LOCAL PRACTICES OF DEVELOPMENT IN SOMALILAND: ARGUMENTS FROM THE HEALTH SECTOR

Daria Zizzola[1]

Abstract

This article's main purpose is to discuss the nature of local practices characterizing a process of gradual development that has recently taken place in Somaliland. This is a mixed method research study conducted in the Hargeisia district and Awdal region of Somaliland between 2007 and 2011. The focus of this study is on the health sector and all the peculiarities distinguishing national health policy regulating the supply, maintenance, and control of services, as well as the procurement of alternative services by private or private-non-profit medical structures. Contrary to a wide tendency considering humanitarian assistance in Somaliland as a monopoly for Western agencies, evidences are brought here of a shift in the composition and diversification of stakeholders involved in the health care. Therefore, this paper preliminarily discusses the role of new social actors, the Islamic charities and the Somali Diaspora, that are emerging as key contributors to the provision of care treatments and financial support to public hospitals. These actors are also engaged in opening and running private clinics that have rapidly mushroomed in a stimulating environment free of central monitoring and quality standards. Analysis is based on data collected during two fieldworks in Somaliland and an extensive review of literature on the subject.

Keywords: Somaliland, health sector, humanitarian assistance, local development, Diaspora

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Introduction

Somaliland became a self-declared Republic in 1991 and is still unrecognised by the international community. Notwithstanding the limits deriving from its political virtuality, a class[1] of entrepreneurs and businessmen have slowly appeared in the country. This has happened thanks to those commercial activities and investments that have nurtured Somaliland's narrow basin of resources passing through non-conventional economic channels run outside governmental authorities. Many scholars have investigated this informal sector and its features. For instance, William Reno speaks about Somaliland and Puntland arguing that state collapse and shifts in the global environment can be compatible with the formation of orderly multi-communal polities that are able to manage their connections with the global economy, even as they are extremely marginal to it.[2] Generally speaking, globalization and its effects on local[3] economies directly involve least developed countries and their dependence on changes in major markets for internal development. Somehow states like Somalia can facilitate a mechanism that in those contexts goes deeper and faster than in others, where political apparatuses try to control and gain economic interests. Deregulation and globalization by default involve a rapid and extreme form of structural adjustment with the disappearance of governmental intervention in the economy.[4]

The Somaliland economy clearly shows a strong predominance of international actors in the regular sector, while informal business relies comparatively more on native agents (including members of the Somali Diaspora) who have become its main protagonists after the fall of the dictatorship.[5] The Somali Diaspora, as it emerges from the latest works, seems also to be a critical financer in those fields not taken into consideration by the state, mostly through organized collective remittances. Health and higher education[6] are grounds of reference for considerable support while so far the great burden of assistance has been provided by the United Nations.

It stands clear that, though health care is usually considered attached to the sphere of public administration, here it can be rightfully inscribed in a hybrid dynamic where public services attract and shelter private initiatives creating a favourable milieu for investments with a comprehensive social participation. The aim of this article is twofold: First it explains the concrete difficulties and gaps affecting the public health sector. Second, it attempts to investigate how alternative actors have attempted and continue to attempt to fill the gaps in the national health system in order to gain material benefit, visibility, or simply a higher social status. This paper introduces a complex debate on those factors relevant to the construction of a clear picture of the health care structure as it has disclosed itself during the fieldwork. A major challenge to research has been represented by the problematic access to

[1] For details on the formation of social classes among pastoral people in the Horn of Africa see: Aronson D. (1980), Kinsmen and Comrades: toward a class analysis of the Somali pastoral sector, *Nomadic People*, Vol. 7, pp. 14-23; Geshekter C. (1985), Anti-colonialism and class formation - the Eastern Horn of Africa before 1950, *International Journal of African Historical Studies*, Vol. 18, No. 1, pp. 1-32; Hussein A. B. (1980), The captive intelligentsia of Somalia, *Horn of Africa*, Vol. 3, No. 1, pp. 25-37.

[2] Reno W. (2003), *Somalia and survival in the shadow of the global economy,* Queen Elizabeth House: Working Paper*,* Oxford, University of Oxford, p. 5.

[3] The word *national* can prove much controversial when used to address the Somaliland context; to the contrary, the term *local* better emphasises the multiplicity of economic networks that can be found in either regional, national, or domestic levels (like in the present case study).

[4] Reno W. (2003), *Somalia and survival in the shadow of the global economy,* p. 5.

[5] Hammond L., Awad M, Horst C. et al. (2011), *Cash and Compassion: the role of the Somali diaspora in Relief, Development and Peace-building*, UNDP, Vol. 1; Horst C. (2004), *Money and mobility: transnational livelihood strategy of the Somali diaspora*, Geneva, Global Migration Perspectives; Kleist N. (2008), Mobilizing 'the Diaspora': Somali Transnational Political Engagement, *Journal of Ethnic and Migration Studies*, Vol. 34, No. 2, pp. 307-323.

[6] Higher education is a major target for researchers while health is as yet only narrowly investigated.

the private sector where actions of alternative stakeholders are strongly concentrated. The same can be said for what concerns Islamic charities whose hermetic attitude has created a climate of suspicion towards them. As such, this paper is based on two research questions: 1) What is the level of development, sustainability, and reliability of the health care system in Somaliland; and 2) who are the key-stakeholders operating in the sector and how do they relate with each other and integrate or affect the local context? In an attempt to address the research questions, the article begins with an overview of the health care system currently working in Somaliland. The first section focuses on the fundamental assistance provided by Western agencies; the second part is dedicated to a preliminary investigation of the impact of Islamic charities and the Somali Diaspora in the development of health services.

