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Private Health Care Services in a Fragile Country Context
Somaliland Physicians' Perspective

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Abstract

Fragile states and their complex problems are of international concern. About 15% of the world population live in a fragile country context. Fragile states are characterized by the inability of a government to provide basic functions such as security, legitimacy, governance, public health care. Frequently a vibrant, unregulated private health care sector is thriving. Information about the private health care sector is sparse. Hereby the private providers' own perceptions about their services are nearly never heard. This study focuses on nationally accredited physicians and their private services in a fragile state (Somaliland).

The objective of this study is to understand Somali physicians' perspectives about their role and to identify opportunities for improved contribution.

The methodology is based on in-depth interviews and personal observations of private facilities. Key-informant interviews provide required baseline information. The data analysis is based on a thematic analysis, compatible with a theoretical framework that is inspired by phenomenology.

Three major themes evolved:

- Physicians' own perceived significance of their services
- Access to services
- Health sector regulations

The findings highlight the perceived importance of this sector, related to high quality care and utilization. Motivation to serve is based on both extrinsic (mainly financial) and intrinsic (recognition, appreciation, caring) factors. Intrinsic factors have perceived priority. Income is derived from customers with varying wealth, coming from all Somali speaking regions i.e. horn of Africa. Access for the poor is enabled by physicians' own contributions, however, access for the poor remains problematic. Physicians' activities are completely imbalanced geographically distributed (clustered in three urban settings). There is a strong perception that health sector regulations are lacking. Established regulatory bodies are not empowered. The influx of unregulated external physicians goes unchecked.

To conclude, a uniform strategy from health care access to health care education is missing. The troublesome situation results in a huge willingness of the physicians to participate in regulatory processes.

Keywords:
private health care fragile countries; motivation of physicians fragile countries; quality of care fragile countries; health worker crisis fragile countries; health sector regulations fragile countries

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Elli in heaven, Schorsch on earth and to my daughter Josefine, who is distant, yet always here. Ilona and her two angels. Margit and the swans at lake silver. K&B all over and for the last time Camilla, who went. They all gave me encouragement and confidence to write this thesis.

Dedication

I dedicate this thesis to all Somalianders, with their indelible hope to have an independent country that is internationally recognized throughout the world. This wish can be reflected through the traditional Somali saying:

"Ama buur ahaw ama buur ku tirso (Either be a mountain or attach yourself to one)"

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Abbreviations

CT	Computerized Tomography
DFID	Department for International Development
IDP	Internal Displaced People
MoHL	Ministry of Health and Labour
MDGs	Millennium Development Goals
MCH	Mother Child Health
MRI	Magnetic Resonance Imaging
NGO	Non-Governmental Organization
NHPC	National Health Professional Council
OECD	Organization for Economic Co-operation and Development
SMA	Somaliland Medical Association
SSA	sub-Saharan Africa
UNDG	United Nations Development Group
USD	United States Dollar
WHO	World Health Organization
24/7	twenty-four-seven

1. Introduction and Problem Statement

1.1 Fragile States

Over the last two decades fragile states and their complex problems are gaining more and more international attention. Instability and the resulting problems of fragile states threaten not only their neighbouring countries; they also influence international politics and policies. Approximately 50 states are regarded as fragile and 15% of the world population including about 340 million of the world's extreme poor are living within a fragile state context (World Bank, 2007). A standard internationally agreed definition of the term 'fragile state' as such does not exist. Various organizations utilize different definitions suitable to their different agendas and priorities. The Department for International Development (DFID) defines fragile states as "*those where the government cannot or will not deliver core functions to the majority of its people, including the poor"* (DFID, 2005); and the Development Assistance Committee of the Organization for Economic Co-operation and Development (OECD) as the "*inability or unwillingness of a state to deliver services to its people, or to ensure their delivery"* (OECD, 2005 cited in Oswald and Clewett, 2007). Others like the World Bank in its Country Policy and Institutional Assessment (CPIA), in their scores, emphasize on economic aspects and their impact on state fragility (World Bank, n.d.).

However common sense states that the provision of adequate basic services to the population is missing. In general fragile states are characterized as deteriorating, collapsed, failing legitimacy and or recovering from a major conflict (Brenthurst Foundation, 2011, Newbrander, 2006). As a consequence public confidence and trust in governmental institutions becomes diminished.

Today's world order is very much based on alliances and on predictability of national states. This established system is endangered by violent disintegration of national-states pending between weakness and failure. These fragile states affect their neighbouring countries by hindering their further development. This is related collateral security threats and humanitarian worries are based on mass migration, coordinated and uncoordinated organized criminal activities with related violent clashes, environmental destruction and uncontrolled spread of communicable diseases (Zoellick, 2008).

1.2 Health Care in Fragile States

The "*Global Monitoring Report"* published in 2007 by the World Bank highlights two major global concerns achieving the Millennium Development Goals (MDGs); unsolved gender inequity and fragile states with their limitations to secure a stable life for their citizen (World Bank, 2007). Fragile states are far behind reaching the MDGs. Tremendous public health concerns are faced, about a third of the deaths

from HIV/AIDS occur in fragile countries and a third of those who no access to save water are living there. Half of all the world's children, who die under the age of five, do so in a fragile country context (World Bank, 2007). Obviously a fragile state is unable to provide the basic human needs, such as security, water, sanitation and foremost health care (OECD, 2008). A dramatic burden of diseases (communicable and non-communicable) with disproportionately high mortality - morbidity indicators are the consequence (Newbrander, 2006).

Health services provided by governments of fragile states are generally insufficient or even non-existing. The population of such countries depends on whatever is available from private for profit driven health care to international and or national Non-Governmental Organizations (NGOs) delivered services (IFC, 2009; Pavignani, 2012; Palmer et al., 2006). Instability and safety hazards frequently restrict access for international and national NGOs. In this existing vacuum formal and informal local private health care providers are often the only one who persist and serve the urging demands. In doing so private based health care converts into a dynamic and rapidly growing sector. The available services provided are strongly depending on the individual capacity and motivations. The services range within a wide scope related to availability, accessibility and affordability (IFC, 2009). Mostly private health care services are imbalanced geographically distributed as private providers frequently cluster in and around urban settings. Such urban settings are frequently saver, have a better infrastructure in place and a higher population density with even more people with financial means to pay the services offered (Hosseinpoor et al, 2011; Zivetz, 2006).

The profit making aspect of the private health care sector is often criticized, claiming that financial constraints and consequent limited accessibility to health care present insuperable obstacles to the nation's poor (Hanson et al, 2008). Furthermore evidence is claimed that private providers compared with public providers less often apply medical standards and had less good medical outcomes (Basu et al, 2012) and that promoting the private sector highly unlikely increase universal and accessible health services for the poor (Oxfam International, 2009).

On the other hand it is stated that engaging and supporting private health care providers can have a ripple effect, even on the poor population living in rural settings (Patouillard et al, 2007; IFC, 2009). Presently there is a tendency by international donors to accept the circumstance that major services are paid by customers out of the pocket to private providers. Scaling up these services linked to quality improvement and increased availability for the poor even in underserved areas might be an opportunity to improve the health care situations in theses fragile regions. This leads to an increased interest in

private for profit health care providers. Furthermore in Sub-Saharan Africa (SSA), as one of the global hot spots concerning fragile country settings, the private sector plays already an enormous important role in health care provision (Yoong et al, 2010).

Currently no comprehensive data about private health care in fragile country settings is available (Pavignani, 2012; Newbrander, 2006). Hereby the private providers are nearly never heart. To gain a better understanding I focus my research on one specific segment of the formal private sector serving within a fragile country setting. The country chosen to represent a fragile state is Somaliland in East Africa.

1.3 Somaliland example

1960 shortly after independence the two Somali states the former colonies British Somalia and Italian Somalia, formed the united Republic of Somalia. The newly established state of Somalia was from the beginning exposed to civil unrest between the two founder states based on tribal rivalries and educational and administrative divergences related to the different former colonial rulers. The consequence was a civil war from the early 80's until 1991 with a dramatic outcome. *"This war destroyed 95% of the cities of Somaliland and caused the death of a quarter of a million people and a further one million to become refugees in neighbouring countries"* (Edna Adan, 2010).

After cessation of military operations, Somaliland declared its independence in May of 1991. The country is based on the territory of the former protectorate British Somalia and is ethnographically dominated by the Isaaq clan (Gundel, 2009). Over the years an island of hope and growing stability for Somaliland's 3.5 million inhabitants emerged. Somaliland stands in stark contrast to the rest of Somalia, which continues to be dominated by civil war and warlords (Kaplan, 2008). Despite Somaliland's relative peace and prosperity the nation continues to face problems labelling it a fragile state. For instance the public education system is still nearly none functioning with an illiteracy rate about 70%. Faced problems are exacerbated by persisting non-recognition of the international community and the resulting international isolation (Pavignani, 2012, The Brenthurst Foundation, 2011). Non-recognition of the international community excludes support by international monetary institutions (including the African Union Bank and World Bank), averts possible investors and limits trade and travel activities. Any kind of economic prospects are blocked (The Benhurst Foundation, 2011). Additional causes of instability include the unsolved border issue with the neighbouring and also unrecognized Puntland,

pirating at the boarder coastline and persistent supporting groups for Al-Shabaab (militant Islamist group) activities (Haybsado, 2008).

