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THE REFUGEE HEALTH UNIT OF THE SOMALI MINISTRY OF HEALTH - A HISTORY OF AN EXTRAORDINARILY SUCCESSFUL SOMALI PROGRAMME

Introduction

The Refugee Health Unit (RHU) of the Somali Ministry of Health has gained, in only three years of existence, an international reputation as an outstandingly efficient and successful institution.
The World Health Organization and the Center for Disease Control (Atlanta/Georgia, USA) concluded after evaluating the health services in the Somali refugee camps in late 1982, that "RHU, in the short time of two and a half years, has built what might be the most successful large primary health care programme in the world." (Waldman/Sutherland 1982).

Founded in 1980, RHU is responsible for the guidance and coordination of all health care activities in the Somali refugee camps. In both central and regional offices, the Somali personnel play a decisive role, with expatriates acting as advisors. From the beginning, some of the medical voluntary agencies working in the refugee camps were convinced of the need to follow a uniform policy of preventive health care and to train refugees as health workers. Other agencies became convinced gradually and conformed to this approach as its success was demonstrated.
Through this policy, RHU developed the ability to later adapt to the rather abrupt withdrawal of the international medical teams, which began in 1982 and which has already led to the nationalization of the major part of the programme.
This paper reviews the history of RHU, not so much from a medical point of view but rather as an analysis of the main

reasons for its successful development, and it tries to point out lessons which might be useful for other programmes.

Task, Structure and Policy of the Refugee Health Unit

Organizational Set-up

In the Somali Ministry of Health, the Refugee Health Unit is responsible for the guidance and coordination of all health care activities in the refugee camps in the Somali Democratic Republic. There are 35 camps.with an estimated total population of 700.000 refugees.

In all camps, health care was previously implemented with the assistance of expatriate medical teams. Since 1982, however, the majority of these teams have withdrawn and have handed over all responsibility to the Somali national staff of the RHU.

In the camps, 2600 Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) carry out most of the medical work. They are refugees themselves, who were given formal teaching in the camps and on-the-job training for several months and then passed an examiniation to prove their capability. At first they worked without any payment, but now they are paid a small monthly incentive of 400 SoSh.

In every camp, the CHWs and TBAs are supervised ans assisted by Somali doctors and nurses, employed by the Ministry of Health; in total, there are 20 doctors and 140 nurses working in RHU.

At this time (August 1983), expatriate medical teams still have the responsibility for the health services in 14 of the 35 camps. In seven other camps, the Muslim World League assists RHU by providing curative services.

There are six regional or subregional offices within RHU and one central office, staffed by Somali doctors, nurses, assistant pharmacists and administrators, and supported by ten

expatriate advisers. RHU's budget is provided by the United Nations High Commissioner for Refugees (UNHCR), with the exception of the basic salaries of the national staff, which are paid by the Ministry of Health.

In 1982, the RHU budget amounted to US S 2,7 millions, i.e. approximately US S 4 per refugee per year.

Policy

In its health services, RHU follows a policy of primary health care. Some of the most important principles of this policy are:

- that preventive rather than curative medicine (e.g. immunization, sanitation) is emphasized;
- that health care is given by members of the community, the Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs). Doctors and nurses are responsible for teaching and supervising the CHWs and TBAs and for taking care of referral cases, but they do not implement the basic health care programme themselves;
- that priority is given to the most common and most severe diseases, rather than that resources are diverted to treating rare or minor illnesses;
- that simple and cheap methods are used rather than sophisticated and expansive equipment or drugs.

It is generally agreed that such a primary health care policy is the most efficient approach for meeting the needs for health care in Third World countries, where resources of money and trained personnel are very limited.

History of the Refugee Health Unit

The Formation of the THU

After the Ogaden war 1977/1978 a large influx of refugees from the Ogaden area came into Somalia, mainly during the

years 1979 - 1981. In total, 35 refugee camps were established.

In September 1979, the rapidly expanding numbers of refugees led the Somali government to declare a state of national emergency, and in March 1980 the UNHCR made an official appeal for assistance to the international community.

Refugee aid was initially administered by the Ministry of Local Government, but in 1980, the National Refugee Commission (NRC) was formed as a separate entity responsible for all refugee-related programmes. In the same year the Refugee Health Unit was established (independently from NRC) as part of the Ministry of Health. RHU's responsibilities were to include guidance and coordination of all health care acitivities in the camps.