Methodology & Design

This study is partial fulfilment of the author's Master's degree requirement. Using a mixed research methodology, the study reports on the functioning of the health care system in the Republic of Somaliland. The study was conducted in three major phases: Firstly, a review of scientific publications and grey literature[7] was undertaken to determine major gaps of investigation and, consequently to identify adequate research objectives. Secondly, unstructured interviews were conducted with relevant actors working with medical facilities, humanitarian agencies, and governmental offices. During the interviews, participants' consent and permission were sought after providing the study information to potential interviewees. Particularly, permission to use data collected during the interviews was requested prior to the commencement of the interview. Thirdly, a quantitative model was followed to analyse statistics data collected from medical facilities and international agencies. Data supplied by local informants (hospitals, governmental offices, private clinics) were assessed against those recorded and provided by external sources (primarily the United Nations). The aim was to test consistency between data so as to provide a comprehensive perspective of the health care system's policy framework.

Fieldwork was conducted in 2007 (October-December) and 2011 (November) in the Awdal and Maroodi Jeex regions in the district areas of Boroma and Hargeisa. During the first experience, a distinction was made between hospitals, clinics, and pharmacies operating in the public and the private sector. Administrative and medical staff members were asked about the hospital's functioning, medical practices, administrative and financial management, internal policies, and external support available in the system of care. Personnel working with humanitarian organizations were asked to describe their relationship with local organizations; the model of aid they utilize, and the kind of projects they implementing in the territory. Immediately evident from the collection of such data was the "double dynamic" that initially emerged with regards to the private sector, whereby, medical doctors, directors of clinics, as well as pharmacies' owners, appeared to belong largely to the Somali Diaspora; while at the same time, Islamic charities tended to attribute growth in the financing of some of these local enterprises. For this reason, four years later, a second mission in Somaliland sought to verify peculiar trends recorded in 2007. In particular, research observation turned towards the Diaspora and Islamic organizations' capacity, as "alternative actors", to partake in the provision of medical services to patients in the public sector.[8] Interviewees' typology was extended in order to include individuals acting as intermediaries between medical facilities

[7] Grey literature mainly refers to United Nations reports and country/sector studies produced by stakeholders directly involved in the field.

[8] A third category was detected: it comprised those medical structures born thanks to private initiatives although recognised and partially supported by the Government. The most important private non-profit facilities are the Edna Aden Maternity Hospital and the Manhal Charity Hospital.

and the community: their participation through Diaspora channels or religious projects, and the increasing presence of non-conventional components in the health sector.

Health sector deficiencies and external constraints

> The overall target of the Government of Somaliland in the health sector is to attain the highest possible health status and social well being of the individual family and the community. To provide equitable, affordable and sustainable, preventive, curative and rehabilitative health care services, with the ultimate objective of reducing morbidity and mortality, improving life expectancy and fostering comprehensive social development. (Ministry of Health and Labour, MoHL, 2007).

The statement reported above is the foreword to an official document promulgated by Abdi Aw Dahir Ali, the Minister of Health and Labour who signed the first articulated National Health Policy in 1999. It was this policy that brought the comprehensive Health Sector Reform to light. The same text was published in 2007 as the opening words to the updated national Situation Analysis edited by the Director General, MoHL, Ahmed Abdi Jama.[9]

The survey sought to gauge the efficacy of the previous National Health Reform that is epitomised by the above statement. Beginning with its opening paragraphs, the text underlines the multiple involvements of the donor community, non-governmental organizations, private sector practitioners and key government ministries.[10] At a first glance, the text reveals one core aspect: the close connection between policy implementation and the compulsory participation of foreign agents. A lucid analysis identifies many of the challenges that Somaliland is facing in order to improve its living standards. Major problems are related to:

- Policy gaps;
- Crises in the health service delivery system;
- Institutional inertia/irrational hyperactivity;
- Underdeveloped health management system;
- Absence of a coherent National Health Sector Financing Policy;
- Weak partnership and coordination;
- Critical shortage of trained human resources; and
- Lack of a solid legal framework.

The most urgent policies to be addressed by the administration were a response to matters concerning the establishment of a national drug policy, a reproductive health policy, a health financing policy, a medical diagnostic and hospital policy to guide the technical standards and managerial practices within the broad health sector, and the more troublesome matter of private health sector regulation.[11] The situation was dominated by a critical level of institutional capacity that referred mainly to the lack of resources and operational efficiency of the MoHL. To tackle these challenges, in 2009 the government and international agencies (mainly the World Health Organization, WHO, and United Nations Children's Fund, UNICEF) decided to support a pilot programme whose cornerstone was the Essential Package of Health Services;[12] a system providing the base for primary health care as well as the tools for planning and management. The purpose was to lay foundations and strengthen strategic service provision in the sector. In December 2011 the Ministry of Planning and Development presented, after participatory consultations, the Strategic Plan for 2012-2030 while the Ministry of Health announced the Strategic Plan for the National Health Policy 2012-2015; the documents were discussed with all stakeholders, amended, approved and endorsed in January 2012. They were then submitted to the Health Sector Committee for Somalia in February 2012.

[9] Ministry of Health and Labour (2007), *National Health Situation Analysis*, Hargeysa, Republic of Somaliland.
[10] *Ibidem*, p. 4.
[11] *Ibidem*, p. 8.
[12] The following document outlines the main features of this programme: Pearson N., Muschell J. (2009), *Essential Package of Health Services, Somaliland 2009*, UNICEF.

Despite these moderate progresses, the distance between policy makers and patients today is still remarkably wide. This Gordian knot has arisen because of the lack of popular confidence in public institutions and the poor quality of treatments delivered. The situation is further aggravated by the difficulties faced by the staff employed in medical facilities.[13] It seems practically impossible for workers to devote their complete time to public facilities because of the low level of wages the Ministry is able to grant them. For instance, a nurse can earn only US$40 per month while a physician earns an average of US$60; these wages are below the subsistence level and cannot generate effective commitment by employees in the public system.[14] In August 2011 the Ministry of Health increased the salaries of health personnel as follows: physician US$132, qualified nurse US$108, auxiliary nurse US$82, and support staff US$50.

