DEVELOPMENT EXPERIENCE IN SOMALIA

" Nomads aren't all bad"

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A paper to be presented at the African Studies Conference,
Burgmann College, Australian National University,
Canberra, 24-26 August, 1985.

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An experience illustrating:

1. Emergency relief aid stimulating genuine development in the national health care sector.

2. The value of networks of well-motivated workers within a national ministry bureaucracy.

3. ADAB/Australian NGO cooperation on a bilateral programme in an "almost-too-hard category" country in Africa.

4. Development programmes can adapt to nomadic lifestyles without having to "denomadise" the nomads.

5. Suitable roles for Australian health workers in rural health care programmes in Africa.

SOMALIA: THE CONTEXT

One of the least developed countries in the world, with an estimated per capita annual income of US$240.

Situated in the troubled Horn of Africa, it has alienated much of the rest of Africa by going to war with Ethiopia in 1978, defying the sacredness of colonial boundaries. In contrast with most other African nations, Somalia has a rather homogeneous population. Rather than having several nationalities within its borders, ethnic Somalis live outside its boundaries in large numbers in Kenya, Ethiopia and Djibouti. Political tensions do exist between patrilineal Somali clans.

Life expectancy (1982): 43 years.

Infant Mortality Rate - approximately 170/1000 live births.

Population(excluding refugees) - approximately 4 million.

GNP annual growth between 1960 and 1979: -0.5%
Total Debt (1982) : $1 billion
Average per capita growth in food production 1970-80 : -1.7%

Somali Government budget devotes 25% to defence

8% to education
3% to health

REFUGEE EMERGENCY

One of the major refugee emergencies of the past two decades occurred in Somalia betwen 1979 and 1981, when upwards of 1 million persons fled from Ethiopia. The quite dramatic success of the refugee health care programme has received scant publicity. Most of the credit goes to the Refugee Health Unit within the Ministry of Health, which established policy and coordinated the relief work of 30 different foreign agencies. The Unit comprised Somali doctors and nurses who insisted upon an appropriate and sustainable health programme.

In contrast with relief programmes elsewhere, the Somali health programme was standardised and well-coordinated, despite the fact that refugees were housed in 35 camps scattered throughout the country. The R.H.U. formulated a programme which would:

1. Aim at the population most at risk - young children and women.

2. Involve the refugee population in its own health care through extensive training of health workers and utilisation of traditional healers and birth attendants.

3. Concentrate on the most prevalent health problems.

4. Stress preventive and promotive health care rather than curative.

5. Use appropriate technology and local materials.

6. Limit the range and quantities of medicaments used.

7. Standardise treatment protocols and training curricula.

8. Insist that all agencies follow guidelines set by the RHU.

9. Establish good, basic management of the programme, with regional offices and frequent communication between the central office and the 35 camps through regular field visits, monthly newsletters and regular workshops.

The programme was a success both in terms of rapid improvement in health and nutrition status of the refugees and in attaining a remarkable level of self-management at the camp level by refugee health workers. In 1979, the infant mortality rate was estimated at 250/1000, dropping to about 80 by 1983 (half the national figure)

FROM REFUGEE HEALTH TO NATIONAL P.H.C.

During the refugee emergency, dozens of Somali doctors and hundreds of nurses were mobilised to work in the camps, and later in the central or regional coordinating units. The experience of working in a well-planned and 'successful' programme stimulated intense interest in community health amongst a significant proportion of Somali health professionals. This tended to counterbalance the previous preoccupation with urban, hospital-based medical care which prevails in most developing, and of course developed , countries. When the national PHC programme was launched in 1982, there was already a core of experienced and motivated health workers in the country. A few went abroad on study scholarships and were lost for the time being, but the majority remain in the country.