At this time, an increasing number of voluntary agencies were providing health care in the different camps. These agencies, coming from various countries and ideological backgrounds, often had very different concepts for their medical work, the majority of them being oriented to a curative rather than preventive approach to their work.

Most of the expatriate personnel were on short-term contracts, sometimes only staying for a few weeks, and often having little or no experience of medical care in Third World countries. The majority of the Somali staff, seconded by the Ministry of Health to work in the refugee camps, also lacked experience. For example, in March 1980 the Ministry assigned 21 doctors, having just completed their medical training in Mogadishu, to work with the refugees.

As a result, there was no common health policy in the refugee camps. Most of the medical work was curative and therefore failed to improve the health status of the community. This situation was frustrating to many health workers.

Formulatiing and Implementing the Health Policy

While RHU was being formed, basic principles which would govern the future health care policy for the refugees were outlined. Health surveys in the camps, conducted by the Center for Disease Control and other organizations, indicated the most urgent health problems and the priorities for intervention. Medical personnel in the field came to a workshop in Mogadishu in June 1980. During this meeting the first edition of the now well-known 'Guidelines for Health Care in the Refugee Camps of the Somali Democratic Republic' was created. A standard drug list was establiehed, and plans were developed for the training programme for the Community Health Workers and Traditional Birth Attendants, and for the first round of immunization.

Thus, the first important steps were made towards a _uniform health programme_ in all camps, which was to be the key to the success which has been achieved in the following years.

During 1981, the health policy was further developed in discussions between the medical staff in the camps and central RHU. Frequent field visits by the central staff, and workshops held in Mogadishu, provided opportunities for such discusssions, and the monthly 'RHU Newsletter' became an efficient tool for spreading information.

The actual implementation of the policy met with all the numerous obstacles which are encountered in refugee health programmes. Feeding programmes, the CHW training programme, mass immunization campaings etc. absorbed most of the work.

The _key activity_ of this phase, however, was _to convince_ all the medical teams of the need for and efficiency of this primary health care approach. Medical personnel, who had experience mainly in western curative medicine, had to be convinced of the need to prioritise preventive health care. They had to be shown that certain refugees, many of whom had been scarcely literate nomads before, could assume responsible

positions in the delivery of health care, after being trained as CHWs or TBAs.

RHU needed to keep reminding the voluntary agencies that they would not be staying in Somalia forever. Therefore, in order to leave behind an efficient health care system, they had to prepare from the outset for the day when they would hand over responsibility to the Somali staff. This meant that the first task of the expatriates was training, and that the only methods and supplies which should be used in their programme were those which would be available for the Somali staff once the expatriates had withdrawn.

There was a turning point in the health status of the refugees around mid 1981. The food supply was stabilized, clean water was made available, and slowly the acute emergency phase, with its high morbidity and mortality rates, ended.

The 'Hand-Over' Phase

In 1982, RHU entered the present phase of its development, which is characterized by the phasing-out of the expatriate medical teams.

Starting with Sabacad camp in April 1982 and Jalalaqsi IV and Ban Mandule camps in August 1982, most medical teams gradually left the camps. With few exceptions, the hand-over to the nationals has been well-prepared and coordinated with RHU.

By August 1983, expatriates remain in charge of the health services in only 14 camps, while the national staff and the CHW have taken the responsibility in 21 camps.

RHU has asked each voluntary agency to evaluate the standard of health care in "their" camp six month after their withdrawal. So far, these evaluations and the on-going supervision of all camps by regional and central RHU staff show that the hand-over has been very successful in general, and that the national staff and the CHWs and TBAs are continuing to deliver efficient health care.

RHU's Programme - Criteria for its Success

In December 1982, the World Health Organization and the Center for Disease Control evaluated RHU's health programmes. They concluded that "the RHU, in the short time of only two and a half years, has built what might be the most successful large primary health care programme in the world." (Waldman/Sutherland 1982).