There is no actual annual Gross Domestic Product (GDP) presented in the "*National Development Plan 2012 -2016"*. This is related to the absence of macroeconomic data. Remittances from the diaspora contribute up to 40 percent of the household incomes. Despite the unavailability of data can be assumed that Somaliland's income per capita is relatively higher compared to the numbers presented for the Republic of Somalia. This is related to achieved peace and political stability. Regardless cross Somaliland regions income per capita and year ranges from $250 to $350 (Ministry of National Planning and Development, Republic of Somaliland, 2011). The local economy is nearly completely depending on livestock trade to North Africa and the Middle East. The difficult economic situation is reflected in the unemployment rate of nearly 70 percent in the working age group (Kaplan, 2008).

1.4 Somaliland's Health sector

The consequence of the barbaric civil war between 1982 and 1991 and further civil unrest between 1994 and 1996 was a complete destruction of all essential health care infrastructures. Human resources of the health sector vanished related to mass migration or killings. Madame Edna Adan Ismail, former Foreign Minister of the Republic of Somaliland and founder of the Edna Adan University Hospital in Hargeisa describes the situation she witnessed during those years as follows:

"- - - there was nothing, / the health workers had been killed or had left the country, / the country is empty of health professionals and there is one who is called - - - who is still practicing, there was one with five beds and he was someone, who had a private maternity clinic and it was something that was absolutely not satisfactory, unsafe, unprofessional, unethical. The Group Hospital, // the government hospital has refugees living in it with the chicken with the goats and with the donkeys that was the Group Hospital - - -"(Madame Edna Adan Ismail interview, 18th June, 2013 by Grothuesmann). Somaliland had to start from zero:

"It was Berlin after the Second World War, // but at least in Berlin you had educated people, / you had a Marshall plan, / you had people who could rebuild, but in Somaliland the people are poor, / they are less educated, / the people have fewer resources and nobody came to help Somaliland, // there was no Marshall plan. We became our own Marshall plan; / we became our own resources, / we became, we could do whatever we want with whatever resources we had, // small or whatever- - -"(Madame Edna Adan Ismail interview by Grothuesmann, 18th June 2013).

Tremendous progress has been made towards re-establishing the country. Regardless Somaliland's principal challenge remains the delivery of adequate health care for the nation. Health indicators of Somaliland are considered world-wide to be amongst the worst (Leather, 2006; Pavignani, 2012). The annual maternal mortality ratio is estimated to be between 1000 and 1400 per 100 000 live birth. Life expectancy at birth is stated to be between 47 and 57 years. Only vague annual numbers for infant mortality rate about 90 per 1000 live birth and under-five mortality with about 145 per 1000 live birth are presented in the "*National Health Policy Draft"(*Republic of Somaliland Ministry of Health, 2011). The healthcare sector in underserved Somaliland is dynamic, unregulated and complex and is characterized by an opaque patchwork of public and private providers. The situation is further complicated by a flowing and unregulated exchange of staff and resources between public and private healthcare sectors.

The Ministry of Health and Labour (MoHL) is restricted by inadequate financial, infrastructural, and human resources (Pavignani, 2012). According to the "*National Development Plan 2012 -2016"*, in 2011, 7 hospitals, 87 health centres and 160 health posts in Somaliland are run by the public sector. Nearly all these facilities are dramatically understaffed and are lacking essential equipment and utilities (Ministry of National Planning and Development, Republic of Somaliland, 2011). The situation becomes even more dramatic based on the fact that nearly all physicians of Somaliland are based in the major urban settings. In the governmental services on average there is only one physician for 47 000 citizen available. The 2011 budget for the Ministry of Health remains at 3% of the national budget, which is far below the aimed 15%. Currently the state allocation is about 1.25 USD per capita per year for health (Republic of Somaliland Ministry of Health, 2011). Despite its obvious ineffectiveness the MoHL claims to regulate the overall health care provision within the country (UNICEF, 2009).

In this situation the private sector emerged and tries to fill the existing gaps. These physicians are frequently also employed on part time basis in one of the remaining public health care facilities (Hanson et al., 2008). In addition to these mentioned problems in the year 2010, three hundred national and international non-governmental organizations (NGOs), including faith based organizations were registered with frequently uncoordinated activities (SomalilandPress, 2010). Parallel to the formal private health care sector (accredited medical physicians and pharmacologists) people also seek help from the extensive informal private health care sector in place which includes traditional healers and a vast variety of other non-recognized medicine vendors (UNICEF, 2009).

1.5 Focus of Research

I focus my research on nationally accredited physicians who work exclusively or parallel to their public services in for-profit private facilities. These providers are offering services ranging from advanced medical care of the highest international standard, to services based on elementary clinical examinations and essential devices (Newbrander, 2006, personal observations June/July 2013). How valuable their contribution to the health care provision is difficult to state because very little research has been published on this subject. My research examines the aforementioned preconceptions toward the private health care sector for possible imbalances. Thereunto the private health care providers' perceptions towards these allegations has never been adequately reported.

Exploring these aspects will contribute to the research worthy question: what are the Somali physicians' perspectives about their private services and role within the health care sector? Understanding their perspectives on their role might be key to enable a better utilization of their services, which could be harnessed to the benefit of all.

2. Objectives

The main objective is to understand the Somali physicians' self-perceived roles, their responsibilities and motivations within the private health care sector.

The specific objectives of this research are to:

- Describe the characteristics and defining features of private health care delivery served by nationally accredited physicians of Somali origin
- Understand the Somali physicians' perspectives about their practices and challenges within private services
- Analyze the Somali physicians' perspectives about their contribution to the overall health care provision
- Discuss the findings with relevant literature and elaborate on opportunities for improved contribution of the Somali doctors to overall health care

3. Research methods and approaches

The primary data related to my study was gathered during a four week field work conducted between the 15th June and 16th July 2013. The field study was based on a qualitative approach. The applied qualitative methods were as listed:

- In depth-interviews with national doctors (semi-structured)

- Key-informant interviews
- Simple (unobtrusive) observations

The selected qualitative methods facilitated the analysis of research questions from different perspectives (Golafshani, 2003). Due to the inherent characteristics of the chosen qualitative methods, each method allowed unique and individual insights and enable triangulation of the obtained data.

3.1 In depth-interviews with national doctors

To understand the individual doctor's perspective, I conducted twenty-four face-to-face, semi-structured, in-depth interviews (Boyce and Naele, 2006). All the interviews for this study were held in English. Interview participation was on a voluntary basis and only after informed consent was given. The obtained data is used anonymously and confidentially. Prior to starting an interview the study objectives were explained and the interviewees were guaranteed that the given information will be used for research purposes only. The interviewees were informed about further usage of the recordings and assured that all saved files will be deleted as soon as my thesis would be completed. No incentives were given to the interviewed physicians.

The in depth interviews were based on a developed interview guide (Annexe I), which reflect the research focus of my study. The guide was pretested for relevance by interviewing two Somali doctors prior to the beginning of my project (June, 2013). The adapted guide was what I applied. Despite the interview guide, I sometimes deviated toward a more open and informal interview approach as it accommodated the incorporation of new ideas and themes.

Presently about two hundred accredited physicians of Somali origin are working in Somaliland (Dr Achmed Ali Saeed, deputy chairman of Somaliland Medical Association, personal interview by Dirk Grothuesmann, 18 June 2013). The preface for selecting and contacting the interviewees was based on recommendations from acquaintances and information obtained from the Somali Medical Association (Somali Medical Association, n.d.). The initial method for this research was purposive sampling (Tongco, 2007); more information was collected following a theoretical sampling approach. Through theoretical sampling I could clarify research gaps and uncertainties that had accumulated during previously conducted interviews. Theoretical saturation was achieved after the interviewees offered no further perceptions about their services (Sabraini et al, 2011). All interviews were transcribed respecting specific conventions (Annexe IV). The interviewees were grouped taking into account the geographical location of their related facilities (Hargeisa, Berbera and Boorama).

3.2 Key informant interviews (1. Dr Mohamed Muuse, 2. Madame Edna Adan Ismail)

The key informant interviews were conducted for two different reasons:

- First to provide baseline information about private health care of Somaliland (Dr Muuse, MoHL, personal interview by Dirk Grothuesmann, 17th June 2013)
- Second to gain an understanding of the historical context and consequent development of physician related private sector (Madame Edna Adan Ismail, 2013. Interview by Dirk Grothuesmann, 18th June, 2013)

Dr Mohamed Muuse is an accredited physician and Somaliland citizen. He serves as the deputy manager of the combined private-public health care program of the Ministry of Health and Labour (MoHL) in Somaliland; he managed his private clinic until he began working for the MoHL in 2011. He provided important baseline data for this research; he gave an overview about the specific country context as well as insight into the most current situation of physician driven private health care. Up to date no comprehensive information concerning this subject has been published. All available information is based on 'common knowledge' and oral narratives. The knowledge obtained from this key informant interview served as the prerequisite for my subsequent field work.

Madame Edna is a former Foreign Minister of Somaliland and long-time employee of WHO, where she served as the maternal and child health representative for many years at the Horn of Africa. Since 2002 she is the successful entrepreneur of her own non-profit charity Edna University Hospital in Hargeisa. Madame Edna, now 75 years old, has been a witness to the historical development at the Horn of Africa since more than fifty years.