Moreover, the significant shortage of drugs and alleged low staff competence in the public sector makes the private sector apparently preferable for patients. The majority of health facilities rely on Non-Governmental Organizations (NGOs) or other international funders for medical equipment and medicine. Partners charged, for instance, with a hospital's medical and logistic support are often not accountable for the whole of its requirements. This entails many inefficiencies and overlaps with other suppliers, which constantly reduce the reliability of the public sector. The capillary integration of hospital incomes through a cost-sharing based strategy has given more room for manoeuvre to hospital capacities. The Regional Health Board, an organ that contributes to fundraising within civil society and local communities following specific requirements from the medical facility, supports the structure. The last consideration is particularly true for the Hargeisa General Hospital in the capital. District and regional hospitals face great difficulties when they rely on these types of shared-cost initiatives. In the remote rural areas, referral hospitals are supported by at least one major international organization that coordinates the essential activities providing funds and medical equipment. Community involvement is more difficult where wealth concentration and urbanization are less developed.

Lack of education among health consumers shows that both care seeking behaviour and utilization patterns are somehow dictated by individual socio-cultural dynamics, which are complex and unstable.[15] The crucial choice between a private or a public source for care delivery is based on the combination of multiple factors: patients proximity to the clinic, rural or urban context of the hospital, the nature of the disease which has to be treated and the gravity of the symptoms, which are usually not heeded until the level of risk is high and not resolvable with traditional or religious practices.

Other sharp constraints are associated with administrative problems, insufficient vocational awareness of operators and managers, inadequate skills and inappropriate attribution of expertise. The problem of uncertainty over the self-reported competence of medical personnel is due to the impossibility of ascertaining their degree of expertise after the civil war, as the professional and educational registers were destroyed. A certain number of graduate students are currently employed to cover technical and managerial profiles, and there is a mounting partnership between institutions providing higher education and the medical clinics where students are engaged at the end of their academic path. For instance, the Edna Aden Medical Hospital, a private non-profit teaching hospital, provides regular courses for laboratory technicians, nurses, and midwives and has recently launched a course for pharmacists. The University of Hargeisa has pushed forward to establish close linkages with the Hargeisa Group Hospital and many other facilities are trying to offer learning

[13] Davis A. (2008), *Intermediate standardized "salary support/incentive". Payment scale for civil servants and health workers*, EC Health Sector Development Fund Coordinator, Somaliland, Proposal Paper IV.
[14] *Ibidem*, p. 6.
[15] See Mazzili C., Davis A. (2009), *Health care seeking behaviour in Somalia. A literature review*, UNICEF.

courses to new generations of students. The scarcity of human resources is one of the problems that are gradually shrinking, owing to the progressive availability of skilled individuals coming out of the universities. Despite the reduction of demand for qualified workers, the level of proficiency and reliability of medical operators is still insufficient, while the deficiency of postgraduate courses forces students to seek their specialization abroad. This is the only solution for students who can afford international mobility.[16]

The situation is exacerbated by the problem of access.[17] Public health services are not uniformly distributed across the national territory. Equipped medical facilities are gathered in towns, leaving remote areas partially isolated. Evidence from data collected in 2011 show some changes compared with 2007. The difference consists mainly of the increase in the number of primary Health Posts, HP, and Mother and Child Health centres, MCHs; nevertheless, the level of services quality remains still very low primarily in the countryside.

People living in the countryside have only been marginally affected by improvements in health services brought by the international community and the central government. Settling far from the main urban areas to follow their traditional life-style, medical care has always been a real challenge for pastoral and semi-pastoral nomads. Their customs and practices do not allow them the possibility to benefit from good quality services. They require a different approach that could rightly address the rural population through mobile units, roaming around major nomadic tracks and disposing of essential medical packages and technical workers. This happens despite the opposite tendency to settle at the outskirts of the cities because of the worsening of climatic conditions that has brought many pastoralists into towns to look for alternative incomes.[18] The national policy, currently being drafted, will give more prominence to the connections between referral regional hospitals and the scattered health posts where community health workers are the only professionals available to patients.[19] Moreover, the internship programme, involving doctors coming out from universities and ready for practice and training in medical facilities, is managed in order to cope with rural and urban exigencies: doctors and physicians are recruited for their first year of internship inside teaching hospitals while in the second year they are employed in the National Service Program, with special focus on the peripheral zones (almost all the internship period is spent inside regional hospitals).

The administrative apparatus has to tackle these issues while looking at the same time at the extreme centralization of resources (vertical approach of the Ministry). Diverse offices have multiplied in the effort to mark out the allocation of resources to peripheral regions (Regional Health Offices and District Offices). This measure has highlighted the need to revise legislation on the decentralization of health services, which was left incomplete and inoperative according to the Law 23/2002 on functional assignments to local districts. Definitely, this norm was never sufficiently financed to be effective nor was subsidiary regulations put in place to clarify the sector service delivery mandates of local government.[20] The mobilization of resources as well as the empowerment of the decentralized units through the empowerment of their human and organizational resources constitutes major ambitions.

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16 This reflects what reported by graduate students of the Faculty of Medicine of the University of Hargeisa working at the Hargeisa Group Hospitals and the Regional Health Board.

17 Interview with Ahmed Hassan Golle, Regional Health Officer, Ministry of Health, November, 2001. Notwithstanding the strong dependence on foreign assistance for decentralized services provision and facilities maintenance, the Director argues that cost-sharing procedures ensure that rural health posts savings are sufficient to cover 65 percent of running costs. On the other hand, discrepancies that emerged during discussions with other actors underlined the sharpness of issues like salaries not corresponding to those of Community Health Workers and the reliance on foreign agencies for drug supply.

18 On the process of urbanization in Somaliland see Ciabarri L. (2010), *Dopo lo Stato. Storia e Antropologia della Ricomposizione Sociale nella Somalia Settentrionale,* Milano, Franco Angeli.

