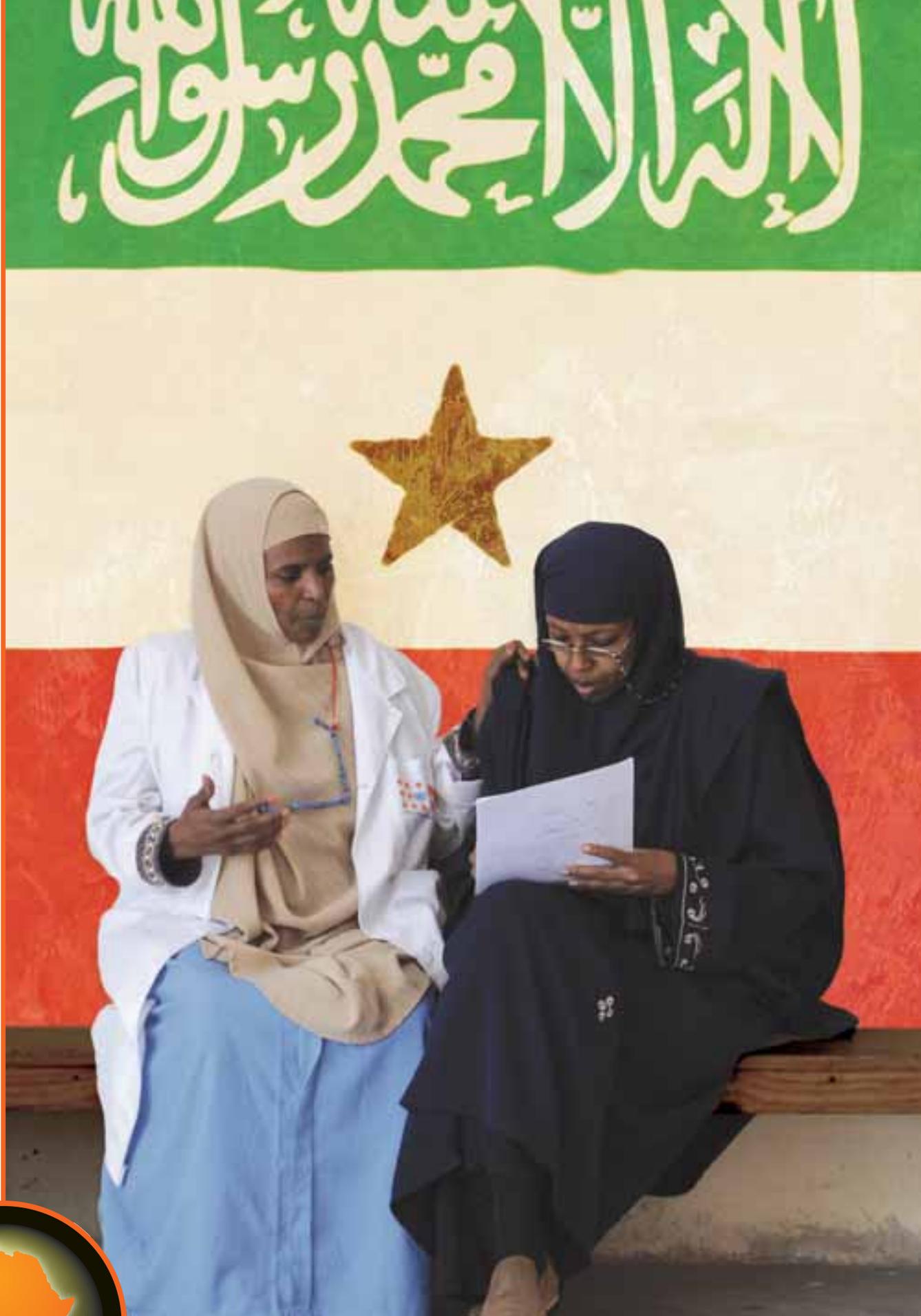


POLICY VOICES SERIES

# Africa Research Institute



**PATIENCE AND CARE**  
Rebuilding nursing and midwifery, in Somaliland  
By Fouzia Mohamed Ismail



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## The Author

Fouzia Mohamed Ismail was educated in Burao and Hargeisa, in Somaliland. In 1974, Fouzia graduated as a midwife and public health nurse in Mogadishu, capital of Somalia. For the next 15 years, midwifery and public health nursing were the focus of her work.

In 1989, during the civil war in Somalia, Fouzia moved to Canada, where she graduated with a BSc in nursing from the University of Ottawa. Between 1990 and 2004 Fouzia worked at the South-East Ottawa Centre for a Healthy Community, co-ordinating the promotion of adult health and community health nursing. During her career in Canada, Fouzia received an award from the Lilly Foundation and the Canadian Diabetes Association for primary and secondary care professionals working in diabetic care. She also received an award for leadership in health promotion from the Somali Centre for Family Services, and the Canadian federal certificate of merit for her work in community health.

In 2004, Fouzia returned to Somaliland and was one of seven founder members of the Somaliland Nursing and Midwifery Association (SLNMA). For two years she worked as the focal point for maternal and neo-natal health at the United Nations Children's Fund (UNICEF) in Hargeisa. In 2007, she was appointed executive director of the SLNMA.

Fouzia is a member of the board of directors of the Somaliland Non State Actors Forum, an organisation which seeks to ensure that the voices of ordinary Somalilanders are heard by governments and other international institutions which have an influence on policymaking in Somaliland.

## The Policy Voices Series

The Policy Voices Series highlights instances of personal achievement with wider implications for policymakers in Africa.

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The series also seeks to encourage competing ideas, discussion and debate. The views expressed in the Policy Voices Series are those of the author.

## Acknowledgements

This manuscript was researched and edited by Edward Paice, based on transcripts of interviews with Fouzia Mohamed Ismail and others. Africa Research Institute would like to acknowledge the assistance and encouragement received from Somaliland's Deputy Minister of Health Nimo Hussein Kowdan, Edna Adan Hospital, Roda Ali, Mohammed Yusuf Warsame, Amina Hassan Hussein, Fadumo Osman Ahmed, Faduma Sheikh Aboubakr, Hibo Mohamed Abdillahi, Mumtaz Dahir Farah, Fadumo Kahin, Andy Leather, Rachael Coker, Sharon Horder, Gillian Barber, Michael Walls, Mohammed Yusef and Keith Gubbin.

Cover illustration created by Krishna Stott from an image kindly supplied by Mauricio Vazquez at Health Poverty Action.

This project was made possible by the generous assistance of Richard Smith.

Africa Research Institute



Published by Africa Research Institute, 2011  
ISBN No. 978-1-906329-16-7

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## Administrative regions of Somaliland



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## Somaliland timeline

**June 26th 1960** – British Protectorate of Somaliland gains independence.

**July 1st 1960** – Act of union between State of Somaliland and former Italian Somalia to create the Somali Republic. Northern territories are represented by four ministers in a 14 member cabinet and 26% of parliamentary seats.

**October 21st 1969** – Army commander Major-General Mohamed Siyad Barre seizes power in a *coup d'état*. Somali constitution suspended. Supreme Revolutionary Council established. "Scientific Socialism" adopted as ideological framework for development of Somalia.

**April 1981** – Somali National Movement (SNM) formed in London by diaspora members of the Isaaq clan to launch insurgency in north-west Somalia. SNM headquarters established in Ethiopia.

**February 24th 1982** – Riots in Hargeisa follow arrest and trial of 28 professionals – the "Hargeisa Group" – who had organised an initiative to improve Hargeisa hospital.

**April-May 1988** – Somalia and Ethiopia sign peace agreement ending a decade of hostilities. Deprived of the use of bases in Ethiopia, SNM attacks cities of Hargeisa and Burao. Civil war and repression intensify in former Somaliland. Tens of thousands of civilians killed by Somali government forces, and hundreds of thousands flee to Ethiopia or abroad.

**January 27th 1991** – President Siyad Barre flees Mogadishu and Somali government overthrown. SNM ousts national army from north-west Somalia.

**May 18th 1991** – Leaders of the Somali National Movement (SNM) and elders of northern Somali clans announce Somaliland's withdrawal from union with Somalia. Abdirahman Ahmed Ali "Tuur" sworn in as first president of the Republic of Somaliland.

**1991-7** – Sporadic inter-clan hostilities interspersed with succession of localised peace meetings and major peace conferences.

**1993** – Borama National Peace Reconciliation Conference leads to a second administration led by President Mohamed Ibrahim Egal, formerly prime minister of Somalia, 1967-69.

**May 31st 2001** – In a referendum, 97% of Somaliland voters approve a new constitution which confirms Somaliland's independence and a multi-party political system.

**December 2002** – Local council elections contested by six organisations.

**April 14th 2003** – Presidential elections contested by three political parties. Dahir Riyal Kahin becomes first elected president of Somaliland, his UDUB party winning a contest deemed "reasonably free and fair" by 80 votes.

**2005** – African Union mission finds that Somaliland's claim to independence is "unique and self-justified in African political history" and recommends that "the case should not be linked to the notion of 'opening a Pandora's box'".

**September 2005** – Parliamentary elections held for 82 member House of Representatives.

**June 26th 2010** – President Ahmed Mohamed Mahamoud "Silanyo" (Kulmiye party) elected president by a vote deemed "free and fair" by international observers.