3.3 Simple (unobtrusive) Observations (June/July 2013)

Most of the interviews took place at the physicians' workplaces; they either owned the clinics or hospitals themselves, or they worked there as employees. After I communicated my request to interview the physician I was usually accommodated into the facility's common waiting area. There I was able to gather some comprehensive and authentic first impressions unobtrusive observations (Bouchard, 1976). Main aspects of the facilities; like cleanness, spaciousness in the waiting area, seating accommodations, and availability of the reception area, were easily observable. Client characteristics such as gender, age and style of clothing, provided an understanding of the client population. I also studied client and staff interactions, and formed an opinion about the facility's connection to a pharmacy and their available

stockpile. After I completed my interviews the serving physicians usually took pride in showing their diagnostic and treatment rooms, and if available also their attached laboratory.

Unobtrusive observation proved to be helpful in triangulating the information given within the in-depth interviews. I summarized my unstructured observations in short memos. The information is used anonymously and cannot be traced back to individual facilities.

3.4 Literature Research

My literature study relied upon electronic databases and online libraries, PubMed and other search engines. I frequently utilized the free library data base of the Copenhagen University Library Service (CULIS) associated with the Royal Library. Furthermore I consulted Google, Google Scholar, Google Book Search, Wikipedia, websites of diverse international humanitarian aid organizations, homepages of the different ministries of Somaliland/Somalia, homepages of different government agencies and the United Nations Development Group (UNDG).

Major search terms used as exemplified were:

Fragile states, failed states, weak states, health services in fragile states/collapsed states/weak states, health crisis Sub-Saharan Africa/Somalia/Somaliland, public health Somalia/Somaliland, health worker crisis Somalia/Somaliland, private health sector Somalia/Somaliland, rebuilding health system Somalia/Somaliland, private health sector for the poor/Sub-Saharan Africa/Somalia/Somaliland, health worker motivation, quality of care, health care regulation.

The above listed, as well as additional search terms, were used in multiple combinations but the resulting data was seldom specific to Somaliland; most of the generated data addressed the whole of Somalia. Whenever possible I tried to disaggregate the data to get information exclusive to Somaliland. However, no health indicators for Somaliland from 2011 and 2012 were available. Scholarly literature is also devoid of recent literature or baseline data about the private health care sector in Somaliland. Characteristic to the common Somali oral tradition I obtained many important references and specific information about valuable aspects of the historical and present context of Somaliland while conversing with key-informants (Dr Muuse, Madame Edna Adan Ismail).

3.5 Theoretical framework

The theoretical framework based on a thematic analysis which is inspired by phenomenology. The phenomenological approach captures my study participants' perspective, specifically their thoughts related to the services they offer as physicians in the private sector. The physicians share their

experiences and perceptions about their services and the environment within which they work (Tuohy et al, 2013). The phenomenological approach suits my professional background as well as the research topic (Balls, 2009). As a medical doctor I habitually take a patient's current mind-set and past experiences into consideration in order to form a diagnosis; by doing so I regularly apply aspects of the phenomenology. I proceed by introducing the theory of phenomenology which inspired my theoretical framework.

3.5.1 Phenomenology

Robert Sokolowski (2001) describes phenomenology in his book "*Introduction to phenomenology"* as "*phenomenology is the study of human experience and of the ways things present themselves to us in and through such experience"(*p. 30). Phenomenology is based on the concept *"that every act of consciousness we perform, every experience that we have, is intentional: it is essentially 'consciousness of' or an 'experience of' something or other"* (Sokolowski, 2001).

Phenomenology enables me to identify phenomena perceived by the physician related to the services they provide. Perceptions and their associated insider's information were obtained by in-depth interviews. Shared experiences from the perspective of the study participants based on their knowledge and subjectivity are foundation for the evolving themes related to my research focus. The approach enables an understanding of the physicians' everyday reality in detail based on perspectives and interpretations about their services offered. Consequently the world around and within the physicians provide their services becomes accessible for my research.

3.5.2 Phenomenological reduction

Phenomenological concept of reduction or bracketing is utilized to control possible effects of pre-existing conceptions against the research focus (Fischer, 2009). My professional background and my work experience in Somaliland demand the application of this method. Bracketing is used to avoid becoming emotionally fixed on challenging topics. Unawareness about existing preconceptions could bias the whole research process. According to Tufford and Newman (2010) "*bracketing can mitigate adverse effects of the research endeavour, importantly it also facilitates the researcher reaching deeper levels of reflection across all stages of qualitative research: selecting a topic and population, designing the interview, collecting and interpreting data, and reporting findings, which could contort the results and consequent interpretations."* Bracketing in my research process is limited to my own

preconceptions during the research process. It has to be preceded that participants *"preconceptions are part of their presented perspectives"* (Tufford and Newman, 2010).

The concept of phenomenological reduction was applied throughout all phases of my in-depth interviews (from the preparation phase to the transcription and analyses of the data).

3.6 Data analysis

The theoretical frame for my analysis is based on the thematic analysis approach (Clarke and Brown, 2006). Focussing on the research questions, thematic analysis encompasses the identification of the recurrent and most relevant themes evolving from the body of data. Thematic analysis is not theoretically bound. It is applicable to a range of theoretical approaches which makes it suitable to phenomenology. According to Clarke and Brown (2006), "*thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data"*. The identified themes are important for the description of the researched phenomenon (Fereday and Muir-Cochrane, 2006). According to Clarke and Brown (2006), "*a theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set"*. An inductive approach assures that the evolving themes are strictly related to the obtained data. This leads to a data driven process to analyse the given findings (Alhojailan, 2012). My research approach and the related time constraints favours a semantic level within my analyse process. Evolving themes are centred on oral narratives and their associated meanings, rather than interpretations beyond the spoken word (Clark and Brown, 2006).

The applied approach of thematic analysis for the data obtained follows the six stated step by step guide published by Clarke and Brown (2006):

- *Familiarize yourself with your data*
- *Generating initial codes*
- *Searching for themes*
- *Reviewing themes*
- *Defining and naming themes*
- *Producing the report*

In my presentation of my analytical process applied I go through the different steps. This enables the reader to follow how I derived my defined themes stated.

Familiarization with the data was achieved through the field work and circumstance that all data was obtained by me. In addition to each interview I regularly documented my observations and impressions in memos. I transcribed more than 400 pages containing raw data. During repeated readings I searched for repetitive patterns within the individual interviews and the entire data set. The start of the beginning coding process was set by primary markings and underlining of the sections of the data that included interesting aspects of information. I looked for similarities and differences within the single interview and the whole data set. I generated my codes manually within a staged process in two different phases. Suitable to my applied inductive approach I generated first in vivo codes and in the second phase as descriptive codes. The process of structuring and organizing the code pool derived potential themes. Several cycles of structuring, revising and organizing the code pool refined these themes and sub-themes. Further processing of these themes and sub-themes enabled the establishment of consistent and condensed key-themes and sub-themes suitable to the overall data set. These common themes evolved through the inductive analytical process were stated by nearly all interviewees. Beside this unique themes emerged stated by few or single interviewees. In-depth processing of these themes and sub-themes established condensed definite key-themes and sub-themes. Inductive and analytical data procession exuded the commonality of perceptions expressed by almost all interviewees. Despite the overall prevailing themes, some thought deviations of a few individual interviewees also needed to be taken into consideration. Finally the produced report brings all mentioned aspects together.

3.6.1 Data reduction and theme selection

Relevance of developed codes and evolving themes to my research focus was guiding principle during the data reduction process. This process enabled to manage the huge amount of semantic data. The large data pool was reduced based on a structuring and selection process. I started with the development of a thematic codebook and assessment of the frequency the themes were stated by the different interviewees. The selection of definitive themes and their sustaining data was based on the number of interviewees who mentioned the same theme and the subjective importance themes were stated. Lastly the selected and presented themes are based on my conclusion of the analysis process.

3.6.2 Post observational analysis

I based my analysis on what I heard, saw and experienced during my visits at the selected health care facilities. At each facility I gathered, and later recorded impressions related to the presented infrastructures, maintenance, available equipment and organizational structures. Respect for each

facility's anonymity prevented me from recording detailed descriptions. The information served mainly to triangulate the data which I collected during the in-depth interviews.

3.7 Feasibility and ethical considerations

Ethical considerations prevailed primarily due to Somaliland's fragile state status. In this kind of setting attention has to be given to every detail of someone's behaviour. Unfamiliarity with the complex situation may cause misunderstandings, which can quickly escalate into destabilization of the given, fragile structure. Formal and informal codes of conduct have to be followed without exception. Adherence to religious regulations bound to a conservative Islamic society poses a prerequisite to all research conducted in this part of East Africa.

Data from personal interviews conducted with Dr Said Ahmed Walhad (Dean of Amoud University), Dr Achmed Ali Saeed (deputy chairman of Somaliland Medical Association), Madame Edna Adan Ismail and Dr Muuse (MoHL) is presented with each interviewee's explicit permission. The Ministry of Health of Somaliland approved my study approach and related field work by the representing contact person Dr Mohamed Muuse. He also clarified security issues and related travel requirements and restrictions.

3.8 Personal background and characteristics

My personal professional background of more than 15 years of gynaecology and obstetrics in different Asian and African settings, including my working experience in Somaliland (2010 – 2011), allowed for the unique opportunity to conduct my research in Somaliland. Awareness about my personal background assured reflexivity. My individual characteristics, such as age, gender, and life experiences were also taken into consideration. All these above mentioned aspects have been incorporated in order to grant my research credibility and relevance (Clancy, 2013).