19 Interview with Dr. Essa Jama, Internship Program Coordinator, Ministry of Health and Labour, November 2011.

20 *Study on sector functional assessment within Education, Health and WASH in Somaliland*, Geopolicity, UN Joint Programme on Local Governance and Decentralized Service Delivery, April 2012, p. X.

Furthermore, the effectiveness of data collection, information systems and surveillance systems still mirror the gap between the theory of running a public administration and the constraints of its implementation, albeit limited improvements[21] have been achieved thanks to the capacity of some individual reporters in rural MCHs and HPs.

Somaliland's critical situation is worsened by deficiencies in the allocation of the national budget to the Ministry of Health. The national policy published by the government in 2007 shows a budget contribution percentage fixed by the Ministry of Health and Labour inferior to the average of 2 percent of the total amount. The budget planning for 2010 reached 2.4 percent,[22] an increase that appears in any case insufficient to cover all the needs of the whole sector.[23] The level of capital resources was finally raised to the ceiling of 3.1 percent in 2011. As a result, public health care reveals a large dependence on non-governmental organizations and international donors. In the last decade aid to Somalia has increased from US$23 million in 2000 to US$103 million in 2009,[24] almost a fivefold growth in ten years.[25] This has profoundly affected Somaliland not only with respect to the traditional economic practices of the area but also to the modalities through which inhabitants have started behaving with relation to financial inflows that have been feeding the rehabilitation programmes since the end of the conflict. There is a wide literature supporting the thesis that humanitarian aid negatively impacts on least developed countries in regards to livelihood improvement.[26] In the face of the absence of international recognition, businessmen in Somaliland have been able to find some preferential economic channels leading to the birth of a lucrative shadow economy,[27] from which, in turn, primarily the private health sector has thrived.

Although it is dominant in the production and financing of health services, dealing with the private sector is an awkward matter because of a range of factors: private drug sellers and clinics are not well disposed toward sharing information with unknown researchers; pharmacies are elusively used as medical laboratories and outpatient clinics; and there is a gap in the mapping of private activities at a local, regional and national level where many deficiencies are consequences of the need to establish a suitable monitoring policy. In recent times several private businessmen have invested in the medical sector, opening clinics and pharmacies, often without any competence. This kind of endeavour has proved itself a profitable deal and has made the sector particularly attractive in contexts of submerged economies.[28] Save for the picture of commercial operations behind the great share of private pharmacies, the fieldwork has evidenced the presence of qualified doctors and other professional figures belonging to the Diaspora who have decided to return to their homeland and to venture in such a lucrative activity of drug retailers or to set up diagnostic centres and medical laboratories. By and large, an issue of concern has remained over the level of qualification, accountability, and transparency of people operating in this arena, a problem

[21] Rahmaan Bakayale A., Regional Health Ministry Information System & Nur Mohamed, CCM (Comitato Cooperazione Medica), Survey on Maroodi Jeex Quarterly Activity Briefing (July-Sept. 2011); Interview with Abdi Wab A. Jama Makruma, Wash (Water, Sanitation & Health) activist, Regional Health Office, November, 2011.

[22] *Commentary on Somaliland Budget 2010*, in Somaliland Patriots, online: http://www.somalilandpatriots.com/news-10150-0, (accessed: 3/12/2010).

[23] Interview with Mohamed Khadar, Health Planning General Director, Ministry of Health and Labour, November 2011. The conversation referred to the new National Policy and its financial forecasts which were not going to exceed three percent of the national budget, about US$4 million.

[24] Capobianco E., Naidu V. (2011), *A decade of aid to health sector in Somalia, 2000-2009*, Washington D. C., The World Bank, p. 20.

[25] United Nations (2011), *Somalia. Consolidated Appeal*.

[26] For instance, Sahnoun M. (1994), *Somalia, the missed opportunities*, Washington D. C., United States Institute of Peace Press; Macrae J, Zwi A., Duffield M. Slim H. (eds.) (1994), *War and hunger: rethinking international responses to complex emergencies*, London, Zed Books.

[27] Reno W. (2003), *Somalia and survival in the shadow of the global economy*.

[28] Here submerged is meant as a synonym of informal economy as described in the introduction.

that is far from resolved yet. Nevertheless, these challenges are tentatively tackled by a pilot programme led by an international organization[29] that, for instance, aims at strengthening linkages between the Ministry and independent medical retailers through the pattern of social franchise. This is done by providing training and consultancy to retailers that, in turn for submitting to a standardised management of their pharmacy, are awarded a brand of excellence and accountability, which should increase their attractiveness to consumers while improving the level of quality and professional reliability. Unfortunately this programme is limited to the urban district of the capital and it is only in its initial phase (early 2012).

Previous reflections on both the public and private health sectors drive the discourse to a fundamental consideration: the broad framework of national healthcare cannot be independent of Western support, at least for the time being. The participation of foreign actors in the reconstruction of a sustainable public health system has frequently been undertaken without coordination among the involved humanitarian agencies. Implementation phases have gone hand in hand with little knowledge of the local context that is essential to ensure projects' efficacy and their positive impact. Along with the lack of aid harmonization, thorough studies on health project financing trends emphasize a clear shift of funds from horizontal to vertical planning. The last ten years have been decisive in the major allocation of capital to vertical programmes like polio, followed straight by tuberculosis, Human Immunodeficiency Virus, HIV, and malaria prevention and treatment (Millennium Global Funds goals). After the peak, reached in 2006, the inflow of funds slightly decreased leaving them heavily funded if compared with other programmes (in particular horizontal ones). On the contrary, non-communicable diseases, reproductive health or nutrition have not received equal distribution, though there seems to be a relative increase in the latest expenditures. Emergency services are another matter of endowment, which represented approximately 25 percent of the total annual funding between 2006 and 2009.[30]

