qarhis clinic

This was confirmed by the UNICEF representative who pledged increased support to the clinic in the form of additional staff training and the provision of a fridge and freezer and regular vaccine supply.

Breakdown

The community was then asked what proportion of the running costs of the clinic it would be willing to shoulder and a summary budget was presented to facilitate calculations. A discussion among sub-clan heads began in plenary and became very animated. Ten minutes later the meeting was almost out of control and was adjourned to allow consultations between the sub-clans. People met in smaller groups outside the schoolhouse and the meeting resumed after an hour. The Head of the Village Council announced that the community would be willing to contribute fifteen per cent of the running costs of the clinic.

This announcement was greeted with applause from the meeting and in an important gesture symbolizing government cooperation with the plan, the director general pinned a one-dollar bill to a picture of a collection box drawn on the blackboard at the front of the room, to represent the Directorate of Health's commitment to cover 5 per cent of the budget. Other people then came forward to pin various sums of money to the picture of the Community Health Fund as a sign of their commitment to the agreement. Altogether six contributions were made representing the central government, local government, UNICEF, the Red Crescent and the community.

The Community Health Management Plan

Key components of the community health management plan were worked out among the stakeholders and presented at a final meeting with the community the following day. The strategy was based on the principle of placing the clinic and its staff, its immediate users

and the existing Community Health Committee at the centre of health service provision in Qarhis. This reflects the wider community's perception of the service as it exists in Qarhis. These three actors are linked to a network of direct and indirect relationships, which includes the SRCS and the Directorate of Health, other health service providers in the community, volunteers and supporting agencies such as UNICEF and WHO (see diagrams 10.2 and 10.3 on pages 41-42). The plan's overall aim was to field experiment a new strategy for sustaining primary health care in Qarhis, based on a co-management approach to community participation in the running and resourcing of the clinic. The plan elaborated a series of objectives and responsibilities which are presented in the following section.

❖ Objectives and Proposed Activities

The following objectives were designed to provide a holistic solution to the question of sustainability of the service, involving all stakeholders and taking a long term view to break out of the month-by-month relief programming approach which was seen to permeate the provision of health in Qarhis.

- a. Increase the level of community participation in the planning and management of the health service;
- b. Based on the increased involvement of the community in the service, upgrade the quality and range of services provided;
- c. Establish a community financing scheme based on collective contributions; and
- d. Strengthen partnerships between the community and other public and private sector health actors in order to embed the service deeply within the emerging health infrastructure at 'national' level.

A series of activities was agreed for each objective.

Increase the level of community participation

Five main sets of activities were proposed to increase the level of participation by the people of Qarhis, mainly through the offices and efforts of their representatives on the Community Health Committee:

- Reactivate the Community Health Committee
- Sensitize the Community regarding the Community Health Plan

- Formalize Community responsibilities
- Promote community-based volunteer action

Upgrade the quality and range of services provided

Five main sets of activities were proposed to upgrade the range and quality of services provided by the SRCS clinic in Qarhis:

- Conduct capacity building of staff skills
- Introduce Primary Health Care Laboratory Service with WHO
- Establish cold chain and permanent immunization service with UNICEF
- Promote Information and Education on Sexually Transmitted Diseases and HIV/AIDS
- Physical and environmental improvement within and around the clinic

Establish a Community Financing Scheme

- Devise a system for the contribution of 15 percent of the clinic running costs
- Collect and account for the contribution
- Set up the Community Health Fund

Strengthen Partnerships between the community and other public and private sector health actors

- Consolidate existing partnerships with UNICEF, WHO and the Directorate of Health, and explore new working relationships
- Work with the Directorate of Health to align the Qarhis health service with emerging policies and laws
- Inform private sector providers about the field experiment and promote working relationship with them.

✘ The Responsibilities of the Different Participants

- The Red Crescent agreed to upgrade clinic services and committed to:
 - Increase monitoring by the Garowe Red Crescent health office;
 - Provide additional training and supervision for clinic staff;
 - Provide of a cold chain facility at the clinic;

- Establish of a primary health care laboratory for Qarhis clinic and provide funding for any materials not available in the Qarhis community;
 - Review the drug kits being supplied to the clinic and the feasibility of providing additional and, or, alternative medicines.
- The Community pledged a broader engagement on the part of community members to support the improvement of community health status, and a more active participation in the running and resourcing of the clinic, and specifically to:
 - Provide water, maintenance, cleaning and security of the clinic;
 - Contribute locally available materials, water and labour for the construction of the laboratory premises;
 - Participate in health and sanitation campaigns;
 - Contribute 15 per cent of the running costs of the clinic to the community health fund;
 - Carry out additional work to upgrade the environment around the clinic, through, for example, tree-planting.
- The Community Health Committee: agreed to a more active role in the governance and support of the clinic, and specifically to:
 - Collect money for the community contribution to the health fund;
 - Monitor services and liaise with the Red Crescent to provide feedback on quality and user satisfaction; and
 - Ensure maintenance, cleaning and security of the clinic are carried out systematically
- The Directorate of Health: committed to provide 5 per cent of the running costs of the clinic and to co-ordinate its activities to the greatest extent possible with the SRCS within the limitations of its resources.
- UNICEF: committed itself to the improvement of the service provided by the Red Crescent clinic and specifically to:
 - Provide additional staff training;

- Donate a fridge an freezer and regular supply of kerosene to establish a cold chain at the clinic;
- To ensure a regular vaccine supply was available at the clinic.

✖ **The Community Health Fund**

The community health fund was to be made up of the annual contributions from the community to the service, and all charges collected from patients using the new laboratory services. This fund would be complemented by donations from the Directorate of Health - which will provide 5 per cent of the running costs of the clinic - and the Red Crescent, which will be responsible for the balance of the running costs.

A six-member management board was established to manage funds and ensure transparency and accountability. The community agreed to provide three members (including the chairperson); the Red Crescent would provide two members from its branch in Garowe and the Directorate of Health would appoint one member.

Conclusion

Action research is an effective approach to enlist local people's participation in the study of social situations to improve their understanding of them and engage their commitment to improve them. Its potential as a participatory tool goes far beyond its traditional use as an alternative to conventional research methods.

Qarhis has a sound socio-economic base, with regular income from livestock production, lobster fishing and the sale of water to nomads. This diversification income provides a safety net, at the community level, against the consequences of the livestock ban and unforeseen events such as drought and conflict. There is a strong culture of participation to provide for communal needs and sub-clan coping mechanisms and traditions of participation in burden-sharing augur well for increased community involvement in the running and resourcing of the community clinic.

Clinic users are not wholly satisfied with either the quality or the range of services provided by the clinic and this will be a prerequisite to increased participation on their part. The success of the field experiment depends on the ability of the Red Crescent and the clinic to make perceptible improvements in the clinic service. The limited range of services available to community members and consequently, the frequent need to travel to Garowe for certain services are at the heart of user dissatisfaction and addressing these issues raises important questions about the capacity of the Community Health Committee and the Red Crescent to expand the range and deepen the quality of services provided by the clinic to meet the expressed needs of a widely dispersed and heterogeneous population.

Some members of the Qarhis health committee are clearly committed to improving the health status of the community, and this acts as a conductor for a limited degree of community participation in some areas of support to the clinic. However the committee does not function effectively and a concentrated capacity building initiative will have to be undertaken by the Red Crescent to enable this committee to take on a meaningful role in the co-management of the clinic. Again, success will depend on the capacity of the Red Crescent to build effective governance capacity through training and the introduction of basic administrative systems and tools.

In conclusion, an agreement was reached between the community, the Directorate of Health, the Red Crescent, UNICEF, WHO and the Federation to set up a field experiment undertaking significant changes in the planning, management and resourcing of health services in the community of Qarhis. This field experiment would provide a rigorous test for the hypotheses proposed in chapter 8, and the assumptions on which they were based.

* * *

The next chapter will describe the outcome of the field-experiment conducted in Qarhis through the community health management field experiment and analyse the extent to which the real world experience corresponds with the hypotheses, presenting lessons and recommendations from the fieldwork to inform the development of a methodology for community health recovery.

9.

Lessons from the Qarhis: A New Programming Model

Introduction

The previous chapter described how a case study was undertaken in a remote Puntland community to elaborate an in-depth profile of the socio-economic conditions of the community and develop a participatory management framework for the running and resourcing of the clinic there. This chapter presents an analysis of the experiment and describes how this led to the development of a community management model which was applied by the Red Crescent to a range of clinics in other communities in Puntland and Somaliland. The first section presents an evaluation of the extent to which the community health plan succeeded in achieving the objectives set during the community planning exercise, i.e. -

- Greater community participation in the planning and management of the health service;
- Increased quality and range of services provided;
- Establishment of a community financing scheme; and
- Strengthened partnerships between the community and other health actors.

The chapter then asks how the outcomes of the field experiment compare with the four working hypotheses that emerged from the pre-study and the assumptions upon which they were based. Each of these working hypotheses and assumptions is reviewed against the evidence from their practical application through the field experiment. The implications for the research question and the initial thesis are then examined, conclusions are drawn, and the replication of the model beyond Qarhis is described..

Implementation of the Community Health Plan

The Community Health Plan was originally intended to be implemented over a period of one year, beginning in April 2001. However, a delay in the processing of funding for the

health program led to the suspension of the research initiative and consequently the community health plan. It took a full year before the funding was made available, and in the meantime, conflict had returned to Puntland after almost a decade of peace and recovery. The autonomous sub-national state was no longer accessible and efforts to revive the Qarhis community health plan would require a significant commitment from the community and the clinic nurses and one or two health staff remaining in the Red Crescent office in Garowe, the only people with access to Qarhis.

Contextual Factors

The delay in funding combined with a number of contextual factors at local level to thwart the best efforts of the Red Crescent to continue the project as planned and Qarhis and Puntland joined the South Central Zone of Somalia as a 'no-go' area for much of late 2001 and the first half of 2002.

Contextual Factors: Livestock Ban, Suspension of Remittances, and Drought

The livestock ban that was imposed on Somalia by the Gulf States in September 2000 had not been lifted during the field experiment, and remains in place at the time of writing, four years later. The impact on the Somali economy has been devastating. Prior to the bans (the first occurred in 1997) the mainstay of the domestic economy was livestock production. Annual exports of 3.5 million camels, sheep and goats brought in an estimated \$120 million to Somali producers and customs duties accounted for 85 percent of Puntland government revenue. Household revenues have also been hit hard, both as a result of the lost income, and also because the scarcity of foreign currency has produced a devaluation in both the Somali and Somaliland shillings, pushing up the cost of imported goods (UNDP, 2001).

Drought and the Decline in Diaspora Remittances

The economic hardship caused by the livestock ban was compounded by two further setbacks: a major drought which hit northern Somalia towards the end of 2001, and the sharp fall-off in remittances from the Somali diaspora following the closure of two of Somalia's *xawaalaad* - the money transfer or remittance companies - Barakat and Da'habshil, ostensibly as part of the US led 'war on terror' in the aftermath of '9/11' (the September 11th 2001 attacks in New York and Washington). Livestock herders' incomes

fell as water prices increased. As the drought worsened, many thousands of livestock were lost. Meanwhile, a significant proportion of the remittance income that has reportedly been central to the survival of the Somali economy for the past two decades was blocked when the operations of the transfer firms were suspended. There were suspicions that the *xawaalaad* were being used by terrorist groups to transfer funds and operations were suspended. The loss of remittances has had a devastating effect on families who depended on relatives abroad for regular income (Menkhaus, 2004; IRIN, 2002; UNDP, 2001).

Constitutional Crisis and Conflict

These setbacks were compounded by a major outbreak of conflict in Puntland in late 2001. The Puntland government that was elected by the Garowe constitutional conference had a mandate to rule until July 2001. In June 2001, President Yusuf requested an extension of his government's mandate for a further three years to allow work on the building of the Puntland State to continue without a new electoral process which he felt would have a destabilizing influence. After lengthy consultation, the traditional elders' council agreed to grant a one year extension, which Yousef declined on the basis that it did not allow him enough time to achieve certain objectives. Shortly thereafter, the head of the judiciary in Puntland invoked a provision in the constitution calling for elections within one month of the termination of the previous mandate to govern. A constitutional assembly of elders was convoked and after deliberation, an opposition leader, Jama Ali Jama was appointed new President. He duly went about forming his government. Abdullah Yusuf refused to recognise his authority and withdrew to his traditional base in Galkayo, from which he launched an attack in November. Fighting continued into spring 2002, when Yousef's forces routed Ali Jama's militia from Qardho, his traditional base (IRIN, 2002). By late summer 2002, the situation had stabilised and Puntland was again accessible to humanitarian agencies after almost one year during which time many activities were suspended.

Because the Red Crescent is a Somali organisation, staffed by local people, the integrated health program was able to continue, but supervision was severely restricted as a result of the crisis, which limited travel in the Galkayo and Garowe areas and between Garowe and Bosasso, in the direction of Qarhis.

Access

Access to Somalia has been a problem since the war in 1990. Occasional kidnappings and threats to the security of expatriate staff had resulted in most agencies maintaining their Somalia operation offices in Nairobi. Most humanitarian activities in Somalia are carried out by Somali staff that have been recruited locally by the implementing agency. Technical assistance, monitoring and evaluation activities are carried out by expatriate staff if and when access allows. Access is severely restricted however by the limited number of flights into the country. The most common route is by ECHO flight³⁷. ECHO - the European Union humanitarian agency - provides flights to different locations in Somalia several times every week when the security situation on the ground allows. However, there is no guarantee that agency staff, consultants or researchers will travel, as capacity is limited to 20 persons per flight and seats are assigned according to a set prioritization: ECHO personnel are priority 1; those working for programs funded by ECHO are priority 2; UN staff and certain NGOs are priority 3; and Red Cross and Crescent and others are priority 4.

In the period 2000-2001 when the three research missions were carried out, access was provided by the ICRC on flight Red 444, a flight which rotated between ICRC operations in Somalia and those in Sudan. Internal flights were arranged with the ECHO service. Security-related disruptions have been frequent in the post-9/11 period. At one point, there was a ban imposed on all flights into Somalia following reports received by US intelligence that *Al Qaeda* was planning to use a light aircraft filled with explosive to fly into the new US Embassy in Nairobi, and access was severely restricted for a period of three months. During this period, a planned trip to Qarhis to revive the Community Health Plan had to be cancelled because it was impossible to get there. A year later, plans to support local Red Crescent staff in evaluating the field experiment, were disrupted on two occasions and eventually scrapped completely when seats could not be secured on the ECHO flight and an alternative routing via Ethiopia was closed at the last minute due to aircraft engine failure.

³⁷ The UN also runs a service, but charges non-UN personnel \$700 each way - the ECHO flight is free.

Evaluating the Field Experiment

The overall aim of the evaluation was to determine whether the experiment had succeeded in achieving the objectives set during the community planning exercise, i.e. –

- a. Increase the level of community participation in the planning and management of the health service;
- b. Based on the increased involvement of the community in the service, upgrade the quality and range of services provided;
- c. Establish a community financing scheme based on collective contributions; and
- d. Strengthen partnerships between the community and other health actors in order to embed the service deeply within the emerging health infrastructure at ‘national’ level.

The achievement or partial achievement of these objectives would provide a strong indication of the validity of the hypotheses based on the extent to which the activities had led to increased community involvement and – consequently - improved sustainability of the service at local level.

Findings of the Evaluation

The data collection was carried out by a team composed of Federation health program staff, working with participants in the field experiment, i.e. - the Qarhis Community Health Committee members, staff from the Red Crescent office in Garowe and Galkayo and officials from the Puntland Directorate of Health. During four days the data collection team gathered an extensive body of information that could be analyzed to determine whether the activities had been implemented effectively and the extent to which the objectives had been achieved. A range of research techniques was used:

- Meetings with people from the community, including elders, health committee members, representatives of women and youth groups;
- Randomly sampled household interviews (both settled and nomadic groups);
- Analysis of clinic records and Red Crescent documentation;
- Depth interviews with clinic staff;
- Group interviews with staff from Red Crescent Garowe branch.

Increase the Level of Community Participation

Four main sets of activities were proposed to increase the level of participation by the people of Qarhis, mainly through the offices and efforts of their representatives on the Community Health Committee:

- a) Reactivate the Community Health Committee
- b) Sensitize the Community regarding the field experiment
- c) Formalize Community responsibilities
- d) Promote community-based volunteer action

✧ **Reactivate the Community Health Committee**

A new health committee was appointed in July 2002 by the community elders representing the Qarhis sub-clans. Based on discussions with community members during and after the community planning event, formal 'Guidelines' setting out the role and responsibilities of the Community Health Committee, and Terms of Reference for individual members, were drafted by the Red Crescent staff. These tools were presented to Committee members for feedback in July 2002 and revision took place during several subsequent meetings. When the drafts had been finalized, an introductory one-day orientation workshop was held in November 2002, to familiarize all committee members and formally agree the proposed roles and tasks.

Red Crescent staff prepared training material to cover five main areas of community service management:

- Workshop facilitation;
- Committee management skills;
- Financial skills;
- Secretarial skills; and
- Community health.

Training material and sessions were designed based on existing material and staff worked to create culturally appropriate training tools (presentations, role plays, illustrations, proverbs, poems, etc.) to deliver the material in a way that would build committee members' capacities to co-manage the clinic, taking into consideration the different levels of formal education that members have.

Subsequently, training on basic service administration and management skills was provided for all committee members. The Chairperson, Vice-chairperson, Treasurer and Secretary were given specific training for these roles. The training was given over five-days.

Committee members expressed their satisfaction with the process and noted that the Community Health Committee had now assumed formal responsibility and authority to represent the community with regard to members' health, both in overseeing the functioning of the Red Crescent clinic, and with respect to external actors. Whereas members had mixed and confused ideas about their roles and responsibilities before receiving the ToRs, Guidelines and training, they were now fully aware of what is expected of the committee, and understand they have been mandated by the community, the Red Crescent and the Directorate of Health. Since the training, the Committee has taken and implemented a number of important decisions about the clinic. It has resolved a long-standing dispute over the ownership of the land around the clinic, and planned and organized the construction of a wall around the clinic with adequate space for future expansion of the facility to meet the needs of the growing population.

The Committee has been very active in a number of key areas:

- Mobilizing community support for the upgrading of services
 - Monitoring staff attendance and service provision at the clinic
 - Establishing and running the Community Financing Scheme
 - Mobilizing and organizing community volunteers
 - Reporting to Red Crescent on the progress of the field experiment
-
- The Committee oversaw the establishment of a primary health care (PHC) laboratory in the village and mobilized material and labor for its construction (see paragraph 2.2.2).
 - It had also been very active in supervising the performance of clinic staff and absences were reported to the responsible Red Crescent Field Health Officer in Garowe for disciplinary action. The Committee complained to the Red Crescent on one occasion about the absence of clinic staff from their posts and the subsequent lack of service

during normal working hours and the Red Crescent Chairperson had written a warning letter to clinic staff about this. Both the Committee and individual community members confirmed that staff attendance had improved significantly as a result and was no longer a problem. In spite of – or perhaps as a result of this new relationship of authority and accountability - the Committee seemed to enjoy a good relationship with the clinic staff.

- The Committee had also been active in the mobilization and organization of volunteers, for health education and awareness in the community, as well as clinic maintenance and cleaning.
- The Committee provided regular reports and feedback to the Red Crescent Field Health Officer (FHO) about progress made and problems encountered. The F.H.O. had visited Qarhis several times per month during the field experiment to support the reactivation of the Committee and to help with its activities, particularly during the first months before the Committee had received formal training and lacked experience. The level of co-operation between the FHO and Committee members was impressive.

✘ **Sensitize the Community Regarding the Community Health Plan**

During the evaluation, twenty households in the village were selected at random for depth interviews to determine whether the community had been sensitized regarding the Community Health Plan and whether they were satisfied with the services, the role of the Community Health Committee and the community financing scheme. A set of questions was drafted in advance to guide the evaluators and people were asked about the following:

- Household Information: size, lifestyle, income sources and levels;
- Use of clinic; frequency, health problems, level of satisfaction with opening times, staff presence, treatment by staff, diagnosis, medicine received, and outcome – i.e. – cure;
- Awareness of the community health plan;
- Knowledge of the community financing scheme.
- Improvements in the quality of service in the clinic over the past year;
- Further improvements sought in the range and quality of the service; and
- Use of laboratory services and satisfaction level

All those consulted were found to be aware of the field experiment and the main elements of the community health plan, including the upgrades to clinic services, the expectation of the community and the type of activities being carried out by the Committee. The Committee had obviously briefed the community well on the main aspects of the plan, as evidenced by the success they have had in mobilizing community funds, material, labor, volunteers and interest. The successful collection of the community contribution, month after month for a full year, in often adverse conditions, required significant organization and extensive communication with community members from the seventeen different sub-clans. This suggests that it maintained frequent contact with the community throughout the field experiment and kept them well informed about developments on the project. There was an overwhelming level of satisfaction with the service provided by the clinic and the fact that the community had been selected for participation in the research project, and consequently was receiving the benefits of increased investment in their health service. Those consulted expressed their willingness to increase their participation in accordance with their means in order to ensure the continuation of the service.

✧ **Formalize Community Responsibilities**

The responsibilities of the community were formalized in the Community Health Committee Guidelines that were agreed with the community in November 2002 and subsequently adopted by the Committee.

The Community Health Committee's mission is:

to act as a representative and accountable link between the community and the Red Crescent in order to increase community ownership of the health facility and thus improve the efficiency and effectiveness of the service it provides. Where appropriate the Committee may act as a forum for wider collaboration with other health care providers.

In order to fulfill this mission the community agreed to work through the Health Committee with the clinic staff to achieve the following goals:

- Improved access to quality health services for all community members.
- Increased community ownership of the health facility.
- Improved efficiency and effectiveness of the health facility.

- Reduced mortality and morbidity in the community.
- Sustainability of the health facility through reduced dependence on external support.

The Committee, on behalf of Qarhis community, took on the responsibility for the mobilization of community resources for the running, maintenance, security and cleaning of the clinic. As a result, a range of activities have been successfully carried out by the community:

- The community has collected and contributed 15 percent of the running costs of the clinic during the field experiment period;
- The doors and windows in the clinic have been replaced;
- The clinic buildings have been whitewashed;
- Linoleum and tablecloths have been provided in the waiting rooms;
- Committee members and clinic staff periodically organize the cleaning of the clinic compound.

✧ Promote Community-based Volunteer Action

Following a dissemination campaign by the Red Crescent branch in Garowe together with the Community Health Committee, a total of 20 volunteers have been recruited and trained during the field experimenting period. The branch also carried out a first aid training course for volunteers. Each volunteer provides health information and education to twenty households in the community. They also encourage mothers to vaccinate their children and subject to requests from clinic staff, visit the homes of defaulters (people who have not completed the full course of immunization) to encourage them to return to the clinic for the outstanding vaccinations. The Committee helps to organize and oversee a shift-system whereby volunteers assist the clinic staff with growth monitoring, weighing and measuring the children. Volunteers also participate in periodic sanitation campaigns in the village.