3.9 Limitations of the study

Time limitations and minimum financial resources posed major challenges to my field work. Safety and security issues while travelling in Somaliland presented an obvious limitation in form of travel restrictions to three of the six administrative regions (Sool, Sanaag and Togdheer). Free movement in the 'safe' areas was only possible in the company of a private security guard and delayed administrative procedures created additional drawbacks. Therefore the fieldwork of my research was limited to the Maroodi Jeex region of central Somaliland with the capital of Somaliland Hargeisa, Sahil region and its seaport city Berbera (Annexe III) and to the north-western Awdal province with its provincial capital Boorama (Annexe II, Figure I).

My research is limited as it represents only perspectives of male physicians. I was unable to conduct interviews with female doctors for two reasons; first, female run facilities do not exist, and second, local conduct prohibits a visiting male from directly interacting with females. Notwithstanding several female students graduated since early two thousand from national medical education programs at Amoud University and Hargeisa University (Dr Said Ahmed Walhad, Dean of Amoud Medical School, personal communication 4th July 2013).

Other limitations included:

- Most doctors could only be interviewed at their place of work during working hours, during which they were busy consulting their patients. The time available to conduct in-depth interviews was therefore often limited.
- The flow of a busy private clinic, with interruptions from waiting patients, questioning nurses, ringing mobile phones and complete stand-stills due to frequent prayer times was also hindering.

I was there for grateful for any opportunity that allowed me to conduct an interview. Additional limitations were affiliated to the applied research methods. Initially, purposive sampling of the interviewees depended on outside information and my judgement. Subsequent theoretical sampling was determined on preliminary interpretations of the first interviews during which I was possibly influenced by the consolidated information and their emerging themes.

Using in-depth interviews as primary research method introduces a potential for biases; for example, physicians with private practices in favourable locations (Hargeisa) may be more influential; others might take the opportunity to propagate personal opinions during the interview. The interviews were conducted in English, which was neither the interviewer nor the interviewees' mother tongue. Triangulation was limited to my observations, interviewee data and the sparse literature about the specific context available.

Somaliland dominated by the Isaaq clan (Gundel, 2009); nearly exclusively acquaintances from the Isaaq clan were part of my pre-existing network, which might have influenced my field work. My Christian faith and Caucasian race might have prevented the interviewees from fully accepting my presence amongst them.

Furthermore despite commonalities between fragile countries each country faces a magnitude of challenges unique to its own context (Mcloughlin, 2012); therefore conclusions related to a fragile country have limitations to be generalized.

4. Findings of the field study

The analysis of the in-depth interviews is based on the methodology described in section (3.6). First I was left with 10 themes and related sub-themes. Further data reduction and theme selection was based on the structuring and selection process mentioned. I excluded themes (e.g. specific non-recognition aspects, medical education, international recognition of medical degrees acquired in Somaliland, medical specialist training, international and national NGOs, non-profit and charity based health care providers) above the scope of my thesis. By further grouping I could reduce the number from 10 to 3 final themes. Clan related issues are only mentioned when essential for the understanding of the given context.

The final themes and sub-themes are as follows:

- Physicians' self-attributed significance
  - Physician's perceptions
  - Physicians' motivation
  - Quality of services
  - Spectrum of services
- Access to services
  - Main clientele
  - Client demographics
  - Access for the poor
- Health sector regulations
  - Enforced regulations
  - Omitted regulations
  - Unregulated human resource management of physicians
  - Demand for regulations
  - Regulatory bodies
    - National Health Professional Council
    - Somaliland Medical Association

Furthermore participants' characteristics are presented. I also summarize the results of my unobtrusive observations and present a short overview of Somaliland's private health care sector as perceived by Dr Muuse, (MoHL, personal interview by Dirk Grothuesmann, 17th June 2013). The information provided

by Madame Edna Adan Ismail about this particular fragile country's historical context and development of the current private health care system is covered in the relevant sections.

4.1 Participants:

Twenty four male physicians were interviewed for this study. At the time they were between 28 and 60 years old. Eighteen of them were in the capital Hargeisa, four in Boorama and two in Berbera. They graduated medical school between 1977 and 2012. Seventeen hold degrees from Amoud or Hargeisa University in Somaliland or from Mogadishu University in Somalia; the others completed their studies in Sudan, Russia or Pakistan. Fourteen participants are married, and ten of them have between one and thirteen children.

All interviewed physicians serve in private facilities. Seven doctors work exclusively in the private sector. Two of these seven doctors serve exclusively in one private facility, the others work for between two and five private facilities. The remaining physicians practice in the private as well as in the public health care sector. These seventeen doctors, who serve parallel in public institutions, work there from one day per month, up to six days per week. The average working hours per 24 hours spend in the public health care sector varies from one to four hours. The time spend in private facilities varies from seven days to one day per week, with working hours between 4 to 6 hours per day, up to 24 hours seven days per week over months. Two of the doctors are medical specialists with internationally accredited diplomas.

4.2 Physicians' self-attributed significance

4.2.1 Physicians’ perceptions

All participants give great value to the services they provide. The private sector demands a clear and regulated workflow and it is characterized by a motivated staff executing defined tasks. One physician explains it as follows: *“- - - nurses are committed, = because we are looking at them weather they did their things. Doctors are on shifts, they look weather they did their things or not, everything is settled”* - male, age 56, [interview 12].

Sixteen of twenty-four doctors work in both, the public and the private sector. This might explain why most feel the need to point out the differences between the public and the private sector: *“If we compare to the governmental hospital doctors and nurses are low paid, they are less motivated and you cannot find even in the night a doctor. In our hospital the service is twenty-four hours, you can get any, all the doctors twenty-four, twenty-four seven // and nurses are ready.”* - male, age 29, [interview 1].

Ownership creates a clear separation between public and private services and defines the physicians' own importance: *"- - - the major differences to the public services there is owned by the government, it is government and the private is owned by someone or run by private NGO or private people - - - "* - male, age 29, [interview 1]. *"- - - always private there are people, special people that own it and they can manage a hospital, the health system, how is working and aeh // always control the service."* - male, age 29, [interview 22]. *"- - - the private is providing good health service according to governmental hospitals, because it is sponsored by ownerships - - - "* - male, age 28, [interview 9]*." - - - the man who is responsible for the private health care is the manager of the hospital and he is a doctor also. He knows how can survive his patients - - -"* - male, age 29, [interview 22].

Many interviewees use examples from the public sector to differentiate from the private health care they provide: *"- - - in Somaliland, // we don't prefer as in public hospitals because they don't have good services and they don't have even the doctors, / they don't be committed for their work."* - male, age 30, [interview 5]. *"- - - the public services are weak rather then, // comparing to the private and the services are very low comparing to the private services. "* - male, age 45, [interview 10].

Almost all participants find demotivated or absent staff, especially during emergencies, to be a particular feature of public health care; this stands in contrast to the members of the private sector: *"- - -when I was in - - - (public) hospital, one night there was an emergency we couldn't find the laboratory technician, we couldn't find the nurse, we couldn't find the theatre and it was middle of the night someone who is having bleeding. If this is in a private hospital all things are available. In this private hospital I work in, I do not worry about weather I miss laboratory technician nor the nurses, the theatre technician. Everybody, everything is ready and available."* - male, age 29, [interview 1].

Low quality of care is described as one of the main reasons why people do not seek health care in the public sector: *"- - - even with the hygiene and the moral, the people are really desperately staying with the public, because they don't have good quality service."* - male, age 31, [interview 6]. *"- - - in Somaliland, // we don't prefer as in public hospitals because they don't have good services - - -"* - male, age 30, [interview 5]. *"- - - they think that the government hospitals are not well served, poor services, that is why people come in the first place comes to private clinics. They think the hospitals have long queues, poor services that is what they associate in their minds with."* - male, age 58, [interview 19].

The incompetent and demotivated work force of health care workers in public services is believed to have its origin in inadequate salaries and insufficient working conditions: *"- - - the governmental hospitals the staff who is working there is not motivated. I am the doctor, the doctors salary is fifty*

United States Dollar (USD) per month, // what about the nurse, it is less than that. So the staff is not motivated, sometimes the drugs and the equipment is not available - - -" – male, age 56, [interview 12]. Most physicians report the low governmental wages to be the main reason to enter private business: *"- - - the salary of the doctor working for the government is one-hindered USD, = than they need to go for the money in order for their homes for their children, they have to work as a private."* – male, age 29, [interview 1]. "*The government salary is around one hundred USD to one hundred and thirty USD and that is not enough for their cars fuel for a month and this (working in private) is ve:::ry financial in my point of view."* - male, age 30, [interview 23]. The situation is different in the private sector, and a major reason why skilled staff leaves the public sector: *"- - - when you are in private you offer your staff a good salary so that they can do a good job, they are really motivated, = they are highly motivated - - - "* – male, age 32, [interview 4]. Consequently the public sectors is understaffed: The public, as well as the private sector charges for services provided: *"- - - there are some variations, but nothing is for free even in the public - - -"* – male, age 53, [interview 13].

Most physicians are aware of the problems created by costly fees, but they rectify the higher fees in the private sector with better services: *"In private we charge money, so when the patient pay their money they get a good service, but aeh in public the patients don't pay money, so the doctors who are working there only for a very little few, few hours in those hospitals, so the patients cannot get a good care in those hospitals."* – male, age 32, [interview 4].

Continuous education and further career development are opportunities that are mostly related to employment in the governmental services: *"- - - to work in the public hospital will give you another chance just to proceed your education = just to practice your profession in there as a general, // aeh as a part time doctor. So you still find in public hospitals another chance - - - you cannot earn money but you can get experience, knowledge and upgrade in your CV for scholarships and things like that."* – male, age 31, [interview 7]. The main referral governmental hospitals enable to get hands on complex clinical cases and gain further experiences. *"- - - as a junior doctor you see different cases. So it is a grade up for my knowledge, // as well I see senior doctors, who have great knowledge and I see cases I have never seen before - - -"* – male, age 28, [interview 3].