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Sources: Edward Paice interviews with Rt Hon Abdirahman M Abdillahi, Speaker of the House of Representatives, February 16th 2011; Mark Bradbury, *Becoming Somaliland*, 2008; Michael Walls and Steve Kibble, *Beyond Polarity: Negotiating a Hybrid State in Somaliland* in *Africa Spectrum*, Vol. 1, 2010, pp.31-56; Mohamed Hassan Ibrahim, *Somaliland's Investment in Peace: Analysing the Diaspora's Economic Engagement in Peace Building* Diaspeace Working Paper No. 4, August 2010.

## Somaliland health indicators

Life expectancy – 47 years

Infant mortality rate – 113/ 1,000 live births

Under 5s mortality rate – 188/ 1,000 live births

Maternal mortality rate – 1,600/ 100,000 live births

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Source: UNDP Human Development Report 2001

## Somaliland health professionals and facilities (public and private)

Hospitals – 24

Hospital beds – 1977

Health centres – 85

Health posts – 170

Doctors – 111

Nurses – 405

Midwives – 112

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Source: Ministry of Health and Labour 2009

The land mass of Somaliland is c. 137,600 sq. km and the population variously estimated at between two and 3.4 million. The variance suggests that all the above statistics should be treated as indicative only.

## Foreword

“What do you do when conflict has destroyed all your institutions and professional associations?” This was the alarming question confronting Fouzia Mohamed Ismail and other health professionals in Somaliland in the 2000s. Their predicament is common to many post-conflict societies, in Africa and elsewhere.

When Somaliland declared its independence from Somalia in May 1991, the country’s infrastructure had been ravaged by the final years of fighting in a civil war lasting almost a decade. According to one observer, the city of Hargeisa “from the air resembled a city of dry swimming pools, which on closer inspection were shells of houses whose roofs had been systematically looted”. Burao and other urban centres were in a similar state of ruin. Rural areas were “littered with landmines and unexploded ordinance”.<sup>1</sup> Half the population had fled to refugee camps or abroad.

The provision of health services in Somaliland played a crucial role in fomenting opposition to the regime of President Mohamed Siyad Barre in distant Mogadishu. In the late 1970s, a group of young professionals who had been educated abroad decided to refurbish and improve the main hospital in Hargeisa. Built by the British in 1953, the hospital had once been renowned as one of the finest in East Africa. As north-west Somalia was progressively starved of resources by the central government in Mogadishu, it had fallen into a lamentable state of disrepair.

Within a year, the “Hargeisa Self Help Group” had transformed Hargeisa hospital. But the activities and intentions of the group roused the suspicions of the Somali government. Twenty-eight members were arrested. On the day of their trial, February 24th 1982, a mass protest broke out in Hargeisa and several students were killed by soldiers. “Somalilanders remember this day as the beginning of the civil war,”<sup>2</sup> explains Mark Bradbury in his indispensable study, *Becoming Somaliland*. Although spared the death penalty, the last members of the Hargeisa Group were not released until 1989.

In the 1990s, little was done to rehabilitate the rudimentary pre-war health service in Somaliland. Internecine divisions, an acute shortage of skilled manpower, and a lack of financial resources were among the factors which fostered inaction. In post-conflict states, public health is seldom the most pressing priority.

Since 2000, a great deal has changed in Somaliland. The country has earned plaudits for what has been described as its “hybrid political system that fuses elements of kinship affiliation and ‘modern’ constitutional design”. Presidential, parliamentary, and local council elections have been held. There have been no major lapses in peace. “While Somalia is essentially a failed state with international recognition, Somaliland possesses all the attributes of a working state, but without the recognition”,<sup>3</sup> two foreign observers of the 2010 presidential election remarked.

Relative stability brought experienced health practitioners back to Somaliland. In 2004, seven highly-qualified, experienced nurses and midwives founded the Somaliland Nursing and Midwifery Association (SLNMA). Fouzia Mohamed Ismail was among those founder members, all of whom shared a determination to rebuild their professions. “It was difficult to know where to start”, Fouzia concedes. In the few functioning health facilities, standards of patient care were shocking. One of the SLNMA’s first tasks was simply to ascertain how many nurses and midwives there were in Somaliland.

In *Patience and Care*, Fouzia describes how the SLNMA set about designing curricula, revitalising nursing and midwifery schools, training a new generation of nurse leaders, instigating continuous professional development for nurses and midwives, and advocating for better regulation of health services in Somaliland. She is candid about mistakes that have been made, factors which hamper improvements in patient care, and what needs to be done to consolidate progress. The role of international partners and the diaspora in developing better health care in Somaliland is described, and the importance of community participation and consensus emphasised.

While the process of change in Somaliland has been distinctive, Fouzia's account is relevant and informative to health practitioners anywhere.

The concept of global health holds that healthier populations are more likely to prosper and enjoy peace. In his 2007 Global Health Partnerships report, Nigel Crisp, chief executive of the National Health Service in England, called on developed countries to "grasp the opportunity...to support a massive scaling-up of training, education and employment of health workers in developing countries". At the time, an innovative partnership between King's College Hospital in London, the Tropical Health & Education Trust, and Somaliland health training institutions was already seven years old.

According to Andy Leather, director of the King's College Hospital Centre for Global Health, "global health has come alive, and a lot is to do with Somaliland and what has come out of it". He is adamant that UK health professionals receive more from the interaction with partners in Somaliland than they give – and that healthier populations in the Horn of Africa and elsewhere are "in all our interests".<sup>4</sup>

### **Edward Paice**

Director, Africa Research Institute

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6 1. Mark Bradbury, *Becoming Somaliland*, 2008, p.3  
2. *Ibid.*, p.56

3. Michael Walls and Steve Kibble, *Beyond Polarity: Negotiating a Hybrid State in Somaliland*, in *Africa Spectrum* Vol. 1, 2010, pp.31-56  
4. Edward Paice interview with Andy Leather, Sept 28th 2011

# 1. Introduction

I attended girls' boarding schools in Burao, the main city in Somaliland's Togdheer region, and Hargeisa, the capital. At the time, in the 1960s, the school system was still based on the British model. That only changed in 1974, five years after the revolution which brought Siyad Barre to power in Somalia. The same year, I graduated as a nurse in Mogadishu, Somalia's capital.

After graduation, I completed two more years of training – one year in public health and one year in community midwifery. For some time, I worked in Mogadishu. My husband was a businessman. In 1989, during the civil war, we left Somalia and took our family to Canada.

The qualifications of nurses who had graduated from Hargeisa's nursing school were recognised by Canada – it had a very good reputation. If you had been to one of the other Somali schools, in Mogadishu, you had to do a five month "top-up" course. I took my BSc Nursing degree at Ottawa University and worked in Canada for 14 years. Many tens of thousands of Somalis arrived in Ottawa during the civil war.

In August 2004, I moved back to Somaliland. My children were grown-up and, like many others of my generation, I thought it was time to give back to the country that educated me. Somaliland had reasserted its independence from Somalia in May 1991, when the Siyad Barre government in Mogadishu collapsed. By and large, Somaliland had been peaceful since then.

Anyone who left Somaliland before or during the civil war in the 1980s returns to find a different country to the one they remember. The infrastructure, the institutions – everything was destroyed. Hargeisa was flattened. It is very disorientating. The streets and landmarks you once knew do not exist. People even talk in a different way.

After the war, Somaliland's hospitals were in an atrocious state. When I returned to the country I found that the former nursing school in Hargeisa had not functioned for

years. In fact, nursing and midwifery – as most people would envisage these professions – were almost non-existent. They had died.

The only real signs of life in the health sector in Hargeisa were at the new hospital which Edna Adan Ismail had built. That opened in 2002. Edna was married to Somaliland's president at that time, Mohamed Haji Ibrahim Egal, and was championing the re-establishment of professional nursing and midwifery. In Borama, in the west of the country, the University of Amoud was also preparing to open a nursing faculty and was training doctors.

When I started to meet some midwives and nurses, I said to them "Nobody is going to do anything for us, until we do for us." I could see that there were so many challenges, but I thought that if we were unified we could work towards tackling them one by one. There were very few of us. But we shared the same objective – we wanted to re-establish our professions.

## 2. Headcount

In November 2004, three months after returning to Somaliland from Canada, I was one of those who founded the Somaliland Nursing and Midwifery Association (SLNMA). At our inaugural meeting, there were seven people present. It may sound incredible, but the first task was to establish how many nurses and midwives there were in Somaliland. We had no idea how many others were in the country.

We managed to find the old register for Hargeisa's nursing school and, by a stroke of good fortune, the Mogadishu registers had been rescued by a Somaliland nurse who was working in Somalia's Ministry of Health at the beginning of the civil war. He had brought them to Hargeisa for safekeeping.

There were about three thousand names on the registers, for all Somalia. But there was no way of knowing where

people were, what they were doing, or whether they were even alive. Many health professionals were killed during the civil war. At the end of 2004, the annual report from Somaliland's Ministry of Health and Labour (MOHL) said that there were 109 qualified midwives in the country. The World Health Organization estimated the number of midwives at 35.<sup>1</sup> At the SLNMA, we decided to conduct a thorough survey in Somaliland's six regions, in order to determine the number of nurses and midwives – and ascertain what training they had received.