Upgrade the Quality and Range of Services Provided

Five main sets of activities were proposed to upgrade the range and quality of services provided by the Red Crescent clinic in Qarhis:

1. Capacity building of clinic staff skills
2. Establish a Primary Health Care Laboratory Service with WHO

3. Establish a cold chain and permanent immunization service with UNICEF
4. Promote information and education on sexually transmitted diseases and HIV/AIDS
5. Improve the physical and environmental conditions within and around the clinic

✧ **Capacity Building of Clinic Staff Skills**

Clinic staff had adjusted well to the changes brought about by the field experiment and responded to the increased demands of the community and the Health Committee. New tasks such as laboratory testing and volunteer training, and new roles in co-operation with the Committee and the community have been accepted and carried out. All three staff have been given training in a number of areas during the period of the field experiment, ranging from a Training-of-Trainers course on HIV/AIDS awareness, to cold-chain maintenance, laboratory testing, nutrition and case management.

However there appear to be weaknesses in the management and supervision system that have prevented further improvements to the quality of services provided by the clinic:

- The standard supervisory checklist is not systematically used by the FHO during visits to the clinic. Clearly this would identify weaknesses that could be addressed with on-the-job training and contribute to improved performance by the clinic staff. Moreover, the presence of the Field Health Officer in consultations during supervision visits would demonstrate to community members that monitoring and quality control take place, further enhancing the value of the service, and translating into increased user-satisfaction.
- There had been no formal appraisal of clinic staff by Red Crescent management during the field experimenting period and it is not clear that any system exists for carrying out annual appraisals of clinic or program staff.
- The Garowe Red Crescent office did not appear to have any record of training provided to Qarhis clinic staff during the year, nor any formal training plan.

✧ **Introduce Primary Health Care Laboratory Service with WHO**

The lab was built in a joint action between the community who provided the labor and most of the construction material, the Red Crescent who provided funding for some roofing and other construction material which had to be sourced outside Qarhis, and some of the furniture and WHO which provided the lab design, equipment, reagents and training for the

three clinic staff on laboratory management and testing. Apart from providing stocks of reagents for the tests, WHO have undertaken to monitor the quality of the laboratory services and have made three supervisory visits. However, no formal agreement has been established between the Red Crescent and WHO about continuing support and collaboration such as supply of reagents, training and supervision of the laboratory technician, or maintenance of microscopes and other equipment.

During the evaluation, the lab was found to be untidy with reagents and stock cards not organized in any orderly fashion. This again raised the question of supervision and monitoring and the need for systems at the Red Crescent branch in Garowe to take on board the extra workload. However, the Garowe office did not appear to maintain any records of the number, type or outcome of tests done by the lab nor the amount of revenue generated, indicating that the branch does not keep records of the lab activities or performance.

✂ **Establish Cold Chain and Permanent Immunization Service**

As part of the upgrading of services at Qarhis clinic, UNICEF provided a fridge, a cold box, a vaccine carrier, ice bags and safety boxes. The following vaccines are supplied on a monthly basis BCG³⁸, DPT³⁹, OPV⁴⁰, measles and TT⁴¹, though the nurse reported that one antigen is regularly missing (TT was missing during the evaluation visit). The arrangement is governed by a written agreement with UNICEF who also provided training on cold-chain management, child illnesses and nutrition for the clinic staff. The Head Nurse is responsible for the cold chain. The equipment has functioned well throughout the field experimenting period and vaccines have been delivered regularly apart from the one missing antigen.

While the service was the source of increased satisfaction among community members, a review of vaccination statistics revealed that although coverage of Tetanus Toxoid vaccination for pregnant women doubled, there has been little change in the children's immunization levels during the field experiment period. Clinic staff and the FHO noted there was some discrepancy in the numbers of children registered and that the resident

³⁸ Bacillus Calmette Guerin, an anti-tuberculosis vaccine

³⁹ Diphtheria, Pertussis and Tetanus

⁴⁰ Oral Polio Vaccine

⁴¹ Tetanus Toxoid

under-five population in Qarhis may have been overstated to attract additional aid resources. They agreed to conduct a census of the children under-age-five in the village and verify if the immunization levels had actually improved. Nevertheless, there appeared to be some weaknesses in the monitoring and supervision system in Garowe as the unchanged vaccination levels seem to have gone unchecked.

✎ Promote Information and Education on STDs and HIV/AIDS

The head nurse participated in an HIV Training-of-Trainers course run by the Federation during the period of the field experiment and subsequently carried out training for the twenty volunteers, who in turn conducted sensitization and awareness raising activities with households in the village.

✎ Physical and environmental improvement

Significant progress had been made in improving the clinic compound and surrounding environment:

- A stonewall has been built around the clinic land to protect it from straying animals and preserve the property for planned expansion in the future;
- Clinic buildings have been whitewashed and maintained in good condition;
- Trees have been planted in the compound; and
- Table and screen sheets in the clinic were replaced.

Establish a Community Financing Scheme

To establish a community financing scheme based on collective community contributions, the Community Health Plan stipulated that the following activities would be carried out by the Qarhis community health committee, supported by the Red Crescent office in Garowe:

- a) Devise a system for the contribution of 15 percent of the gross clinic running costs, equivalent to approximately 40 percent of net costs;
- b) Collect and account for the contribution;
- c) Set up the Community Health Fund.

✎ Devise a System for the Contribution

The Committee designed a collective financing mechanism to mobilise 15 percent of the running costs of the clinic, and organized and oversaw the collection of the community contribution during the field experiment period in spite of a serious drought and a constitutional crisis.

After the Community Action Planning exercise and the signing of the agreement, the Committee conducted a series of consultations with the heads of the seventeen sub-clans living in the community. Together they agreed that the seventeen sub-clans would contribute a fixed share of the 15 percent in proportion to the size and wealth of each sub-clan. Wealth was to be determined according to ownership of livestock and water storage pools (*barkads*). The head of the sub-clan was made responsible for the sub-clan's contribution, which was to be collected on a quarterly basis.

The heads of sub-clans were also consulted about the use of the community contribution at the end of the year. The Committee had received proposals to spend the health fund on one of two projects – the construction of a delivery room at the clinic, or the construction of a wall around the clinic land. Following discussion with the heads of sub-clan, and meetings with the community, a decision was made to build a wall around the clinic land to improve the surroundings and safeguard the land for future expansion of the clinic. This certainly meets the overall goal of using resources generated by the community to carry out perceptible improvements in facilities and services. The wall has been partially constructed when the evaluation took place.

✻ Collect and Account for the Contribution

The community contribution has been collected in full and accounted for correctly. This was a major achievement by the Committee and the Red Crescent support team in Garowe Red Crescent, given the unfortunate serious of events which occurred in Puntland during the period of the experiment; including a major outbreak of conflict, a constitutional crisis, a drought, and an ongoing livestock ban. During the drought incomes in the village were seriously affected. Some families lost their livestock and businesses in the community did not prosper as a result of the general loss of income. As a result, some households could not pay their contribution. Many young people left the village to seek work on the coast, fishing or labouring on construction sites. In most cases, they sent money back to their

families, some of which was used to make up the outstanding contributions. To make up the shortfall, some members of the Health Committee traveled to Eyl, a big fishing town on the coast, and negotiated with the owners of some of the lobster fishing companies to contribute to the Community Health Fund. In this way, the 15 percent contribution was made up. On a number of occasions, Committee members and clinic staff made individual contributions to compensate for smaller shortfalls when individual households could not meet their responsibilities as a result of the overall economic situation.

✧ Set up the Community Health Fund

During the community planning event when the field experiment was set up, it was decided to establish a management board to oversee the collection of the community contribution and create a community health fund using this contribution and fees generated by the new lab. The Management Board was to be composed of three persons: a Chairperson to be proposed by the Committee; a Secretary to be proposed by the Directorate of Health; and a Treasurer to be proposed by the Red Crescent. However, no action was taken to follow up on the establishment of the Management Board. There was therefore no separate mechanism to oversee the community contribution and no formal procedures were established for the use of the money. As a result, no financial plan was drawn up for the community health fund. This contributed to a lack of transparency in accounting for the lab fees, as well as some confusion about the use of the money raised from the lab fees.

The Red Crescent Garowe office participated fully in the collection of the community contribution and any decisions about the use of money from the contribution and generated by the lab, despite the absence of formal procedures.

Strengthen Partnerships

Three areas of activity had been agreed under the Community Health Plan:

- a) Consolidate existing partnerships with UNICEF, WHO and the Directorate of Health, and explore new working relationships
- b) Work with the Directorate of Health to align the Qarhis health service with emerging policies and laws

- c) Inform private sector providers about the field experiment and promote working relationship with them

✧ Consolidate Existing Partnerships, Explore New Relationships

Partnerships with WHO and UNICEF had been strengthened through the construction and running of the PHC laboratory, and the establishment of the cold chain. Both of these key partner organizations visited Qarhis on three occasions during the field experiment, providing training, quality control and support to the Community Health Plan. As a result, Qarhis was included in the UNICEF 'Clean Delivery Kits' program to supply sterile sheets and childbirth-related supplies to expectant mothers and reduce the risk of infection during labour and childbirth. The clinic had also received insecticide-treated bed nets from WHO as part of the 'Rollback Malaria' campaign.

One of the most important outcomes of the improvement of partnerships was the restoration of the Basic Development Needs (BDN) program in Qarhis by WHO after several years of inactivity. The Basic Development Needs approach seeks to achieve a better quality of life by promoting an integrated bottom-up socio-economic developmental process through active community involvement, self-management and self-reliance. WHO uses the approach to provide support for inter-sectoral collaboration.

As a result of the constitutional crisis NGO and governmental activities were significantly reduced – and at one point suspended – during much of the field experimenting period. Consequently there have been no real opportunities to develop new working relations in Qarhis.

✧ Align health service provision with emerging policies and laws

The temporary suspension of the functions of the Health Directorate halted the development of health laws and policies for most of the period in question. The loss of co-operation previously afforded by the Director General was an unfortunate setback to progress that had been made during and between the three research missions. The former Director General had negotiated the government's commitment to contribute 5 percent of the cost of running the clinic in Qarhis, to complement the community's 15 percent

contribution. This 5 percent contribution had not been made. The new Director General had also participated in the research missions and was both familiar with and very supportive of the field experiment. During the final months of the field experiment the new DG visited Qarhis on two occasions and pledged the health administration's continued support. He also promised to honor the pledge to contribute 5 percent of the costs of running the clinic.

✱ Inform Private Providers, Promote Working Relationship

Private sector providers such as Traditional Birth Attendants (TBAs), pharmacy owners and Traditional Healers in the village had been informed about the Community Health Plan, including the owner of a new pharmacy and a healer who had recently settled in the village. Additionally, a register of all private sector providers had been established at the clinic. The clinic staff had developed strong relations with four TBAs operating in Qarhis community. The TBAs report each delivery to the clinic and they are provided with sterile instruments and material for deliveries as well as training. No working relationships have been developed with the other private providers, either by the Committee or by the clinic staff.

Results vs. Hypotheses: Towards a New Programming Model

The field research set out to test a number of hypotheses and assumptions about the potential for community involvement in health service provision and the implications for improved sustainability of services as a result. The following section presents an analysis of the field experiment outcomes against the initial working hypotheses.

Community Management

Based on analysis from the literature review and the Puntland pre-study, the following hypothesis was generated about community involvement in the planning and management of health services:

Hypothesis 1: Community involvement in planning and management can lead to significant improvements in the quality, appropriateness and sustainability of local health services.

In support of this hypothesis, the research set out to test the following assumptions:

A.1.1: Communities would make better use of their local health service, and be more concerned about ensuring its sustainability, if they were given the opportunity to participate meaningfully in its organization and development.

A.1.2: Programming approaches that are based on locally-appropriate solutions – instead of standardized, 'one-size-fits-all' kits – and are informed by the expressed needs, priorities and concerns of local residents, and the socio-economic circumstances of individual communities, can engage the involvement of local people in the provision of sustainable health services.

A.1.3: If the range and quality of services and treatments responded to local people's priorities, they would have less need to use alternative providers and could be persuaded to redirect out-of-pocket expenditures into some form of community fund for the facility.

Results from the Field Experiment:

The results of the evaluation strongly endorse the hypothesis and assumptions drawn from the literature review on community involvement in health development and the findings of the pre-study. The change in the focus of the service towards serving the expressed needs, priorities and concerns of local people and the concomitant shift in accountability has produced a major improvement in the quality, appropriateness and sustainability of the service. The community management approach was successful in increasing the level of community involvement in both the running and resourcing of the clinic. The community has been very active in a number of key areas:

- Mobilizing human, material and financial resources for the upgrading of services including the construction of the new PHC laboratory, maintenance, renovation and refurbishment of the clinic, and active support for the use of the vaccination services available as a result of the newly established cold chain;
- Designing the community financing system, assigning roles to the heads of the seventeen sub-clans and accepting responsibility for its effective functioning, collecting the individual contributions within the sub-clans and making up the 15 percent of the

running costs of the clinic during the field experiment period, diversifying revenue sources when disaster – in the form of severe drought – struck the area and prevented some households from making contributions;

- Monitoring clinic staff attendance, attitudes and the quality of service provision at the clinic and working with the Red Crescent Field Health Officer to produce improvements in the level of staff performances and the quality of services;
- Mobilizing community volunteers to organize and support information and education on sexually transmitted diseases and HIV/AIDS, conduct village clean up campaigns and undertake improvements to the environment around the clinic;
- Frequent, regular reporting to Red Crescent on the progress of the field experiment and close collaboration with the Red Crescent, WHO and UNICEF on the upgrading and expansion of services at the clinic.

The Committee, on behalf of Qarhis community, took on the responsibility for the mobilization of community resources for the running, maintenance, security and cleaning of the clinic. Specifically, the Committee oversaw the following improvements to the clinic by the community:

- The construction of the new laboratory building;
 - The construction of the clinic perimeter wall;
 - The replacement of the doors and windows in the clinic;
 - The whitewashing of the clinic buildings;
 - The provision of linoleum and tablecloths in the waiting rooms;
 - The cleaning and maintenance of the clinic compound.
- Participation in the implementation of the community health plan was not restricted to a few members of a quickly selected committee. The evaluation indicates that almost everyone in the immediate vicinity of the Qarhis community participated to varying degrees in the activities to improve the service. Raising local people's awareness and sensitizing the community about the objectives and activities set out in the community health plan was critical in achieving this. The high level of participation contributed to the overall success of the approach in expanding the range and increasing the quality of the services, as evidenced by the range of activities that were completed including the

construction of the laboratory, the successful collaboration of the seventeen heads of sub-clan to make the community financing scheme work, the recruitment and activities of the volunteers, the construction of the perimeter wall, and the maintenance of the clinic premises.

At local level the upgrading of services has been very successful: the quality and range of health services available to the people of Qarhis and the surrounding communities has improved significantly, creating a real opportunity for people to reduce the risk of illness, and improve their health condition.

- The physical and environmental improvements have given a tangible dimension to the increased range and quality of service. External improvements such as the construction of the stonewall around the clinic land, the painting and maintenance of clinic buildings, and the planting and nurturing of the new trees have made it clear even to those people who do not have any need to use the clinic or only use it rarely, that their investment is being used productively and increased the visibility of the clinic in the community. Internal improvements such as the replacement of table and screen sheets complemented the increased range and quality of services and demonstrated to users that their clinic is developing and improving.

Clearly, the practical benefits of the expanded range of services have encouraged the people of Qarhis to contribute financially to the service. In particular, the tests available at the PHC laboratory and the permanent vaccination capacity as a result of the establishment of the cold chain have both reduced the need for local people to travel to Garowe to seek these services at alternative facilities and this has saved them time, money and inconvenience.

- A total of 528 tests had been conducted at the lab since it began functioning in October 2001: 118 urine analyses; 195 stool examinations; and 215 for malaria. The lab conducts tests to diagnose malaria, parasites and urinary tract infections. All tests are priced at SSh15.000⁴² each. Previously patients had to travel to Garowe where tests cost SSh30.000. The Committee pointed out that a return trip to Garowe costs SSh150.000

⁴² SSh20,000 = \$1

for transport and SSh25.000 registration fee is charged to see the doctor before referral for testing. This doesn't include the cost of overnight accommodation and any medicines prescribed. Consequently, according to the Committee, the availability of testing is greatly appreciated by the community. This was confirmed by almost everyone spoken to during the random household survey (one person was not aware of all the services provided by the lab).

- Both the Committee and community members consulted also expressed their satisfaction with the establishment of the cold chain. The upgrade in services was considered to be a major benefit to the community for two reasons: first, people – and especially women and children - in the community and surrounding communities would be able to receive the appropriate vaccination without having to make a costly and time-consuming journey to Garowe, which was the case previously when the Qarhis clinic only had immunization facilities when a specific immunization campaign (e.g. UNICEF National Immunization Days) was taking place. This would help improve health conditions and address specific causes of morbidity and mortality in the Qarhis area. Second, the new immunization service would bring people who needed to be vaccinated to Qarhis from surrounding communities, including nomadic herders and their families, and they would bring additional business to the village.

Community Financing

The field experiment set out to test the following hypothesis about community financing:

Hypothesis 2: Collective financing schemes that accommodate communities' seasonal income and asset realization cycles can provide a significant proportion of the direct costs of basic health services.

In support of this hypothesis, the research set out to test the following assumptions:

A.2.1: Collective community financing schemes that are based on an appropriate assessment of people's willingness and ability to pay can maximize local contributions by

facilitating households' participation while helping protect household asset bases and contribute to long term recovery.

A.2.2: Communities are willing and able to contribute to financing schemes that are based on an appreciation of their income from livestock-trading, migratory and seasonal work patterns, and remittances linked to religious celebrations.

A.2.3: Community financing schemes based on local traditions and mechanisms to take care of the poor and the vulnerable, can overcome the inequities inherent in user fee and cost recovery systems that exclude the poor from health services, force people to borrow money for fees, increase indebtedness and spread the burden of ill-health throughout the community.

Results from the Field Experiment:

The findings of the evaluation strongly support the hypothesis and assumptions bearing out the analysis conducted in the literature review, in particular the positive correlation demonstrated by Preker *et al* (2001) between willingness to contribute to community owned and run schemes, and guaranteed access to quality services that address communities' perceived health priorities.

- The establishment of a collective community financing scheme based on the community's own assessment of the wealth and poverty ranking of people living in the village, and their commitment to the scheme, was an important achievement in itself. The scheme has demonstrated that it is possible to generate a substantial proportion of the overall running costs of the clinic, without imposing user fees and excluding the poorest in the community. The community reverted to traditional mechanisms for pooling revenues and sharing risks, compensating for the inability of the less well-off who cannot afford to contribute (and would not have been able to afford user fees) thereby protecting them from exclusion from the service.
- For the scheme to have succeeded in meeting the 15 percent contribution in spite of conflict, drought and an ongoing livestock ban, is a major accomplishment. Community

responsibility for the scheme allowed for collection of the contribution according to the local socio-economic context to accommodate seasonal patterns of income whether households earned their living from activities related to livestock rearing, fishing or other means. It also allowed revenue generation to be diversified when the drought provoked an economic crisis for many people in the community. The collective nature of the scheme drew on the solidarity inherent in the Somali culture to ensure that people lived up to their responsibility for maintaining the community health facility, even when times were difficult and money scarcer. The engagement of heads of sub-clan to collect the contribution invoked social controls over the behaviour of community members that ensured people met their obligations in the traditional system that has functioned in Somalia for many, many generations.

- During the field experiment, the main source of income for the community collapsed because of the drought. Families lost their livestock, and the teashops, general stores and other small businesses lost out because the passing trade from nomadic herdsmen declined to a trickle. Many men – and some young women – migrated from the village, to try and find work in Garowe, or in the fishing villages along the coast. The quarterly collection of revenue facilitated the change in income generation, allowing local people to continue using the clinic, even though they may have had no money to pay fees or buy medicine. It also allowed the health committee to engage in alternative fund raising activities, seeking contributions from fishing businesses along the coast that have traditionally benefited from the convenient supply of labour provided by young people from Qarhis. If a user-fee cost-recovery system had been in place at the clinic, many people would have been excluded from the service because of the drought and other economic problems, or they would have been forced to sell household assets or borrow to access the service. This was not necessary because of the collective financing system which maintained a service that was open to all, without user charges. Moreover, the clinic continued to receive the quarterly contribution, income which would have been forfeited by the clinic if user fees were charged.
- Although the Health Fund Management Board was not convened, the systematic involvement of the Red Crescent office in the establishment of the scheme, the

collection of and accounting for the contributions, and decisions about the use of the revenue, suggest that the Board was actually functioning, but without the Health directorate representative, because of the ongoing conflict. Nevertheless, the formal use of the Management Board would help to embed valuable planning and implementation practices in the community. For example, the Board would be charged with ensuring that the correct procedures are followed, including the preparation of a financial plan with forecasts of the amounts to be raised, and the cost of each item or activity. This would help avoid overspending, partially-completed projects, and deficits. It would also ensure that certain smaller improvements can be made to the clinic and that a minimum contingency fund is retained in case of emergency or unforeseen expense.

Health Service Recovery

The research also set out to test the following hypothesis and assumptions about the potential role of the Red Crescent in the establishment of an effective public health sector in Puntland:

Hypothesis 3: The Somali Red Crescent can provide an institutional platform for the rehabilitation of local health services, channelling the efforts of a wide range of actors and donors into a community-owned strategy for sustainable recovery.

A.3.1: Coordinated action among the various public and private stakeholders involved in health service provision, based on a shared vision and strengthened partnership, can contribute significantly to the creation of an effective public health system in Puntland.

A.3.2: The traditional mandate of the Somali Red Crescent as auxiliary to the government in the field of health and disaster response, and its unique position as the de facto public health service in Puntland confer a unique authority to inform the development of policy by the Directorate of Health.

A.3.3: Programmes which recognize – and where possible include – other local service providers, both formal and informal, have a better chance of long term success than those

which ignore the potential winners and losers from changes in the structure and provision of health services in a community.

Results from the Field Experiment:

In the short term, findings from the evaluation of the field experiment strongly support the hypothesis and indicate assumptions A.3.1 and A.3.3 are valid. The outbreak of conflict prevented any rigorous testing of assumption A.3.2 concerning the SRCS ability to influence DoH policy. However, the SRCS – as a unique local actor with a nationwide presence and a legal mandate – demonstrated its potential as a focal point for community health service recovery. Implementing partners rallied to support the SRCS strategy and provided excellent support to the Community Health Plan, contributing to a significant expansion of the public health system in the Qarhis area and illustrating the potential that exists for expanded co-operation at other clinics. The establishment of a new PHC laboratory, a functioning cold-chain and HIV/AIDS awareness education activities has extended the range and appropriateness of the service considerably.

- Malaria is a leading cause of childhood deaths in Somalia. It also contributes to anemia in children and is a common cause of school absenteeism (UNICEF, 1999). The availability of testing facilities will greatly enhance the capacity of the Qarhis clinic to address malaria in two ways. First awareness of the potential to diagnose malaria will increase the likelihood that mothers will seek treatment at the clinic, thereby increasing greatly the child's chance of survival. Secondly, although international recommendations suggest treating any fever in children as if it were malaria, fever is often caused by other health problems and ruling out malaria as quickly as possible increases the chances that the real problem will be diagnosed and treated. Diagnosis at the laboratory may also help identify the exact cause of the fever and the correct treatment to be followed. Lab testing will also improve the capacity of the clinic to deal with another main cause of childhood morbidity: diarrhea. The provision of tests for Urinary Tract Infections represents a significant expansion of the clinic's capacity to improve women's health. UTIs are a major cause of female morbidity and the availability of testing will help improve women's health considerably.