Promotion of private business and patient recruitment are additional reasons to mingle with the public sector: *"- - - many patients they visit me in Hargeisa Group Hospital and customize my popularity - - - "* – male, age 28, [interview 3]. *"- - - they visit me in the morning in the aeh aeh // public general hospital*

and I say, you visit me in the afternoons in my clinic when you need more time, // and then they visit me." – male, age 30, [interview 4].

Some physicians see working in the public sector as an opportunity to serve the poor: *"- - - in the public hospital I am happy to work here, because here the patients who come are more poor patients, // I am happy to give or provide opportunity to treat the poor patients that cannot afford to come into the clinic. I want to treat the poor patients that cannot afford to go to the private sector. So for my moral, for my moral I am a doctor, // so I am very happy to have the opportunity to meet the poor people here."* – male, age 45, [interview 10]. For most interviewees their patient's health seeking behaviour illustrates the difference between public and their private services: *"- - - the majority of the patients are just happy to go the private; the service of the private is just more effective than the public"* – male, age 45, [interview 10]. *"- - - the private sector of Somaliland is considered as the major part and almost all patients living in Somaliland are going to private - - -"* – male, age 32, [interview 4].

Collaboration within the private sector exists in form of casual connections between the providers; it is a way to access additional services or equipment: *"if there is some cases difficult now aeh for example we don't have aeh in this hospital an ophthalmologist so we are sending them to the other private hospital - - -"* – male, age 32, [interview 2]. The same informal collaboration exists between the public and private sector: *"- - - when I am in the Group Hospital, when we need CT scan or MRI we have to send him to the private sector to reach a diagnosis."* – male, age 28, [interview 3].

Recently a formal cooperation called public private mix for TB and malaria cases has been established to assure standardized treatment and data collection for these specific diseases. One participant explained it like this: *"We have a system called public private mix, // so if I see a patient who is complaining cough for more than three weeks and fever like this and weight loss, and I am assuming that the patient is maybe a TB patient we stop to examine in the private area // and we send to the hospital, because the TB services in the public they are free."* – male, age 45, [interview 10]. The program is still facing many problems and a detailed presentation is beyond the scope of my thesis.

Additional details about physicians' perceptions regarding their services are recorded in detail in the following sub-themes: physicians' motivation, quality of services, spectrum of services.

4.2.2 Physicians' motivation

The most frequent and most emotionally expressed aspect of motivation was related to factors, such as being needed and appreciated: *"- - - the motivation is still helping my people. I do not want to go for money business or anything else besides helping all these people - - -"* – male, age 32, [interview 4].*"- -*

- I want to help my people // because the majority of the people is poor, that is why I am working there." – male, age 39, [interview 8]. Purified commitment to work as physician is stated: *"- - - I like to contribute, sacrifice all my time for the hospital, for the patients /// I would like to sacrifice and give all my time for the patients - - -"* – male, age 28, [interview 9]. *"I want to help my society, // to help if the aeh // need health service, // I have to know I have to help them."* – male, age 29, [interview 21].

Many participants name the persisting health care crisis in Somaliland as a primary motivation to serve in the private sector to make a change: *"Somaliland have a quite a lot of health care problems //. They need more to help them and from health educated they know how to solve these problems, // that is why we come here to serve and we are concern about these health topics."* – male, age 30, [interview 5]. *"The people need people, who have a kind of expertise for the job that we do. The rarity of the people who have that expertise is forcing us to do it."* – male, age 53, [interview 13]. Others explain it like this: *"- - - so many of the patients request me to set up a private clinic to meet me and when I see the request of my patients, of many patients and many patients come here without complain of - - -, they want to discuss with me any other diseases so they request me to set up at any other area so that they can meet me and to facilitate other people, other clients have a chance to meet me //."* – male, age 45, [interview 10].

A major motivation factor to serve in the private sector is related to a better income generation. Priority hereby has the secure source of income and sustaining an adequate level of living for the family and not enrichment. *"- - - I need money to survive to support my family. I have been studying medicine for seven years, I have to work hard and get help to my people and get enough pay salary = and the private hospitals is the only place where you can get paid well and if you compare the salary - - -"* – male, age 29, [interview 1]. *"- - - all the doctors are going now for private so that they can earn and work to earn, so that they have some income actually." – male, age 32, [interview 4]. "So when they see that the government is not paying good or enough of salary they prefer to go private sectors."* – male, age 31, [interview 6]. *"- - - everybody knows best is private, so if you are a businessman you must make business."* – male, age 31, [interview 7]. *"The private sector, in the private sector, it is to supplement your income - - - "* – male, age 58, [interview 19].

All interviewees are at least part time employed in the private sector: *"In Somaliland every doctor has a clinic, has a private clinic, because it is there where he earns his living. There is no doctor who has not, everybody is doing."* – male, age 55, [interview 20]. The same participant stated that were it not for the income generating opportunity provided through private businesses, they would still be suffering from

the disastrous consequences of the war; now at least they are able to provide care for the population: *"We have to find a way to sustain our selves, because there was nobody paying us, // we have families and still we were not getting anything, at that time the government was not paying anything, nothing. So we have to have a way to sustain ourselves to be able to stay, otherwise we would have to go somewhere else."*

Many of the interviewed doctors have large families and social responsibilities, all in need of financial support. These social obligations are strong motivations: *"I am working here in the private // while I stay here in the town or my village I am trying also to cover up my other needs the needs of my family, *I am a father of two children and I am also responsible of other children* // who my dead brother left, so I have to cover all other things my family needs. "* – male, age 31, [interview 6]. *"I have three children, I have a family, I have brothers, sisters, they need my help, that's why I have open here."* – male, age 39, [interview 8]. *"- - - my plan was actually when I came here aeh / was actually to support my family. I have four brothers and aeh / one sister and they are in different colleges."* – male, age 32, [interview 2].

Better infrastructure and resource availability are other factors for seeking work in the private sector: *"Everybody, everything is ready and available that is why we prefer private - - -"* - male, age 29, [interview 1]. *"Public services are hugely under-resourced and then they don't have the capacity to see patients."* – male, age 30, {interview 23].

Mainly for fresh graduated doctors the private sector opened the only reliable opportunities for employments. The following statement is an example of the difficulties they experience in the current market: *"- - - students who are graduated, aeh when they have finished their internships, they are running from here to there to get some employment."* – male, age 32, [interview 2]. *"- - - the government doesn't offer an opportunity as an employment. So aeh // the private sector came up to us and asked to work for them. So that is how we end up in private sector first - - -"* - male, age 29, [interview 14]. *"- - - Somaliland is a small country, no independency, there is no job, // the government couldn't able to give you your fee, your salary, so we are searching, // we are always searching where we can get a job, weather it is private or it is government. So now aeh, / I am working with a private hospital - - -"* – male, age 29, [interview 22].

One participant summarized the difficulties faced and the related necessity to stay always ready to take any reliable livelihood opportunity: *"I come from a long way of learning, I have a hard struggle to go*

through my school days, because I have no other opportunity to work hard because I have no other chance in this country.“ – male, age 31, [interview 7].

4.2.3 Quality of services

Perceived the private health care sector fulfils all needs: *” - - - the private care, aeh // people they get what they need. That means, // if they need a surgery, if they need immediately, any emergency cases / they will get it.”* – male, age 32, [interview 2]. *“- - - the majority of the patients are just happy to go the private. The service of the private is just more effective than the public.”* – male, age 45, [interview 10]. Their services offered are described as sophisticated and twenty-four-seven available and this is contrary to the public services. The following statement refers to this perception: *“- - - they come in special times, like during the night time. Mostly during the night time we do caesarean section, because they come to refer from the government hospital, because of lack of doctors, who can do them. And the patient cannot wait until tomorrow, than the nurse / the midwife send us the patient, because they know the private hospitals have the doctors available who can do them, who can do that, who can manage.”* – male, age 29, [interview 1].

The 24/7 availability of physicians seems to be a major plus point for the providers themselves, as well as for the clients: *“The most important thing for our people, // they like the availability of doctors.”* – male, age 29, [interview 1]. *“I think it is more interesting private // aeh, because they are providing the services by the doctor, doctors and health worker, // so they are trying to do more.”* – male, age 28, [interview 3]. *“In our hospital the service is twenty-four hours, you can get any, all the doctors twenty-four, twenty-four seven // and nurses are ready- - - if there was no nurses, no doctor than there is poor quality of care = *you can understand straight forward*.“* – male, age 29, [interview1].

The following statement exemplifies perceptions about the quality of care provided: *“- - - good quality means // aeh the provided care for the patient is as much as the patient needs, = satisfying the patient and also aeh // helping him to cure or get the *proper treatment and diagnosis*.”* – male, age 29, [interview 14]. *“- - - the private care, aeh // people they get what they need. That means, // if they need a surgery, if they need immediately, any emergency cases / they will get it.”* – male, age 32, [interview 2].