### 3. No patient care

The initial skills assessment of nurses and midwives by the Somaliland Nursing and Midwifery Association (SNLMA) showed that there was a tremendous need for training. It was almost overwhelming. Most nurses had received no refresher training or skills upgrading for a very long time. Standards were shocking. Basic patient care skills – bedside manner, ethics, communication – were completely absent. In the hospitals, it was clear that no more than 30-40% of patient care was being done by nurses. Friends and relatives had taken over the job of nurses.

Our nurses and midwives had been through a lot. But we knew that the SLNMA had to convince them to change. This was an issue of national importance. It is not always easy – especially with older colleagues who are set in their ways. It is hard to tell someone who has been nursing for 20 years and has been in the refugee camps that they are doing things wrong, or are missing something.

When the SLNMA conducted its skills survey, we found that some nursing staff were not washing their hands because of a lack of running water and sinks. There was an acute shortage of gloves and gowns in hospitals. There was no money for such things.

Hospitals were hotbeds of infection rather than institutions for treatment and recovery. For example, if a patient stayed

### Edna's Hospital

Edna Adan Hospital (EAH) took four years to build and opened as a 25 bed maternity unit in March 2002. By April 2011, hospital staff had delivered nearly 11,000 babies. From the outset, the hospital treated patients with non-maternity needs – a total of 10,000 in-patients and 65,000 out-patients to date. As a non-profit institution, EAH charges fees. In practice, many patients who are unable to pay are treated for free.

Edna Adan Ismail, founder and director of the hospital, was one of the first nurses selected from Somaliland for a scholarship to study in the UK. In 1961, she returned as a qualified state registered nurse (SRN) and midwife, and took charge of the female section of Hargeisa Group Hospital. In 1997, Edna retired from a career with the World Health Organization (WHO). Her pension and other personal assets were directed to the fulfilment of a long-held ambition.

Edna Adan dates her determination to build a hospital to her teenage years. After World War II, her father Adan "Dhakhtar" co-ordinated the training of medical assistants in Somaliland. In 1950, he was running the hospital at Erigavo, in Sanaag region, during the *Abaatii Siigacasse* ("Season of Red Winds") drought – a disaster which was magnified by a subsequent locust invasion, influenza epidemic, and a malaria epidemic which killed 1-2% of Somaliland's population.

Somaliland friends and organisations provided Edna Adan with one third of the initial investment in the hospital, including donations of building materials, construction equipment and expertise. The government provided land – a former military parade ground during the Siyad Barre regime – in the Dumbuluq neighbourhood of Hargeisa.

In Somaliland, fewer than 10% of women are attended during childbirth by trained health workers. Widespread anaemia and female genital mutilation, or cutting, exacerbate reproductive health problems. In 2006, Somaliland's maternal mortality rate (MMR) was 1,600 deaths per 100,000 – one of the highest in the world. In the nine year period to April 2011, the MMR at Edna's hospital was less than half the national rate.

EAH has expanded from 25 to 69 beds. In 2009-11, funding was secured for three new operating theatres for obstetric fistula patients and emergency obstetrics. Since 2005, EAH's major external backer – Direct Relief International, based in Santa Barbara, California – has provided more than US\$1.1m of assistance.

Sources: Edna Adan Hospital; public presentations by Edna Adan; World Health Organization, Regional Health Systems Observatory – Somalia, 2006.

in Hargeisa Group Hospital for longer than 48 hours they would acquire at least one extra infection. The hospital was built in 1953 to serve a population of 30,000. The city's population is now estimated at more than 700,000. At least the SLNMA was able to ensure that every department had somewhere to wash with soap. That was a start.

If you were to look on the bright side, you could say that Hargeisa Group Hospital – and other hospitals in Somaliland – provide us with one of the toughest training environments in the world. Nursing and midwifery students who can cope in these facilities during their training will be able to cope with anything that is thrown at them during their careers.

## 4. Foundations

In our first strategic plan, drawn up in 2006, the members of the Somaliland Nursing and Midwifery Association (SLNMA) set out the core values and functions of the association. Our code of conduct emphasised the importance of:

- Transparency, accountability and professionalism
- Team spirit, courtesy and respect
- Efficiency and effectiveness
- Commitment to results and service

The promotion of safe, good quality patient care delivered by properly qualified nurses and midwives was our prime objective. We set ourselves a number of tasks which were vital if we were to progress towards this goal:

- Design and implement an appropriate legal framework for nursing and midwifery
- Develop and promote professional standards and guidelines
- Educate and train nurses and midwives
- Ensure that nurses are consulted and heard by government ministries and in their places of work
- Conduct research to improve and advance nursing and midwifery

In 2006, the SLNMA started to conduct workshops aimed at improving patient care, encouraging interaction between nurses, and preparing people for changes in the workplace that were necessary and long overdue. The association produced newsletters to keep everyone informed about what it was trying to achieve. Annual awards for nursing and midwifery excellence were introduced, to motivate members and underpin our attempt to improve the status of our profession.

Since the civil war, nursing has not commanded much respect as a profession in Somaliland. Many people regard it as a slightly inferior career – as if nurses are second to doctors, or merely doctors' servants. I understand why this has happened. It is partly because health care became little more than a business in the absence of state investment and oversight – and doctors earn much more than nurses. The stigma was even more pronounced in the case of male nurses, about 40% of the profession.

The SLNMA's members are determined that nurses and midwives should be valued for their skills and dedication, as was the case in Somalia and Somaliland before the civil war.

## 5. Strengthening the health system

A great deal was achieved between 2000 and 2006, although it did not always feel like that. Two groups graduated from the nursing school at Edna Adan Hospital, the first doctors were in training at the University of Amoud and the University of Hargeisa, and the old nursing school at the Institute of Health Sciences in Hargeisa reopened. Many basic improvements were made at Hargeisa Group Hospital. But everyone recognised that largely unco-ordinated efforts by institutions and individuals were not the best way forward. Health professionals needed to come together and agree a comprehensive plan.

## King's College Hospital, London – Tropical Health & Education Trust – Somaliland Partnership (KTSP)

A chance meeting in the mid-1990s between a consultant surgeon at King's College Hospital, Andy Leather, and the former medical director of Hargeisa Group Hospital, Abdirahman Ahmed Mohamed, led to the formation of the King's College Hospital – Tropical Health & Education Trust – Somaliland Partnership (KTSP) in 2000. The Tropical Health & Education Trust (THET) is a charity which fosters and supports links between UK health professionals and their counterparts in developing countries. The involvement at the outset of members of the Somaliland diaspora and the flexible, responsive – as opposed to prescriptive – nature of the partnership have underpinned its longevity and success.

KTSP's first fact-finding visit to Somaliland in 2000 confirmed the dire state of the country's health services. The main referral facility, Hargeisa Group Hospital, was little more than a shell. In the absence at the time of a ministry with the resources and staff to lead improvement, KTSP established a base at Edna Adan Hospital (EAH). Within hours of the arrival of seven UK specialists for KTSP's pilot training visit in 2002, the first baby was delivered by staff at EAH.

By the end of 2005, KTSP staff and volunteers had made more than 40 trips to Somaliland. Specialists in anaesthesia, general medicine, mental health, midwifery, nursing, obstetrics and gynaecology, orthopaedics, pharmacology, urological surgery, dermatology and physiotherapy each spent between two weeks and four months working with staff at the new University of Amoud medical school, Borama Hospital, Hargeisa Group Hospital, the Hargeisa Institute of Health Sciences and the Somaliland Nursing and Midwifery Association. At Hargeisa Group Hospital, initial support included the refurbishment and reorganisation of the accident and emergency department, and emergency skills training.

"The ultimate objective of KTSP is to rebuild capacity in Somaliland", says Andy Leather, director of the King's Centre for Global Health, one of the clinical partners supporting KTSP. "However, the reason that this link works so well is that it is a true partnership

for reciprocal benefit – a fundamental principle for any partnership."

In Leather's view, the doctors and other health professionals who volunteer to spend time with colleagues in Somaliland receive more than they could possibly give. "If you want a fast track to leadership development, send a health professional – be it a nurse, a doctor, or a pharmacist – to a country like Somaliland; you begin to think more laterally away from the tunnel vision of western medicine, you mix with some inspiring people trying to solve problems against all the odds. You begin to think how healthcare could be delivered differently."

In 2007, a £2.5m grant from the UK's Department for International Development (DFID) enabled a consortium including KTSP, Save the Children Fund, Health Unlimited, Liverpool School of Tropical Medicine, and the Royal College of Obstetricians and Gynaecologists to embark on a more extensive, three year "health systems strengthening programme" (HSSP). Grants from the European Commission and Comic Relief also support KTSP's work in Somaliland.

Public training institutions are the principal Somaliland partners in KTSP. In 2011, King's College Hospital organised 60 teaching trips focusing on obstetrics and gynaecology, mental health training for nurses and undergraduates, leadership and management, curriculum development, support for the University of Hargeisa's BSc Midwifery degree course based at EAH, and pharmacy management at Hargeisa Group Hospital.