- The establishment of a functioning cold chain has also expanded the range of services at the Qarhis clinic. The cold chain provides a permanent immunization capability with access to vaccines for the main childhood and maternal killer diseases which would otherwise have only been available periodically or would to be sought in Garowe. WHO and UNICEF guidelines stipulate that children should receive a BCG vaccination against TB, three doses of DPT vaccine to protect against diphtheria, pertussis and tetanus, three doses of polio vaccine, and a measles vaccination in their first year of life (UNICEF, 1999). Vaccination rates in rural and nomadic populations are particularly low, owing to the absence of functioning cold chains to preserve vaccines, and the consequent lack of capacity to provide vaccinations when rural or nomadic children are brought to health facilities for consultation. The introduction of the cold chain in Qarhis and the establishment of a permanent capacity to vaccinate have produced an important expansion in the range of services at Qarhis clinic.
- Increasing awareness about STDs and HIV through the training received by the head nurse, and the use of the community volunteers to disseminate this through specific communication, information and education strategies, represents an important improvement in the clinic's capacity to prevent infection and improve the health of both women and men in Qarhis. In 1999, only 36 per of women in Somalia had ever heard of AIDS. In rural and nomadic populations the proportion was 13 percent (UNICEF, 1999). Women in Somalia suffer from a range of reproductive health problems as a result of social and cultural factors such as Female Genital Mutilation, high levels of sexually transmitted diseases (currently estimated at 25 percent) that render them particularly susceptible to STD and HIV (IFRC, 2002h). The community of Qarhis has an important migratory character arising from a number of factors: 50 percent of the population is nomadic; many of its young people spend the months between September and May living away from home working as fishermen, and its geographic location between the coast and the interior means there are frequent visitors.

Inconclusive

Due to the renewed conflict during the experiment, it was not possible to test the assumption about the potential for the SRCS to inform the development of policy by the

Puntland Directorate of Health. This was unfortunate given the President's position on cost recovery and it remains unclear as to whether the SRCS would be able to compete with the influence on health policy that has clearly been exercised by the World Bank through UNICEF. In the long term a series of questions remain to be answered about the commitment of the government of Puntland and the international community to a political solution which will determine whether or not health service recovery can take place. For example, progress in the field experiment on building partnerships was mixed, largely as a result of the unstable political climate which restricted access to Qarhis and severely limited interaction with external actors. Furthermore, the constitutional crisis slowed the progress that had been made in constructing productive formal and informal relations with the emerging Directorate of Health, and prevented the development of new partnerships. And in the absence of a regulatory framework legitimizing the activities of mainly informal private sector providers, opportunities to develop relations with this important group were never likely to be exploited.

- Partnerships with UNICEF and WHO were strengthened considerably, and their support in upgrading the range and level of services was a key element in the success of the field experiment. UNICEF delivered on its commitment to provide a functioning cold chain and a regular supply of vaccines and training for clinic staff. This has been consolidated through the establishment of a formal agreement, and there is considerable potential for additional co-operation that would further enhance the quality and range of services available in Qarhis and other clinics. WHO supported the establishment of the PHC laboratory and is reviving its Basic Development Needs project in Qarhis. Partnership on the BDN brings the possibility of a range of developmental initiatives linking socio-economic initiatives to improved health and welfare in the community.
- The constitutional crisis set back progress that had been made by building a successful working relationship with the Directorate of Health in the research phases. A strong partnership had been built with the former DG on the project and he was a driving force in the process, present and active during every meeting and lending his influence and authority to help shift obstacles and build consensus. However, the interruption to government services in Puntland and the reorganization of the Ministry of Social Affairs

resulted in a temporary suspension of the Directorate's activities and the replacement of the DG. This in turn slowed the development of a more active, systematic role for the Directorate of Health in the running and resourcing of the clinic. Since the end of the crisis, the new Director General has been very supportive and the continued engagement of the DoH looks secure.

- It seems that the failure to convoke a meeting of the Management Board during the period of the field experiment arose as a result of the constitutional crisis and the absence of a functioning health directorate. The Directorate of Health was not in a position to participate during some months due to the constitutional crisis. Abdurrahman Said, the Director of Health in the Puntland government under President Yusuf remained in place when the constitutional crisis happened and was thus perceived to be supporting the new President Jama Ali Jama. When fighting broke out, Said was forced to flee with Ali Jama's forces and was replaced by the Yusuf administration. Rather than seek to engage the Directorate of Health in the convocation of the meeting, and risk enflaming political divisions within the community as to which Director of Health to contact, the Committee avoided any contact with the DoH.
- Although productive relations have been developed with the TBAs in Qarhis, no attempt has been made to involve other private sector providers. While there is clearly reluctance on the part of the SRCS and the clinic staff to legitimize the activities of a mainly informal and unqualified sector, this represents something of a lost opportunity to increase participation of key figures in the community and thus improve the sustainability. Pharmacy owners and Traditional Healers are often important opinion leaders in the community. By building constructive relations with this group, the clinic can reduce the risk of being perceived as a threat or competitor, and strengthen the belief that maintaining the clinic is in everyone's interest. Securing the participation of this group in the community health plan can thus broaden the sense of ownership of the facility by the community and contribute to its sustainability in the long run.

Community Recovery

The pre-study produced the following hypothesis and assumptions about the potential of the Red Crescent to empower local people by building their capacities to take control over their health choices:

Hypothesis 4: The Somali Red Crescent is uniquely positioned to harness the driving potential of communities in the recovery process and empower local people to take control of their health services. Given the appropriate investment, the Red Crescent can build the institutional and individual capacities to enable communities to take responsibility for their health.

In support of this hypothesis, the research set out to test the following assumptions:

A.4.1: Token community participation paying lip-service to donor requirements ignores the skills, talents and capacities that exist in local communities for planning, organizing and managing services, and the role of traditional leadership and institutions in meeting community needs.

A.4.2: A strategic investment in the operational capacities of the Somali Red Crescent could produce a shift in its role from direct service provider to facilitator and supporter of communities in co-management of the health services.

A.4.3: The Red Crescent can develop the structures, systems and capacities at local level to enable local people play central role in the running and resourcing of their health service.

Results from the Field Experiment:

The findings from the field experiment strongly support the hypothesis and the assumptions on which it is based. The experiment essentially ‘operationalised’ Freire’s theory that people are ‘uncompleted beings’ and if they are given the opportunity and tools they can come to understand and change their lives and their world. The participation that was made possible by the SRCS capacity building initiative promoted a process of change, helping people to overcome their exclusion and marginalization from an important dimension of

their development. Adhering to Kahssay and Oakley's (1999) definition of participation as an end in itself – a transfer of both responsibility and means for genuine engagement in the running of the health facility – the experiment fulfilled the four key requirements quoted in the literature review as essential for empowerment:

- Access to information;
- Inclusion/participation of poor people;
- Accountability;
- And local organizational capacity (WB, 2002).

By developing and implementing a strategic community management and training initiative and building the capacities of the Health Committee, the SRCS has *empowered* the community of Qarhis to assume a degree of responsibility for, and authority over the effective functioning of their health facility. By formally mandating the Health Committee, and supporting its decisions and activities, the approach created a process of empowerment through which ownership of community health has shifted from the external Red Crescent Society to the community.

- The community management approach facilitated a process of empowerment, in the sense of giving local people both the authority and the capacity, to bring about the changes that would create a health service which meets their needs and will continue to meet them. By formalizing the role and responsibilities of the community, the approach harnessed the enthusiasm generated during the community planning exercise and institutionalized the commitment made by the people of Qarhis in the formal structure of a community committee, with office-bearers, duties, and guidelines for the completion of those duties. Instead of the a temporary expression of local people's aspirations for the type of health service they would like to have, the community management approach formalized their acceptance of responsibility to bring about the changes needed to improve and help sustain the health service and thereby take control of their own health.
- This process of empowerment gave the community direct control over the quality of the services provided at the clinic by introducing a previously non-existent relationship of accountability between the clinic staff and the community. As a result the quality of service has improved significantly as evidenced by improvements in staff presence,

skills and attitudes and their adherence to opening times. Clinic staff skills and abilities have been improved as a result of the training they received and this has helped improve the quality of services provided at the clinic. Quality has also been increased in two other areas: first, as the Health Committee reported the problem with staff presence during the normal clinic opening hours has been resolved and the service is now available to the public at the appropriate times. Secondly, as community members and users pointed out, the attitude of the staff has changed. They are now formally accountable to the community, through the Committee, and this has encouraged them to take more time with patients and to be more courteous. However, systems and procedures for clinic staff supervision, appraisal and training appear to be inadequate as indicated by the failure to formally appraise clinic staff during the field experiment period and the failure to use supervisory checklist.

- The recruitment, training and organization of volunteers in the community contributed to this process of empowerment in a number of ways. First, members of the community, by accepting to become volunteers, acknowledged that, ultimately, they – not someone else - were responsible for improving the health of the people in the community of Qarhis. Also, by becoming volunteers and undertaking training in first aid, these local people – along with the members of the health committee - acquired some of the skills needed to understand the reasons for the health problems of the community, and therefore to be able to do something about them. The volunteers also helped increase the sustainability of the clinic service in two ways: first, a very visible and active participation in the promotion of the community's health through increased volunteer activity; and second, by assisting the clinic staff with growth monitoring, health education and sanitation has helped reduce pressure on clinic staff during the busy dry season, contributing to an improvement in their performance.
- The reactivation of the health committee has created an important structure within the community through which the concerns, priorities, needs and aspirations of local people can be addressed. The concept of a health committee is no longer based on tokenism, reallocation of menial tasks to save program costs, or polite tolerance of occasional requests for information, consultation or participation by a few local people on the

periphery of output-based programming. As a result of the community management approach, a group of locally-appointed people have been mandated by their community, and have assumed the responsibility to engage in the planning, implementation, resourcing and supervision, in short, the co-management of the community health service.

However, the strategic investment in the operational capacities of the Somali Red Crescent required for a shift in its role from direct service provider to facilitator and supporter of communities in co-management of the health services did not take place. The outbreak of conflict limited access and consequently management support and supervision of branch health programming staff from Nairobi, and a decision by one of the main donors to cut funding resulted in a reduction of the staffing base. Consequently, the capacities of the SRCS to support community management actually decreased during the period of the experiment. And – in spite of the best efforts of the remaining staff – the consequences are evident in some aspects of the clinic services. Immunization rates remain low, despite the successful establishment of a functioning cold chain, and while this can be blamed on a range of problems including security, the constitutional crisis, drought, nomadic lifestyle, etc., there is no getting away from the fact that these rates are a direct result of the failure to invest in the human resource base. The current level of staffing at Garowe SRCS branch is not adequate to support seven clinics in widely-dispersed, often isolated and difficult to reach communities, let alone build the community systems and capacities that will be needed to make the clinics sustainable at local level. The organization is unlikely to maintain its current capacity as relief health provider and will certainly not be developed into the kind of enabling organization needed to support community management initiatives if a strategic investment in management systems and staff structures is not forthcoming.

Implications for the Thesis

The research started from the following thesis about the provision of health services in post-conflict communities:

Humanitarian organizations, working in partnership with local NGOs and emerging health authorities, can harness the potential and resources of communities and empower them to participate fully in the running and resourcing of their local health services, ensuring the appropriateness and sustainability of services and contributing to the post-conflict recovery of an effective public health system.

Local Ownership for Sustainable Recovery

The findings of the field experiment support the contention that in the absence of a stable government and a functioning health service, community management is the key to sustainability in restoring and maintaining health services, and hence the foundation for effective rehabilitation of the service sector. Local people and their institutions bear the consequences of the success or failure of recovery programming and therefore should own the overall process of rehabilitation. The field experiment demonstrated that increased local responsibility and accountability for health produced a significant improvement in the range, quality and sustainability of the service. The opinions, concerns, priorities and circumstances of the local people – the users and potential users of the facility - are no longer peripheral to the planning and organization of the service, or the day-to-day implementation of the Red Crescent program. Instead, these people have taken centre stage, assuming responsibility for their own health and the actions and choices that influence it.

Building Local Capacity: Empowering and Enabling

Through a twin process of empowerment – acceptance of responsibility and authority - and enablement – through institutional and individual capacity building, the potential and resources of the community of Qarhis have indeed been harnessed by the Red Crescent, coordinating and concentrating the efforts of the various health actors, and empowering the community to assume a significant degree of control over its own health service. This has clearly facilitated a change in the quality and range of services as local people have sought and obtained additional services which respond to local perceptions of their health needs. This twin process helps people evolve from passive program beneficiaries to individuals possessing valuable knowledge of their communities and an appreciation of how to effect and direct change at local level.

Equity through Collective Resourcing

At the same time, the successful organization of a community financing scheme has reduced dependence on external resources to sustain the health service, and local funds now provide 40 percent of the direct cost associated with the clinic. Unlike the user-fee schemes based on out-of-pocket payment at the time of illness, the collective financing approach has successfully tested a system of pre-payment and risk-sharing, designed according to the local socio-economic context to accommodate contribution payments based on the income generating and asset realization patterns of the Qarhis community. This pooling of revenues and sharing of risk within the community has facilitated transfers from better-off to poorer people in the community, healthy to sick, and the business-people to the unemployed. The community-based structure of the system, using collective decision-making and implementation based on the involvement of representatives of all seventeen sub-clans promotes a high degree of shared responsibility and control over the behaviour of individual households and that helps protect against moral hazard, adverse selection, and induced demand.

Contributing to the post-conflict recovery of an effective public health system

While the experiment provides conclusive proof of the willingness and ability of local people to support the recovery of community health services, it brings into sharp relief the willingness and ability of the international community and implementing organizations like the SRCS to deliver this recovery. The experiment exposed weaknesses in the Red Crescent capacity to support both the clinics in the delivery of the improved and expanded range of services, and the community management approach. These weaknesses relate to problems with supervision and monitoring capacities, reflecting the need for improvements in management systems and staff structures and supporting the contention that a structural investment in the Red Crescent will be required to enable the organization to evolve from a relief health provider to an enabling organization.

Beyond Qarhis: A Programming Model for Community Management

The Qarhis field experiment was used to develop a community management programming approach to involve local people and communities in the planning and management of

health services, and the mobilization and use of local resources. A number of changes were made to make the community management model more effective and facilitate the development of a generic model as a basis for replication in other communities served by Red Crescent clinics in Puntland and Somaliland. The generic model was built from the experience gained in designing and testing the Qarhis model but did not contain all the same features. For example, the community contribution strategy for other communities differed depending on their individual socio-economic profiles and circumstances. Similarly the amount of the contribution and the manner in which it was raised also differed from one community to the other. What did not change however was the principle of collective contribution based on willingness and ability to pay. The fundamental basis for the community management approach thus remained:

- The establishment of a system for community management;
- The development of individual and collective capacities within the community to enable meaningful and active participation in the running and resourcing of the clinic;
- The improvement of the level and range of services provided to meet the community's needs and expectations and thus engage their participation;
- The agreement of a community financing formula that suits the specific socio-economic conditions of the community and the creation of appropriate systems to collect and account for that contribution; and
- The strengthening of the service provider's local capacity to support the community in its new role and implement the agreed community health plan effectively.

Red Crescent health program and branch staff were trained in the approach and equipped with the skills and tools to be able to introduce this community management model in any community where the Red Crescent is providing services.

Within the first year of the evaluation of the Qarhis pilot, this generic community management model was replicated in six other communities in Puntland and Somaliland, and led to sharing of the responsibility for the running and resourcing of these clinics with local people in return for a significant expansion in the quality and services. Subsequently, the model became the basis for a Five Year Strategy that was developed by the Red

Crescent to implement the community management model in all our clinics in Puntland and Somaliland.

Lessons and experiences from the development of the community management model were used by the International Federation of Red Cross and Red Crescent Societies and the Somali Red Crescent to develop a series of generic learning and programming tools to support community health programming in other post-conflict situations.

The community management model was introduced to the Afghan Red Crescent Society and programming partners in Afghanistan in 2003 and programming based on the community management approach began there in 2004.

Conclusion

The results of the evaluation strongly endorse the hypothesis that community involvement in planning and management can lead to significant improvements in the quality, appropriateness and sustainability of local health services. The change in the focus of the service towards serving the expressed needs, priorities and concerns of local people and the concomitant shift in accountability produced a major improvement in the quality, appropriateness and sustainability of the service.

The findings of the evaluation also provided conclusive evidence to support the hypothesis that collective financing schemes based on communities' seasonal income and asset realization cycles can provide a significant proportion of the direct costs of basic health services. By ensuring local people had access to quality services that addressed their expressed health priorities the Qarhis scheme was able to significantly increase people's willingness to make financial and material contributions.

The impact of the field experiment strongly supports the hypothesis that – in the short term at least – the Somali Red Crescent can provide an effective platform for the rehabilitation of local health services. The outbreak of conflict prevented any rigorous testing of the SRCS ability to influence DoH policy. However, the Red Crescent demonstrated its

potential for channeling the efforts of a wide range of actors and donors into a community-owned strategy for sustainable recovery.

Finally, the experiment demonstrated clearly that the SRCS – as a local humanitarian organization – is uniquely positioned to harness the driving potential of communities in the recovery process and empower local people to take control of their health services.

While the strategic investment in the operational capacities required for a shift in SRCS role from direct service provider to community management facilitator did not take place, the findings from the evaluation of the experiment overwhelmingly support the thesis that the SRCS as a local humanitarian organization can harness the potential of communities to participate meaningfully in the running and resourcing of their services and provide a sound basis for the long term recovery of community health services. It remains to be seen however, whether the international community is genuinely committed to providing the resources and investment to support local humanitarian actors in this role.

* * *

10.

Conclusions: Extending the Boundaries

Extending the Boundaries

This thesis set out to address the question of health service recovery in conflict-affected states without fully functioning governments. In addition to the review of relevant literature in the fields of development, political science and health economics, the collapse of the health system in the conflict-affected region of Puntland, Somalia was the focus of a three year action research initiative to identify and address the practical challenges of rebuilding sustainable health services in conflict-affected, resource poor contexts. The research was undertaken in the difficult and remote environment of a state which has existed without a government for over a decade, with no functioning air carrier or national organizations, and regular, frequent outbreaks of violence. The research resulted in the development of an alternative model of health service delivery, within the institutional context of Red Crescent support, which was field-tested and then replicated in communities throughout Puntland and Somaliland. The new approach incorporates community empowerment and management, introducing financing modalities based on seasonal income flows of beneficiaries and local people's engagement in the sustainable provision of essential health services.

Conclusions

The conclusions are clear: under certain circumstances, and given the appropriate support, communities in Fourth World countries like Somalia possess both the willingness and the ability to take control of their local health facilities. In doing so, they improve and expand services – like routine vaccinations, trained health worker-assisted births, insecticide-treated bed nets, and health education – that can make an enormous difference to the quality of their lives, often the difference between life and death. By empowering local people to take cognizance, responsibility and control over their health services through the

community management model, the Red Crescent made a significant contribution to sustainable community recovery.

Community management therefore can be used to engage local people to provide services in ways that traditional forms of public service cannot, using responsibility and incentive systems based on the shared values and commitments of families and communities that bind people together for life. This operational dimension of civil society and social capital presents a real prospect for establishing or restoring essential services in these countries where government capacity and resources are so severely limited.

The research also suggests that important questions remain about the willingness and ability of the international community – as opposed to the local community – to support the development of institutional capacities to ensure the long term recovery of essential health services in Somalia and other Fourth World countries. The Puntland government can barely afford to allocate \$0.19 per person per year in a good year – i.e. before the livestock ban destroyed its general revenue base. The international community – led by the World Bank and the IMF – continues to insist that health services must become ‘self-financing’ – which they continue to argue implies user-fees and financial recovery, as opposed to community recovery. The priorities they impose on Fourth World governments are liberalisation, deregulation and privatisation, with debt servicing accounting for a higher proportion of the national budget than health and education combined, and little real prospect of reversing the long term decline in living standards for the vast majority of people. This thesis however concludes that successful expansion of health services can only be sustained by an approach that locates health in the broader context of people’s living and working conditions and takes into consideration the social inequities in these countries, where – for the majority of people - survival is determined by their ability to eke out a living on an income of less than one dollar per day. Research here suggests that a ‘community recovery’ approach that combines a broad initiative to build the structures, systems and capacities within a community that allows local people to become involved in the planning and management of their health services, with a community financing scheme based on collective contributions, would produce a significant increase in the quality, range and consequently sustainability of local health services.

However, it remains to be seen whether developed countries and donor organizations will be willing to make the investment in local organizations like the Red Crescent to enable them to introduce and replicate community management and build the systems and capacities within communities, to empower local people to take responsibility for their health services. In the medium term, essential services could be ensured for the population of the Fourth World if the developed world did nothing more than live up to its word. A generation ago developed countries pledged to donate 0.7 percent of their income to official development assistance. Today their contribution is barely equivalent to 0.25 percent of GNP on average, totaling \$70 billion. The UN Millennium Project has demonstrated that the additional \$130 billion of aid that would accrue from compliance with the pledged 0.7 percent would be more than enough to scale up health and other social services in developing countries to a level where they would be able to achieve the Millennium Development Goals (Sachs & McArthur, 2005).

Strengths and Weaknesses of the Approach

Using a community management approach requires significantly more organization, and assumes the availability of a local partner to assist with preparation and planning. It may be limited by community members' reluctance to participate, and by lack of prior knowledge of their abilities. It also requires a shift in agencies' function from delivering services, to 'facilitating and supporting communities' increased role in their delivery. It may take longer and require facilitation and training expertise. It may revive or provoke conflict between clinic staff and community members or representatives over control or responsibility for the management of health activities including the community health facility, and inevitably people's expectations have to be raised in order for them to become engaged.

But it empowers local people by demystifying the issues around community health behavior and building confidence to confront health needs and associated problems. By sharing knowledge - about health needs, problems and treatments, living conditions, available resources, and a host of other individual, household and community characteristics - between community members, clinic staff, district health officials, local

authorities, agencies' staff – community management builds consensus on priority problems and generates ideas for solutions to tackle them. This helps to change the mentality built up through years of relief health that services are planned and delivered by an external party - usually an aid agency, with little or no involvement or responsibility on the part of ordinary community members. Community members engaged in the process develop their capacities, individually and collectively, to question, investigate, design, plan, communicate and manage, and to do it together, as a community, a group of people seeking to improve their health conditions and their lives, extending their abilities and empowering them to confront and deal with other problems they encounter in their daily lives. To paraphrase Turshen (1999:3), this process of community recovery shifts the focus away from “How can people pay for health services?” towards “How can people secure the long term health of their communities?”