Looking at the financial inflow patterns from the United Nations (UN) and multilateral donors on the whole, many arguments arise from their utilization. Generally, supporting vertical projects has the effect of concentrating resources rather than decentralising and wisely distributing them. This trend is changing slightly. Information gathered during the last fieldwork has shown a new commitment among donors: issues like mental health, largely undervalued and relegated among non-urgent priorities in the whole national policy, have been recently reconsidered in the light of a new perspective. Today a committee gathering stakeholders involved in the mental health field has been formed under the Ministry of Health patronage. Similar changes related to other aspects, like education of healthy practices, family planning, improving awareness of drug consumers, and investing on decentralization and sustainability would represent a decisive step forward in the future health policy. According to UN humanitarian praxis, local recipients are not devolved a high degree of managerial power; to the contrary they are vested only with limited capacity to participate in the development process. The contribution that foreign workers can draw from Somali operators, employed in-land, is often lost and left aside by the priorities set by donors, which typically emphasize the lower risk of operations where results are obtained through fund centralisation.

The government's role in the panorama of foreign aid is not totally crippled, but evidence shows that political inadequacy and unpreparedness are still major shortcomings in

[29] The project of social franchise among private pharmacies was initiated by PSI (Population Services International) in July 2011 and in November 2011 it involved around 50 pharmacies in the urban area of Hargeisa. The partnership with MH and Edna Aden Teaching Hospital for training has enabled retailers to apply a standard policy based on individual performances which in turn gives them access to economic incentives in the case of successfully run activities. This is a first and important step toward the integration of the private sector in the national health policy.

[30] Capobianco E., Naidu V. (2011), *A decade of aid to health sector in Somalia, 2000-2009*, Washington D. C., The World Bank, pp. 24-25.

the administration of Somaliland. Bureaucratic stratification and parasitism are the main threats to improvement. The practical and theoretical competence of managers and supervisors is poor, whereas deficiencies in the organizational framework undermine all stages of performance. Many offices have been established to nurture an administrative class eager to gain personal profits from dealing with external financial assistance. The debate around the effect of humanitarian intervention in contexts of delicate rehabilitation, as in countries like Somaliland, remains vigorous.

Introducing the role of Islamic Charities and Diaspora

The development discourse needs to be integrated with further analysis reflecting the manifold presence of old and new players in the local landscape who can be recognised for their engagement in the health system. Islamic organizations and the Somali Diaspora are taken into consideration because of their representativeness in the sector. But, very adjacent to and sometimes intermingled with them, stands the group of the civil society represented by those local entrepreneurs who attract donations for charitable activities with the purpose of acquiring visibility and advertising themselves. This article introduces a complex debate on those factors relevant to the construction of a clear picture of the health care structure as it has disclosed itself during the fieldwork.

Islamic charities are a difficult topic for non-Islamic researchers. Various elements intensify the distance between humanitarian action, as it is perceived in a Westernized model, and its Islamic opposite: in this case modalities of fund-raising, project implementation and target definition differ considerably. Muslim societies do not see a distinction between religious and political-economic life.[31] Humanitarian assistance therefore belongs to specific attitudes that claim to address socioeconomic issues in foreign countries within an Islamic framework.[32] A substantial disparity among aid patterns derives to some extent from the different financial procedures used in the Muslim world. The Islamic banking system is run separately from that of the Western financial network. In the same way, capital used by donors for humanitarian aid follows parallel economic webs. Indeed, the majority of Islamic charities regard accountability as merely a courtesy owed to donors; most have not adopted the kind of procedures common in the West. This lack of financial transparency also makes studying Islamic humanitarianism particularly difficult.[33]

Andre Le Sage and Ken Menkhaus interestingly wrote about Islamic charities after fieldwork in Somalia. The chief outcome of their research seems to be still valid, and is probably the finding of Islamic charities' largest achievement: the provision of public funds to support a private sector which in turn delivers public services. That is why the Islamic charities give the Somali people the capacity to develop sustainable strategies of self-recovery. Muslims operators feel more comfortable in the Somali context and they can easily interact with local people since they are more entrusted than non-Muslim stakeholders; finally, Somali people have often become part of education and work exchanging programs in neighbouring Arab countries for training. They have the chance to raise their social status and to return to re-invest in the homeland.[34] On the whole, Islamic charities seem to have a deep knowledge of the local background that improves their projects' efficacies. Thereby, a deeper

[31] "Because there is no separation between ethics and law in Islam, there is also no separation between economic and humanitarian principles since both derive legitimacy from the Islamic sources of law, i.e. Shari'a." See Salih M. A. M. (2002), *The Islamic NGOs in Africa: the promise and peril of Islamic voluntarism*, Occasional Paper, Centre of African Studies, Copenhagen, University of Copenhagen, p.3.

[32] Wiktorowicz Q., Farouki S. T. (2000), Islamic NGOs and Muslim Politics: a case from Jordan, *Third World Quarterly*, Vol. 12, No. 4, p. 687.

[33] Benthall J. (2003), Humanitarianism and Islam after 11 September, *Humanitarian Action and the 'Global War on Terror'*, HPG Report No. 14, p. 43.

[34] Le Sage A., Menkhaus K. (2004), *The rise of Islamic Charities in Somalia: an assessment of impact and agendas*, Montreal, paper presented to the 45th Annual International Studies Association Convention 17-20 March 2004, p.15.

communication between Western and Islamic agents would foster cooperation and the sharing of diverse aid models while confronting respective shortcomings that could be extremely helpful. Le Sage and Menkhaus collected data in the southern region and in relation to the education sector. However, the impact of Islamic aid in Somaliland's health care has still to be assessed properly.