Since 2000, more than 100 UK health professionals have participated in KTSP activities in Somaliland. Some have visited many times. THET has eight local and international staff in Somaliland and five in the UK to support the partnership.

Sources: Edward Paice interview with Andy Leather, September 28th 2011; Andy Leather et al., *Working together to rebuild health care in post-conflict Somaliland*, The Lancet, September 23rd 2006; Jacqui Thornton, *Global health – it's not just malaria*, guardian.co.uk, June 14th 2010; THET.

In 2006, representatives from all health care sectors sat down for two days with a handful of international partners who knew Somaliland well. As part of the planning, we set out to identify which partners were right for each area in which we needed help. One of them was KTSP – a partnership between King's College Hospital, London, the

Tropical Health & Education Trust (THET), and health professionals in Somaliland – which had been working with Edna Adan Hospital and other institutions since 2000.

We said to KTSP that it would not help if they only worked with doctors, or with the Ministry of Health and

Labour (MOHL), or with the Somaliland Nursing and Midwifery Association (SLNMA). If that happened, we knew we would achieve nothing in Somaliland. Everyone agreed, and together we drew up a three year “health systems strengthening programme” (HSSP).

In the HSSP, we identified and acknowledged the main deficiencies of health care provision in Somaliland:

- Useage of public health care low
- Health care infrastructure inadequate given the requirements
- Shortage of experienced and well-qualified personnel
- Poor quality of basic nursing, midwifery and community health worker training
- Inadequate continuous professional development (CPD)
- Negligible access to health services outside main urban centres
- Large pay differential between public and private sectors
- High cost of treatment in both private and public sectors
- Quality of health care highly variable
- Health services largely unregulated
- Public confidence in public health services low
- Work of nurses and midwives undervalued, and their contribution as part of a multi-professional team seldom acknowledged

We knew we could not address all of these problems at once. The HSSP was a first step, and its purpose was to improve and increase the training of skilled health practitioners, and improve the delivery of maternal and child health care.

Five UK partners were chosen to assist in the implementation of the programme, which began in 2007. The main components were:

- Human resource development and training, and support to health training institutions and professional bodies in the health sector (King’s College Hospital and the Tropical Health & Education Trust)
- Design and delivery of life saving skills courses in

emergency obstetric care and newborn care (Royal College of Obstetricians & Gynaecologists, International Office)

- Training and supervision of primary health care staff (Save the Children Fund UK)
- Health education and dissemination of information about changes in the health care sector (Health Unlimited)
- Programme co-ordination and management (Liverpool School of Tropical Medicine and Liverpool Associates in Tropical Health)

By the end of 2010, the programme had created or implemented:

- A common examination schedule for medical students and an internship programme for newly graduated medical students
- A national nursing diploma curriculum
- Nurse tutor training for 26 graduates
- Life saving skills training for about 200 doctors, nurses and midwives
- Mentoring of Ministry of Health and Regional Health Board staff
- A curriculum and training for community health workers
- Technical and financial support for the Somaliland Medical Association and SLNMA to build their respective memberships, commence CPD programmes, address regulatory issues and work towards the establishment of a National Health Professions Council
- Radio programmes disseminating information about public health system
- Teaching support programmes, including the provision of e-tutorials by King’s College Hospital staff with medical undergraduates at Amoud and Hargeisa universities on the Medicine Africa website ([www.medicineafrica.com](http://www.medicineafrica.com))

## 6. The SLNMA

Until 2007, the Somaliland Nursing and Midwifery Association (SLNMA) was a voluntary organisation. Many experienced nurses, midwives and other health professionals with strong national and international links gave freely of their time and expertise. This was the SLNMA's greatest asset. Of course there were disputes and disagreements, often quite fierce ones. But everyone was always allowed their say – that is our way in Somaliland – and we all fundamentally agreed about what we were trying to achieve.

The SLNMA received funding from the health systems strengthening programme (HSSP) to support its work. As our commitments and obligations were increasing rapidly, and our partnership with the Tropical Health & Education Trust (THET) and King's College Hospital was becoming more complex, we needed a full-time director. This was discussed by the board. Some members had complicated family or work situations which prevented them from taking on the role. Eventually, I was appointed director, reporting to a board of nine elected members, who each serve a two year term. I left a job with the United Nations Children's Fund (UNICEF) to take up the new position.

A full-time programme officer was also appointed at the SLNMA. Many people, from Somaliland and abroad, still came to help us on a voluntary basis. But we were on a more formal footing after the HSSP commenced.

The role of the SLNMA within the HSSP was to:

- Improve the quality of nursing and midwifery education and training
- Promote an enabling environment for nursing and midwifery professions through legal, regulatory and policy reform
- Ensure participation of nurses and midwives in national planning and programme development processes
- Promote professional standards and quality patient care
- Advocate on behalf of nurses and midwives, and

promote recognition of their contribution to the effective functioning of a health system

- Strengthen the capacity of the SLNMA

We wanted the SLNMA to act as a bridge, connecting nurses and midwives throughout the country with local and international organisations offering training opportunities.

In 2007-08, the first year of the HSSP, the SLNMA established stronger links with training institutions and hospitals in Somaliland's six regions. Each region became a sort of autonomous chapter of the SLNMA. The heads of nursing schools became regional representatives of the SLNMA, with their own committees. They will always remain involved with the association, but they are very busy in their full-time jobs. In time, it might be beneficial for the SLNMA to have its own dedicated staff in each region.

At the SLNMA headquarters in Hargeisa, it is our job to support the regions by responding to their training needs, providing office and skills laboratory equipment, and keeping them in touch with what is happening elsewhere. The regions have different needs and resources. The SLNMA must advocate for them all equally. As a professional body, we must try and ensure that everyone is pulled up to the same level.

## 7. Regional nursing and midwifery schools

I shall describe the five regional nursing schools in the order they were established:

- Edna Adan Hospital, Hargeisa, Maroodi Jeex region
- Institute of Health Sciences in Hargeisa, Maroodi Jeex region
- Institute of Health Sciences in Burao, Togdheer region
- University of Amoud Faculty of Nursing in Borama, Awdal region
- Institute of Health Sciences in Las Anod, Sool region

By 2012, there will also be four midwifery schools in Somaliland, at:

- Edna Adan Hospital
- Hargeisa Institute of Health Sciences
- University of Amoud
- Borama Institute of Health Sciences

### **Edna Adan Hospital**

After the civil war, Edna Adan Hospital (EAH) was the first institution to train nurses and midwives in Somaliland. The psychological effect on the nation of having a new hospital that was also training a new generation of nurses, and later midwives, was considerable.

By 2010, 59 general nurses had gained their three year diploma from EAH. Two early nursing graduates from EAH qualified as doctors in 2011. They are a great credit to our system. EAH has also trained 70 pharmacists, 27 laboratory technicians, and provided post-basic training for 42 midwives. In 2011, 70 students enrolled for the nursing diploma.

EAH, the University of Hargeisa and the Ministry of Health inaugurated Somaliland's first BSc Midwifery degree in 2011. Based at EAH, and supported by the Tropical Health & Education Trust (THET), the 18 month course is designed to equip graduates to teach, as well as supervise, other midwives and support staff.

### **Hargeisa Institute of Health Sciences**

The Hargeisa Institute of Health Sciences, the government nursing school before the civil war, reopened in 2003. It had been closed for almost two decades. About 100 students enrolled for the inaugural three year nursing diploma course, and 180 enrolled in 2011.

Hargeisa's nursing school is different to the community nursing schools in the regions, and to the one at Edna Adan Hospital. In many respects, Hargeisa is a typical capital city. Absenteeism and drop-outs are far too

prevalent. On the inaugural nursing diploma course, about 80% of the 100 students were male. While almost all the girls graduated, only 48 of the men did.

Some female nurses have said to me that the boys lack stamina and are not prepared to work hard. That is their opinion. It is certainly the case that many young men view the nursing diploma as business training which will help them secure a job at a private pharmacy or medical facility. So if they get a job whilst they are training, they abandon the course. Men are often under greater pressure than women to take up any employment opportunity which arises during their studies.

### **Burao Institute of Health Sciences**

Burao nursing school started life under a tree in 2005. It is headed by Fadumo Osman Ahmed, who had nursed in the refugee camps during and after the civil war. She had no books, no training equipment – nothing. Burao Institute of Health Sciences is a community venture. Dahabshiil, Somaliland's leading money transfer company, built the first classroom and provided skills training equipment, computers, office equipment and salary support for the staff. Books and other teaching materials were provided by THET.

The first batch of 31 nurses – 21 female and 10 male – graduated from the three year nursing diploma course in 2008. By May 2011, 94 more had graduated. A number of them have gone to work in Sool region, in the east of the country. Dahabshiil has added a second classroom, and the first graduates each donated one month's salary to fund a new skills demonstration room.

At Burao General Hospital, graduates from the nursing school now occupy the positions of matron, head of laboratory, head of out-patients, head of hospital management and information systems, and team leader of maternal and child health. The new generation has made a huge difference to the hospital. It was in a dire state. Apart from the dilapidation, there used to be sharps on the floor, staff chewing the stimulant *qaad*, no waste

disposal system, no bedpans or sheets for patients – it was appalling.