Recommendations for Practice

The research identified an important conclusion for international organizations seeking to support local service providers such as the Red Crescent: the challenge is to develop the institutional ability to consistently develop and support community management programming – empowering communities by helping them build workable partnerships with health authorities and partner agencies, and developing their capacities to create and implement solutions to improve and sustain their own services. The approach used here to inform the design of a research strategy and the development of the new programming model was action research, combining exploratory and problem-solving approaches, beginning with a general objective of changing or improving practice and initiating a series of cycles involving investigation, analysis, planning, acting and evaluation. The development of this new model was only possible through an active partnership with a local organisation such as the Red Crescent. The case study was selected as the most appropriate strategy to address the research question, beginning with an initial pre-study which was carried out in the Puntland State of Somalia to generate working hypotheses and inform the elaboration of a field research plan. But few international organizations possess the capacities or the organizational culture to adopt such an approach. International organizations from INGOs to UN agencies and development banks must change the way

they work if this is to happen. Rigid organizational cultures, inflexible project design and approval regulations, single year funding cycles and security restrictions continue to hamstring the same organizations who claim to have created “new” ,” flexible”, and “responsive” units and approaches to facilitate operating in conflict. Few staff are trained to any real depth in community planning approaches, and the time required to secure genuine community engagement in planning and implementing programmes is rarely ever given. This institutional restriction will need to be addressed if the international community is to play a meaningful role in the recovery of communities affected by conflict and absent governance capacities. The alternative is to await the establishment of fully-functioning governments, a distant prospect in many Foth World countries, or to continue to fail to improve health conditions for the poorest people in the world.

Future Research

A number of issues warrant further research. There is little doubt that some donors would be willing to fund approaches such as the community management model if they were confident that the organizational capacities existed to support and sustain local agencies whose presence and commitment are a prerequisite for success. Further research is needed to identify the organizational structures and systems that need to be built or sustained in order to support community management. This goes beyond the issues of human, financial and material resources and organizational design, to include a greater understanding of the impact of civil war on local people’s engagement and their varying responses to these formal institutions and organizations. Why and under what circumstances do local people disengage from or engage with local organizations and institutions in times of conflict, and how can such organizations be reconstituted in a manner that secures local people’s confidence and therefore their willingness to engage and contribute their time and resources? And how can the international actors provide adequate, consistent and timely support to the creation or reconstitution of these local organizations?

* * *

Annex 1

Review of Traditional Research Methods

Review of Traditional Research Methods

The following section presents a brief overview of the three traditional research strategies; case studies, surveys and experiments. A definition of each strategy is followed by a description, and an examination of their strengths and weaknesses. Their feasibility in the context of conflict-affected developing countries is then examined to determine if and under what conditions they would be appropriate for research in this context..

The Case Study

Robson defines the case study as

‘a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence’

(Robson, 1997:52)

▪ Overview

Its typical features include the study of a selected single case or a small number of related cases of an individual, group or situation, within its own context, using a range of data collection techniques (Robson, 1997:40). Typically case studies are used for exploratory and descriptive research questions – what Robson refers to as ‘how’ and ‘why’ questions. Hence the case study is frequently considered as the exploratory stage of a research strategy (Robson, 1997; Yin, 2003; Bowling, 2000). For example, Bowling (2000) describes the case study as the study of a case or small number of cases which is characterized by intensive, in-depth exploration of past or current events, using a combination of observation, interview and documentary analysis. Its usefulness is mainly as an exploratory tool, and for generating hypotheses:

‘a research method which focuses on the circumstances, dynamics and complexity of a single case, or a small number of cases’.

Bowling, 2002:403-406

This narrow interpretation has been criticised as a ‘common flaw’ in researchers approach to the case study (Yin, 2003:12). For example, Yin (2003) articulates a more inclusive and pluralistic view, arguing that each of the traditional strategies can be used for all three purposes – exploratory,

descriptive and explanatory. The defining requirements for the use of the case study approach are: a) the paramount importance of contextual conditions to the phenomena being studied and; b) the need for prior knowledge of the context and subsequent triangulation of data from multiple sources of evidence, as a result of the complexity of these contextual conditions (Yin, 2003:12).

Both Robson and Hakim distinguish between five types of case study which may be used for policy or theoretical and policy research (Robson, 1997:146-166; Hakim, 2000:63-75).

- i) Individual case histories providing a detailed and substantiated account of a person's experience have been used extensively to study different lifestyles, cultures and behaviour – whether in migrants, criminals, drug addicts or other characters.
- ii) Case studies of social groups are particularly useful for two types of social group situations: either where there are small groups in direct contact with one another (e.g. families or work-teams), or to study a larger group with a common identity and shared activities or interests, such as an occupational group or lobby group.
- iii) Case studies of organisations or institutions are commonly used to provide a detailed profile of organizations or institutions and their patterns and processes.
- iv) Case studies of events, roles and relationships are often used in social science to explore behaviour of specific roles, relationships in occupational interactions and responses to specific events.
- v) Community Studies are studies of a local community, village or town to describe and analyse the main aspects of community life such as its political and religious activities, family life, work and pastimes. Such studies usually provide a detailed profile of the particular community and the pattern of social life, but it can also be used to address specific questions and issues (Robson, 1997; Hakim, 2000).

▪ Strengths

a) Flexibility: The case study strategy has a wide range of uses: from a descriptive report providing a detailed profile of a particular social phenomenon, to the careful testing of a well-defined thesis which can be undertaken when an intellectually rigorous approach achieves 'experimental isolation' of selected social factors in their natural setting (Hakim, 2000:60). Descriptive case studies can also be exploratory when there has been relatively little previous research on a particular phenomenon. Case studies may also present a detailed profile of social features or patterns which are held to be representative of other cases. Case studies can also be used to investigate or confirm causal processes behind observed patterns or correlations (Hakim, 2000).

b) Multiple sources of evidence: Because case studies may use a range of different sources such as observation, unstructured interviews, document research and structured questionnaires to provide a multi-dimensional picture of the phenomenon being investigated, they can provide unique insights into complex social phenomenon (Bowling, 2000).

c) Depth: Case studies can be used to articulate a 'richly detailed portrait' of a complex social phenomenon in simple terms and thus make knowledge available to the lay person (Hakim, 2000).

d) Cost: Small-scale case studies require relatively little organization and can be undertaken by one person. As a result they can be considerably less costly than, for example, a survey or an experiment.

▪ Weaknesses

a) Credibility: The case study has traditionally been viewed by social scientists as a weak method, or 'soft option', inferior to other research strategies, lacking sufficient precision, objectivity and vigour (Yin, 2003:xiii; Robson, 1997:56). Despite this stereotyping they continue to be used extensively in social science research, particularly psychology, sociology, political science, social work, business and community planning. Yin argues that this is because the stereotype is incorrect, caused sometimes by poor quality work, sometimes by confusion with teaching case studies which are altered and adapted at will to demonstrate a particular leaning point. Case studies resemble experiments in that the goal is to conduct research whose findings can be generalized to theoretical propositions and not to populations or universes. In generalizing from one case to another, therefore, it is important to make the distinction between *analytical* and *statistical* generalization (Yin, 2003:10-11). The critical issue therefore is to demonstrate that the findings from case studies are reliable and valid. Robson (1998:56-59) refers to the need for '*rigorous* case studies' requiring attention to design, data collection, analysis, interpretation, and reporting .

b) Validity: Generalisations from one case to a wider population can be difficult to substantiate, mainly because of the individuality of any particular case being examined (Bowling, 2000; Barakat et al, 2002). Bowling (2000) goes so far as to state '*the material they generate is not generalisable*'. Hakim however, contends that confidence increases when more than one case is used, either through analytical inference when cases are selected to cover the known range and variation or through statistical inference where more than one hundred cases are examined (Hakim, 2000). However, for most researchers the reality of limited time and financial resources means that the intensive nature of case studies limits the number of cases that can be studied.

c) Objectivity: Hakim (2000) notes that case study findings are open to interpretation based on the interests and views of the researcher. The need for close involvement of the researcher and the resulting influence on the persons or events involved may also undermine the objectivity of the findings (Robson, 1997). Other research strategies are also vulnerable to bias, but in case study research it seems to be more common and less frequently overcome (Yin, 2003).

The Survey

The term 'survey' refers to the collection of standardized information from a specific group of people. This information is usually collected from samples of individuals selected from a known population, using a questionnaire or structured interview. Usually a relatively small amount of data is collected in a standardized form from each individual. The value of surveys comes from their ability to use sample populations to provide profiles and statistics that can be generalized to the whole population (Robson, 1997).

▪ Overview

Surveys are typically used to seek information about a respondent's own characteristics and circumstances, their behaviour and practices, and their values, beliefs and attitudes. The household survey in particular has specific advantages for conducting research on questions relating to socio-economic status and lifestyle, addressing issues of shared responsibility or common concern (Robson, 1997; Hakim, 2000; Bowling 2002).

Surveys are recommended for descriptive studies such as how many people in a population behave in a certain way, or possess a particular attribute, opinion or belief. Research on the incidence or prevalence of a phenomenon, or efforts to predict certain outcomes, tend to favour the use of survey strategies - what Yin refers to as 'who' and 'where' questions or derivatives such as 'how much' and 'how many' (Yin, 2003). If people are likely to be familiar with the research topic and may be able and willing to respond accurately to questions, and if it is possible to obtain a representative sample of the population, then a survey may be the most appropriate method (Robson, 1997).

Hakim (2000) distinguishes between *ad hoc* sample surveys and regular surveys. *Ad hoc* surveys are commonly used in developing countries to provide descriptive statistics at various levels, often in the absence of a national census. The regular sample survey is commonplace in industrialized countries where it is used to generate data on topics of ongoing concern to central and local government, businesses and other large institutions. In the latter case, the one-off sample survey is used for in-depth enquiry to supplement and extend the information from regular surveys and to

study causal processes. Additionally, survey data can be used for exploratory research or to explain phenomena and provide data for testing hypotheses.

Timing

Robson (1997) cautions against one of the most common mistakes associated with conducting a small scale survey – underestimating the time required for all stages. He provides a useful time budget for the different phases from initial design to computer entry, suggesting that a total of at least six months will be required before analysis and interpretation can begin.

Box A7: Time-budget for a survey of about 1,000 interviews

1. *Initial design work* including sample design and selection takes a minimum of six weeks.
2. *Questionnaire construction* including pilot work and the design and printing of the final questionnaire takes at least another six weeks.
3. *Briefing* the interviewers, followed by the fieldwork phase, for say, twenty interviewers, each covering fifty respondents takes another six weeks.
4. *Editing and coding* can start at the same as the fieldwork, but, to allow for postage and sorting out problems is likely to run on for a further six weeks.
5. *Computer entry and editing* takes about four more weeks.

(Robson, 1997:122)

▪ **Strengths**

- a) The survey is an effective and relatively simple strategy for measuring attitudes, values, beliefs and motives or retrieving information about the past history of a large set of people. It can be adapted to collect representative information from almost any human population. They can be extremely efficient at providing large amounts of data, at relatively low cost, in a short period of time (Robson, 1997).
- b) Associations between different factors can be identified and measured using sample surveys. Sophisticated computer programs such as SPSS make it possible for sample survey designs to study causal processes, advancing and testing explanations for particular associations and social patterns (Hakim, 2000).
- c) Surveys can be replicated in different communities, areas or even countries simultaneously or in the same location at intervals of time (Hakim, 2000)
- d) They allow anonymity, which can encourage frankness when sensitive areas are involved. The interviewer can clarify questions, encourage participation and involvement (Barakat *et al*, 2002).

- e) Highly structured surveys provide high levels of data standardization, i.e. - standardized measurement that is consistent across all participants (Robson, 1997; Hakim, 2000).
- f) A key advantage of the sample survey strategy is its transparency or accountability. Both the methods and the procedures used in a survey can be made available, as well as the results. Most survey reports provide the sampling procedure, the questionnaire, procedures for analyzing the data, information on the sampling frame used, analysis of non-response and more. Datasets can be archived and accessed for secondary analysis. Moreover, evidence to support the conclusions can be presented in tables within the report so that readers can see whether they are well founded or open to alternative interpretation (Hakim, 2000).

- **Weaknesses**

- a) The standard use of the structured questionnaire limits the depth and quality of the data that can be obtained through a survey (Chambers, 1999; Hakim, 2000).
- b) The accuracy of the information provided by the respondents depends on a range of personal characteristics including their honesty, memory, motivation, knowledge, experience, and personality. Social desirability bias is also an issue: respondents generally will want to be seen in a favorable light and won't necessarily report their beliefs, attitudes, etc. accurately if this would make them look bad (Robson, 1997).
- c) Phrasing of questions may give rise to misunderstandings and result in inappropriate responses and data. Similarly, data quality can be undermined when respondents do not engage meaningfully because they may be uninterested and responses may be insincere or flippant, or when respondents do not believe the information they give will be treated confidentially and give partial or obscure answers (Barakat & Ellis, 1996; Robson, 1997; Chambers, 1999).
- d) Interviewer bias: inexperienced interviewers or interviewers who are in a hurry or have a vested interest in the outcome of the survey may influence the responses, resulting in inaccurate or partial responses (Robson, 1997; Chambers, 1999).
- e) Responses may be influenced by the interviewer-respondent interaction where there are issues of class, ethnicity or authority (Robson, 1997).

The Experiment

Experiments measure the effects of controlled change of one variable on another. In its strictest form the experiment is defined as

A research strategy involving the assignment of subjects to different conditions; manipulation of one or more variables (called 'independent variables') by the

experimenter; the measurement of the effect of this manipulation on one or more other variables (called 'dependent variables'); and the control of all other variables.

Robson, 1997:78

▪ Overview

Its advantage lies in its ability to establish causal relationships, to establish whether a certain intervention will produce a specific impact on a particular subject, or whether changes in one variable produce changes in another.

Essentially two or more differently treated samples of individuals (usually an experimental group and a control group) are composed randomly, and a controlled change is effected to one or more of the variables within the experimental group, followed by the measurement of the effect of this change on a small number of variables. Control of other variables is critical to minimise variation between the two groups, i.e. – the two groups should be equivalent and studied systematically under identical conditions – other than the controlled change to the experimental group. This requires both random allocation of individuals to a given group, and experimental control over which group will be exposed to the phenomenon being tested (Robson, 1997; Yin, 2003; Bowling, 2000, Hakim, 2000).

Ideally, the two groups are studied before and after the experimental change is introduced and at the same points in time. This pre- and post-testing allows conclusions to be drawn about the impact of the controlled change (Robson, 1997). Bowling (2002), notes that 'pre- and post-testing' is not always possible. Compensatory tactics such as the use of post-test only and retrospective pre-testing have been used, for example following emergency surgery.

Robson (1998) however, points out that it is impossible to infer any kind of effect from the single-group, post-testing experiment and rejects it as a waste of time and effort. Similarly, he judges the outcome of any pre-test, post-test single group experiment to be of questionable validity, vulnerable to change from other uncontrolled events, developments in the group between measures, and statistical regression. In the absence of a control group it cannot be inferred with any certainty how much the group would have changed from pre-test to post-test in the absence of the treatment. In both cases he suggests that the case study methodology may be more appropriate (Robson, 1997:87-92).

Experiments are highly focused studies, which can generally only deal with one or two independent and dependent variables, in order to meet the strict control requirements. The variables have to be

carefully selected, usually based on a great deal of preparatory work (Robson, 1997; Hakim, 2000; Bowling, 2002). Robson (1998) notes that in real life situations there is often inadequate knowledge about the subject being studied to allow for such selectivity of focus, or as he puts it '*you often don't know enough about the thing you are studying*'. Their uses are further narrowed by the reality that many causal processes are straightforward and reasonably-well understood and are most useful when the existence of any causal relationship is in question, or when the magnitude or direction of the causal effect is unknown (Hakim, 2000).

Experiments require total control over subject behaviour (Yin, 2003). The problem with doing experiments outside the controlled environment of the laboratory is that it is generally quite difficult – if not outright impossible - to achieve control of the other variables which might affect the outcome of the experiment. Even if the special conditions required to facilitate the staging of an experiment can be created, they are likely to produce reactive effects (Robson, 1997; Hakim, 2000). The classic example of this is the Hawthorne effect observed during studies of working practices in Western Electric Company in the 1920's and 1930's. Changes in heating, lighting and other variables by researchers investigating working conditions produced improvements in productivity irrespective of the changes made. Some interpretations suggested that workers were responding positively to the special treatment of the experimenters' attention, though others argue that there is no empirical support for these particular reactive effects (Robson, 1997, Bowling 2002). Nevertheless, despite the controversy surrounding the interpretation of the Hawthorne findings, it is accepted that sensitization to the special conditions created for experimental research can produce reactive effects in the subjects (Bowling, 2002).

Hakim questions the value of separation of, for example, selection and treatment effects if they would normally operate together in the real world, pointing out that if participation in certain programmes is voluntary, there is little point in trying to find out what effects they would have on people who would anyway refuse to participate in them. In this context there is no meaningful control group and single group experiments may be appropriate (Hakim, 2000).

▪ Strengths

a) Establishing causal links: The main strength of the experiment is its ability to establish causal relationships (Robson, 1997). Bowling (2002) goes so far as to state that it is the only research strategy which can, in principle, yield causal relationships, though neither Yin (2003) nor Hakim (2000) agree with this narrow interpretation. This capacity to deliver more definitive answers about causal links is, however, a worthy compensation for the narrow range of

information that can be generated by an experiment, making it an essential strategy for developing explanations of social events, behaviour and attitudes (Hakim, 2000).

- b) Internal validity: The requirement for experimental control and random assignment produces a high degree of internal validity. This applies both to the independent variables and a range of extraneous additional variables are present (Robson, 1997).

- **Weaknesses**

Experiments have a range of weaknesses in relation to human subjects and their environments.

- a) Limited use in social research: True experiments take place in a laboratory where experimenters can maintain the maximum degree of control over variables – the greater the control the higher the internal validity (Robson, 1997). Their usefulness in empirical social research other than social psychology is therefore limited
- b) External validity: The high degree of manipulation of behaviour required to conduct experiments properly creates a unique, unrepresentative environment which may not be easily replicated.
- c) Experimentation with human subjects: This may not always be possible or feasible and raises questions about the willingness of people to become subjects in any particular testing exercise. There are also issues of ethical concern when administering or withholding treatments or medicine, or subjecting people to stressful or distressing treatment purely for research purposes (Hakim, 2000)
- d) The high degree of control may result in the experimenter artificially producing the predicted outcome, or provoking the opposite reaction when the subject reacts rebelliously in response to the intense focus of the exercise (Hakim, 2000).
- e) True experiments cannot be used to research past events since they have, by definition, already occurred and no control can be imposed retrospectively. There are examples of ‘retrospective experimentation-type studies’ but these produce less convincing evidence about causal relationships (Robson, 1997).

Traditional Research Methods in Conflict Settings

The following section will examine the feasibility of the three traditional research strategies in the context of conflict-affected developing countries.

The Case Study

The case study is '*one of the most powerful research designs*' (Hakim, 2000:61) mainly due to its ability to exploit evidence from a range of data collection methods to provide more rounded and reliable accounts of social issues (Yin, 2003; Hakim, 2000; Bowling, 2002). Direct observation, interviews, documentary analysis, artefacts, video and audiotapes can all be used to develop, triangulate and validate findings. Yet, the findings will essentially be worthless unless the data have been gathered honestly in the context of the question or phenomenon being studied. The study will not have construct validity: if we don't gather the data in a genuinely conflict-affected situation then it does not address the research question, nor measure what we say it measures. That is to say, unless we can gain access, in a post-conflict area without a stable government, to a health service delivery organization which is willing to allow us to observe, interview, gather documents, texts, artefacts and other evidence, the case study strategy will be of limited use. This issue of feasibility is not restricted to the question of geographical access, but access to a subject unit and the people (e.g. – health service providers, users, non-users, managers, partners etc.), records, relationships, processes and experiences within its domain. This is an important question because the 'unique strength' of the case study is its reliance on these sources of data (Yin, 2003:8) and there are real-world issues which present significant obstacles to the granting of such access. These issues can be presented under the following main headings: integrity, security, and practicality.

- **Integrity**

In the difficult circumstances of aid in the context of conflict, limited access and restricted monitoring and control, organizations usually want to direct enquiries towards the more positive and successful aspects of their work. Most organizations working under the practical restrictions prevailing in conflict-affected situations are likely to think twice about allowing researchers free access to internal documents other than the usual reports, evaluations and project updates carefully written or edited to deflect criticism or conceal poor performance and failure. Random access to beneficiaries, program staff and local partners is another tricky issue which might risk to depict an agency in a bad light. One only has to consider for a moment the stage-management of media visits to program sites, or the number of signatures required on consultant contracts restricting disclosure or publication of any information without prior permission in writing by (sometimes very) senior management. The competence of aid organizations is increasingly under the spotlight and they are more and more careful to ensure that they are seen in a good light. Competition for donor funding has never been tighter and the prospect of a researcher questioning practice and policy raises questions about use of any findings, publication of reports or articles. Chambers (1999:99) sums up the dilemma succinctly:

‘The NGOs [...] do not dare to be so frank about their own performance [...] The NGO and bilateral courtiers and critics feel compelled to keep their privates covered.’

There are also issues of internal politics – what might be termed a lack of cohesion between different components of a single organization or between close partners – details of which might be damaging if they emerged in the public realm.

▪ **Security**

Any organization working in a relevant context will have at least three good reasons to be concerned about the security implications of facilitating access to a conflict-affected area by an independent party or parties:

- ✘ *The safety of the respondents:* Respondents or informants who agree to meet and discuss with researchers, or pose for photographs, may divulge - or be accused of divulging - sensitive information about the conflict situation and be targeted as a result for ‘informing’ or ‘collaborating’.
- ✘ *The researcher’s safety:* The researcher’s safety may be at risk because of a lack of familiarity with potential threats. Despite the number of aid workers that have been killed in recent years, security guidelines and restrictions are still flouted on a regular basis by visitors, consultants and new personnel.
- ✘ *Subsequent problems with hosting organisation safety:* NGOs and aid agencies do go to a lot of trouble and invest a lot of time and money in training their staff on security and trying to improve the security environment for their operations. Offensive, threatening, arrogant or culturally-insensitive behaviour by visiting researchers, consultants etc. not only places the offender at risk, but also results in the organization becoming a target, often long after the visitor has departed.

▪ **Practicality**

At both personal and institutional level the inconvenience and cost of hosting a research visit in conflict-affected areas raises a number of practical problems associated with field conditioning, workload, and cost. Practitioners in field environments and particularly in conflict-affected situations adapt their behaviour develop a specific life-style and set of routines after living in that context for a period of time, which both enhances their personal security and closets them from the often significant deprivations associated with life in conflict-affected areas. This includes formal

and implicit rules about curfews, no-go areas, profile, and dress-sense and so on, as well as who to engage with and who to avoid. In some cases, hosting visitors, particularly ‘outsiders’, can be a welcome break from this imposed routine. However, for some practitioners, this is not always the case and the presence of a team of researchers or ‘experts’ can be a disruptive and unwelcome experience to be avoided if at all possible. In some organizations the institutional culture may be closed or even secretive as a side-effect of a (sometimes) distorted sense of neutrality or confidentiality, and research visits may be actively discouraged or officially barred.

The additional workload of organizing transport and accommodation, arranging meetings, site-visits, interviews, and accompanying visitors can also be quite high for staff that are already overloaded with program implementation demands. In these cases, it may be difficult to engage the full co-operation of the field team or the researchers may be left to make their own arrangements.

There may be direct or opportunity costs or both attached to the hosting of a research visit which might cause the organisation to reject any such requests. For example, access to Bosnia during the war, Afghanistan at different times, Somalia today, all require or required air transport, and although there are systems which allocate priority to agency staff, any commitment to transport a team of visitors would have to be honoured. Also the opportunity cost of staff engagement in the organizational tasks as outlined above can be considerable.