Timeliness is a very important aspect regarding quality of care: *“- - - whenever patient comes, within one minute a doctor is also here and he takes the service and gets an examination. Within one hour he gets the results and within thirty minutes when he arrives he can get his antibiotic.”* – male, age 29, [interview 22]. *“Whenever they come to the hospital they ask the nurses, where is the doctor? Than they*

get a doctor within five minutes when they ask, that is what they get, that is how they compare and this is what they get in our private service." – male, age 29, [interview 1]. Especially in the evening and night hours the availability of physicians in private is given. *"Some people are working during the day, // so when at night they need a doctor, // they need a private place to do so."* – male, age 35, [interview 18]. *"- - - you can get nurses and doctors in a private hospital any time even at midnights - - -"* – male, age 28, [interview 9]. One participant expressed what he and many of his colleges believe good quality health care should be like: *"- - - if the patient comes after 2 o'clock after midnight, is there a doctor weather he can get or not. It can increase the quality, if you have the doctors and nurses available. If you have nurses and doctors together it increases teamwork that increases the quality of care of the patient."* – male, age 29, [interview 1].

The high quality health care they serve is for the participants confirmed in the health seeking behaviour of the population. Almost all participants emphasize that the people of Somaliland prefer private health care services: *"If it is private sector, it is good service and the people like private sector."* – male, age 39, [interview 8]. *"- - - the Somalis like the private sector. They think it is more efficient - - -" – male, age* 58, [interview 19].

In the physicians' perceptions good services are linked to the fees paid for the services; as stated, this is in accordance with their patients' perception: *"- - - when the patient pay their money they get a good service - - -" – male, age* 32, [interview 4]. *"Is it a traditional belief in our custom, when you pay more you get better services - - - " – male, age* 29, [interview 1].

4.2.4 Spectrum of Services

The private health care sector is providing a whole range of services: from essential physical examinations based on ordinary medical devices (stethoscope, hammer) to sophisticated diagnostic and surgical techniques. These are examples for common services offered in small private clinics: *"We depend on our clinical judgment plus // we have laboratory which we, which we can do the basic things - - -"* – male, age 29, [interview 1]. *"- - - the first step is the physical exam, / that is the most important and that investigation, / I give a good time for that, for the physical examination and the history."* – male, age 60, [interview 15].

The following statements exemplify typical work situations physicians are exposed to in their clinics: *"I do clinical work, so children, olds, adults, women everybody comes and there are sometimes referral cases, for instance if there is a surgical case, or gynaecological cases, or orthopaedic case. Sometimes I*

*meet psychiatric patients, so I see all types of pathology; *I mean sick people come to visit me*." – male, age* 58, [interview 19].

Specialty clinics and several private hospitals occasionally deliver high-end health care. The perceived motivation to do so is often profit driven: *"- - - in Somaliland you can find different things in the private centres, // because they are mainly money orientated. You can find whatever you want; / you can find different specialties, contradictory to the public where the patients cannot find *everything what they need*."* – *male, age*e 31, [interview 7]. *"- - - they stay with a lot of equipment, because they have a lot of source of income."* - male, age 31, [interview 6].

The perceived opinion is that this is beneficiary for the entire population of Somaliland: *"There is one CT scan in Somaliland it's owned by private doctors. It increases the quality before we usually send the people to Ethiopia // when we have to do the CT scan."* – male, age 29, [interview 1]. Difficult and complex treatments and surgical procedures are offered in private centres likewise. *"- - - we do here operations, any kind of operations, we make prosthesis, total hip replacements and hemi arthroplasty (surgical repair of joint). We make Iliazarow for bone length - - -"* – male, age 28, [interview 9].

The services offered depend on the individual skills and training and the infrastructure of the facilities. Even preventive care, such as vaccinations and counselling are offered through private health care facilities: *"- - - we give the people how and what to know about preventive care and vaccinations, // aeh and aeh mother child spacing this is what we are just giving. - - - we are giving them explanation, = more explanation about their diseases, hypertension, diabetics more *so that they can understand that*."* – male, age 32, [interview 2].

Although most doctors work as general physicians and do not have certified accreditations within their clinical work, they are often seen as specialist in their field: *"I'm working here as a general physician and mainly I am the only doctor in Somaliland who is doing endoscopy and colposcopy and I work as gastroenterologist."* – male, age 30, [interview 5].

Most clinics and all assessed private hospitals are affiliated with a pharmacy and laboratory: *"I have consultation for the doctor, / I have a laboratory department and I have a / pharmacy to sell some drugs."* – male, age 45, [interview 10]. *"- - - we have a good laboratory, / a ve:::::::ry good lab - - -"* – male, age 60, [interview 15].

4.3 Access to services

4.3.1 Main clientele

Adequate financial means to pay the user fees are required from most of the patients: *"- - - in private hospital people, who can pay they go there. - - - most people who have a job or who are working come to our hospital."* – male, age 29, [interview 1]. *"They pay as all the private sectors, they pay the investigations and they pay the treatment and also the medications, all of them pay."* – male, age 30, [interview 5]. *"They have to pay something definitely, there is nothing for free."* – male, age 53, [interview 13]. *"- - - usually patients, clients who visit this hospital are those who can afford to pay // the fees, which is expensive compared to the public."* – male, age 29, [interview 14]. *"- - - mostly privates, they are expensive and // poor people cannot be reached. Mostly they do not for free cases, // because the bed, the lab, the instruments, / all they pay themselves."* – male, age 28, [interview 9].

4.3.2 Client demographics

People from the nearby neighbourhood to all over Somaliland and beyond are utilizing the private health care sector. Sometimes even Somalis living in the diaspora in Europe or the United States are utilizing these services; the more exclusive and specialized the services are, the further people are willing to travel.

Here the related statements the variant client demographics: *"- - - the customers are the neighbours and certain times from the market and from different fields according to their needs."* – male, age 28, [interview 3]. A participant with a mid-level facility (small private hospital in Hargeisa) explained it as follows: *"- - - fifty percent of the patients are from Hargeisa and the surrounding towns but we have also a good number, about fifty percent the patients come from eastern provinces of Somalia like = Puntland and eastern provinces of Somaliland like = Erigabo and Burao."* – male, age 32, [interview 4]. Two specialized physicians said: *"- - - almost eighty percent of my clients come outside of Somaliland /// Somalia // and Djibouti // and Ethiopia and even some Somali, who live in England they come to me and those who live in the Arabic countries come to me"* – male, age 30, [interview 16] and *"they are coming from every Somali speaking region of the horn."* – male, age 55, [interview 20]. In the summer times Somalis from all over the world are utilizing especially specialist services as well. *"- - - during the summer time = we receive the patients when the people are coming back from all over the world, = you know the Somali people, they are living all over in the world - - -."* – male, age 56, [interview 12].

4.3.3 Access for the poor

All participants are aware that financial constraints are a major obstacle to access private health care, which can lead to dramatic consequences: *"Those who cannot pay, those who live on less than one USD they cannot pay an operation which needs one-hundred USD. Than they were suffer, than they will suffer form that morbidity and mortality of that problem."* – male, age 29, [interview 1]. *"You will die or you will have to pay, or the poor people they will know that they cannot pay that much amount of money so they will not take that patient, their people to the hospital, = because they know when they take him to the hospital they cannot pay them, it is no sense in taking that patient to the hospital when you can't pay."* – male, age 32, [interview 2].

Emergency treatment for those without financial means is occasionally provided for: *"- - - patients who cannot afford a bed, for instance unconscious patients, who have no money, we do the tests for free we give the bed for free, then we send them up (to the ward)."* – male, age 32, [interview 4].

Most medical doctors perceive themselves as part of their communities, including the poor: *"- - - we are part of the community and when we see the patients requires that services that should have been given to them and they cannot afford, *we can give them*."* – male, age 56, [interview 12]. Some feel responsible to do so. *"- - - it is my role for the clinic, if the patient cannot afford the consultation fees, it comes to me free. Every day we have three to four patients without fees or free consultation."* – male, age 45, [interview 10]. *"The communities are divided in those who are rich and those who do not get even one USD per day, most of the families now here do so. The reason why I do now two days free of charge because I saw I see a lot of patient really say we skip our meal because of lack of income in the families."* – male, age 31, [interview 6]. Even though consultations can be free, lab works and drugs still need to be paid for: *"- - - free of charge is just for the fees of doctors, the rest is to pay, the labs and everything, the drug service and so on and so forth."* – male, age 53, [interview 13]. *"- - - even if we tried to see the patients for free, to write the medications so we are not changing anything there are problems because there is no free medications for them."* – male, age 32, [interview 2].

Some physicians provide scheduled, free consultation days: *"On Monday people didn't pay anything, it is free on Mondays, // so we have a day were they don't pay anything. - - - it is personal - - -"* – male, age 30, [interview 5].

Arranging health care services for the poor usually depends on the individual case and the discretion of the doctor in charge: *"- - - that is my decision to give some services without payment, because when we were students they told us to facilitate our people, who have problems."* – male, age 35, [interview 18].

"- - - we figure out the patients who are really very needy and find the patients out who can really not afford. = We tell them and if they really cannot pay they get for free." – male, age 32, [interview 4]. *"- - - we see whether he is real poor or not. If he is real poor we do everything for free, /// even the surgery - - - the decision is made by the administration and the doctors together."* – male, age 28, [interview 9].

The individual case presented within the Somali cultural context is often part of the selection criteria: *"When you are Somali you can understand in our culture who can pay or not. Like supposed you say your wife she needs caesarean section, // yes than her husband says yes I'm accepted and he can give you the consent but he does not have the money to pay. That is the time we sometimes / we discuss and the director gives them free of charge - - - that is the only way how we can know if the patient can pay or not because everybody likes his wife and children and when they have money nobody says we don't have money // for to pay."* – male, age 29, [interview 1].