The hospital has been rebuilt. There is a proper sharps policy, each patient receives their own sterile dressing kit, hand-washing according to proper aseptic techniques is enforced, and equipment from the nursing school is being used to improve nursing care.

In 2010, the nurses successfully managed a cholera outbreak – something they would not have been capable of five years earlier. But the hospital lacks specialist medical and nursing staff in key areas – obstetrics, intensive care, diabetes treatment, paediatrics and mental health. The small number of wards also makes it difficult to provide special care or enforce isolation.

In 2011, the nursing school added a one year post-basic midwifery course. Fadumo plans to start an 18 month community midwifery training course, and community health workers from the villages are already receiving training. The school is at full capacity. It needs many things, not least a perimeter fence to stop goats, donkeys and people from disrupting classes.

### **Faculty of Nursing, University of Amoud, Borama**

The University of Amoud was established in 1998, 5km outside Borama, the main city of Awdal region. Amoud was Somaliland's first institute for tertiary education, and was established by Awdal residents and diaspora to try and stop young people going abroad for professional training. You could call Amoud a “community university”. The local community remains closely involved with all aspects of the university, and vice versa.

There were originally two faculties at Amoud – education and business. The medical faculty opened in 2000, and the first seven doctors qualified in 2007. This was a historic moment – Somaliland had succeeded in training its own doctors for the first time. The students were examined by professionals from King's College Hospital, London. By 2010, Amoud had produced 31 qualified

doctors. To put this in context, in 2006 there were only six doctors in Awdal region, attending to a population of about 350,000.

Amoud opened its nursing faculty in 2005, offering a four year BSc Nursing degree – another first for Somaliland. Fourteen of the 16 students who embarked on the degree qualified in 2009. This nearly doubled the number of nurses in Awdal. In their foundation year the nurses were taught alongside first year medical students. All of them experienced outplacements at maternal and child health centres across Awdal region, and were taught the importance of community outreach.

The best students from the foundation year in 2010 opted to become nurses rather than doctors, and many of the qualified nurses are pressing to take a master's degree. This is an encouraging sign that the nursing profession is gaining status in Awdal. In 2012, Amoud will also introduce community midwifery training.

The medical and nursing faculties of Amoud are closely linked to the hospital in Borama. The hospital was built in 1921 and is the only one in Awdal. It has 350 beds and treats about 12,000 cases each year. The hospital is run by Dr Nimco Sheikh Aboubakr, and her sister Faduma is dean of the nursing faculty at Amoud. Like me, both came back to Somaliland from Canada.

### **Sool Institute of Health Sciences**

Sool Institute of Health Sciences in Las Anod, in the far east of Somaliland, is the newest school. Amina Hassan Hussein, the director, began the first three year nursing diploma course in 2008. Thirty-four students graduated. Amina's team of instructors all trained in Mogadishu before the civil war.

The need for nurses and other health professionals in Sool is extreme. The region has the lowest social and health indicators in the country. There is no water or electricity supply, even in Las Anod.

## A new generation of nurses

By Roda Ali

Deputy director, Somaliland Nursing and Midwifery Association (SLNMA)

I met Edna Adan in November 1999, while she was building her hospital in Hargeisa. Edna told me that she wanted to start a nursing diploma programme. I was interested, but first I asked her about the political situation in Somaliland. I was not aware exactly what was happening in my country. I had only moved back in September 1999, after the death of my father.

I was born and brought up in Qatar, and had worked there for 20 years as an intensive care nurse and part-time lecturer at the university. I still have nothing but fond memories of Qatar, and I owe that country a great deal. But I thought I could do more back in Somaliland, given the urgent need for health professionals in the country.

Edna and I soon discovered that the number of fully qualified nurses in Somaliland was minimal. This was hardly surprising. During the civil war, many people had fled abroad or to refugee camps. Some nurses had returned from the camps, but in most cases their educational background and scientific knowledge was not up to the standards envisaged by Edna for her hospital.

We knew that when the hospital opened we could not have nursing students and patients arriving at the same time. So we devised a six month pre-nursing training programme before the hospital opened. This was similar to a nursing auxiliary training programme which I had started in Qatar. The students would learn some basic English, anatomy and physiology, mathematics, and patient care – such as taking temperatures, body weight and vital life signs, and giving bed baths.

Three hundred girls answered an advertisement for the programme. In June 2000, we interviewed all of them in a single day. They sat a written exam which tested their knowledge of rudimentary biology, English, mathematics, physics and chemistry. It contained questions like, “What is a cell?” Only two candidates had graduated from high school – that year was the first since the civil war in which girls had completed secondary education in Somaliland. None of them had ever seen a computer.

HOPE *worldwide*, an American NGO, supplied us with seven volunteers to assist with the selection process and launch the six month training course. Forty-one girls aged 16-25 were chosen. Our plan was to take the best and enrol them on a three year general nursing training course after their six months basic training. At the end of the six months, 11 of the 41 had dropped out for various reasons – marriage, family commitments and so on. For one or two who had grown up in refugee camps, the strict timing and intensity of the course proved too exacting.

While the basic training was taking place, we developed a nursing curriculum which was approved by the Ministry of Health and Labour at the end of 2000. The 30 successful candidates from the basic training moved straight on to the general nursing training programme.

Volunteers enlisted by the Tropical Health & Education Trust (THET) were instrumental in encouraging interaction, and an understanding of different cultures and religions. One of them even used the film “Braveheart” in her English lessons. We took the girls on outings to Berbera and Sheikh so they could see different parts of the country. We took them to the Maan-Soor hotel, whose opening was an event of great symbolic importance for war-torn Hargeisa – and Somaliland. In 2001, we instigated sports after overcoming the students’ unwillingness to wear trousers. Nurses need to be physically fit and agile. By the end of the course, the students were doing aerobics and even held a fashion show. All of this was a huge shift for them.

The 30 young ladies were highly motivated, and an inspiration to everyone involved in their training. All of them graduated in 2003. Now they are agents for change. Seven went to Hargeisa Group Hospital and have improved it beyond measure. One is director of training at Edna’s hospital, and another two have qualified as doctors at the University of Amoud in Awdal region. I am very proud of them all.

There are two small hospitals in Las Anod. The general hospital, built in 1948, is in poor condition. Medicines, sheets, mattresses, and equipment of all sorts are in very short supply. The Kuwait-based NGO Al-Manhal Islamic Society opened a new specialist unit in 2010.

## 8. Nurse tutor programme

The greatest concern at the Somaliland Nursing and Midwifery Association (SLNMA) after the inaugural nursing diploma course at Hargeisa's nursing school was the standard of teaching. Some of the tutors had extensive practical experience, but had received very little professional skills development. Many were "old school", and had not taught anyone for a long time. Skills laboratory equipment was in very short supply, and at the time it was difficult to provide much practical experience on the wards at Hargeisa Group Hospital.

The overall quality of teaching input also suffered from a reduction in the number of overseas health professionals who were able to come to Somaliland in the aftermath of the terrorist attacks on the USA on September 11th 2001. The standard achieved by the first batch of graduates was low. It was not their fault. Many were very capable. But in the rush to train nurses we failed to do the job properly.

At the SLNMA, we discussed what had gone wrong at length. It was not a disaster. But in order not to make the same mistake again we had to take a step back. We decided that we had to train a new generation of nurse tutors, as well as a new generation of nurses. We also recognised that we needed to instigate more continuous professional development (CPD) for existing nurses and nurse tutors.

A thorough appraisal of the situation was carried out in conjunction with King's College Hospital and the Tropical Health & Education Trust (THET). In 2007, our proposal to start a nurse tutor programme was approved by everyone involved. Roda Ali, the SLNMA's vice-chair at the time and a very experienced nurse tutor, agreed to run the course. The next step was to draw up a curriculum.

There were many difficulties and disagreements between the 11 members of the curriculum committee. It was a complex process. People had different opinions about exactly what we should be seeking to achieve, and how. But it was an inclusive process – no one could later claim they

had not been involved, or that their views had been ignored.

By March 2008, we had produced a third draft of the curriculum. We recognised that we needed to upgrade the basic nursing knowledge and skills of the students. This could be done by reviewing the topics they had covered in their nurse training, but this time looking at them from an educational perspective. The sixteen month course had nine modules:

- Educational theory, practice and skill base (seven weeks)
- Educational approaches to reproductive health (seven weeks)
- Educational approaches in pathophysiology, pharmacology and biostatistics (seven weeks)
- Educational approaches to adult nursing (seven weeks)
- Educational approaches to mental health nursing (seven weeks)
- Administration and management in education (seven weeks)
- Educational approaches to community and primary care nursing (seven weeks)
- Educational approaches to paediatric nursing (seven weeks)
- Reflection and evaluation (two weeks)

Each module consisted of 120 hours theory and 36-48 hours practice. The first module was really a foundation course. We needed to improve the English, IT and study skills of the students before we could go any further.

About 40 people applied to join the course and we selected 26 students – 17 men and 9 women. Selection was done purely on merit. Candidates had to pass an entrance exam and go before a selection panel. There was some pressure to admit various people's cousins. That sort of thing happens in Somaliland, as elsewhere. But as the Ministry of Health and Labour, and the Ministry of Education, were involved in the programme management we managed to resist the pressure.