The Survey

The use of standard questionnaire surveys in conflict-affected or developmental contexts without adaptation or alteration has been criticized as particularly disempowering because of their tendency to exclude local people from key aspects of the design and analysis process (Chambers, 1999; Barakat *et al*, 2002). Ordinary people can also be intimidated by the rigid application of the structured or semi-structured questionnaire or may simply be unable to construct a cohesive response to questions that have little meaning for them in the aftermath of conflict or loss (Barakat, 1992).

In ‘*Whose Reality Counts? Putting the First Last*’, Robert Chambers rejects the use of standard surveys in developmental contexts as

‘long-winded, tedious, a headache to administer, a nightmare to process and write up, inaccurate and unreliable in data obtained, and leading to reports, if any, which were long, late, boring, misleading, difficult to use, and ignored’

Chambers, 1999:111

Surveying by professional researchers has become ‘robustly sustainable as a rural and urban industry’ – an industry with little value other than as an exercise in employment for professional consultants, involving the participation of local people only tangentially, if at all (Chambers, 1999:122). Chambers justifies such trenchant criticism of questionnaire surveys by explaining that they are part of an established systemic process which is riddled with anti-poverty biases and ignores local people’s knowledge. This status quo is consolidated by the use of questionnaire surveys to ‘distort peripheral realities and fit them into centrally-pre-set frameworks’. This occurs in the three main stages of the survey: constructing the questionnaire; interviewing respondents; and analyzing the data (Chambers, 1999:93-7).

In the context of health service delivery or aid programming, the surveying process is rarely initiated by an entirely neutral, unbiased party. As a rule the objective is to provide baseline data for an organization with – at a very minimum – a particular mandate, and often with preconceived notions about what would constitute a solution to the problem. Questionnaires may only serve to reconfirm the limited knowledge that the external researcher had in the first place. This is because of their often highly structured design, which requires an action-reaction type response. They require precise responses to closed questions, producing multiple-choice simplifications of often-complex phenomena, and usually excluding even simple combinations or permutations of circumstances such as multiple sources of income. Data collected is strictly limited to what was asked and does not extend beyond the limited perspective of the external researcher who prepared the questionnaire. It cannot, therefore, challenge their preconceived notions about the problem and, or its solutions. *‘What is not asked about is not found out about and cannot be part of the analysis’* (Chambers, 1999:95). The greater the volumes of data, the more the analysts are forced to select, to choose what to present, what to focus on. This according to Chambers *‘necessarily reflects their priorities and predispositions, which are then reinforced’* (Ibid.:95).

Missing valuable opportunities to learn from people who might be able to provide a much richer, informative, detailed, broader picture of complex local circumstances, they are unlikely to correct misconceptions, introduce new ideas, or construct new hypotheses to replace wrong ones. Hence, to paraphrase Chambers, they do not inform, they only reconfirm, and they often reconfirm partial or incorrect solutions.

It would appear then from that the weaknesses inherent in the survey as a research method can only be overcome by genuine participation of local people in the various stages of designing, drafting,

conducting and validating the findings of the survey. This would require considerable additional work in the preparation of the survey and may not always be feasible in conflict-affected situations where access is limited and participation may be difficult to engage. There are some circumstances however where it may be possible, for example given the support of a local organization such as a Red Crescent society which has been working closely with local people for years and has provided assistance and built up trust. If their assistance could be secured to help plan, organize and prepare such a survey exercise, and critically – to engage the trust and participation of local people, then it may be possible to conduct a valid survey in a conflict-affected context.

The Experiment

It is highly unlikely that the circumstances prevailing in conflict-affected areas would ever allow random subject assignment (Barakat *et al*, 2002). Given the limited usefulness of true experiments in the field of empirical social research due to their artificial setting, a number of real-life variations have been used for social experiments in more natural settings. These quasi-experimental designs offer less rigorous tests: there may be no control group, or no control over subject-assignment, but it may be possible to overcome or at least compensate for these limitations through additional testing, a more rigorous validation of results, and the elimination of rival explanations for the results obtained. Quasi-experimental designs can thus be developed with many compensating strengths offering a more useful approach than true experiments in real-life contexts (Hakim, 2000). Robson (1998) highlights three main advantages:

- ✘ *Generalizability*: Experimentation in natural situations tends to produce results which are more representative of real-life where control is often minimal.
- ✘ *Validity*: The element of obedience which is generally present between the experimenter and the subject in laboratory settings is much less pronounced in real-life settings. Again, this increases the possibility that the findings are a better reflection of reality.
- ✘ *Subject availability*: Laboratory experiments have to be staged and subjects have to be found and assigned to particular roles and task – real life experiments generally allow the study of the subject *in situ*, obviating the need for and reliance on effective subject role-play.

Field experiments however do require some degree of control over the context to allow the introduction of the explanatory variable and the testing of subsequent reactions. This requirement

for control will depend on the extent to which people and their institutions are open to considering different approaches. There may be considerable fatigue in communities which have had services imposed on them for years by external organizations. Somalia may be a case in point after more than a decade of broken promises. On the other hand, the same people may welcome the fact that they are finally being given some degree of control and responsibility for their services and be willing to participate in such a field experiment.

Local health authorities however should be approached with caution: emerging administrations that are trying to gain some authority over the profile and character of the patchwork of services provided by different external actors and impose some sort of policy framework may be unwilling to cede control over services in order to facilitate experimentation. Again, the participation and support of a local or national organization such as the Red Crescent society, with influence on these authorities and institutions, may be the key to the success of any experiment.

Conclusion

In conclusion it would appear that all three traditional strategies can – to some extent - be adapted for use in conflict-affected environments when certain critical conditions exist: in the case study, the critical condition is access; in the survey, the key issue is participation; and in conducting a field experiment the primary element is control. The participation of a major local organization such as a Red Crescent society may be the key to negotiating these conditions. As we have already secured the co-operation of the Somali Red Crescent in the research activities, we can move forward to address the main question about methodology: Which strategy is the most appropriate to address the research question?

* * *

Annex 2: The Puntland Pre-study Data Collection Program

THE PUNTLAND PRE-STUDY April 18th to May 5th, 2000

DATA COLLECTION PROGRAM

April 18: Arrive Nairobi

Interviews:

- Federation Head of Somalia Delegation, Ola Skuterud
- Head of Federation Regional East Africa delegation, Francoise Le Goff
- President Ahmed Hassan and Secretary General Hassan Nur, Somali Red Crescent Society
- Norwegian Red Cross Regional Representative, Eilif Torma
- ICRC Head of Delegation, Michel Duffour

Meeting with Inter Agency Standing Committee (IASC) Team conducting an assessment of reintegration prospects in Somalia

April 19: Nairobi

Interviews:

- Federation Health Officer for Somalia, Aisha Mohammed
- UNICEF, Roberto de Bernardi
- AMREF, Chris Wood
- MSF Holland, Patricia Smith

April 20: Nairobi to Galkayo

- 06:30 ICRC Red 444 flight to Galkayo, Puntland (via Mogadishu K30)
- 12:00 Arrival Galkayo – process visas
- 13:00 Visit to Red Crescent Rehabilitation Centre
- 14:00 Interview with General Abdi Nur, Vice President, Red Crescent
- 15:00 Visit to Galkayo market
- 16:00 Interview with Governor of Muduug region
- 17:00 Interview with MSF Galkayo staff
- 18:00 Interview with Hawa Mohammed, director of Peace and Development Centre
- 19:00 Visit to Daltone

April 21: Galkayo to Garowe

- 06:00 To Garowe by road
- 08:00 Visit to Ba'adweyn village and clinic
- 10:00 Interview with President Abdullahi Yusuf and members of his cabinet
- 15:00 Focused Group Interview with SRCS Garowe branch
- 17:00 Interview with religious leader of Puntland, Islam

April 22: Garowe

- Interview with Mohammed Haji, Diakonia representative
- Visit to Garowe SRCS Referral Hospital, focused group interviews with hospital staff
- Interview with Minister of Health and Social Affairs and the Director General of Health

April 23: Garowe

- Health Sector workshop with Minister of Social Affairs and staff, Minister of Planning and staff, Minister of International Co-operation and staff, UNICEF, UNESCO, WHO, UNDP, Diakonia.

April 24: Garowe

- Interview with UNESCO Puntland representative George Murito
- Visit to Dangoroyo clinic; focused interview with clinic staff
- Interview with District Commissioner for Dangoroyo

April 25: Garowe to Bosasso

- Drive 450km from Garowe to Bosasso, with stop halfway in town of Qardho
- Interview with Dr. Basher, Action Against Hunger representative, Qardho
- Visit to Qardho District Hospital

April 26: Bosasso

- Interview with Dr. Campbell, Head of WHO Office
- Visit to Bosasso General Hospital, interview with Dr. Shaachuur
- Visit to UNICEF office, interview with Per Lundgren, Regional Program Officer
- Interview with Dr. Mohammed Aynab, Governor of Bari region

April 27: Bosasso

- Interview with WFP Head of Office
- Visit to Bosasso Port, interview with Ahmed Said Nur, Director of Bosasso Port
- Visit to Kuwaiti Technical Institute, Bosasso
- Visit to CARE office, Bosasso, interview with CARE teamleader Abdiljabar H. Dini

April 28: Bosasso

- Visit to Bosasso IDP camp
- Interview with Dr. Mohammed Hassan, Minister of Finance

April 29: Hargeisa

ECHO flight from Bosasso to Hargeisa via Djibouti

- Interview with Minister of Health and Labour, Mohammed Hussein and Director General of Health, Dr. Abdul Rahman
- Meeting with SRCS Somaliland, interview with SRCS Co-ordinator Ali Sheikh
- Group interview with SRCS Branch Chairmen: Ahmed Mohammed, Las Anod Branch; Abdurahman Abdullahi, Hargeisa Branch ; Abdi Awal, Borao Branch; Haji Nur, Borama Branch.

April 30: Boroma & Boon

- Visit to Boroma Regional Hospital, interview Regional Health Officer
- Visit to Boon clinic, interview with clinic staff

May 1: Hargeisa

- Visit to Hargeisa branch
- Visit Norcross Rehabilitation Centre
- Visit UNICEF Somalia HQ, interview Dr. Romanus Mkerenga

May 2: Hargeisa to Nairobi

May 3: Nairobi

- Preparation of draft report summarising main findings

May 4: Nairobi

- Presentation of main findings to Somalia Aid Co-ordination Body

May 5th Nairobi

- De-brief with ICRC Head of Delegation
- De-brief with SRCS President and Secretary General
- De-brief with Head of Regional Delegation
- De-brief with Federation Head of Somalia Delegation
- Exit Nairobi

* * *

Annex 3

Planning and Organizing the Survey

1. The Puntland Participatory Survey

Having identified the participatory survey as the ideal method, the survey was undertaken in three distinct stages:

- Stage 1: Planning and Organization
- Stage 2: Preparing and Conducting the Survey
- Stage 3: Results, Feedback and Validation

This section describes how the Puntland Participatory Survey was planned, organized and executed.

1.1. Planning and Organization

The survey was organized in collaboration with the Nairobi-based Somalia Delegation of the International Federation of Red Cross and Red Crescent Societies, and the Somali Red Crescent Society. Initial planning was based on the rehabilitation assessment produced during the pre-study. Visits to Geneva by the Head of the Somalia delegation and the President of the Somali Red Crescent Society also presented the opportunity for meetings and discussions about the survey mission preparations. A checklist was prepared and distributed to clarify roles and responsibilities, and to act as a focus for discussions on progress and completion.

Training Material

Training material was prepared in advance covering the following subjects:

- What is research, and why do we research with specific reference to quantitative survey in a post-conflict context where baseline data is often absent.
- Introduction, application of community mapping and defining clinic catchment area.
- Stratification according to lifestyle, e.g. - nomadic, rural, urban, and displaced.
- Identifying and defining Units of Analysis.
- Defining a household with particular reference to Somali culture.
- Introduction and application of community mapping and socio-economic differentiation in order to inform and facilitate sampling.
- Wealth ranking according to life style groupings.
- Sampling techniques.

- Basic techniques and approaches for conducting interviews.

Introductory Questionnaire

Very little previous research had been done on the functioning of the clinics, their use (other than standard statistical reports provided on a monthly basis by the clinic staff), their standing in the community and the extent to which the community participated in the service. There were also concerns about the ability of community representatives to engage meaningfully in the planning and preparation of the survey. When questioned, Red Crescent staff and Federation delegates had little knowledge about the aptitudes and abilities of the potential participants in the preparation workshop other than their status as clinic staff or community representatives. A qualified senior manager of the Red Crescent suggested that Somalia's traditional oral culture would preclude the participation of most community representatives from written work and mathematical exercises which would be required, for example, to calculate samples. He suggested that this would probably be offset by the combination of formally-educated clinic staff with community representatives in working groups and subsequently in interviewing teams.

An introductory questionnaire was prepared, seeking information about community profile, health behaviour, the role and performance of the clinics and the community health committees, and the broader provision of health services in Puntland. Questions were also included about participants' previous experience of training and their expectations of the process. A copy of the questionnaire was sent to each participant in advance of the workshop. Analysis of these questionnaires prompted the first of many revisions of the training material the day before the workshop began.

2. Preparing the Survey Exercise

The survey preparation workshop took place in Garowe, Puntland between Thursday 29 July and Friday 4th August, 2000. For the first time since the Red Crescent Integrated Health Care program began in 1993, Red Crescent clinic staff and community representatives from the twelve communities came together with SRCS senior management and branch staff to discuss the program, community health behavior and clinic services.

Aim and Objectives of the Workshop

The aim of the workshop was to enable community representatives and clinic staff to conduct a household survey to collect baseline data on household profiles, traditions of participation, health behaviour and livelihoods.

Five objectives were set:

- To develop a common understanding of the study and its objectives;
- To share knowledge and experience among community members, clinic staff and representatives of the health administration and agencies providing health-related aid;
- To introduce social survey research and data gathering methods including participatory appraisal techniques;
- To design a questionnaire to be used in the household survey;
- To develop a plan for the conduct of the survey.

Workshop Methodology

The methodology involved the progressive development of participant's ability to prepare and conduct a small-scale household survey on the one hand, and facilitators' ability to understand the complex local, cultural and social context and its implications for the design of the survey, the composition of the questionnaire and the wording of individual questions. A participatory learning approach was used, combining classroom-style facilitator-participant interaction with both formal facilitators and community elders facilitating sessions depending on subject matter and expertise, experience and authority. Structured and unstructured group work was used. Techniques included participatory mapping of communities, catchment areas, populations, sub-groups and services; well-being and wealth ranking; seasonal calendars describing variations in climate, population, health service utilization, water resources, labor patterns and migration; listing; role-playing; observation; simulation and real-life practice. Beginning with introductory sessions explaining basic concepts of research, surveying and data gathering, the workshop increased in complexity and practicality to engage participants in the mapping of their communities' catchment area, differentiating between lifestyles and economic status, the design of representative samples from their respective communities, and eventually the development of the questionnaire to be used in the survey.

Participants

In total 50 community representatives, clinic and program staff, and administration personnel took part in the survey preparation exercise:

- 8 health program staff from the Red Crescent offices in Garowe and Galkayo;
- 24 clinic staff: two staff from each of the 12 clinics;

- 12 community elders: one from each of the 12 communities;
- 4 staff from the Directorate of Health and the Ministry of Planning;
- 2 staff from UNDP and UNESCO.

Translation and Interpretation

Two participants from the Red Crescent, who were fluent in English and had previous experience of data gathering, provided interpretation (both English-Somali and Somali-English) continuously throughout the workshop. Translations of some of the workshop material into Somali in advance of the workshop were made by Red Crescent staff. Translation of written material was also required during the evenings of the workshop, particularly in relation to the development and refining of the survey questionnaire during the final days of the workshop. Although every effort was made to ensure that the terms, concepts and technical vocabulary were transferred appropriately into Somalia, there were instances of confusion throughout the workshop. The participation and support of Red Crescent staff was invaluable.

Special consideration

Specific consideration was given to religious, cultural, linguistic and social sensibilities throughout the workshop. Participants were consulted about a variety of cultural issues and allowances were made – often on both organizers’ and participants’ sides. Breaks were organized to coincide with prayer times, work on Friday was limited to short sessions after the visit to the Mosque, and several lactating mothers from among the clinic staff were given additional time to nurse their babies. The official holiday on August 1st -Puntland Day - was observed.

3. Designing the Survey

An adaptation of Robson’s method for mounting small scale surveys was used to design and prepare the survey (Robson, 1998; pp. 133-145).

- 6) Sort out the general purpose and specific information requirements:
- 7) Determine the population and the sample to be selected
- 8) Construct the questionnaire.
- 9) Testing and final preparations
- 10) Finalize plan of action and conduct the survey

The survey was designed and prepared with the full, active and at times, highly animated participation of the participants in the workshop.

Step 1: General Purpose and Specific Information Requirements

Translating the hypothesis into a more specific aim facilitated the determination of the different topics to be researched and what information provided in order to substantiate the hypothesis. This was broken into three separate steps:

- a) Clarifying the research question;
- b) Developing a range of subsidiary topics, relating to the central question;
- c) Determining the specific information required.

1a: Clarification of the research question

As noted earlier, the central contention of the research is that sustainable recovery of local health services can only be ensured by meaningful community participation in the running and resourcing of these services. It was further posited that the potential for such participation will be determined by the extent to which the community is willing and able to participate in the running and resourcing of their clinics. The aim of the survey therefore, was formulated more specifically as: *To provide baseline information about the twelve communities in order to determine their willingness and ability to participate in the running and resourcing of their clinics.*

1b: Identification of the subsidiary topics

Different topics - which will require further investigation in order to deliver the information to substantiate or disprove the hypothesis - were identified and itemized.

- User profile: We need to learn as much as possible about the users of the Red Crescent clinics and their characteristics. If the users are the community members, what size is the average household and what are the average ages of its members?
- To determine the community's willingness to participate it is necessary to examine a number of factors relating to traditions of participation in the community, for example, the existence of community committees or projects, and their focus, the extent and nature of participation in communal action or services.
- People's willingness to participate in the running and resourcing of the clinic will also be determined by the perceived value of the clinic. This in turn will be determined by their health needs and their health behavior – i.e., their health problems and their use of health services. It will also be a function of the quality of the service provided by the clinic and people's access to

alternative options, which depends on the existence of alternative community health facilities. Thus, it will also be necessary to study community members' opinions and satisfaction levels in relation to the services being provided by the clinics.

- To determine their ability to contribute materially to the maintenance and resourcing of the clinics, it is necessary to quantify the level of material resources people possess. A community's material resources are made up of its collective and individual income and assets (money, livestock business premises, vehicles, water sources such as barkads, etc.), and by individuals' access to credit and charity. An important indicator of people's ability to contribute to the running of their clinic will be the existence of any regular income and its source – whether from employment, business, remittances or other sources. How is this income used and is it used for health purposes?
- If there are livestock and other assets it will be important to know how and why decisions are made to sell them and whether health needs are a determining factor. It will also be important to ascertain whether, in the absence of income and assets, people have access to credit and under what conditions will they borrow.
- The introduction of user fees at all three referral hospitals in Puntland also raises the question of whether or not cost recovery has an impact on health behaviour and status and warrants further examination.

1c: Formulation of specific information requirements

There is a need for detailed information on each of the subsidiary topics listed above. Sets of questions and sub-questions need to be formulated about each topic:

- To understand who uses the clinics we need basic information about user profile:
 - Who are the users of the clinics?
 - What size is the average household and what are the average ages of its members?
- To establish people's willingness to participate:
 - Is there an active culture of participation in the community? Are there functioning community committees or projects?
 - If so what is their focus?

- What is the extent and nature of participation by community members in communal action or services?
 - What value do community members place on the clinic?
 - What are their health needs and their most common health problems?
 - How often do they use the clinic?
 - How much do they value quality of the service provided by the clinic?
 - What alternative health services do people have access to?
 - How do they decide which ones to use?
- To determine people's ability to contribute materially to the running and resourcing of the clinics:
 - What are people's main sources of regular income? (From employment, business, remittances or other sources)?
 - How is this income used?
 - Is it used for health purposes?
 - What assets do people possess? (Money, livestock business premises, vehicles, water sources such as barkads, etc.)
 - Why do people dispose of assets?
 - Is the money sometimes used for health purposes?
 - Do people have access to credit?
 - If so why do they borrow?
 - From whom?
 - For what purposes?
 - Is health one of them?
 - Has the introduction of cost recovery at the three main referral hospitals in Puntland impacted on people's health behaviour?
 - In what way?
 - Can people afford to pay?
 - If not how do they manage?

Six specific subjects were identified for the formulation of the survey questionnaire:

- i) Household Profile and demographic characteristics
- ii) Traditions of participation, if any, and the mechanisms or practices through which they are exercised

- iii) Household health behaviour: health problems facilities used to treat them
- iv) Main sources and use of household income
- v) Households assets and their use
- vi) Impact of user fees on the use of health facilities

Step 2: Determination of the Population and the Sample to be Selected

This involved working with the participants to make three distinct decisions which would determine, by and large, how the survey would be conducted:

- a) *Determine the population and the unit of analysis*
- b) *Identify most the appropriate sampling strategy*
- c) *Decide on sample size*

a) The Population and Unit of Analysis

The community representatives and clinic staff worked in teams to define their constituencies, using mapping techniques to define catchment areas and user groups.

Catchment Area

The teams proposed a list of criteria to determine their clinics' catchment areas:

- i. Distance from clinic: This applied to permanent settlements, villages from which users might walk or be brought to the clinic by camel or motorized transport.
- ii. Transport infrastructure: In most cases people might walk or travel by camel up to 20 km but where there was a road this could be extended up to 50 km or more depending on the location of alternative facilities.
- iii. Proximity of a water source: Water is a major attraction in Somalia and during the dry season nomadic families travel great distances to access water. This also brings them into the community or within walking distance of the clinic.
- iv. Migratory patterns: Similarly traditional migration routes for nomads would bring large numbers of users into clinic catchment areas at various times during the year.
- v. Natural boundaries: Valleys and plains constitute natural catchment areas for clinics located in major settlements with inhabitants from outlying villages making regular journeys for various commercial and personal activities.
- vi. Physical obstructions: mountains, canyons and rocky terrain all constituted physical obstruction which might prevent access by people from some villages in the locality.

Each team then produced a map of their catchment area indicating the settlements from which users were drawn, maximum distances, roads, mountains and rivers, nomadic migratory routes and alternative health facilities. In plenary discussion afterwards it was decided that the catchment area is defined by access and attractions; where access is a function of the normal walking distance, extended by the existence of transport infrastructure, and traditional nomadic routes, and reduced by the presence of physical barriers; and attractions may be a water source, market, pharmacy or veterinary supplies, health service facility, a mosque or telecommunication point (telephone or radio).

Sample population

The workshop then set about identifying the population for the survey. Working on the principle that the concept of *population* relates to all the cases to which the research question applies, the following approach was agreed: the survey seeks to determine the extent to which people in the communities served by Red Crescent clinic are willing and able to contribute to the running and resourcing of these clinics. It can be inferred that the people in question are the users of the clinics, since, in most communities, the Red Crescent clinics are the only existing health facility, and at any rate people who do not use the clinics would not be willing to contribute to them in the first place. It can be determined therefore, that the population for this survey will be the users of the Red Crescent clinics in the twelve communities.