Some consider providing health care for the poor as part of their Somali culture: *"You know we are Somalis we always look after the poor. I already told you that is our centre, if anybody is not able to pay the fees who comes to you, you are asked to continue. I, every doctor is like that."* – male, age 55, [interview 20]. *"- - - if you see a patient with a clinic and the patient has nothing, you can help as much as you can because Somalis are usually quite close people, so they are a very close society so they can help each other including me."* – male, age 31, [interview 7].

Physicians may go as far as putting their patients into categories according to their financial means: *"- - - we have two different categories, in our services and in our accommodation also. You know the people, who can afford they can pay as it is and the people who cannot afford, // * we give then freely the accommodation and the drugs although*."* – male, age 56, [interview 12]. He did not explain the selection process.

Most participants point out that the fees charged in their private facilities are cheap: *"You know in here usually the fees are extremely cheap. So many patients can afford to pay that, it is about three to four USD."* – male, age 31 [interview 7]. *"- - - our treatment is not so expensive so that most of the patients can that afford."* – male, age 29, [interview 17].

However, specialized treatment and diagnostics can exponentially increase the charged fees: *"- - - initially you have to pay seven USD and = then if you need any neuro-diagnostic tests that is, actually if you need an MCS or EMG or if you need an EEG it depends aeh // that is between fifty and seventy USD*

// each." – male, age 32, [interview 4]. *"- - - we just opened our MRI but for paying it is around two hundred."* – male, age 45, [interview 10].

4.4 Health sector regulations

4.4.1 Enforced Regulations

All study participants mentioned the importance of regulations and controlling mechanisms within the health care sector. This major theme is present in every aspect of their professional life. Only two physicians felt that that there are adequate governmental structures which are regulating and controlling their work. Their facilities are located in Hargeisa, the capital of Somaliland: *"- - - they (government) are regulating, because they have to give for the license, they have to give a license to open a private clinic and actually supervise. They sometimes actually come and check the total, = they come and check the certificates and make actually sure that they give a good service to the people."* – male, age 32, [interview 4].

They describe a registration process for their facilities with regular inspections: *"It (his facility) is registered in the ministry of health. We need .haha. // even when you need a driving license, / if you don't have that license you cannot run your own sector until registered for the ministry of health."* – male, age 28, [interview 3]. *"We are now under the policy of the government of the ministry of health and check from time to time and make sure that we are giving good services to the people and they are actually controlling the public and the private."* – male, age 32, [interview 4]. Both facilities were newly established and maybe some kind of regulation process implementation has stated in the capital setting now.

4.4.2 Omitted regulations

All other participants described a complete lack of regulations in the private, as well as in the public health care sector in Somaliland: *"- - - there is no regulation from the government. The ministry of health they did not regulate. Nobody comes to the hospital and says and wants to look what we are doing. I haven't seen and I have been here three years. I haven't seen even I have been here three years even one person who says I'm from the ministry of health I'm checking all, = I 'm checking what you are doing. Weather we are doing the right things, right procedures, there are no regulations."* – male, age 29, [interview 1].

Lack of regulatory bodies is blamed for most problems in the private sector. Many physicians accredit being recognized as medical doctors to the appreciation of the population they serve and not on earned

certificates or formal qualifications: *"- - - here in Somaliland as you practice you just need people who accept you as gynaecologist or as a good orthopaedic. If the people accept you don't need any other accreditation, you just work for yourself.*" – male, age 28, [interview 9].

The following statements and examples report on their perception about the unregulated situation: *"- - - in Hargeisa for the last five years, for the last three year I 'am here the number of private hospitals have doubled since I'm here = and for the coming years we are expecting they are doubling again."* – male, age 30, [interview 8]. Private health care providers are coming from all over Africa and mainly countries related to the former Soviet Union and start their private health care provision without any prove of fulfilled qualifications and certificates. *"- - - there is a lot of doctors who come from the outside, who are not Somalilanders, they work as public sectors and even we don't know there specialty- - -"* – male, age 30, [interview 5]*."- - - for the last two, three years there are too many doctors from foreign countries, / from Russia, / from Tajikistan, / Pakistan."* – male, age 28, [interview 9]. *"- - - in Somaliland, you drop your bag and you start practicing, so there is no law, no law is regulating, so that is why we have these "quark" local doctors and some other people who come from all over, who we do not know who they are and start doing whatever they want."* – male, age 53, [interview13]. *"- - - now everyone opens a clinic who is a doctor, // no doctor, // someone I don't know where they come from, they come from, // some magic people Kenya, / they are telling put your hand in this machine and we can discover all your diseases and they come from every place. - - - perhaps my grandma who has never been in school // is a doctor now."* – male, age 60, [interview 15].

The increasing number of doctors immigrating from other countries is thought to be a major problem for Somaliland's health care sector: *"You will see every day new advertisements of the new health sector establishment or new doctors that come from country, other country, so there is an increasing number of new facilities and an increasing number of doctors from neighbouring countries and really // there is a very competition between the private sectors."* – male, age 45, [interview 10]. One participant summarized the present situation: *"Everything is here //, because I told you there is no regulation, this is no man's land."* – male, age 30, [interview 23].

4.4.3 Unregulated human resource management of physicians

The unregulated and unbalanced allocation of physicians leads to a dramatic under-provision of physician provided health care in remote areas. Accredited physicians are almost exclusively clustered in urban settings: *"- - - in remote places there is no anaesthesiologist because only big town like Hargeisa, Boorama, Burao, Berbera like this but no other places. Only three four towns, the big cities, //*

anaesthesia available, but small places and small towns and small districts there is no anaesthesiology." – male, age 40, [interview 11].

Although more than twenty students graduate very year form Somaliland universities, the graduates do not leave the major cities to work in rural areas: *"- - - for the health of our communities we graduated young doctors and nurses, // but the problem of them is that they just gather in the major towns. They don't want to go to the remote areas that are the challenging issue."* – male, age 56, [interview 12]. *"- - - like in all other developing countries, the doctors who graduated stick to the big towns, they don't want to go to the smaller towns - - -"* – male, age 53, [interview 13].

The reasons stated for such imbalances are almost all due to a lack of financial incentives: *"- - - if we give them a good salary, they can go; they will go wherever we send them. They can go to the remote areas and they can help the people, = they can get enough salary *that they can survive in that remote area*."* – male, age 56, [interview 12].

Another reason is the collapse of the internship program which used to be run by the ministry of health: *"- - - for the last four, five years universities producing fifteen, twenty doctors per year and with that number there are somehow small coverage for certain towns out of Hargeisa and Borao, because the ministry imposed a law that those who are graduated should go during their first year to this towns. So there is a plan but most of the doctors are still in the big towns."* – male, age 53, [interview 13]. The internship program was cancelled out of financial misbalances in salaries between post graduates and accredited doctors working for the public services. *"- - - doctors who graduated used to go to the towns are getting five hundred USD per month. The dilemma comes when the senior doctors who were already; paid and employed by the ministry, their salary was maybe only one hundred USD. So that makes the things not work. So when they see this in the first year, // maybe the first two year, / they stopped out of the discrepancy."* – male, age 53, [interview 13]. As of July 2013, internship program has not been resumed.

4.4.4 Demand for regulations

Almost all interviewed physicians believe it is the government's responsibility to implement regulatory mandates for the health care sector: *"Like other countries they (the government) could assure private license, = regulate the service people are doing. Everybody can claim being a private doctor and we don't know about their qualification."* – male, age 58, [interview 19]. *"There should be regulations and on the bad things that could be arise from the private sector, this can include malpractice, this can include human // exploitation, financially and whatever and this can involve in a very big crap*

manipulations, this can be and this can happen, // if things are not in a good control." – male, age 30, [interview 23]. *"- - - usually private sectors are just money orientated, so somehow if they are not monitored or guided continuously they can even go the wrong way. The government should have and help as well to monitor and guide the public and private sector."* – male, age 31, [interview 7].

Some voiced strong opinions regarding the subject matter: *"If they don't check who work in private sector, / who works there, / it will be zero, it will be a disaster."* – male, age 60, [interview 15].

4.4.5 Regulatory bodies

National Health Professional Council

In 2001, instituted National Health Professional Council (NHPC) is the carrier of hope for those who perceive the non-regulation as one of the major problem in the health care sector. Legally the National health professional council is supposed to be the regulatory body for all health care professions, such as medical doctors, pharmacists, lab technicians, nurses and midwifes, as well as medical universities and nursing schools (NHPC Somaliland, n.d.). But NHPC has not functioned over the last twelve years. Most participants believe that the NHPC has not been effective until now or that it was just recently established: *"- - - it is called National Health Profession Council, NHPC, it is newly established, now they finished their criteria, standards, register, and license. But before it was not probable, you can come you can work, no problem."* – male, age 28, [interview 9]. *"Actually the Medical Council is very new, // still there is no chairman, / there is no deputy chairman, only there are elected court members, / they are consulted from Uganda, they are consulted form the UK and from Nairobi. All these consultants they developed the tools, for example the tools, for example the standards for accreditation. It is newly established still they don't have the power, they don't have still, they don't have taken any steps, so as here in Somaliland as you practice you just need people who accept you as gynaecologist or as a good orthodedic."* – male, age 30 [interview 17]. *"- - - we are just starting the national health council and the National Health Council will determine the qualifications, // the training and how the work and that are specific issues in the public and private arena."* - - - *the national medical council, which is for the health care providers, the one to register them, they want to accredit them, to hold them accountable for the parts they do."* – male, age 53, [interview 13].