Our aim was to produce nurse leaders who could provide

## Nursing leaders

By Roda Ali

Deputy director, Somaliland Nursing and Midwifery Association (SLNMA)

After the curriculum for the nurse tutor programme was completed, many people thought that it was too intense – that the students would not be able to go the distance. Tuition was six days a week for 18 months, with only one six week break. It was very intense, for the students and the instructors.

Sixteen of the students had done the nursing diploma at Hargeisa Institute of Health Sciences, nine came from Burao Institute of Health Sciences in Togdheer region, and one was from Gabiley, 50km west of Hargeisa on the way to Borama. Some were from very poor families. Two young men from pastoral communities in Togdheer region could not afford the cost of the journey from Burao to Hargeisa. When they heard this, tutors at the Institute of Health Sciences in Burao paid for them to come.

You cannot teach people who are hungry. The Tropical Health & Education Trust (THET) paid for a cup of tea and a sandwich for all the students in the morning. For almost all of them, the course involved financial hardship. Some worked night shifts at the hospital in Hargeisa to make ends meet, some worked in pharmacies in the afternoons. A few did both, including one girl who suffered from high blood pressure.

We insisted on charging a course fee, in spite of the limited resources of the students. This was intended to motivate people and to encourage them to take ownership of the course – to see it as their course, rather than ours. The fee was US\$5 per month for those from the regions and US\$10 per month for those from Hargeisa. In addition to the tuition, we supplied all the books, pens, notebooks and other teaching materials. The students had access to six computer terminals with 24 hour internet connection.

We did not have all the expertise we needed at the beginning. After six months, when the students were ready, I was helped by two clinical trainers and one other instructor. We also received invaluable support from THET. Four or five specialists came out from King's College Hospital for two week placements. They launched each module and showed the students

how to teach, from a practical perspective rather than from a blackboard or by multiple choice. I also brought in friends of mine, and let international NGOs use the students to test health training programmes.

We were paid *per diem* fees by the NGOs, and this enabled me to introduce concepts of financial management and income generation. Whenever we had a float, I encouraged the students to decide for themselves how much to set aside for their tuition fees, how much for living expenses, and how much for outings to places like Berbera and Sheikh. I had to broaden the horizons of the students, as I had done when I was teaching the first group of nurses at Edna Adan Hospital in 2000.

Despite the intensity of the course, and additional hardships like the death of a parent, not one student dropped out. All of them graduated in 2009. Five are teaching at the Hargeisa Institute of Health Sciences, three are in primary healthcare in Hargeisa, one is at the SLNMA, and five have gone on to start a BSc Nursing degree. Of those who came from Burao, three are teaching at Institute of Health Sciences, one is matron of the hospital, one is head of the immunisation programme, and two or three are in primary healthcare. I am very proud of them. They all keep in touch with each other, and with me. Whatever they are doing, I always emphasise that they must keep doing some bedside nursing.

The nurse tutor course created leaders. We ended up with highly motivated individuals with a mastery of nursing skills, an ability to solve problems and to change processes. We told them they will not always be welcome. Some people will see them as a threat. There is often a reluctance to promote the young, and being selected for the nurse tutor course was a promotion of sorts.

I also told the students that they would encounter corruption during their careers. I said to them all, "Don't ever give in. The greater the obstacles in your way, the better you will know that you are on the right track." I also said, "Don't you dare let me down." No one has yet.

professional guidance to nurses and midwives at Somaliland's health facilities. The course developed the strategic thinking, nursing knowledge, communication and decision-making skills, and professional values of a dedicated and motivated group of students. Like them,

we have learnt a great deal from the programme. In the future we can use this knowledge when we create courses for instructors of health administrators, laboratory technicians, pharmacists or community health workers.

## 9. Five new curricula

When the Somaliland Nursing and Midwifery Association (SLNMA) carried out a needs assessment of the nursing schools in 2007, we found that they were using different curricula. Edna Adan Hospital had developed a new curriculum in 2000, but there was no universal standard. At our request, the Ministry of Health and Labour (MOHL) appointed a 17 member curriculum review committee. The committee included the heads of the nursing schools, nurse tutors and representatives from the MOHL. The Tropical Health & Education Trust (THET) provided a specialist nurse and midwife educator, Dr Gillian Barber, to advise the committee.

The committee consulted extensively with students, staff at Hargeisa Group Hospital, NGOs, the Ministry of Education curriculum development centre, the Somaliland Medical Association, civil society organisations and many others. It was a collaborative process, and everyone involved wanted to make sure that we did it right. The process, as well as the curriculum itself, had to reflect well on Somaliland – and on committee members as individual health practitioners.

By the end of 2009, the new national diploma in nursing curriculum was completed and adopted by all the accredited nursing schools. The course comprises six semesters, each with 720 hours of teaching – a total of 4,320 supervised learning hours. The final term focuses on community health and professional development – two issues of particular importance in Somaliland.

The SLNMA's needs assessment also revealed the extent of the shortage of skilled midwives in the country. A curriculum review committee appointed by the MOHL has created curricula for a post-basic diploma in midwifery and a national community midwifery programme. In three years, the SLNMA has helped to develop five new national curricula for Somaliland's health professions.

## 10. Continuous professional development (CPD)

I have said that it was not a disaster when we discovered that early graduates from some of the nursing schools were not all up to the required standard. We knew that we could develop the skills of new graduates in the workplace if we instigated a proper programme of continuous professional development (CPD). The programme was funded by the Tropical Health & Education Trust (THET), who also provided assistance from specialists. The Somaliland Nursing and Midwifery Association (SLNMA) provided THET with all the information about the different requirements at each of the regional nursing schools.

Continuing skills training helps to produce nurses and midwives of the calibre required to change outdated, parochial nursing practices – and will ultimately help to influence health policy in Somaliland. If the SLNMA's members are provided with the means to gain additional skills, and are given proper recognition for their contribution to the rebuilding of society in Somaliland, this will also help with retention of skilled staff.

The basic salary of a nurse at Hargeisa Group Hospital is about US\$100 per month. At a private clinic or international NGO a nurse might earn US\$350-800 per month. For many, good career structures and career development can be sufficient to keep them on the frontline. Financial reward is not the only incentive for nurses and midwives.

In addition to co-ordinating CPD, the SLNMA is working with the University of Hargeisa to develop a “top-up” programme for nurses. This might be a nursing bachelor's or master's degree. We are also trying to develop distance learning for nursing and midwifery tutors around the country. There is great scope to deploy virtual learning and teaching technology, given the poor state of Somaliland's roads and transport networks.

## Continuous professional development (CPD)

By Mohamed Yusuf Warsame

CPD co-ordinator, Somaliland Nursing and Midwifery Association (SLNMA)

I graduated from one of the nursing schools in Mogadishu in 1982, and then completed an 18 month post-basic course in education. After five years working in the Somali Ministry of Health, I went back to study as a nurse tutor while training midwives and nurses at the same time. I have worked for the African Medical and Research Foundation (AMREF) and the Kenya Red Cross. I was also human resources director at the general hospital in Las Anod, in Sool region.

In September 2010, I came to Hargeisa to expand continuous professional development (CPD) for the SLNMA. I did not have to start completely from scratch. Two others had been working on CPD before me, and there was a strategy in place to address the absence of basic patient care skills, such as appropriate bedside manner and communication. But no CPD instructors had been to Sool or Sanaag, Somaliland's eastern regions, before me. Even Berbera, the main port, had received only one visit from CPD instructors.

Travel has been difficult. For trips to the regions, we have had to hire a vehicle and this costs as much as US\$1,500. If we made 10-15 such trips each year – as we planned to – the cost would have been too great. In 2011, the Tropical Health & Education Trust (THET) and the SLNMA were able to provide us with a suitable vehicle.

Our target is to provide CPD training for at least 360 nurses and midwives each year. To be cost effective, we must run courses at least two or three times a year in each of the regions, teaching 25-30 people in each class. The courses last for 10 days – five days are spent with nurses and five days with nurse tutors. The first priority is always to evaluate the skills gaps and needs of an institution. CPD must be responsive and participatory.

There are some common components of all CPD courses. These include basic emergency management for obstetric care, infection control, communication, and the importance of CPD itself. But we design each course according to the needs, time available, and number of students. In my first six months, the CPD team conducted training for 225 people.

We try to be as inventive as possible with each course, despite limited financial resources. We have a reasonable collection of books which enable us to provide students with photocopies of material about

anything from giving an intra-muscular injection to nursing ethics and resources management. A lot of free material is available on the internet, and the SLNMA has provided each nursing school with at least one laptop computer and a projector. Videos are also used to ensure that there is plenty of visual content in each course. Students will lose interest if CPD is only based on textbooks.

If we can help institutions in neighbouring Somalia, we do. In February 2011, a life saving skills course for nurses from Gedo region, in southern Somalia, was conducted at Hargeisa Institute of Health Sciences. The Gedo nurses travelled 1500km to come and study here. There were no language or cultural barriers for them in Somaliland – everything is more familiar than if they went for training in Kenya or Uganda. The nurses can ask us more, and tell us more about what they need to know and the everyday difficulties they encounter.

Two or three years ago, reactions to CPD were not always positive. Some of the older nurses resisted change. Others felt threatened. At first people even asked how much they were going to be paid to undergo training. We told them they would not be paid – but we explained that CPD could give them better skills and this might provide greater job security and the opportunity to earn more.