Deciding on the unit of analysis

A presentation was made defining three units of analysis, the individual, the group and the household, explaining the advantages and disadvantages of each in the collection of survey data. Participants then examined their relevance to the Somalia context. Discussions centred around two issues: appropriateness and usefulness. In the vast majority of cases the male head of the family is the decision-maker and therefore the most appropriate person to disclose certain information. However any one individual would be unlikely to be able to respond correctly to questions on a range of subjects from participation to livelihood to health behaviour. The timing and duration of any interview was also felt to be of importance, given likely preoccupations with work, shepherding and child-minding. While some men or teenage children could be interviewed in the field while minding animals, others may be at work, in the market, with friends chewing *qat*, or at home. Women would likely be at home with children, preparing food or attending to domestic work, but might also be in the market, with neighbours, or even at the clinic. As the survey seeks information about the beliefs, opinions, attitudes, circumstances and behaviour of clinic users, some participants felt that the unit of analysis should be the individual and that clinic patients should be interviewed

as this would be the most effective way together information about health behaviour, and would be the most practical in terms of identifying respondents. However, it was felt that individual would be unlikely to disclose this type of information in a group context. Community representatives and clinic staff agreed that the most efficient, appropriate and convenient unit would be the household.

The workshop then reviewed the advantages and drawbacks of the household as a unit of analysis elaborated in the training material.

Advantages:

- Any adult member of the household can be approached as it does not require specific individuals to be present. This often obviates the need for prior appointments or return visits.
- Usually more than one member of household will be present for the interview which can lead to more accurate responses.
- Households are easily identified and therefore relatively easy to map for sampling purposes.
- They also lend themselves to observation to substantiate or extend the information provided in the respondent interview.
- Households represent a suitable linking point between the individual and community.
- Focusing on the household as a unit of analysis highlights mutual capacities and vulnerabilities.
- The security of the household atmosphere permits questions of income, assets and family labor.

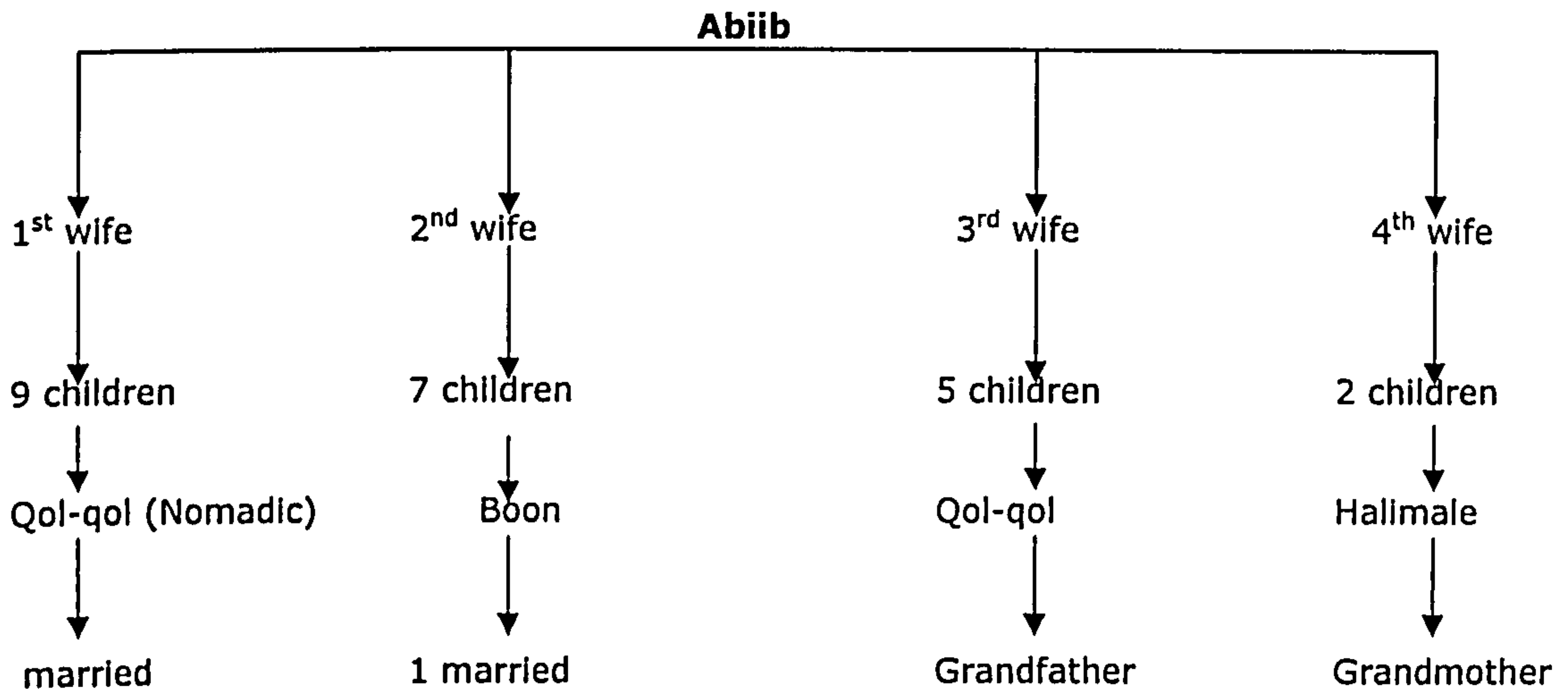
Drawbacks:

- Clinic users are drawn from diverse groups and surveyors are unlikely to find all these groups in one geographic location.
- Most households will probably contain several clinic users, and this may led to confusion when conducting the interview or completing the questionnaire.
- Use of the household as a unit of analysis assumes that the household members' behaviour is based on the principle of mutual support. This will not always be the case.
- Using the household as a unit of analysis may not allow for individual health vulnerabilities and capacities to emerge.

These drawbacks were noted and it was agreed they be kept in mind when selecting the sample, constructing the questionnaire and undertaking the interviews. Participants then worked in groups to define the concept of household. Questions arose, such as to which household men with several wives belonged, and whether people needed to live under the same roof or could be living in several adjacent buildings or huts. Eventually the following definition was agreed:

'a group of people from the same family, who share the same sleeping place, cooking area, latrine and materials'

Figure A9: A complex household, one husband, Abiib, with four households



b) Sampling Strategy

Participants were engaged in simulated sampling exercises, selecting samples from the workshop to introduce them to the various sampling techniques: simple random, systematic; and stratified random. Working their way through these three techniques in plenary, participants were confronted with the challenge of selecting a sample which would be representative of the users of the clinic. The main problem was identified as producing a sample which would be representative of all community sub-groups, ranging from nomadic livestock herding- to seasonal fishing groups.

Lifestyles

Discussion followed as to whom exactly were the users of the Red Crescent clinics. The concept of lifestyle was introduced and participants worked out exactly how such differentiation of user groups applied in the Somali context, and specifically in their own communities. Six distinct lifestyles were identified among the clinic users in the twelve communities: Rural, Urban, Nomadic, Displaced, Farming and Fishing.

Wealth-ranking

Terms from the Holy Koran were used to rank families into three categories:

- *Maal qabeyn* or well-off: a person or family with business premises and assets such as livestock, and also has the knowledge to be able to make good use of them. They are seen as people in the community who are expected to help other, less well off people.

- *Daley* or poor: described as those living at subsistence level, having enough resources to survive, but not much more. These people have access to credit and clan or sub-clan support.
- *Caydh* or very poor: dependent on the community, this refers to the destitute and would include for example, most displaced persons living in camps or displaced settlements. Participants noted that this category was characterized by the absence of clan or sub-clan support.

Finally it was decided to use a systematic stratified random sample to select respondents for the survey. This is a commonly used method to ensure that different groups from among the target population are represented proportionally in the sample. It helps ensure against obtaining an unrepresentative sample which under – or over– represents certain groups of the population (e.g. urban dwellers). The target population is divided into layers (strata) and sampling from the strata is carried out using simple or systematic random sampling.

Sampling Frame

Discussions during the workshop and consultations with various local actors including administration officials and aid organizations confirmed that there was no valid sampling frame from which to select the inhabitants of the twelve communities. The last census was conducted in 1990, prior to the war and much of the data no longer has any bearing on the reality of post-war Somalia. Neither the Directorate of Health nor its district officials had any data on the local inhabitants. The most valid statistics were seen as coming from the Red Crescent clinic's patient registers. Frank discussion with the clinic staff however, revealed a number of drawbacks as a result of the difficulty in keeping up to date records:

- **Deceased patients:** in a context where as many as fifty per cent of the population are nomads, one child in four dies before they reach the age of five, and where up to forty five women die every day from childbirth-related conditions, maintaining an up-to-date patient register is all but impossible.
- **Addresses:** Where patients are still living and have not moved, finding them may prove difficult. Since the war many new settlements have developed, and often they do not have street names or house numbers, as there are no functioning local authorities.
- **Fixed abode:** Nomadic households, by definition, have no fixed abode and the possibility of finding the same patient or family from one season to the next is slim.
- **Duplicate names:** Staff admitted that in the past, new patient cards were completed for each visit to inflate patient numbers or in some cases out of laziness.

All of these problems would make it difficult to find and interview people identified using the patient register. Duplicate names would also introduce bias in the sampling process as strata sizes are inaccurate. It was agreed that the patient registers would be reviewed and up-dated prior to the sampling process, with duplicate registrations and deceased patients being removed and where possible addressed being added.

c) Sample Size

Three main principles were introduced:

- the larger the sample, the lower the likely error in generalizing survey results to all users (Bowling, 2000);
- the larger the range of user groups being surveyed, the larger the sample required to register the circumstances, behavior, opinions attitudes and beliefs all groups and particularly minority groups (Robson, 1998);
- the practice of using smaller samples in surveys to study causal processes, develop and test explanations, particularly in the early stages of the work (Hakim, 2000).

While some clinics like Sinujiif serve relatively small permanent communities, some also provide services for bigger urban centers like Galkayo. In general clinics serve a catchment area with a permanent population of at least 1,000 people. All clinics experience major variation between wet and dry seasons, with some attendance in some remote clinics increasing tenfold during the dry season when nomads are drawn to the villages to water their livestock at bore-holes, shallow wells and *barkads*. Following discussion it was estimated that a survey of 60 households in each community would provide data on between 10 and 20 per cent of the clinic users, and that this would be a feasible workload for community representatives and clinic staff.

Step 3: Construction of the Questionnaire

Having identified what specific information we are seeking and from whom, the workshop set about constructing the questionnaire. This involved determining:

- a) What questions were to be asked;
- b) Their precise wording;
- c) The sequence in which they would be asked; and
- d) The layout of the questionnaire.

Preparation of a draft household survey questionnaire

A draft household survey questionnaire had been prepared and translated into Somali prior to the

workshop as a basis for this exercise. It was introduced to workshop participants following the completion of the core training and preparation modules. The participants reviewed the questionnaire and worked out a new draft based on their knowledge of the Somali context and their awareness of local custom, behavioural mores and sensitivities. Difficulties with developing the questionnaire and formulating questions centred around five main concerns:

- i. personal offence due to questions about respondents' marital status,
- ii. disclosure of information about incomes, household assets and spending behaviour;
- iii. ability to recall past events, practice or behaviour, with some participants doubting that respondents would recollect things that happened last year or be able to – for example - calculate expenditures or count visits to the clinic on an annual basis, when Somali culture revolved around seasons and anything that happened more than two seasons ago would be difficult to quantify or recall with any clarity.
- iv. clarity as to what exact information was being sought
- v. reluctance to develop a long questionnaire for fear that respondents would limit the amount of time they would be willing to engage with the interviewer

The participants worked on the drafting and revising questions over two days and nights. It was a lengthy process fraught with disagreements and marked at one stage by a walk-out of some participants who became frustrated with the process and clashed at personal level. Eventually a range of questions were drafted seeking information on six specific subjects:

- Household Profile
- Household Assets
- Livelihood and Income
- Traditions of Participation
- Community Health Facilities
- Impact of the introduction of user fees in the referral hospital

Step 4: Testing and Final Preparations

Interactive training was provided for participants on five specific aspects of preparing for and conducting interviews: Interviewer Qualities; Approaching People; Preparation; Conducting the Interview; and Notes to be taken for the analysis stage. A two page summary *Guide to Interviewing Respondents* was prepared and distributed (See Annex 6)

To test the questionnaire, thirteen teams visited four areas (an urban area and a displaced community within the town of Garowe, a rural community outside Garowe, and a nomadic community near Sinujiif about ninety minutes drive from Garowe) to test the questionnaire. Each team was required to complete 3 questionnaires. Interview duration, difficulties in gaining access to households, lack of clarity in questions and reluctance to divulge information, were all noted. During the evening the teams returned to the workshop and presented their feedback on the testing exercise. Problem questions were revised and it was noted that an average of 45 minutes was required to complete each interview. A final review of the questionnaire was completed. Overnight the final version of the questionnaire was prepared so that 800 copies could be made during the next days to give to teams before they left Garowe, as several of the clinics are located in remote areas up to seven hours drive from Garowe. The final version of the household survey questionnaire contained 37 questions on six different aspects of households' health and socio-economic conditions. A copy of the questionnaire is attached at Annex 5.

Finalize Survey Plan of Action

Participants elaborated an action plan for the conduct of the survey. Thirteen teams were constituted: one team composed of one elder and two clinic staff for each of the 12 clinic communities, and a thirteenth team, composed of SRCS Garowe health program staff, to support and monitor the surveying process and take specific responsibility for the compilation and tabulation of the raw data. To support the process and guard against incorrect sampling, a guide for devising individual samples and conducting the surveys in individual communities was prepared and provided to each team (*Planning Your Survey* – attached at Annex 7).

On return to their respective communities, the clinic staff and community representatives held open meetings with community elders, heads of sub-clans, women's and youth groups and the wider community to share the objectives of the study and the methodology for the survey. Based on the planning guide, each team then selected their sample households to be surveyed and proceeded with the interviews to complete the questionnaires.

* * *

Annex 4: Survey Preparation Checklist

ACTIVITIES	RESP.
Workshop organization <ul style="list-style-type: none"> • Confirm hotel reservation for all participants • Confirm ECHO flights for 5 resource persons/facilitators; or alternative arrangements for commercial flights • Rent/buy equipment/stationary needed in workshop (overhead projector, 3 flipcharts, related stationary material) • Reserve Conference room adequate for 60 persons • Organize breaks and lunch for +/- 60 persons for 10 days of workshop • Reserve opening and closing dinner for 60 persons plus any guests • Organize Group Photograph on morning of workshop • Prepare certificates for participants, with copy of group photo • Prepare specific budget for Puntland related expenses 	SRCS SRCS SRCS SRCS SRCS SRCS SRCS SRCS SRCS
Invitations <ul style="list-style-type: none"> • Issue invitations to participants from Garowe & Galkayo RC and 12 clinic locations • Issue invitation to DG of Health • Inform/Invite Min. of Social Affairs, Planning • Invite a representative from relevant partners (UNICEF, UNDP, WHO et al) 	SRCS SRCS SRCS SRCS
Workshop Program <ul style="list-style-type: none"> • Draft workshop program, circulate and request comments • Finalize program and circulate • Translate program 	SD SD SRCS
Training Material <ul style="list-style-type: none"> • Prepare training manual elements for formal training sessions • Submit bullet-point presentations from training sessions for translation • Translate bullet point presentations • Reproduce bullet-point presentations on OHP slides 	SD SD SRCS SRCS
Participant Folders <ul style="list-style-type: none"> • Compile program, plus training presentations • Photocopy for all participants and prepare for distribution on first evening 	SRCS SRCS
Preliminary Questionnaire <ul style="list-style-type: none"> • Draft Preliminary Questionnaire • Translate Preliminary Questionnaire • Send to participants for completion prior to departure for workshop 	SD SRCS SRCS
Household Survey Questionnaire <ul style="list-style-type: none"> • Review WHO questionnaire, 1998 Somaliland survey, UNDP survey etc. and prepare sample questionnaire • Translate and photocopy 60 copies of sample to be presented in workshop • Standby for 60 photocopies of draft 1 for testing exercise • S/b for 800 copies of final version of questionnaire after testing & revision 	SD SRCS SRCS SRCS

Annex 5: Puntland Survey Questionnaire

Household Survey for The Puntland Health Sector Rehabilitation Study.

The intention of this Questionnaire is to obtain information that will be used in planning and assessing Health Sector Rehabilitation in Puntland Somalia by the Somalia Red Crescent Society and the International Federation. This Survey will be undertaken by SRCS clinic staff in collaboration with community elders. The questionnaire contains 6 Question clusters aiming to explore the Basic Household Profile, Existing Community Assets, Community Health Facilities, The available Hospital Services and General Livelihood and Income data.

Cluster number:

Household number:

Name of clinic catchment area:

Classification of community of which household is a member:
(Urban, rural, agriculture, nomadic, displaced, refugees, Fishing...)

Name of village:

Date and time of interview commencing:

Time of interview finishing:

Name and title of persons conducting interview:

What are the Names, estimated ages and household status (Head of household, wife, etc) of persons being interviewed:

Names of persons being interviewed	Approximate age of persons being interviewed	Household status of persons being interviewed

1. General Household Profile

1.1. What is the gender of the head of the household:

(ring response)

Male

Female

1.2. What is the Marital status of head of household: *(ring response)*

Single Married
 Divorced Widowed

1.3. What is the age of all males and females in the household:
(insert number of persons in each relevant box)

	<1 year	1-4 years	5-10 years	10-15 years	15 years +	Total
Male						
Female						
Total						

2. Community Participation

2.1. Does any member of the household belong to any community committee that contributes to the support of a community service, such as a Health Committee, Education Committee or Water Committee?

Yes No *(ring answer)*

(If Yes, proceed to Question 2.4., if No, ask Question 2.2. and 2.3, then proceed to Section 2.5)

2.2. If No, ask what Committees do other community members participate in?
 List:

- 1)
- 2)
- 3)
- 4)
- 5)
- 6)

2.3. Why does the household not participate in community committees:

(explain a, b, c, d and e and ask which of these explains why the household does not participate - the household can choose more than one answer. If there is another answer not listed, write the answer as f.).

a. Financial

- b. Committees and activities do not meet household needs
- c. Time
- d. Can get the service provided by the committees without participating
- e. Not been asked
- f. Other (specify)

2.4. Who in the household participates in community committees?

Ask who participates and their status, e.g.- father, mother, grandfather, and record in column 1. Then, for each household member listed, ask the names of the community committees they participate in (record in column 2). Ask if there is a partner agency (such as an NGO), and if the reply is 'Yes' ask and record the name of the partner organisation in column 3. Then briefly describe the role of each household member in the community committees they participate in (record in column 4).

1. Household member	2. Name of the committee	3. Partner agency	4. Brief description of role played in the Committees

2.5. Does any member of the household participate in a community project or activity?(for example, digging a water well).

Yes No (ring answer)

(If Yes, proceed, If No proceed to Section 3.)

2.6. Which members of the household participate in a community project or activity, and how do they contribute?

- How often do they make these contributions?

(Ask which household member participates in any community project or activity (record the status (for example, father, mother, grandfather)of the household members that participate in Column 1).

For each household member listed in Column 1, ask the name or type of Community project or activity they participate in (record response in Column 2.).

Then for each Community project or activity in Column 2, ask if the household members contribution is Financial, Labour or decision making (record the answer in column 3.). If the contribution is none of these, ask what the contribution is and briefly record that response in Column 3.

Then ask, for each project or activity contribution, ask how often contributions are made: are they made Weekly, Monthly, Annually, Seasonally, then record each response in Column 4. If none of these categories describe how often contributions are made, write in Column 4 Other.

1. Household Member 2. (husband, wife, mother, father, etc.	2. Name or type of Community project or activity	3. Type of contribution: Financial (F) Labour (L) Decision making (DM) Others (O)	4. How often are participatory or financial contributions made? Weekly (W) Monthly (M) Annually (A) Seasonally (S) Other (O)

2.7. If the household makes a financial contribution to a Community project or activity, then what is the most important reason for paying? (ring the right answers. There can be more than one answer)

- a. Cannot have access to the same service
- b. Meets household needs better than alternative service providers
- c. Community pressure to participate
- d. Other (specify).....

2.8. Who in the household decides whether to make a financial contribution to a Community project or activity?

3. Household Assets

3.1. Which of these listed types of livestock did the household own throughout the past year?

(put a \checkmark in the box for each livestock type that the household has owned in the past year)

	\checkmark box if Household have owned in past year
Camel	
Goat	
Sheep	
Cattle	
Chicken	
Other (specify).....	

3.2. How many of these livestock did the household own throughout the past year in each season?

(First, ask for each livestock type how many the household owned in the Dry seasons in the past year and record the numbers in Column 1.)

(Secondly, ask how many of each livestock type the household owned in the wet seasons in the past year, and record the numbers in Column 2.)

	1. Dry seasons (number of livestock)	2. Wet seasons (number of livestock)
Camel		
Goat		
Sheep		
Cattle		
Chicken		
Other (specify).....		

3.3. What activities or household needs is the sale of livestock used for?

(Ask each activity or need separately and record response by drawing a ring around the correct answer).

Education	Yes / No
Loan repayment	Yes / No
Food purchasing	Yes / No
Health needs	Yes / No
Livestock health needs	Yes / No
Clothing	Yes / No
Business	Yes / No
Other activity (specify).....	Yes / No

3.4. Who in the household decides to sell livestock?

3.5. Does the household have any other assets that can be sold when needing resources? If Yes then list:

3.6. Does anyone in the household ever borrow money to pay for activities or household needs?

Yes No (ring)

(if No, then proceed to section 4)

3.7. Who in the household can borrow and for what purposes would the borrowed money be used for:

3.8. From whom can the household borrow from and in which season?

(Ask whether the household can borrow from each source of credit, and if the answer is Yes for a source of credit, ask in which seasons and put a √ in the box of the seasons that the loan can be borrowed in)

Source of credit	Can borrow from	
	Dry seasons	Wet seasons
Family/kin/clan		
Friends		
Neighbours		
Credit scheme		
Bank		
Other (specify).....		

3.9. Does the household ever borrow for health needs,?

Yes No (ring response)

(if no, proceed to Section 4.)

If Yes, Ask when they borrowed, for which health need, which health facility was used.

3.10. Does the amount that can be borrowed preclude the use of some Health Facilities?

Yes No (ring)

(if no, proceed to Section 4.)

3.11. Which health facilities can and cannot be afforded if borrowing money for health needs? (list)

Health facilities afforded:

Health facilities not afforded:

4. Community Health Facilities

4.1. Which of the following health facilities has the household used in the past year?

(Ask each health facility separately and Place a \checkmark in the box if used)

Traditional Healer (TH)		Private Doctor (Priv)	
Maternal Child Health (MCH)		Pharmacy (Phar)	
Out Patient Dept. (OPD)		Hospital (hos)	
Health Post (HP)		Private clinic (PC)	
SRCS Clinic (SRCS)		Other (specify).....	
		(Oth)	

4.2. Which health facilities are most used by the household?

Ask for the 3 most used facilities and rank them with the most used as 1)

- 1)
- 2)
- 3)

4.3. In which seasons does the household use the above health facilities?

(Use the abbreviations listed in the table for Question 4.1. and tick the boxes for the health facilities used in each season)

	TH	Hos	HP	SRCS	Priv	Phar	Ghos	Oth
Wet seasons								
Dry seasons								

4.4. How important are the following factors in determining the choice of health facility?

(Ask each factor separately and ask if it is very important, important or not important, then place give the factor a score and place a number in the box for each.)