Looking at the criteria for this and for other positive statements about RHU (e.g. Dietz 1983), one might call this programme successful for three main reasons:

- as a medical programme, its successful outcome had to be shown in medical terms, such as in reduced morbidity and mortality rates. Available data clearly confirm the improved health status of the community.
  For example, the number of cases of measles was drastically reduced by immunization campaigns. (Measles is one of the most important causes of death of children in the tropics.) While in 1981, with immunization not yet completed, there were 6438 cases of measles reported in the camps, causing 476 deaths, in 1982 there were only 31 cases and no deaths after complete immunization.
  This shows what a striking effect preventive medicine can have on the health of a population.
  One can also observe the well-functioning preventive and curative health services in the camps, such as feeding centres, maternal and child health clinics, health posts, child and adult clinics, TB clinics, health education and sanitation programmes, to confirm the success of the health programme;
- as a relief programme, the refugee health care had to be designed in such a way that the refugees themselves took the maximum responsibility for it, so that they were given the skills to help themselves, skills which they would

also be able to use in the future after leaving the camps. By training more then 2600 CHWs and TBAs and by leaving the implementation of most of the health work to them, this goal was achieved;

- as a development programme within the Somali Ministry of Health, and with the aid of foreign agencies, a principle aim was to build up the national structures in such a way that, after some time, the Somalis could take over the responsibility for the programme, continuing the work without expatriate help.

Although this process of hand-over is not yet completed, experience up to the present time shows that it has so far been very successful.

Possible Reasons for the Successful Development of RHU

When trying to explain why RHU developed in such a way, firstly two principles have to be mentioned which were respected in the development of RHU and which are valid in any relief or development programme.

One of these principles is the involvement of the people, i.e. not to impose help on the community but to help the people to help themselves. By training thousands of refugees as CHWs and TBAs and giving them the responsibility for the health care, the refugee health programme fulfilled this role.

Another principle of any aid programme performed with the assistance of foreign agencies is that, from the outset, the programme must be designed for that time when the expatriates have withdrawn. National structures must be built which can continue the work independently. As shown above, RHU from its very beginning had prepared for hand-over by the voluntary agencies to the national staff.

For sure, complying with these basic principles was an unalterable precondition of RHU's successfull development. There are some other factors, however, to be mentioned:

- the way RHU's policy was developed: it started with a scientific assessment of the health situation, and from this assessment clear priorities were chosen in order not to divert scarce resources to less important fields. The policy was developed in continous discussions with the medical staff in the field, which is of utmost importance for any practical programme;
- the building-up of a strong Somali organization, such as the Refugee Health Unit, was crucial for the health programme. A strong central organization was needed to bring all the different agencies together into one common health policy; and this organization had to be a Somali one, in order to continue the programme after the withdrawal of the expatriates.

  The separation of RHU from the National Refugee Commission and its integration into the Ministry of Health was important in the development of RHU. The Ministry of Health gave support to RHU, but at the same time enough independence in technical decision-taking. Now, a gradual integration has begun with the Ministry's national primary health care programme;
- the uniformity of the health programme in all camps, which RHU achieved with the cooperation of all the voluntary agencies, laid the base for the successful training programme and eventually for the successful hand-over.

  Any such programme is, in the end, dependent on the individuals who help in implementing it. The effort of all the medical staff in the field and in the central office, from the CHWs to the medical doctors, has to be commended.

Critical Remarks

So far, this paper has emphasized the successful aspects of the RHU programme. At least some critical remarks should be added:

- the health status of the refugees is, despite all efforts, still vulnerable. The outbreak of scurvy in the refugee camps (A. M. Magan et al. 1983) and the recently increasing malnutrition rates are indications of serious hazards in the present refugee situation;
- it may still be too early to make a final judgement about the success of the hand-over of the health services to the national staff, for some camps have only been in the responsibility of the nationals for several months;
- RHU's programme is presented in this paper as a rather self-reliant programme, independent from expatriate personnel. However, it is of course totally dependent on funding by UNHCR. This is inevitable for a large refugee programme in a country like Somalia;
- the uniformity of the programme, one of the most striking features of the Somali refugee health care system, is limited. There are voluntary agencies who still follow their own health policies in the camps, sometimes upsetting the uniform system of RHU, e.g. by introducing large amounts of inappropriate drugs. Cooperation for an efficient programme seems to be especially difficult when aid is influenced by political considerations.

Outlook

Recently, plans are being elaborated to settle at least some of the refugees in the Somali Democratic Republic and to dissolve the camps. The Refugee Health Unit would then probably be integrated into the National Primary Health Care

Programme (PHC). Already now, a large number of personnel trained in RHU have been transferred to the national PHC programme. It will be a challenge in the next few years to use the maximum of medical and organizational experience gained in RHU for the benefit of the National Primary Health Care Programme.

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