Things have changed very quickly. The younger nurses are keen and receptive. They will provide leadership for the future. Older nurses must adapt, or they might lose their jobs.

The SLNMA is working on a credit system with the Ministry of Health and Labour, the University of Hargeisa, and the National Planning and Education authority. We have set a target of 60 hours of CPD training every year for all nurses. All registered nurses have a booklet and their CPD hours are entered by the instructor.

CPD training does not have to be given by the SLNMA. Courses run by the World Health Organization and other bodies are also recognised. We want the CPD hours to count towards higher qualifications that are being established in Somaliland, like the BSc Nursing degree. It is better to improve standards by providing incentives and encouragement than by being dictatorial.

## 11. National Health Professions Council

When the Somaliland Nursing and Midwifery Association (SLNMA) was established in 2004, there was no functioning health regulatory body in Somaliland. A Health Professions Act was passed by Parliament in 1999 but it had not been implemented. Although the Act provided for the creation of a Health Professions Council, no such body existed. For two years the SLNMA pushed hard to establish a council, alongside the Somaliland Medical Association (SMA), which was formed in 2005 and represents doctors.

In 2008, the Tropical Health & Education Trust (THET) provided two specialists to assist the SLNMA, as well as an office for a working group to amend and update the 1999 Health Professions Act. The working group included two nurses, two doctors, a representative of the Ministry of Health and Labour (MOHL), a lab technician, a pharmacist and a legal adviser from the Somaliland Legal Association. The steering committee appointed by the ministry included the minister himself, the head of the SMA and me.

The working group had to prepare the accreditation tools and memoranda of understanding for the MOHL, the Ministry of Justice, the Ministry of Commerce, various other ministries, and the police – all the parties who would be involved in monitoring compliance with a new Health Professions Act. It was an enormous task, and especially complex when it came to the contentious issue of pharmaceutical licensing. Almost all distribution of pharmaceuticals in Somaliland is in the hands of unlicensed, private operators. Many people regarded the prospect of better regulation as a threat, including some doctors.

The amended Health Professions Act was approved by Parliament in 2011. The drafting of the Act, and the creation of a National Health Professions Council (NHPC), was given impetus by the fact that the Minister of Health appointed by the new government in 2010 – Hussein Mohamoud Mohamed – is himself a doctor. He

knew what we were trying to achieve, and why. The NHPC has appointed an executive director and has started work, in anticipation of ratification of the Act. In due course, accreditation committees will be created.

There is consensus that the NHPC must not rush into enforcement. It would be counter-productive and contentious if, for example, all pharmacies deemed to be operating outside the law were simply shut down overnight. Public awareness campaigns will help to inform people about what is happening. The trust of both professionals and patients is essential if regulation is to fulfil its purpose of providing better, safer health services to the population.

## 12. Competence audits

In order to ease the workload of the National Health Professions Council (NHPC), the Somaliland Nursing and Midwifery Association (SLNMA) started to set up quality assurance activities in 2011. We developed forms with which to carry out a competence assessment of practising nurses and midwives. All our members were asked to complete these forms, so that we can verify the information on the SLNMA register relating to their qualifications and training. This nationwide process will be finished by the end of 2011, and all members will be given a photocard which bears their personal details and their number in the register.

In collaboration with the SLNMA, the renamed Ministry of Health (MOH) appointed a committee to assess all private nursing and midwifery schools. This audit is not straightforward. There are many private health institutions. Some so-called nursing schools were started as purely commercial enterprises which do not follow the new national curriculum for a nursing diploma, or adhere to the professional standards set by the SLNMA.

We will conduct assessments with an open mind. But any nursing and midwifery schools that do not meet the criteria set down by the MOH and the NHPC may be

closed down. Proper systems of accreditation will help to ensure that people do not waste their time and money.

Some private nursing schools charge US\$30 per month or more – twice as much as Hargeisa’s Institute of Health Sciences. Private health services are big business in Somaliland. Private pharmacies and imported generic drugs are everywhere. There is no regulation, and the people dispensing medication and suggesting treatments are often completely unqualified.

## 13. A professional association

The advertisement placed by the Tropical Health & Education Trust (THET) in 2007 for a co-ordinator for the nurse tutor programme read:

“There are no minimum entry requirements for the basic nursing courses [in Somaliland] and abilities vary enormously in each class. Nurse training schools are not accredited and graduates are called nurses without any professional examination or registration. Once “qualified” there are no promotional opportunities, no systems of appraisal and no recognition. By and large, the quality of nurse and midwife training is low and many people graduate whilst still being unable to perform basic tasks.”

This was a realistic assessment of the state of nursing and midwifery education and standards at the time. But I think we have made reasonable progress since then.

The Somaliland Nursing and Midwifery Association (SLNMA) has played a leading role in developing five new national curricula – for the nursing diploma, the nurse tutor programme, the BSc Midwifery degree, the post-basic diploma in midwifery, and the community midwifery programme. Continuous professional development (CPD) has been put on a more rigorous footing, and is more extensive. The nurse tutor programme has created new leaders in our profession and was widely acclaimed. Regulations and oversight are improving.

We have barely scratched the surface. The value of a curriculum lies with the teacher and the student. Patient care is still not good enough, and there are substantial gaps – for example, in emergency and mental health care.

The SLNMA has nearly 600 registered members. In 2011, about 160 nurses and midwives assembled in Hargeisa for the annual general meeting. That was quite an improvement on the turnout of seven at our inaugural meeting, in 2004. At the annual general meeting, the members exchanged information about common problems, developed a strategic plan for 2011-15, and awarded prizes in recognition of merit. The members are all committed to improving treatment and care of Somalilanders. We will continue to tackle things in our own way, with the help of local and international partners whom we trust.

## 14. Recommendations

**Good leadership** is the most important thing if we are to improve the standard of health care in Somaliland. We have some proven leaders in the health sector, but not enough. Initiatives like the nurse tutor programme and the medical faculty at the University of Amoud are creating a new generation which is committed to changing – and raising – standards. But the process of change is in its infancy.

Any country that finds itself in a similar predicament to that of Somaliland may be tempted to rush into training nurses and midwives as quickly as possible. If you are seeking to expand in a sustainable manner, it is important to ensure first that there is an adequate **cadre of experienced, locally-trained nursing and midwifery tutors**. We learned this lesson the hard way in Somaliland. Poor tuition and outdated curricula create sub-standard nurses and midwives. But good tutors provide leadership in the workplace as well as the classroom.

Many of our institutions require more **professional management**. It is very hard for a nurse to improve standards in an environment in which someone cannot be

reprimanded or dismissed because of clan, or other, allegiances. Skilled professionals must be allowed to do their jobs properly, without unwarranted interference or hindrance. Otherwise all the effort and expense expended in training them will be wasted. Basic record-keeping and information management are still lacking in many institutions.

**Better regulation** is necessary in order to raise standards and protect the public. The new Health Professionals Act needs to be ratified by parliament, thereby enabling the National Health Professions Council (NHPC) to do its work. The NHPC must not rush in to regulate everything and everyone immediately. It must take time to develop and instil confidence. If this does not happen, there will be an increasing number of unqualified people masquerading as doctors, nurses and midwives in Somaliland, and a burgeoning trade in counterfeit and illicit pharmaceuticals. This is a threat to public safety, and will undermine all the work aimed at building confidence in the health system. As a matter of urgency, we also need a **Mental Health Act**. The treatment of the mentally ill in Somaliland is inhumane.

**A more realistic health budget** is required if the Ministry of Health is to play an authoritative role in regulation and help to co-ordinate international assistance from donors and the diaspora – as it should. Revenue of US\$1-2m a year is not sufficient to create a functional ministry overseeing the health needs of more than three million people.

Financial remuneration is not the be-all and end-all for nurses and midwives. In every country, health professionals will earn more in the private sector than the public sector. But **good career structures, continuous professional development, and public recognition of good service** count for a lot, and can help to compensate for income disparities. For many health professionals, it is more rewarding to work in a hospital in Burao or Borama, for example, than to be a desk officer at an NGO or work in a private pharmacy – provided an adequate salary is complemented by other incentives.

**New hospitals are not the most important priority in Somaliland.** Even a hospital in a very poor physical state can be made to provide adequate service if it has a core of competent administrative staff, half a dozen dedicated doctors, and skilled matrons on each ward. Some smaller investments are needed. For example, the members of the Somaliland Nursing and Midwifery Association (SLMNA) would benefit enormously if it had a proper resource centre with a library, computers, training facilities, and one or two rooms to accommodate nurses and midwives from the regions who have to visit Hargeisa for professional reasons.

There is better service provision in the west of the country than in the east. This needs to change. **The regions must develop at a similar pace and provide comparable facilities.** I hope that members of the diaspora and local businesses will lead the way in tackling the imbalance by investing in all regions. There should be no “health divide” in Somaliland.

**Professional ethics and standards** are much more important than bricks and mortar. Things still happen in Somaliland that really should not. For example, on occasion some professionals have refused to operate in life-threatening situations unless they are paid. As far as nursing and midwifery are concerned, the SLNMA and the regional schools must continue to produce – and support – nurses and midwives who are a credit to their profession.