(Score: 1 = Very Important, 2 = Important, 3 = Not Important)

Part-time employment		
Seasonal employment		
Agricultural production		
Remittances (relatives abroad)		
Business		
Trading (cross boarder)		
livestock sale/production		
Other (specify.....)		

6.2. In which seasons does the household receive financial income from each income providing source:

(ask each income providing source separately and put a ✓ seasons box for each season where financial income is available from that source)

	Wet Season	Dry Season
Full-time employment		
Part-time employment		
Seasonal employment		
Agricultural production		
Remittances (relatives abroad)		
Local business full-time		
Trading (cross boarder)		
livestock sale/production		
Other (specify.....)		

Notes/Observations: (develop symbols that can be added while asking questions)

For example, were there any signs that the person(s) seemed unsure or deceiving in any response given to any question?

If the person(s) refused to answer any questions: note questions

Was there any observations of the household or surroundings which contradicted the answers given in the interview?

1.4. (Make notes after interview is completed)

OBSERVATIONS ON HOUSEHOLD AND COMMUNITY ENVIRONMENT

Checklist:

Known/visible health facilities

Visible transport - public/private

Quality of land for agriculture

Quality of land for livestock grazing

Visible livestock types/numbers

Sources of water available to household/community

School facilities

Community religious structures

Annex 6: Guide to Interviewing Respondents

- 1.1 Interviewer Qualities
- 1.2 Approaching People
- 1.3 Preparation
- 1.4 Conducting the Interview
- 1.5 Notes for Analysis Stage

1.1 Interviewer Qualities

- 1.1.1 Friendly – no one likes to speak to an aggressive interviewer
- 1.1.2 Committed – if you are bored or disinterested in what you are doing the respondent is unlikely to respond
- 1.1.3 Motivated - and motivating in the way that you approach the interview. Long questionnaires in particular can be tiring and if you are already tired or seem to be tired you will not get the full participation of the respondent.
- 1.1.4 Sensitive – some of your questions may provoke an emotional response from your respondent – e.g. how many children have
- 1.1.5 Trustworthy - If you want people to be open and honest with you they must first feel comfortable that you will not disclose this information or use
- 1.1.6 Clear – the respondent should hear the questions clearly without having to ask you to repeat, otherwise they
- 1.1.7 A good listener – you may need to ask questions to clarify the response. The respondent should not have to repeat their answer because your mind wandered or you were not listening.
- 1.1.8 Neutral – do not make judgmental or subjective comments on the answers you receive. E.g. – How many children in your family? 12. – Oh dear that must be awful' etc.
- 1.1.9 Discreetly dressed: do not overdress or under-dress as this may give the wrong impressions, for example raising expectations that a wealthy organization is coming to provide services, or – by dressing too casually – offend people.
- 1.1.10 Record replies accurately – write clearly and complete the questionnaire properly.

1.2 Identifying your respondent

- 1.2.1 Follow the sampling frame that has been developed during the workshop. Try first to find the person that has been selected after stratifying your patient register
- 1.2.2 If the person refuses, select a substitute – if possible using the same selection process - to replace this person.
- 1.2.3 Change of address – you may find that the person has changed address and moved somewhere else. You should try to find them if they are in the same location (street or village). If you find them and they refuse.
- 1.2.4 If the selected respondent has changed address and you don't find them please select another respondent - if possible using the same process.
- 1.2.5 If the selected respondent is deceased, apologize and - if appropriate sympathize. Select another respondent - if possible using the same process.

1.3 Preparations

- 1.3.1 Plan your interviews carefully allowing time for each interview and also time for travel between the interviews,
- 1.3.2 Don't forget you list of names and addresses of your selected respondents!
- 1.3.3 Bring your own ID to introduce yourself.
- 1.3.4 Bring enough questionnaires and some spare copies as you may make mistakes, lose some or spill tea or coffee on them.
- 1.3.5 Bring a map of the area in case you get lost or need to ask for directions.
- 1.3.6 Carry some leaflets with general information about the SRCS, as this is helpful for people to understand your objectives and also represents a valuable opportunity to disseminate SRSC messages, for example, about humanitarian values, health education and behavior.
- 1.3.7 Use a blue ink ballpoint pen – bring enough of them in case you lose, break or use up what you normally carry. If you run out of blue use black. These colors are easier to read and photocopy. Do not use pencil – even if you are afraid you will make mistakes. Pencil may fade. Use a biro and strike out if you make a mistake.

1.4 Conducting the interview

- 1.4.1 Be positive and look happy – even if you are not or if you have traveled for three and a half hours across a camel track to get to there. Take a few minutes before the interview to organize yourself and then begin your interviews.
- 1.4.2 Introduce yourself and briefly explain the project so that people understand why you are asking all these questions and what you are going to do with the answers.
- 1.4.3 *'We are undertaking a study to improve the quality of our clinic services in this area'*
- 1.4.4 Be positive and confident about what you are doing – if you appear confident, the respondent will be more willing to co-operate.
- 1.4.5 Speak in a calm, neutral and non-judgmental manner.
- 1.4.6 Show polite interest. Do not apologize or appear embarrassed when asking personal questions as this only makes it more difficult for the respondent to answer them.
- 1.4.7 Ask the questions as they are written in a non-biased and open manner. Do not ask biased or leading questions such as 'You don't have 100 camels by any chance?'
- 1.4.8 Differentiate between the open and closed questions and record the answers correctly – if the respondent's reply isn't indicated on the questionnaire, tick 'other' and carefully note their reply.

1.5 Notes for Analysis Stage

- 1.5.1 Note any difficulties gaining access to people's homes or any reluctance to participate in the interview.
- 1.5.2 Note the questions that are problematic – which ones and why.
- 1.5.3 Note the way that people respond – individuals or groups coming together to participate.
- 1.5.4 Note the time the interview takes in order to inform you planning for the next set of interviews.

Annex 7

Planning Your Interviews

1. Take your Patient Register for the past 12 months
2. Remove duplicates to avoid double-counting, or patients who you know are deceased.
3. Sort your patients into groups by lifestyle – dividing them into 4 groups:
 - a. Urban
 - b. Rural
 - c. Nomadic
 - d. Displaced
4. Calculate the number of each category, for example:

Urban	498 patients
Rural	750 patients
Nomadic	1261 patients
Displaced	25 patients
Total	2734 patients
5. Calculate each category as a percentage of the total:

Urban	$498 \times 100 / 2734 = 18.22\%$ of all patients
Rural	$750 \times 100 / 2734 = 27.43\%$ of all patients
Nomadic	$1261 \times 100 / 2734 = 46.12\%$ of all patients
Displaced	$225 \times 100 / 2734 = 8.23\%$ of all patients
6. Re-check your calculations and make sure that the total equals 100%
7. You need to complete a total of 60 interviews from your patient register. Calculate the number of interviewees (also known as respondents) that you need to interview from each lifestyle category based on these percentages:

Urban (18.22% x 60):	$18.22 \times 60 / 100 = 11$
Rural (27.43% x 60):	$27.43 \times 60 / 100 = 16$
Nomadic (46.12% x 60):	$46.12 \times 60 / 100 = 28$
Displaced (8.23% x 60):	$8.23 \times 60 / 100 = 5$
8. Re-check your calculations and ensure that the total makes 60.
9. Now you know that from each of the four groups of patients you need to select
 - 11 urban users
 - 16 rural users
 - 28 nomadic users
 - 5 displaced users

10. Selecting your interviews from each group is now relatively simple. For example:

Urban users: you need 11 users from your total of 498, so you will select every 45th name (498 / 11) from your list of urban users;

Rural users: you need 16 rural interviews from a total of 760, so you will select every 47th name (760 / 16) from your list of rural users;

Nomadic users: you need 28, so you will select every 45th name from your list of nomadic users;

Displaced users: you need 5 from your list of 225 so you will select every 45th name from your list of users.

11. Check that you now have a total of sixty interviews.

12. Make a plan for completing all 60 interviews:

- a. Get a map and mark out the location of each of the interviews. Group them into sets of interviews that can be completed in one day.
- b. First calculate the travel time you need to travel to and from each location.
- c. Then calculate the amount of time you will need in each location to conduct the interviews. Allow roughly 45 minutes per interview.
- d. Consider how you will reach each location and what arrangements you may need to make (using the branch vehicle, catching a bus, using a taxi etc.).
- e. Remember that you will be working in two teams of two persons each – one SRCS staff and one community representative in each team.
- f. Consider the best way to organize the work so that the Health Center is open and adequately staffed during this period.

13. Now draw up a detailed plan of action for how you will complete the survey. This should specify

- who will go
- to what localities
- using what transport
- conducting how many interviews
- on what days and dates.

14. Send a copy of this plan to the Co-ordination Team in Garowe so that they will know when they can expect to receive your completed questionnaires and begin the processing phase.

15. Now go ahead and start your interviews – good luck: remember your interviewer qualities and smile!

16. When you have completed the survey, contact your Field Health Officer and let them know so that the questionnaires can be collected.

* * *

GLOSSARY

BI	Bamako Initiative
BPI	Better Programming Initiative
CAS	Country Assistance Strategy
CBO	Community Based Organization
CHC	Community Health Committee
CIH	Community Involvement in Health
CMH	Commission on Macroeconomics and Health
CMR	Child Mortality Rate
CPR	Conflict Prevention and Recovery
CR	Cost Recovery
CRC	Convention on the Rights of the Child
DFID	UK Department for International Development
DP	Disaster Preparedness
DPT	Diphtheria /Pertussis /Tetanus
ERU	Emergency Response Unit
FGM	Female Genital Mutilation
GDP	Gross Domestic Product
GNP	Gross National Product
HC	Health Centre
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
ICRC	International Committee of the Red Cross
ICESCR	International Covenant on Economic Social and Cultural Rights
IFRC	International Federation of Red Cross and Red Crescent Societies
IHCP	Integrated Health Care Program
IMF	International Monetary Fund
IMR	Infant Mortality Rate
ISA	Independent Service Authority
LICUS	Low-Income Countries Under Stress
MCH	Mother and Child Health

MDGs	Millennium Development Goals
MDTF	Multidonor Trust Fund
MMR	Maternal Mortality Rate
NGO	Nongovernmental Organization
OECD-DAC	Development Assistance Committee of the Organization for Economic Co-operation and Development
ONS	Operating National Society
OPD	Out-Patient Department
PAHO	Pan-American Health Organization
PCIA	Peace and Conflict Impact Assessment
PHC	Primary Health Care
PNS	Participating National Society
PPP	Project Planning Process
PRSP	Poverty Reduction Strategy Paper
SCF	Save the Children Fund
SRCS	Somali Red Crescent Society
TT	Tetanus Toxoid
UD	Universal Declaration of Human Rights
UF	User Fees
UN	United Nations
UNDP	United Nations Development Program
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCA	Vulnerability and Capacity Analysis
WB	World Bank
WHO	World Health Organization

Bibliography

- Adam, H. 1995. 'Somalia: A Terrible Beauty Being Born?' in I. W. Zartman (Ed) *Collapsed States: The Disintegration and Restoration of Legitimate Authority* Lynne Rienner (Boulder & London)
- Ahmed, I. 2000 'Remittances and their economic impact in Post-war Somaliland' in *Disasters: The Journal of Disaster Studies, Policy and Management* Vol. 24, no. 4, December 2000. Blackwell (London)
- Anderson, M and Woodrow, P. 1989 *Rising from the Ashes: Development Strategies in Times of Disaster* Westview (Boulder)
- Anderson, M. 1995 *Do No Harm: Supporting Local Capacities for Peace through Aid* Local Capacities for Peace Project (Cambridge)
- Arhin-Tenkorang, D. 2000 *Mobilizing Resources for Health: The Case for User Fees Revisited* (CMH Working Paper Series Paper No. WG3:1) WHO (Geneva)
- Arhin-Tenkorang, D. 2001 *Health Insurance for the Informal Sector in Africa: Design Features, Risk Protection, and Resource Mobilization* CMH Working Paper Series Paper No. WG3:1 WHO (Geneva)
- Arhin-Tenkorang, D. 2001 *Congressional Testimony on IMF and World Bank Policies in Africa* www.harvard.edu (eMediaMillWorks Inc.)
- Atkinson, P. 1997 *The War Economy in Liberia: a political analysis* Relief and Rehabilitation Network paper 22. London: Overseas Development Institute, May 1997.
- Barakat, S. 1992 *Reviving War damaged Settlements: towards an international charter for reconstruction after war*. Unpublished PhD Thesis, University of York
- Barakat S. and Hoffman B. 1995 *Post Conflict Reconstruction Strategies* International Colloquium on Post-Conflict Reconstruction Strategies. UNDDSMS & UNIDO (Geneva)
- Barakat, S. and Deely, S. 2001 'Somalia: programming for sustainable health care' *World Disasters Report 2001: Focus on Recovery* IFRC (Geneva)
- Barakat, S., Chard, M., Jacoby, T. and Lume, W. 2002 'The Composite Approach: research design in the context of war and armed conflict' in *Third World Quarterly*, Vol. 23, No. 5 Carfax (Basingstoke)
- Barakat, S., Ehsan, M., Leslie, J. and Strand, A. 1996 *Urban Rehabilitation in Kabul: Bridging between Communities and Institutions* University of York (York)
- Bhusan, I., Keller, S. and Schwartz. B. 2002 *Achieving the Twin Objectives of Efficiency and Equity: Contracting Health Services in Cambodia* ERD Policy Brief No. 6

- Bobbitt, P.** 2003. *The Shield of Achilles: War, Peace and the Course of History* Penguin (London)
- Borton, J.** 1998. *The State of the International Humanitarian System* Briefing Paper 1998 (1) March, ODI (London)
- Bose, S.** 1999 'Kashmir: Sources of Conflict, Dimensions of Peace' in *Survival* Autumn 1999, Vol. 41/No. 3. IISS (London)
- Bowling, A.** 2002 *Research Methods in Health: Investigating health and health services* OUP (Buckingham)
- Boyce, J.K.** 2002 *Investing in Peace: Aid and Conditionality After Civil Wars* Adelphi Paper 351, Oxford University Press for the International Institute of Strategic Studies (Oxford)
- Brabant, K.** 2000 *Operational Security Management in Violent Environments* ODI (London)
- Bradbury, M.** 1999 'Country Updates: Somalia' in *Relief and Rehabilitation Network Newsletter* Number 15, November 1999. ODI (London)
- Bratton, M.** 1995 'Civil Society and Political Transitions in Africa' in Harbeson (Ed) *Civil Society in Africa* Lynne Rienner (Boulder)
- Breman, A. & Shelton, C.** 2001 *Structural Adjustment and Health: A literature review of the debate, its role-players and presented empirical evidence* CMH Working Paper Series Paper No. WG3:3, WHO (Geneva)
- Brunet-Jailly, J.** 1991 'Health Financing in the Poor Countries: Cost Recovery or Cost Reduction?' *Population and Human Resources Department Working Paper Series No 121* World Bank (Washington)
- Bull, H. & Watson, A.** 1984 *The Expansion of International Society* Clarendon Press (London)
- Bzezinski, Z.** 2004 *The Choice: Global Domination or Global Leadership* Basic Books (New York)
- Bzezinski, Z.** 1997 *The Grand Chessboard: American Primacy and Its Geostrategic Imperatives* Basic Books (New York)
- Buchanan-Smith, J and Maxwell, S.** 1994 'Linking relief and development: An introduction and overview' in Institute of Development Studies Bulletin Volume 25, number 4. 1994 *Linking Relief and Development* IDS (Brighton): 2-16
- Callinicos, A.** 2002 'Marxism and Global Governance' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)
- Callinicos, A.** 2003 *An Anti-Capitalist Manifesto* Polity Press (London)
- Callinicos, A.** 2003 *The New Mandarin's of American Power: The Bush Administration's Plans for the World* Polity Press (London)
- Chambers, R.** 1983 *Rural Development: Putting the Last First* Longman (Harlow)

- Chambers, R. 1999 *Whose Reality Counts? Putting the First Last* Intermediate Technology Publications (London)
- Chazan, N., Lewis, P., Mortimer, R., Rothchild, D., and Stedman, S.J. 1999 *Politics and Society in Contemporary Africa* Lynne Rienner (Boulder)
- Chomsky, N. 1997 *World Orders, Old and New* Pluto Press, (London)
- Chomsky, N. 1999 *Profit Over People: Neoliberalism and Global Order* Seven Stories (London)
- Chomsky, N. 1999 *The New Military Humanism: Lessons from Kosovo*. Pluto (London)
- Chomsky, N., Clark, R., and Said, E.W. 1999 *Acts of Aggression: Policing "Rogue" States*. Seven Stories (New York)
- Chossudovsky, M. 1999 *Globalization of Poverty: Impacts of IMF and World Bank Reforms* Zed Books (London & New Jersey)
- Coletta, N.J., Kostner, and M., Wiederhofer, I. 1996 *Transition from War to Peace in Sub-Saharan Africa* World Bank (Washington)
- Collier, P. & Hoeffler, A. 2002 *Aid, Policy and Peace: Reducing the Risks of Civil Conflict* World Bank (Washington)
- Cook, T.D. and Campbell, D.T. 1979 *Quasi-experimentation: design and analysis issues for field settings* Rand McNally (Chicago)
- Cooper, N. 2003 'State Collapse as Business: The Role of Conflict Trade and the Emerging Agenda' in *State Failure, Collapse and Reconstruction* Milliken, J. (Ed) Blackwell (Oxford)
- Cortright, D. and Lopez, G. 2001 *The Sanctions Decade: Assessing UN Strategies in the 1990s* (Boulder: Lynne Rienner)
- Creese, A. and Kutzin, J. 1995 *Lessons from Cost-recovery in Health* WHO Forum on Health Sector Reform WHO (Geneva)
- Cuny, F.C. and Tanner, V. 1995 'Working with communities to reduce levels of conflict: "spot reconstruction"', in *Disaster Prevention and Management, volume 4, number 1* MCB University Press Limited (Bradford)
- DAC 1998 *Conflict, Peace and Development Co-operation on the threshold of the 21st Century*, OECD (Paris)
- De Waal, A. 1997 *Famine Crimes: Politics and the Disaster Relief Industry* African Rights and The International African Institute. James Currey (Oxford) Indiana University Press (Bloomington and Indianapolis)
- De Waal, A. 1994 'Dangerous Precedents: Famine Relief in Somalia 1991-93', in Macrae and Zwi (Eds.) *War and Hunger: Rethinking International Responses to Complex Emergencies* Zed Books (London and New Jersey)

- Dean, J. 2000 'Hardtalk'. Interviewed by Nick Clarke, BBC World April 6, 2005
- Deely, S. 2001 'Care in the Desert' in *Red Cross Red Crescent Magazine*, No. 2, 2001
- Derlugian, G. 1996 *The Age of Transition: Trajectory of the World System 1945-2025* Hopkins, T. and Wallerstein, I. (Eds.) Zed Books (London)
- Detter, I. 2000 *The Law of War* Cambridge University Press (Cambridge)
- Diskett, P. and Nickson, P. 1997 'Financing Primary Health Care: an NGO Perspective' in *Development for Health* Oxfam (Oxford)
- Doornbos, M. 2003. 'State Collapse and Fresh Starts: Some Critical Reflections' in *State Failure, Collapse and Reconstruction* Milliken, J. (Ed) Blackwell (Oxford)
- Drysdale, S., Howarth, J., Poweel, V. and Healing, T. 2000 'Cluster Sampling in Grozny in 1995' in *Disasters: The Journal of Disaster Studies, Policy and Management* Vol. 24, no. 3, September 2000 Blackwell (London)
- Duffield, M. 1994a 'The Political Economy of Internal War', in Macrae and Zwi (Eds.) *War and Hunger: Rethinking International Responses to Complex Emergencies* Zed Books (London and New Jersey)
- Duffield, M. 1994b 'Complex Emergencies and the Crisis of Developmentalism' in *Institute of Development Studies Bulletin* Volume 25, number 4 1994 *Linking Relief and Development* IDS (Brighton): 37-45
- Duffield, M. 1999. *Globalization and War Economies: Promoting Order or the Return of History?* Paper for Fletcher Forum of World Affairs
- Duffield, M. 2001 *Global Governance and the New Wars: The Merging of Development and Security* Zed Books (London)
- Duffield, M. 2001 *Governing the Borderlands: Decoding the Power of Aid* Paper presented at 'Politics and Humanitarian Aid: Debates, Dilemmas and Dissension, Commonwealth Institute. London.
- Duffield, M. 2003 'Social Reconstruction and the Radicalization of Development: Aid as a Relation of Global Liberal Governance' in *State Failure, Collapse and Reconstruction* Milliken, J. (Ed) Blackwell (Oxford)
- Dunlop, D.W. and Martins, J.M. (Eds.) 1995 *International Assessment of Health Care Financing: Lessons for Developing Countries* World Bank (Washington)
- Eade, D. (Ed.) 2000 *Development, NGOs and Civil Society* Oxfam (Oxford)
- Eade, D. and Hill, E. (Eds.) 2000 *Development for Health* Oxfam (Oxford)
- Ehrenberg, J. 1999 *Civil Society: The Critical History of an Idea* New York University Press (New York)

Eklund, N. & Stavem, P. 1995 'Health Financing in Developing Countries' in Shaw, R.P. and Ainsworth, M. (Eds.) *An International Assessment of Health Care Financing: Lessons for Developing Countries* The World Bank (Washington)

Elbe, S. 2003 *Strategic Implications of HIV/AIDS* Adelphi Paper 357, Oxford University Press for the International Institute of Strategic Studies (Oxford)

Evans, G. & Newnham, J. 1998 *The Penguin Dictionary of International Relations* Penguin (London)

Farmer, P. 2001 *Infections and Inequalities: The Modern Plagues* University of California Press (Berkeley)

Farmer, P. 2003 *Pathologies of Power: Health, Human Rights and the New War on the Poor* (California Series in Public Anthropology) University of California Press (Berkeley)

Farmer, P. & Bertrand, D. 2000 'Hypocrisies of Development and the Health of the Haitian Poor' in Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

Financial Times 1998. 'What is Civil Society?' April 21, 1998

Forman, P. 2000. *Good Intentions: Pledges of Aid for Post-conflict Recovery*. Carnegie (New York)

Freire, P. 1974 *Pedagogy of the Oppressed* Penguin (London)

Fukuyama, F. 2000. 'Social Capital' in Harrison, L. and Huntington, S.P. (Eds.) *Culture Matters: How Values Shape Human Progress* Basic Books (New York)

Fukuyama, F. 1992 *The End of History and the Last Man* Bard (New York)

German, T and J. Randel 1998 'Global trends squeeze international assistance' in *World Disasters Report 1998*, Oxford University Press (Oxford)

Gershman, J & Irwin, A. 2000 'Getting a Grip on the Global Economy' in Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