Accordingly, what has emerged from fieldwork conducted in Somaliland's central and western regions is the commonality of channels used by mosques and groups of private individuals to convey financial support inland from abroad, with channels built and intensely exploited by the Somali Diaspora; this in turn has facilitated investigation of Islamic activities is the territory. Even if the academic literature considers Diaspora assistance to medical facilities as something detached from Islamic channels,[35] this study attempts to highlight a substantial change in the traditional division of operational arenas that depicts these two elements as autonomous and isolated. There is a large body of studies that analyzes this trend while evaluating the impact of Diaspora and its role in the Somali economy.[36] Recently scholars have even raised concern in the Diaspora engagement in developmental processes. This is the consequence of a growing consideration of the role of non-conventional actors in the rehabilitation phase among foreign policy makers in Somalia and Somaliland.

To this regard the Manhal Charity Hospital can be mentioned as an emblematic case.[37] This hospital was opened in 2006 in the capital Hargeisa thanks to the initiative of an association called Al-Manhal Charitable Organization. Its mission has been, since its opening, the provision of medical treatment to all patients, charging those who could afford medical fees and granting free services to indigents. The hospital has benefited from the substantial support of several Muslim organizations (Red Crescent (United Arab Emirates), International Islamic Charity Organization, Kuwait Zakaat Fund, Red Crescent (Qatar), Arab Doctors Union, Sheik Eid bin Muhamed Al Thani-Qatar, and Islamic Welfare Organization (Kingdom of Bahrain)), as well as Western donors (UNICEF, WHO, and Global Foundation) and it is worth noting that in the Board of Trustees at its opening have found representation various members of the civil, religious, and political society. Prominent figures were the Mufti of Somaliland, the manager of Telesom, the vice-Minister of the Ministry of Health and Labour, a member of the parliament, the manager of a non-profit Somali organization, the manager of one of the most famous *Xawilaad*[38] in the country, as well as the manager of a construction company. It can be judged that the hospital has succeeded in differentiating the provenance of revenues, thus strengthening its financial viability. The board members belonged to all segments of society and this has allowed them to contain and differentiate the chronic dependence on foreign aid. They had also arranged an operating mechanism that involved local institutions and simultaneously permitted the control of quality levels, establishing a code of conduct and transparency. Even though still today this clinic seems not

[35] Kent R., von Hippel K., Bradbury M. (2004), *Social Facilitation, Development and the Diaspora: Support for Sustainable Health Services in Somalia*, The International Policy Institute, London, King's College.

[36] Relevant references on the Somali diaspora efficiency ratings in Somalia and Somaliland are: Farah A.O. (2009), *Diaspora involvement in the development of Somalia*, DIIPER Research Series, Aalborg, Aalborg University; Erdal M.B., Lindley A. (2010), The early morning phone call: remittances from a refugee diaspora perspective, *Journal of Ethnic and Migration Studies*, Vol. 35, No. 8, pp. 1315-1334; Menkhaus K. (2009), The role and impact of the Somali Diaspora in Peace-building, Governance and Development, in Bardouille R., Ndulo M., Grieco M. (eds.), *Africa's Finances: the Role of Remittances*, Newcastle, Oxford Scholars Publications, pp. 187-202.

[37] Zizzola D. (2012), Health, Islam and Alternative Capitalism: three possible key factors in developing Somaliland, in *Storicamente*, Art. 2, Vol. 8, available online at: http://www.storicamente.org/07_dossier/religion_capitalism_africa/zizzola.htm. In this article the case of Manhal Hospital was reported to demonstrate the peculiarity of the Somali context where developmental policies are coupled with side-factors like religion (Islamic solidarity) and an informal economy nurturing private business (defined as alternative capitalism).

[38] *Xawilaad* is the Somali name for agencies engaged with money transfer. Their channelling Diaspora money sending to the homeland has become fundamental specially in absence of an accountable and fully operational banking system.

to be completely satisfying, autonomous, or respectful to the higher-level standards set in the Western world, the distance separating Manhal hospital and its public counterparts is quite noticeable.

Getting deeper into Diaspora activities, reliable studies have evaluated that the total amount of money remitted for humanitarian purposes have a range of US$130-200 million on an annual basis.[39] While private remittances cover a larger share (ranging between US$3 and 2 billion per year), the quantity of funds allocated to community relief programmes is substantial. References documenting figures used hereby are drawn from the recent country study recorded by a research team led by Laura Hammond and commissioned by United Nations Development Programme (UNDP)[40] Somalia (2011). Diaspora collected funds are spent on tackling issues in many sectors: humanitarian assistance is differently considered from development assistance. The first introduces emergency relief support in the form of family members remitting relatives displaced by war, which is supposed to be merely an extension of conventional remittance practice, and it also deals sometimes with a powerful capacity to provide food for entire Internally Displaced People (IDP) camps to disburse emergency funds on the basis of need rather than purely kinship ties. The second provides more comprehensive support aimed at developing systems (health care, education, public works, etc.) to be more resilient in the long term.[41] Hammond at al. underline how often mosques are involved in sending money through organized donations, just to convey a relevant supply of resources to their community of origin. Little more is said about this mixture of Diaspora and Islamic deeds.[42] It also underscores the effort of private businessmen belonging to the Diaspora, representing approximately 80 percent of all businesses financing. A direct result is that the majority of the largest private companies working in Somalia and Somaliland operate on a shareholder basis, with local and international (Diaspora-based Somali) investors.[43]

Money transfer companies, the Somali *Xawilaad*, are particularly active in encouraging clients to make charitable contributions through special discounts on money sending procedures. This is a common praxis even for large business companies.[44] The supply of money and in-kind resources is extremely important for rehabilitation and reconstruction in post-conflict societies like Somaliland.[45] The great majority of studies stress how remittances are more effective in urban areas rather than among rural communities. But the same works generally confirm the impossibility of mapping the paths of private sums sent for household consumption that have to be included into a generalized blueprint of assistance which goes beyond any geographic criteria. Anyway, it can be concluded that movements related to the integration and exploitation of heterogeneous channels largely used by the Diaspora can however be employed to soften the distance among humanitarian agents since they represent a sort of transverse actor in the dynamics of interaction with all other stakeholders.