In Somaliland, our telecommunications are much better than our transport links. I think that **appropriate technology** can play a much greater role in improving the education of health workers. This is an issue often raised at SLNMA meetings. Nurses and midwives ask us to provide ways in which they can continue their education while they are working. E-learning could be very useful for teaching post-basic specialisations like mental health or emergency skills. Technology can also help us to share our knowledge overseas. Doctors in Somaliland are already sharing their experience of tropical medicine cases

with counterparts in the UK through [medicineafrica.com](http://medicineafrica.com).

There was no master plan for Somaliland's health professionals to follow after the civil war. It took almost ten years for anyone to start doing anything at all. This should not be surprising. Somaliland was a new country, and peace was fragile in the 1990s. Besides, it was difficult to know where to start. What do you do when conflict has destroyed all your institutions and

professional associations? This was the question which confronted us. I would say to any other country in our situation that you must be bold. Resourcefulness, flexibility and patience are essential. So too are partnerships – within the country, with external partners, and with the diaspora – which are built on trust and a shared belief in rebuilding society.

## Mental health

"There is hardly a single family in Somaliland which is not affected by mental illness" according to Fadumo Kahin, a nurse and midwife who moved to Toronto in 1974. "Every family has one or two members who are suffering".

In 2011, Fadumo returned to Somaliland and became director of Hargeisa Group Hospital. "Today," she continues, "I met a woman who, at the time of the civil war, was made to fetch a rope by soldiers. Then she had to watch as the soldiers bound her husband and son, and killed them. What do you think such people feel? Even if they don't appear disturbed, there is something wrong with them. Just walk around Hargeisa, or any town, and you will see the scale of the problem. There is a lot of post-traumatic stress disorder, a lot of schizophrenia and psychosis. And then there is *qaad*, or *khat*, abuse. Now that too causes real problems."

The leaves and stems of the *qaad* shrub have a stimulant effect similar to that of amphetamines. It has been estimated by the General Assistance and Volunteers Organization (GAVO) that Somalilanders spend US\$200,000 on imported *qaad* every day – US\$70m per annum. This is a sum substantially higher than the national budget for 2009-10.

A 2004 survey conducted by GAVO in Hargeisa, Sahil, Togdheer and Awdal regions concluded that the prevalence of mental illness in Somaliland could be "the highest in the world". The World Health Organization (WHO) concurs, estimating that one in three people in Somalia and Somaliland suffer from mental illness. Yet Somaliland has no national mental health policy, and no legislative framework protecting the rights of the mentally ill, or providing for their treatment.

Despite some improvements, conditions at the two public in-patient mental health facilities – a former military prison in Berbera with 42 beds, and a 100 bed ward at Hargeisa Group Hospital – remain lamentable. Incarceration, not treatment, of the mentally ill is all

that is offered. "I helped to build [the psychiatric ward] at Hargeisa Group Hospital with my own hands during the Siyad Barre regime, as part of my youth service in 1970", remarks Fadumo Kahin. "It is like a zoo, it makes me want to cry." Most staff are auxiliaries, with no formal training. Medical input is minimal. There are no full-time practising psychiatrists in Somaliland.

Private "clinics" abound, charging those who can afford the fees up to US\$200 per month to house "crazy" or "mad" relatives. Some sufferers are subjected to traditional healing practices. For others, treatment takes the form of lengthy readings from the Qu'ran by a local sheikh. Most of the mentally sick are simply chained up at home – a practice deemed "culturally acceptable" according to GAVO – or wander the streets, where they are subjected to abuse, beatings and being pelted with stones. Mental health problems are poorly understood by the public, and widely thought to be incurable.

"We are starting from scratch", says Fouzia Mohamed Ismail, director of the SLNMA. "Mental health components have been incorporated into the new nursing curriculum and the training of doctors. An educated awareness of mental health issues among professional health staff is a start. In Borama, there is now a psychiatric out-patient facility, a maternal mental health programme and some community mental health services. They are making good progress there. But together we, and our international partners, must do much more for the mentally ill in Somaliland. It is essential that we change things."

According to the WHO, if the psychological and social impacts of the civil war and its aftermath are not addressed they will jeopardise "the long-term mental health and psychological well-being" of the entire population of Somaliland.

Sources: Edward Paice interviews with Fadumo Kahin and Fouzia Mohamed Ismail, February 17th 2011; General Assistance and Volunteers Organization (GAVO), *Baseline Survey Report On Mental Health Situation In Somaliland*, Nov-Dec 2004; World Health Organization (WHO), *A Situation Analysis Of Mental Health In Somalia*, Oct 2010.



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**A PARLIAMENT WITH TEETH**  
By Samuel Sitta, Wilfred Siss & John Cheye  
With an Introduction by Mark Korten!

**Africa Research Institute** Briefing Note 1102 April 2011

**Old Tricks, Young Guns**  
Elections and violence in Sierra Leone

Sierra Leone is acclaimed as one of Africa's most successful post-conflict states. But the country remains fragile. Every election since independence has been attended by violence. Support for political parties is polarised on ethnic and regional lines, and underwritten by patronage. Youth unemployment is endemic. Amid early preparations for the 2012 presidential, parliamentary and local council elections, these notes examine the causes of electoral strife, and suggest measures for mitigating future violence.

- Peaceful transition from civil war, sustained economic growth
- Corruption rife, new Anti-Corruption Act implemented
- Election violence customary, perpetrated with impunity
- Regional and ethnic identities sustained by political patronage, and corruption
- Burgeoning youth unemployed, marginalised and manipulated
- All party agreement to avert election violence

**Green shoots, deep roots**  
Sierra Leone's 11 year civil war is infamous for images of child soldiers and amputees, and for the trade in "blood" diamonds. In January 2002, a peace ceremony marked the official end of the conflict. By 2004, 72,000 fighters from various factions were disarmed and demobilised. The international peacekeeping force – whose peak strength of 17,500 made it the largest ever deployed by the United Nations – was withdrawn in 2005.

Sierra Leone's army, which had effectively ceased to exist in the latter years of the war, was reformed after a recruitment drive. The new force, comprising 8,500 troops, received extensive training from the UK-led International Military Advisory and Training Team (IMATT). The police service has been restructured and retrained. Despite low salaries, discipline in the army and police has improved.

Successive post-war presidential and parliamentary elections have been won by different parties. In 2002, Ahmad Tejan Kabbah and the Sierra Leone People's Party (SLPP) won the victors. In 2007, Ernest Bai Koroma and the All People's Congress (APC) carried the vote. Both elections were declared free, fair and credible by international observers. Neither result was seriously contested by the defeated party.

President Koroma – formerly the managing director of an insurance company – has impressed international donors with bold declarations to "run Sierra Leone as a business concern", combat corruption and reduce dependence on foreign aid. New laws and regulations, including a more transparent tax code, have been framed to attract private investment. According to Francis and Gilbert (2009), George Soros, Sierra Leone has "the genuine potential to become a leading African economy".

**Economic growth in perspective**

Commercial agriculture, infrastructure, health and education are pillars of an ambitious 'Agenda for Change' launched by President Koroma in 2008. Funding for agriculture increased from 1.7% of the government's budget in 2007 to 10% in 2010.<sup>1</sup> Free health care for pregnant women, nursing mothers, and children under five was introduced in April 2010. Provincial roads have been rebuilt. A US\$90m investment in Bombura Hydroelectric Dam, a project initiated in 1976, has created a facility capable of generating 50 megawatts of electricity.

Sierra Leone remains beset by privation which predates the war. Two-thirds of the population subsists on less than US\$1.25 per day. Almost half the population is malnourished. Maternal and infant mortality rates are among the highest in the world, and average life expectancy is 48 years. Youth unemployment is entrenched. While Sierra Leone's Gross Domestic Product (GDP) is forecast to expand

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# PATIENCE AND CARE

## Rebuilding nursing and midwifery, in Somaliland

By Fouzia Mohamed Ismail

Somaliland's maternal, infant, and child mortality rates are among the highest in the world. A rudimentary health system already beset by under-investment and neglect collapsed completely during the final years of a civil war which ended in 1991. Hospitals and clinics were looted or destroyed. Health professionals fled to refugee camps or overseas. In 2001, when Somaliland held a referendum which approved the adoption of a new constitution and confirmed the country's independence from Somalia, the provision of health care to a population estimated at two to three million remained almost non-existent.

Fouzia Mohamed Ismail was one of the highly-qualified nurses and midwives who returned to Somaliland determined to rebuild their professions. In this timely account, published a decade after the referendum, Fouzia relates what has been done to train a new generation of nurses and midwives, to improve standards of patient care, to develop relevant training programmes, and to foster regulation of the health sector in Somaliland.

Fouzia is candid about the factors which have hampered the development of accessible and professional health services in Somaliland. Many are common to other post-conflict states in Africa, and elsewhere. She explains, clearly and concisely, the way in which obstacles have been overcome. Consensual decision-making, ingenuity, community and diaspora participation, and the selection of appropriate long-term international partners are among the features of a distinctive strategy to revive the nursing and midwifery professions in Somaliland. For Fouzia, the achievement of Somaliland's social and economic goals is dependent on improving the health of the nation.