Gilpin, R. 'A Realist Perspective on International Governance' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Golooba-Mutebi, F. 2004 'Reassessing Popular Participation in Uganda' in *Public Administration and Development* 24 political parties 289-304

Green, R.H. 1994 'The Course of the Four Horsemen' in Macrae and Zwi (Eds.), *War and Hunger: Rethinking International Responses to Complex Emergencies* Zed Books (London and New Jersey)

Hakim, C. (1987) *Research Design: Strategies and choices in the design of social research*. Allen & Unwin (London)

Hakim, C. 2000 *Research Design: successful designs for social and economic research* Routledge (London)

Hansch, S. & Barcus, L. 2000 'Why Aid Agencies are Banking on Micro-credit' in *Humanitarian Affairs Review*, Spring 2000, 38-45

Harbeson, J.W. 1995. 'Civil Society and Political Renaissance' in Harbeson, J.W., Rothchild, D. and Chazan, N. (Eds.) 1994 *Civil Society and the State in Africa* Lynne Rienner (Boulder)

Harbeson, J.W., Rothchild, D. and Chazan, N. (Eds.) 1994 *Civil Society and the State in Africa* Lynne Rienner (Boulder)

Hart, E. and Bond, M. 1999 *Action Research for Health and Social Care: A Guide to Practice* Open University Press

Harvey, P. 1997 *Rehabilitation in Complex Political Emergencies: Is Rebuilding Civil Society the Answer?* IDS Working Paper 60, IDS (Brighton)

Haynes, J. 1996 *Third World Politics: A Concise Introduction* Blackwell (Oxford)

Held, D. 2002 'Cosmopolitanism: Ideas, Realities, Deficits' Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Held, D. 2003 *Global Covenant: The Social Democratic Alternative to the Washington Consensus* Polity (London)

Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Hendrickson, D. 1998 *Humanitarian Action in Protracted Crises*, RRN Network paper 12, ODI, (London)

Herbert, B. 2005 'A Radical in the Whitehouse' in *New York Times*, April 18, 2005

Herbst, J. and Mills, G. 2004 *The Future of Africa: A New Order in Sight?* Adelphi Paper 361, Oxford University Press for the International Institute of Strategic Studies (Oxford)

Heywood, A. *Politics* Macmillan (London)

Hintjens, H. 1999. 'The Emperor's New Clothes: a moral tale for development experts' in *Development in Practice*, volume 9, number 4, August, 1999

Hopkins, T. and Wallerstein, I. 1996 *The Age of Transition: Trajectory of the World System 1945-2025* Zed Books (London)

Human Rights Watch 2000 *Open Letter to the Security Council Concerning the Humanitarian Situation in Iraq* HRW (www.hrw.org/press/2000/iraq0323.htm)

Huntington, S.P. 1991 *The Third Wave: Democratization in the Late Twentieth Century*. Oklahoma (Norman)

Huntington, S.P. 1997 *The Clash of Civilizations and the Remaking of World Order* Touchstone (New York)

IISS 1997 *Strategic Survey 1996/97* Oxford University Press for the International Institute of Strategic Studies. (Oxford)

Ikeda, S. 1996 *The Age of Transition: Trajectory of the World System 1945-2025* Hopkins, T. and Wallerstein, I. (Eds.). Zed Books (London)

International Committee of the Red Cross 1997 *Red Cross & Red Crescent: Portrait of an International Movement*, ICRC (Geneva)

International Committee of the Red Cross 1998 *ICRC Annual Report 1998*: ICRC (Geneva)

International Committee of the Red Cross 1998a *Second Wolfsberg Humanitarian Forum*, Ermatingen, Switzerland, June 5-7, 1998. Unpublished ICRC Report.

International Committee of the Red Cross 1998b *Agreement on the Organization of the International Activities of the Components of the International Red Cross and Red Crescent Movement* ICRC (Geneva)

International Committee of the Red Cross, Geneva & International Federation of Red Cross and Red Crescent Societies 1994 *Handbook of the International Red Cross and Red Crescent Movement* (Geneva)

International Federation of Red Cross and Red Crescent Societies 2002 *The SRCS and Recovery: A LICUS Proposal* Unpublished Project Proposal

International Federation of Red Cross and Red Crescent Societies 2001 'Disaster Data: key Trends and Statistics', in *World Disasters Report 2001: Focus on Recovery* (Geneva) IFRC

International Federation of Red Cross and Red Crescent Societies 1996a *Repatriation, Return and Integration to/in Bosnia Herzegovina, Croatia and the Federal Republic of Yugoslavia* (Geneva)

International Federation of Red Cross and Red Crescent Societies 1996b *World Disasters Report 1996* Oxford University Press (Oxford)

International Federation of Red Cross and Red Crescent Societies 1997a *World Disasters Report 1997* Oxford University Press (Oxford)

International Federation of Red Cross and Red Crescent Societies 1997b *Agreement on the Organization of the International Activities of the Components of the International Red Cross and Red Crescent Movement*, Geneva.

International Federation of Red Cross and Red Crescent Societies 1998a *Emergency Appeal 1998* (Geneva)

International Federation of Red Cross and Red Crescent Societies 1998b *World Disasters Report 1998*, Oxford University Press (Oxford)

International Federation of Red Cross and Red Crescent Societies 1999 *Emergency Appeal 1999* (Geneva)

International Federation of Red Cross and Red Crescent Societies 2000 *World Disasters Report 2000*, Oxford University Press (Oxford)

International Federation of Red Cross and Red Crescent Societies 2001 *World Disasters Report 2001*, Oxford University Press (Oxford)

***Islamic Transitional Government of Afghanistan 2002 Basic Package of Health Services for Afghanistan* Ministry of Health (Kabul)**

Jackson, S and Deely, S. 2001 'Food Crisis in Tajikistan: An Unnatural Disaster?' in *World Disasters Report: Focus on Recovery* (Geneva: International Federation of Red Cross and Red Crescent Societies)

Kagan, R. 2003 *Paradise and Power: America and Europe in the New World Order* Atlantic Books (New York)

Kahssay, H. & Oakley, P. 1999 *Community involvement in health development: a review of the concept and practice* WHO (Geneva)

Kaldor, M. 2003 *Global Civil Society: An Answer to War* Polity Press (London)

Kaplan, R. 2000 *The Coming Anarchy: Shattering the Dreams of the Post Cold War* Vintage (New York)

Keen, D. 1998 *The Economic Functions of Violence in Civil Wars* Adelphi Paper 320, Oxford University Press for the International Institute of Strategic Studies, (Oxford)

Kennan, G. 1948 'Document PPS223' in *Foreign Relations of the United States, Vol. 1, No. 2, 1948* (1976) (<http://www.firehistime.org/georgekennanpps23.htm>)

Keohane, R. 2002 'Governance in a partially Globalized World' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Kim *et al*, 2000: Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) 2000 *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

Kim *et al*, 2000b: Kim, J.Y., Shakow, A., Bayona, J., Rhatigan, J. & Rubin de Celis, E.L. 2000 'Sickness Amidst Recovery: Public Debt and Private Suffering in Peru' in Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

King, E. 1997 *Ending Civil Wars* Adelphi Paper 308, Oxford University Press for the International Institute of Strategic Studies (Oxford)

Klare, M.T., 2001. *Resource Wars: The New Landscape of Global Conflict* Metropolitan (New York)

- Koenig-Archibugi, M.** 2002 'Mapping Global Governance' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)
- Kristof, N.** 2003 'When Prudery Kills', *New York Times*, October 8, 2003
- Kumar, K.** 1997 *Rebuilding Societies after Civil War: Critical roles for international assistance*, Lynne Rienner, (London and Boulder)
- Kupchan, C.A.** 2003. *The End of the American Era: U.S. Foreign Policy and the Geopolitics of the 20th Century* Knopf (New York)
- Landfield, S.** 2001. 'A social change model of health development in the Republic of Georgia' in *Development in Practice* 11(1):110-117
- Le Sage, A. and Majid, N.** 2002. 'The Livelihoods Gap: Responding to the Economic Dynamics of Vulnerability in Somalia' in *Disasters: The Journal of Disaster Studies, Policy and Management* Vol. 26, no. 1, March 2002. Blackwell (London)
- Leftwich, A.** 1984 *What is Politics: The Activity and its Study* Blackwell (Oxford)
- Leftwich, A.** 2000 *States of Development: On the Primacy of Politics in Development* Polity (Cambridge)
- Lewis, I.** 1982 *A Pastoral Democracy A study of pastoralsim and politics among the northern Somali of the Horn of Africa* International African Institute (London)
- Lievesley, G.** 2003 *Oxford Concise Dictionary of Politics* McLean, I. and McMillan A. (Eds.) OUP (London)
- Loescher, G.** 1992 'Refugees Movements and International Security', Adelphi Paper 268 Brassey's for IISS (London)
- Long, C.** 2001 *Participation of the Poor in development Initiatives: Taking Their Rightful Place* Earthscan (London)
- Mackinlay, J.** 2002 *Globalization and Insurgency* Adelphi Paper 352, Oxford University Press for the International Institute of Strategic Studies (Oxford)
- Macrae and Zwi (eds.)** 1994. *War and Hunger: Rethinking International Responses to Complex Emergencies* Zed Books (London and New Jersey)
- Macrae, J and Bradbury, M.** 1998. *Aid in the Twilight Zone: A Critical Analysis of Humanitarian-Development Aid Linkages in Situations of Chronic Instability* A report for UNICEF. ODI/Humanitarianism and War Project. (London and Providence)
- Macrae, J.** 1995 *Dilemmas of 'Post'-Conflict Transition: Lessons from the Health Sector* Relief and Rehabilitation Network Paper 12. ODI (London)
- Macrae, J.** 2001 *Aiding Recovery: The Crisis of Aid in Chronic Political Emergencies* Zed Books (London)

Macrae, J. et al. 1997. *Conflict, the Continuum and Chronic Emergencies: A Critical Analysis of the Scope for Linking Relief, Rehabilitation and Development Planning in Sudan*, in *Disasters*, 1997, 21(3): 223-243

Majavu, M. 2004 *Debt, Reforms And Social Services* in ZNet Commentary, September 20, 2004. www.znet.org

Martin, B. 2004 'It's been nice - and the future's not so bad' in *The Observer*, 5/09/04

Maynard, K.A. 1997. 'Rebuilding Community: Psychosocial healing, Reintegration, and Reconciliation at Grassroots Level', in Kumar, K. (ed.) 1997. *Rebuilding Societies After Civil War: Critical roles for international assistance* Lynne Rienner (London and Boulder)

Mbogori, E. 1999. *Civil Society at the Millennium* Kumarian Press (West Hartford)

McGrew, A. 2002 'Liberal-Internationalism: Between Realism and Cosmopolitanism' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Meier, G. M., and Stiglitz, J.E. (Eds.) *Frontiers of Development Economics: The Future in Perspective* Oxford University Press (New York)

Menkhaus, K. 2004 *Somalia: State Collapse and the Threat of Terrorism* Adelphi Paper 364, Oxford University Press for the International Institute of Strategic Studies (Oxford)

Millen, J., Irwin, A. & Kim, J.Y. 2000 'What is Growing? Who is Dying?' in Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

Milliken, J. & Krause, K. 2003 'State Failure, State Collapse and State Reconstruction: Concepts, Lessons and Strategies' in *State Failure, Collapse and Reconstruction: Issues and Responses* Milliken, J. (Ed.) Blackwell (London)

Miner, L. 1998. 'Report on the Inter-Agency Strategic Mission to Afghanistan', in *Relief and Rehabilitation Network Newsletter* 11 May 1998. ODI (London)

Musgrave, P. & Zeramdini, R. 2001 *A Summary Description of Health Financing in WHO Member States* Commission for Macroeconomics and Health Working Paper Series Paper WG3:3 WHO (Geneva)

Naidoo, T & Tandon, B. 1999 *Civil Society at the Millennium* Civicus (London)

Noji, E. (Ed.) 1997 *The Public Health Consequences of Disasters* Oxford University Press (New York)

Nolan, B. & Turbat, V. 1995. *Cost recovery in Public Health services in Sub Saharan Africa* The World Bank (Washington D.C.)

Norwegian Refugee Council 2004 *Internally Displaced Somalis Face Uncertain Future After Years of State Collapse* www.idpproject.org

OECD 1995 *Participatory Development and Good Governance* OECD (Paris)

Ong , B.N. and Humphris, G. 1994. 'Prioritising Needs With Communities: Rapid Appraisal Methodologies in Health' in J. Popay and G. Williams (Eds) *Researching the People's Health*. Routledge (London)

Pavignani, E. & Colombo, A. 2001 *Providing Health Services in Countries Disrupted by Civil Wars: A Comparative Analysis of Mozambique and Angola* WHO (Geneva)

Pelizzon, T. and Casparis, P. 1996 *The Age of Transition: Trajectory of the World System 1945-2025* Hopkins, T. and Wallerstein, I. (Eds.) Zed Books (London)

Pellegrino, E. 1997 'The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic' in *Journal of Medicine and Philosophy* 24 (3):243-66

Perrin, P. 1996. *War and Public Health: A handbook* ICRC (Geneva)

Pilger, J. 2003 *The New Rulers of the World* Verso (London)

PRCS, 2001. 'Israeli soldiers fire at injured Palestinians to death in front of PRCS crews' A press release issued by the Palestinian Red Crescent Society, 6 November, 2001

Preker, A., Carrin, G., Dror, D., Jakab, M., Hsiao, W., and Arhin-Tenkorang, D. 2001 *A Synthesis Report on the Role of Communities in Resource Mobilization and Risk Sharing* Commission for Macroeconomics and Health Working Paper No. WG3:4. WHO (Geneva)

Pugh, M. 2002 'Maintaining Peace and Security' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Reifer, T. and Sudler, J. 1996 *The Age of Transition: Trajectory of the World System 1945-2025* Hopkins, T. and Wallerstein, I. (Eds.) Zed Books (London)

Reno, W. 1999. *Warlord Politics and African States* Lynne Rienner (Boulder)

Riddell, R. 1997. *Aid in the 21st Century* UNDP (New York)

Roberts, A. 1996. *Humanitarian Action in War* Adelphi Paper 305, Oxford University Press for the International Institute of Strategic Studies (Oxford)

Robson, C. 1993. *Real World Research: A Resource for Social Scientists and Practitioner-Researchers* Blackwell (London)

Rosenau, J. 2002 'Governance in a New Global Order' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

Roy, A. 2004 'Help that Hinders' in *Le Monde Diplomatique*, November 7, 2004

Ruane, J. and Todd, J. 1996 *The dynamics of conflict in Northern Ireland: Power, conflict and emancipation* Cambridge University Press (Cambridge)

SACB 2003 *Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations 2003-2008* (Unpublished Program Description)

Sachs, J.D. & McArthur, J.W. (2005) 'The Millennium Project: a plan for meeting the Millennium Development Goals' in *The Lancet* 2005; 365: 347-53

Schieber, G. J. (Ed.) 1997 *Innovations in Health Care Financing: Proceedings of a World Bank Conference March 10-11, 1997* The World Bank (Washington D.C.)

Schoepf, B.G., Schoepf, C. & Millen, J.V. 2000 'Theoretical Therapies, Remote Remedies: SAPs and the Political Ecology of Poverty and Health in Africa' in Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

Schuftan, C. 1999 'Equity in Health and Economic Globalization' in *Development in Practice* 9(5):610-614

Shakow, A. & Irwin, A. 2000 'Terms Reconsidered: Decoding Development Discourse' in Kim, J.Y., Millen, J.V., Irwin, A., and Gershman, J. (Eds.) *Dying for Growth: Global Inequality and the Health of the Poor* Common Courage Press (Boston)

Shaw, R.P. 1995 'Financing Health Services through User Fees and Insurance' in Shaw, R.P. and Ainsworth, M. (Eds.) *An International Assessment of Health Care Financing: Lessons for Developing Countries* The World Bank (Washington)

Shaw, R.P. and Ainsworth, M. (Eds.) 1995 *An International Assessment of Health Care Financing: Lessons for Developing Countries* The World Bank (Washington D.C.)

Sikora, K. 1999 'Cancer services are suffering in Iraq' in *British Medical Journal*, 16 January, 1999

Silber, L. and Little, A. 1995 *The Death of Yugoslavia* Penguin Books (London)

Silongonyane, M.F. 2001. 'The rhetoric of the community in project management: the case of Mohlakeng township' *Development in Practice* 11(1) 34-44

Simms, S., Rowson, M. and Peattie, S. 2001 *The Bitterest Pill of All: The collapse of Africa's health systems* SCF UK Briefing Paper

Smillie, I. 1995 *The Alms Bazaar: Altruism under Fire - Non-Profit Organizations and International Development* IT Publications (London)

Storey, A. 2000 'The World Bank, neo-liberalism, and power: discourse analysis and implications for campaigners' *Development in Practice* 10(3 & 4):361-370

Stringer, E.T. 1996 *Action Research: A Handbook for Practitioners* Routledge (London)

Stubbs, P. 1998. *The role of NGOs in social reconstruction in Post-Yugoslav countries*, Relief and Rehabilitation Newsletter 10, ODI (London)

Tulloch, J., Saadah, F., de Araujo, R., de Jesus, R., Lobo, S., Hemming, I., Nassim, J. and Morris, I. 2003 *Initial Steps in Rebuilding the Health Sector in East Timor* National Research Council and Columbia University Program of Forced Migration and Health.

Turshen, M. 1999 *Privatizing Health Services in Africa* Rutgers University Press (New Jersey)

Turshen, M. 2000 *African Women's Health* Africa World Press (Trenton & Asmara)

UNAIDS 2003 *AIDS Epidemic Update: December 2003* UNAIDS (Geneva)

UNDESA 2001 *World Population Prospects, the 2000 Revision* UN Department of Economic and Social Affairs (New York)

UNDP 1995 *Building Bridges Between Relief and Development* International Colloquium on Post-Conflict Reconstruction Strategies, UNDDSMS & UNIDO (Geneva)

UNDP 2001 *Human Development Report – Somalia 2001* UNDP (Nairobi)

UNDP 2003 *Human Development Report 2003 MDGs: A Compact among Nations to End Human Poverty* UNDP (New York)

UNHCR 1995 'Post-Conflict Recovery: UNHCR's Capacities and Perspectives', in *International Colloquium: Post-Conflict Reconstruction Strategies* UNDDSMS & UNIDO, (Geneva)

UNICEF 1997 *Multiple Indicator Cluster Survey for Somalia* UNICEF (Nairobi)

UNICEF 1999 *End Decade Multiple Indicator Cluster Survey: Full Technical Report for Somalia* (Nairobi: UNICEF)

UNODCCP 2002 *Global Illicit Drug Trends 2002: ODCCP Studies on Drugs and Crime* United Nations Office for Drug Control and Crime Prevention (New York)

UNRISD 1993. *Rebuilding Wartorn Societies: Report of the workshops on the Challenge of Rebuilding Wartorn Societies and the Social Consequences of the Peace Process in Cambodia 1993* UNRISD (Geneva)

Waitzkin, H. 2000 *The Second Sickness: Contradictions of Capitalist Health Care* Rowman and Littlefield (Lanham)

Waldman, R. & Hanif, H. 2002 *The Public Health System in Afghanistan: Current Issues* (AREU)

Walker, P. 1994 'Linking relief and development: the perspective of the International Federation of Red Cross and Red Crescent' *Institute of Development Studies Bulletin* Volume 25, number 4. 1994 *Linking Relief and Development* IDS (Brighton): 107-111

Wallerstein, I. 1996 'Conclusion' in Hopkins, T. and Wallerstein, I. (Eds.) *Age of Transition: Trajectory of the World System 1945-2025* Zed Books (London)

Wallerstein, I. 2002. *The Essential Wallerstein*. The New Press (London)

Wallerstein, I. 2003. *The Decline of American Power: The U.S. in a Chaotic World.* The New Press (London)

Waters, M. 2001 *Globalization* (Routledge) London

Weisbrode, K. 2001 *Central Eurasia: Prize or Quicksand? Contending Views of Instability in Karabakh, Ferghana and Afghanistan* Adelphi Paper 338, Oxford University Press for the International Institute of Strategic Studies (Oxford)

Weiss, T. 1999 *Military Civilian Interactions: Intervening in Humanitarian Crises* (Rowman & Littlefield) Lanham & Oxford

Whitehead, M., Dahlgren, G. and Evans, T. 2001 'Equity and Health Sector reforms: can low-income countries escape the medical poverty trap?' in *The Lancet*, Volume 358, September 8, 2001

WHO 1990 *The Impact of Macroeconomic Policy on Health* World Health Organization (Geneva)

WHO 1999 *The World Health Report 1999: Making a Difference in the 21st Century* WHO (Geneva)

WHO 2000 *The World Health Report 2000 Health Systems: Improving Performance* World Health Organization (Geneva)

WHO 2001 *Macroeconomics and Health: investing in health for economic development* Report of the Commission on Macroeconomics and Health. (Geneva: WHO)

WHO 2002a *World Report on Violence and Health* WHO (Geneva)

WHO 2002b *Reconstruction of the Afghanistan Health Sector: A Preliminary Assessment of Needs and Opportunities* WHO (Cairo)

Witter, S. 2002 *Health Financing in Developing and Transitional Countries*, Briefing Paper for Oxfam GB.

Witter, S., Ensor, T., Jowett, M. and Thompson, R. 2000 *Health Economics for Developing Countries: A Practical Guide* Macmillan (London)

Woods, N. 2002 'Global Governance and the Role of Institutions' in Held, D. and McGrew, A. (Eds.) 2002 *Governing Globalization: Power, Authority and Global Governance* Polity Press (London)

World Bank 1993 *World Development Report 1993: Investing In Health* OUP (New York)

World Bank 1998 *The World Bank and the Health Sector in Mali: An OED Country Sector Review* World Bank (Washington)

World Bank 1998a *Post Conflict Reconstruction: The Role of the World Bank* The International Bank for Reconstruction and Development/The World Bank (Washington)

World Bank 1998b *The World Bank's Experience with Post-conflict Reconstruction* World Bank Operations Evaluation Department (Washington)

World Bank 1999 'Health Care in Mali: Building on Community Involvement' *Precis Number 188*, Spring 1999 Operations Evaluation Department (Washington)

World Bank 1999 *World Development Report 1999/2000: Entering the 21st Century: The Changing Development Landscape* World Bank (Washington)

World Bank 2000 *Entering the 21st Century: World Development Report 1999/2000*

World Bank 2002 *World Bank Group Work in Low-Income Countries Under Stress: A Task Force Report* World Bank (Washington)

World Bank 2002a *World Bank and User Fees* World Bank Issue Briefs
<http://www.worldbank.org/html/extdr/pb/pbuserfees.htm>

World Bank 2002b *2002 Poverty Update* World Bank Issue Briefs
<http://www.worldbank.org/html/extdr/pb/pbpoverty.htm>

World Bank 2003 *World Development Report 2004: Making Services Work for Poor People* OUP (New York)

Yannis, A. 2003 'State Collapse and its Implications for Peacebuilding and Reconstruction' in *State Failure, Collapse, and Reconstruction*, Milliken, J. (Ed) Blackwell (Oxford)

Zartman, I.W. 1995. *Collapsed States: The Disintegration and Restoration of Legitimate Authority* Lynne Rienner (London)