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[39] Horst C. (2010), *Engaging Diaspora in development. A review of pilot project Pakistan*, Oslo, PRIO Papers.
[40] United Nations Development Programme.
[41] *Ibidem*, p. 19-21.
[42] Interview with Essa Jama, I.P. Coordinator, MoHL, November, 2011. He stressed frequently the high level of mixing ratio of funds when dealing with diaspora and Islamic charities. Rather often, Somali communities abroad channel donations using mosques and other religious connections. This statement is confirmed by other interviewees.
[43] Hammond L., et al. (2011), p. 44.
[44] Kent R., von Hippel K., Bradbury M. (2004), p. 20.
[45] "The scale of diaspora investment in Somaliland exceeds foreign aid and government resources and has therefore had a greater influence than both either these on the economy, livelihoods, and well-being, the reconstruction of infrastructure and social services and technological development. The economic and social investments by the diaspora give them a political and economic stake in their homeland, which the Somaliland government, donor governments, and aid organizations need to reflect in their development strategies." Mohamed Hassan Ibrahim (2010), *Somaliland's investment in peace: analyzing the diaspora economic engagement in peace building*, Working Paper n. 4, DIASPACE, p. 55.

Some remarks can be made on the Diaspora as a means of connection between Western and Islamic aid models. Firstly, these factors show, at least partially, how much external variables weigh on the relation between agencies and the local government. Unfortunately, the struggle for funding and profit gain is a reality in Somaliland. The fragility of a young political apparatus and the low level of trust from citizens are additional challenges. The lack of political consciousness and participation has turned politics into a ground for wealth sharing and interest protection. The space between civil society and individual rights is bridged by traditional and religious leaders who even now are powerful actors charged with the people's confidence. It is not accidental, as confirmed by interviews in the field, that fundraising takes place directly in medical hospitals where leaders are represented. The process is lead by a committee (Regional Health Board) whose task, among many others, is the maintenance of relations with the traditional and religious community.

Secondly, the new role of Muslim organizations is akin to that of their competitors for aid delivery but with marked differences to Western agencies, as has been described above. Their success is due to various reasons, but chiefly the ease experienced by Islamic operators in the local context and the familiarity of country recipients with donors, often chosen for religious and cultural commonality, which helps create a preliminary base of trust between the two parts. Research in the field has highlighted the occurrence of Muslim aid participation into coordinated health programmes, though access has not been accorded to their administrative centres. Their presence in the financial scheme of many hospitals, both public and private, clinics and laboratories is significant and represents a clue to their involvement in the whole health sector.

Recently both the UN and Islamic organizations have begun cooperating in order to address the great exigencies of Somaliland. As Muslim International Non-Governmental Organizations (INGOs) are becoming more open to non-Islamic organizations, their strategy of implementation is progressively changing. For instance, Muslim Aid and Islamic Relief have been officially included in the Somalia Health Cluster Overview and Achievement for 2010. Nevertheless, Western donors are still predominant. It has to be said that a great amount of Islamic aid moves separately from the network where the UN dictates measures and policies, and is circumscribed to medium-scale initiatives. This is a further reason why Islamic channels need a deeper investigation. However, they are not easily accessible to researchers. A similar assumption acknowledges a substantial complexity in the production of a comprehensive analysis of the effective contribution they provide to the health sector. Nevertheless, it is essential to reckon their involvement in the attempt to depict at least the health system's main features.

Thirdly, a further light has been brought to the Somali Diaspora and the boost it brings to socioeconomic development in the homeland. Studies on the impact of aid stemming from Diaspora initiatives toward a pathway of social and political rehabilitation are increasing, even if a wide-ranging degree of examination of the health sector has yet to be accomplished. Direct observation shows that the Somali Diaspora is extremely important to the maintenance of domestic community ventures. Its members do not have an agreed plan of recovery and development but they follow an ad hoc approach by pursuing community needs through trust and kinship ties. Consequently, this pattern implies a detrimental fragmentation of resources. On the one hand, it overlaps and confuses the supply of medical facilities that, for instance, could result from the low consideration and synchronization with others activities. On the other hand, Diaspora initiatives aim to provide services that happen to be useless, for example donating highly advanced medical equipment for clinics where no essential medical treatments are available to patients.

All the same, Diaspora can make a valuable contribution to improving communication among different actors. Indeed, it does not refer only to kinship ties, but is active within

mosques and Muslim schools as well. The support is heterogeneous. For instance, the *Xawilaad* remittance companies are used by Somali communities abroad to send money to Somaliland and are emblematic because of their hybrid nature of private ventures serving private clients while backing always more frequently public initiatives. This is evident in an official overview of funding and partnership recorded by the Regional Health Board of the Maroodi Jeex Region, Somaliland, where a large amount of money belonging to private firms and companies indicates their commitment to development. In 2004 Telesom, one of the biggest telecommunication companies, and Dahabshiil, among the major *Xawilaad* in the country, donated respectively US$15 000 and US$18 000 for the rehabilitation of the Hargeisa General Hospital.[46] Yet, the majority of them are smaller donations based on direct demands from hospitals for ordinary works. Another hybrid case of Diaspora, this time involving Western humanitarian programmes, is the International Organization for Migration, (IOM), Migration for Development in Africa (MIDA)[47] health programme, 'Strengthening the Health Sector in Somaliland and Puntland through the Engagement of Somali Diaspora Health Professionals from Finland'. In 2010 it involved qualified personnel recruiting from Somali communities in Finland to work in a project for local development.