Since 1982, Somalia has embarked on a number of regional PHC development projects, coordinated by a central PHC office in the Ministry of Health. Many of the participants in the refugee health programme now head or take part in these regional programmes. Several of the foreign voluntary agenies involved in refugee relief have transferred their support to the national PHC programme. Not surprisingly, the national programme has been in many ways far more difficult. No longer was the Ministry of Health willing to allow a group of young, rather idealistic doctors "do their own thing" and traditional intra-ministry politics and personal power playing emerged. The financial safety net of UNHCR was also no longer there

AUSTRALIAN INVOLVEMENT IN SOMALI PHC

Community Aid Abroad, an Australian NGO had assisted the refugee health programme in Somalia by providing a medical team in one camp for 2 years. Based on the success of the RHU programme, and encouraged by the Somali Government's eagerness to extend health care to the rural population in Somalia, CAA decided to join with the Ministry of Health in establishing a PHC programme in the remote northern region of Sanaag. The project commenced in 1983 and is funded by ADAB under the BINGO scheme.

Sanaag region has a population of approximately 150,000 semi-nomadic pastoralists. The region is vast, has no tarmac road, poor communications and has received virtually no assistance in development of any sector. The provision of health care in the region prior to 1983 was from one small hospital with scarcely any medical supplies, one doctor and a few nurses. No data existed on prevalent health problems, nor on much else for that matter. The PHC project plans were modest, yet at the same time very ambitious. Four years to build up a community-based health care programme from zero in a region where the "communities" stayed in one place for very short periods of time.

NOMADIC PHC

The PHC project in Sanaag is basically run by staff of the Ministry of Health - a doctor coordinates the programme from the regional centre, a small town of stone houses, piles of rocks and wandering goats. A Somali nurse is the training coordinator and each of the three districts in the region has a core team of trainers of community health workers. The Australian input is in the form of personnel - two nurses and a midwife and an administrator, and the provision of medical supplies, vehicles and other establishment costs.

The project aims to train health workers in each of the villages in the region (about 70 in all) and upgrade the referral facilities - the hospital and the Mother and Child Health care centre. Only essential medicines are used and the emphasis is on training health workers in health education and improvements in water and sanitation.

All sounds very nice, standard PHC. But what problems, what joys!

THE PROBLEMS

While an infrastructure does not necessarily bring better living standards to the rural poor, the lack of one makes any community development in remote regions problematic. No radios, no roads, no fuel, no news.

Nomadic communities move constantly - training, follow-up, provision with essential supplies, health statistics, immunization - all need to be adapted to mobility and flexibility.

Australians who choose to work in remote areas of the developing world are often surprised to find their counterparts less motivated than they expected. One cannot forget national realities - civil servants poorly paid, often forgotten by superiors in the ministry. It's hard to retain one's idealism on $20 a month.

As is the case with many development projects of this nature, the time scale is too short. We seem to want to bring about change at a rate which our own communities and societies have not achieved. We are in too much of a hurry in Africa.

ACHIEVEMENTS

After two years more than twenty communities in the district of Erigavo have at least one trained health worker, selected and supported by those communities and trained, supported and supplied with basic medicines by the regional centre. Health workers keep the centre informed of the communities' movements and thus services like immunization have become possible where they would never have been attempted previously.

While the long-term success of primary health care depends on the political commitment of the government and the health ministry, the sustainable costs in such a programme are minimal, estimated at approximately $1 per person annually. Such an expenditure would provide basic essential medicine and vaccines, growth monitoring and basic ante-natal and post-natal care.

With an almost total emphasis on training, the results of such a programme can survive political and governmental changes. The skills acquired by health workers will always be useful, even if supplies might have to be procured privately in the event of the failure of the ministry of health to continue providing them. The creation of services, however simple they be, where previously there were none, produces a political demand from the communities for their continuation - a demand which local officials like the governor could not ignore.

The initial optimistic concepts of PHC, as espoused in the Alma Ata Declaration of 1978, are gradually being whittled away in many parts of the world. What is often left is a handful of "short-cuts" such as those currently being promoted by UNICEF - oral rehydration salts, measles vaccination, growth charts, etc. While effective ways of lowering mortality rates and thus of great value, in a way they avoid the very difficult issue of community participation in and control of basic health care. Each community is different, and only by the very painful process of working to adapt PHC to the environment and evolving workable models will PHC ever bring about more than just an improvement in statistics.

In Sanaag, that process has been, and still is, very difficult - but at least a process of agonising AT THE VILLAGE LEVEL, not in the faraway capital. Finding out how difficult it really is must surely be a most valuable and important aspect of development. One worthy of support by governments such as ours.

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