If Diaspora seems to be a viable connection between the Western and the Islamic world, humanitarian aid is a matter of concern for businessmen too. Companies and firms are gaining influence and they are continuously growing in their positions as financiers of local projects. They are considered, particularly by the Muslim organizations, as possible partners and joint investors (representative cases are those of private pharmacies, laboratories and clinics where they hold a key role in the financial provision). In spite of their commitment with religious charities, businessmen and prominent members of civil society are also partaking in the policy led by hospitals through dedicated boards that apply to them for assistance and advocacy. Fund collection is pursued, quite efficiently though not systematically, by the administrative machinery whose prerogative - in relations with bigger international agents - is also unquestioned. However, resources deployed by the government and Western agencies award businessmen the chance to gain visibility thanks to their subsidiary support. Though this phenomenon needs deeper investigation to be properly assessed, it would have been unrealistic to address the topic of sustainability in the health sector without appreciating its contribution to it.

Conclusion

This article has tried to accomplish the difficult task of providing far-reaching insight into the administrative constraints that threaten the precarious balance of powers and resources affecting Somaliland's health sector. To summarize, major successes achieved in the health care by the Somaliland Government with essential contribution from external donors we can mention the improvement of institutional capacity; a rise in the number of qualified medical staff and their wages; a progressive involvement of the local community in the decision making and fundraising to health facilities; a slow but steady increase in the budget allocation to the Ministry of Health by the National Government; and, above all, Somaliland's recent reverse trend towards a moderate decline in the reliance on humanitarian assistance where self-sufficiency representing a far - though not impossible - goal. On the contrary, a political failure has been recorded for what regards the poor competence of staff employed in health facilities coupled with a chronic scarcity of human resources; the shortage of drugs and medical equipment; administrative problems impairing the overall system; problems of access to services dividing urban centres from rural areas; and the most

[46] Kent R., von Hippel K., Bradbury M. (2004), p. 20.
[47] Mezzetti P., Saggiomo V., Pirkkalainen P., Guglielmo M. (2010), *Engagement dynamics between diasporas and settlement country institutions: Somalis in Italy and Finland*, Working Paper n. 6, p. 25.

important government incapacity to regulate and coordinate with a competing private sector. To make the point, what has emerged is a still substantial dependence on external aid whereas Western organizations represent a major constituent, with Islamic charities and the Diaspora, constituting more or less integrated factors. Religious linkages with the Muslim community have been reinforced and utilized to build and, where already built, to nurture cultural solidarity and economic development. The sharing of close religious and socio-cultural affinities has been a vessel for both Islamic charities and the Diaspora. Today the situation is rapidly changing because the Diaspora together with local businessmen facilitate contact between the two opposite spheres, the Western and the Muslim donors, and act as their intermediaries. At the same time, the government is not ready to take control of all humanitarian actions because of the lack of skilled professional, financial resources, and managerial capacity. In an attempt to make a tentative forecast, we could say that in the absence of a fully operational infrastructure empowered by strong administrative bodies to ensure a fair balance of interests and harmonize an equal participation of all stakeholders, a reasonable allocation of resources and their utilization will be difficult, especially if the purpose is to initiate an efficient joint-venture amid those committed to development.

APPENDIX: SAMPLE INTERVIEW QUESTIONS[48]

Questions submitted to qualified personnel working inside medical facilities:

1. What kind of logistics and managerial framework lay behind the hospital's running?
2. Can you describe the organizational structure of the hospital?
3. What is the size of the hospital (number of beds/medical wards/pharmacies & medical laboratories/surgical theatres/outpatients ambulatories, etc…)?
4. What is the medical capacity of the hospital (medium range of performances per year/quality standards/efficiency rates)?
5. What kind of services can the hospital provide to patients (diagnostic/laboratory/pharmacy/therapeutic services)?
6. What is the financial policy adopted by the hospital?
7. What is the hospital's relation with the Ministry of Health?
8. What kind of support the hospital receives from the Government?
9. What are the main deficiencies threatening the hospital's activity?
10. Does the hospital adhere to internship programmes in cooperation with local universities?
11. Does the hospital participate in the provision of medical services to assist rural districts?

Questions submitted to government functionaries:

12. Does exist a National Health Policy in Somaliland?
13. Would you describe constraints and successes of the public health sector in Somaliland?
14. How has the National Health Policy evolved since its adoption?
15. What are the Government's long-term objectives to achieve improvement of the national health care system?
16. How does the administrative system manage to cover both urban and rural areas?
17. Would you describe when and how the process of services' decentralization was undertaken?
18. Would you define the level of competence and coordination existing among public officers employed at all levels of government?
19. What is the financial situation in the Somaliland's health sector? What is the level of services offered in the rural areas if compared with the urban centres?
20. What is the role of the private sector? How does the Government manage to cope with private initiatives? Does exist any measure to control the quantity and quality of services delivered by private facilities?
21. What is the role of external assistance? Do you think external aid is still paramount to ensure the sector capacity to provide public services?
22. How do you think reliance on external sources of aid have impacted on the development of a National Health Policy?
23. What kind of shortcomings would you identify in the approach international agencies adopt in the health sector? What would you suggest to ameliorate the level of joint efficiency and cooperation of international agencies with local institutions?

Questions submitted to humanitarian operators:

24. What do you know about Somaliland and the local context (history, culture, society) where your organization operates?
25. How is the relation between your organization and the local institutions?
26. In what terms would you describe the level of harmonization with other international stakeholders? Do you think there is the need for major efforts to guarantee joint coordination among different actors of development?
27. How would you define the Government's capacity to cope with urgent needs and constraints affecting public health care in Somaliland?
28. To what extent your organization contributes to the comprehensive National Health Policy? How did/does your organization participate in its definition?
29. What is the strategy you undertook to facilitate the achievement of Somaliland's financial sustainability? How much do you think will it take to reduce Somaliland's dependence on external aid?

[48] NB: All interviews were unstructured. Therefore, questions were modified according to interviewees' typology. The sample questions above provide only recurrent key issues that were dealt with during interviews.

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