Major problems are hindering the successful implementation of controlling mechanisms initiated by NHPC. Main obstacles are related to financial constraints: *"The implementation of regulations needs budget, needs support from the community, it needs support from the health care providers themselves."* – male, age 53, [interview 13]. Another problem is related to missing implementing and executive power

of the government. *"- - - the government is not strong enough to implement any law. They cannot just implement the law they can sign."* – male, age 40, [interview 11].

Although many thought the NHPC is ineffective, it is their only hope to change the situation: *"The government needs to improve the Medical Council because the Medial Council is the only resource to help the people, the medical doctors and even to help the patients as well as ////."* – male, age 30, [interview 5]. Most participants are aware the process will take a long time. *" - - - everything started for scratch and building that up = and the road is very long and it will take a very long time you know to reach were we aspire to reach, you know."* – male, age 53, [interview 23].

One participant expressed his perception regarding the failure of regulatory bodies as such: *"- - - our poor people and patients and they will suffer more and more until the government will do some regulations = and listen and making it strict and giving them the lesson how to make regulations."* – male, age 29, [interview 1].

Somaliland Medical Association

In 2004 the voluntary based Somaliland Medical Association has been founded. Criteria to become a member are the Somaliland citizenship and a medical certificate issued from a recognized university (Somaliland medical Association, n.d.). One of their major objectives stated is to certify the qualifications of all medical practitioners who intend to work in Somaliland and regulate the formal health sector in coordination with the MoHL and the NHPC. "*- - - if a doctor has any problems the Medical Association is the one to help in any problem which they meet any member of the Medical Association. Any problem related to our medical field, for instance, if someone is threatening him a relative, *the Medical Association is helping*."* – male, age 28, [interview 9]. Others described SMA as quite useful: *"We have an organization the Somaliland Medical Association is the one who is organizing, they already look after us. They are looking after us. They are the once who have to develop."* – male, age 55, [interview 20]. Limitations to fulfil the stated mandate are stated likewise. "*- - - its (SMA) role is quite limited, they just get people to integrate them, they may organize once a year a conference for the members and that is it. They are themselves resource and capacity limited."* – male, age 30, [interview 23].

4.5 Baseline information formal private health care sector; Hargeisa, Boorama and Berbera given by Dr Muuse (personal interview by Dirk Grothuesmann, 17th June 2013)

Today in Somaliland you can find almost any medical doctor or specialist in any field. However, nearly all of them are working and living in the capital Hargeisa. As consequence Hargeisa a town with estimated more than 700,000 citizens in 2013 has a vibrant private health care sector run by accredited physicians. About eighty percent of in total two hundred and five physicians (including the graduates from July 2013) are based in Hargeisa. In numbers more than one hundred sixty of them are now in Hargeisa. As consequence huge regions of Somaliland are under served or even completely without any physician based services.

The physicians are mainly accessible at their private clinic, or during the few hours they work parallel on employment basis or occasionally as volunteer in the public hospitals. As a result there are as many private clinics with affiliated pharmacies in Hargeisa.

In Boorama the private sector is likewise vibrant and increasing. Compared to 2009 many new facilities have opened until 2013. In two thousand and nine there were four clinics and one private hospital. Now there are two private hospitals and twelve clinics and this number still increase. The numbers of accredited doctors in 2013 are about thirty. Related to the university in place (Amoud University it is expected that this number will exponentially increase over the coming years.

Berbera region is out of the challenging semi-desert climate a difficult place to stay for most physicians. The population density is much less compared to Hargeisa region and Boorama, consequently for private health care business Bebera region is less attractive. In July 2013, there are around five doctors in Sahel region in Berbera working. Most of them are serving in public and later in the afternoon or nights in their private facilities. It has no further institutes of health or faculties, which makes it even more difficult for junior doctors to go there.

The exact numbers of physician based private facilities in the assessed three regions are not known. But for Hargeisa it's estimated that there are more than ten private hospitals and more than sixty private clinics and clinical pharmacies (pharmacies including a consulting physician). The number of private hospital remains blurred because some of them depend on non-profit organizations or charity. Continuous new launching of private clinics and clinical pharmacies also make this number difficult to establish. It is worth noting that more than 1300 pharmacies, staffed with nurses (formal and informal) are offering medical consultations as well.

4.6 Simple unobtrusive observations

I visited fourteen private clinics and six private hospitals. Fourteen of those facilities were located in Hargeisa, the remaining ones were in Berbera and Boorama. Of the fourteen clinics, eleven provide general medicine and three centres specialize in radiology, neurology and internal medicine. Two of the private clinics provide inpatient services. The six private hospitals offer various specializations depending on the qualifications of the doctors in charge.

4.6.1 Clinics

With the exception of two, all private clinics are affiliated with a pharmacy. Ideally their drug stock adheres to the World Health Organization (WHO) recommended essential drug list, but some facilities carry no more than basic antibiotics, painkillers and vitamins. Only a few, better equipped facilities have the means for refrigeration and generators which allows them to store and provide vaccinations, anti-venom and insulin.

Most facilities have a small waiting area integrated into their affiliated pharmacy and occasionally seating is provided. In all facilities the waiting areas have to be shared by females and males alike, but they are segregated into gender-specific groups.

In smaller clinics the same person is responsible for registering the patients, as well as for managing the pharmacy. More sophisticated facilities are recognized by designated waiting rooms and an employee who handles registrations and payments. All clinics display transparent payment regulations with standardized user fees. The consultation with a physician cost between 1-7 USD; often the bulk of a facility's income is generated through the affiliated pharmacies and laboratories. The available services vary greatly: in smaller clinics with limited equipment, physicians depend solely on their clinical judgements and basic medical devices such as a stethoscope and a scale. Larger, more sophisticated facilities offer the entire spectrum of diagnostic tools, ranging from electrocardiogram and ultrasound to sophisticated neurological diagnostics and high tech devices such as computer tomography and magnet resonance imaging.

All, but one of the twenty visited clinics are linked to a laboratory. Some offer only haemoglobin and pregnancy tests, while others have the capacity to run sophisticated hormone analysis. In average the facilities are well maintained and electricity is available. Internet is accessible almost everywhere via mobile phones.

Only three clinics have running water. With a few exceptions the other facilities provide water in jerry cans. Often there are no opportunities for hand washing in the consolation rooms. Seven facilities have functioning sanitation.

At the beginning of their careers, newly graduated physicians often enter an alliance with a pharmacy or a lab owner, both the pharmacy/lab owner and the physician profit from their collaboration. Once the physician is financially and professionally more established, he opens his own facility. Auxiliary services depend on individual capacities and often also on NGO or charity investments. In average the interviewed physicians claim to be available in their clinics six days/week for 3 to 6 hours.

4.6.2 Hospitals

Four of the visited private hospitals are located in Hargeisa, the other two are in Boorama. All facilities have affiliated pharmacies and laboratories and two also operate their own supermarkets within the compound. The hospital compounds, except for one, are fenced and guarded. Patients are obligated to buy their drugs and treatment/diagnostic related devices from the house-intern pharmacies, which are managed by certified, national pharmacologists. The drug stock is generally comprehensive, adhering to the essential drug list of WHO; ready to use kits required for specific surgeries, e.g. caesarean sections are also for sale.

Transparent user fee policies are in place and designated personnel collects the money for surgeries, inpatient stays and all other diagnostic procedures.

The hospitals' infrastructures range from dilapidated facilities to brand-new constructions, some of them housing state-of-the-art diagnostic equipment. All hospitals offer general surgeries, gynaecology and obstetrics, and few are additionally specialized in paediatrics and internal medicine.

Most of the hospitals are owned and managed by well-known Somaliland doctors or other individuals with health care backgrounds. On all six premises, doctors are available 24/7. In three of the hospitals the doctors on night duty are recent medical school graduates who work during the day in the public sector. The other hospitals employ full-time house doctors. Staff working hours are organized into shifts. Generally speaking, the inpatient wards are spacious, with a capacity ranging between twenty to sixty beds. In all hospitals private rooms can be arranged for additional fees. The patients depend on their relatives for food; if this is not feasible it is possible to order and pay for food from the hospital.

5. Discussion

5.1 Physician run private health services

In all the interviews it became obvious that the physicians' believe that their private services are of utmost importance to the entire Somaliland population. In their perception it is the only reliable source of health care. Although their services are offered mainly in urban settings, they insist that urban slums and underserved rural areas also benefit. Several participants use the example of poor women, who are more likely to take their sick children to a private health care provider, than to a public facility.

The consideration of the historical development of the health care sector after the civil war is essential in order to understand the current circumstances. At the beginning health care providers started from zero and every effort to deliver health care was initiated by private providers. The physicians with their private services filled the gap of defining structures and expanded their services. Up to date, participants believe that private facilities are still the major contributors to the health care system.

The availability of physician based services varies by regions. Somaliland suffers from a dramatic health worker shortage, especially regarding accredited physicians. Almost all physicians are located in the three cities I assessed: 190 of 205 accredited doctors (July 2013) are living and working in Hargeisa, Boorama and Berbera (Dr Muuse, personal interview by Dirk Grothuesmann, 13th July 2013). Rural areas are especially affected by the shortage. For overall Somaliland (3.7 million citizens) on 1000 people come 0.05 physicians. A WHO supported publication about health worker shortage in SSA published comparable low numbers for only four other countries: Republic of Tanzania, Liberia, Sierra Leone and Central African Republic (Kinfu et al, 2009). A fragile country context in Somaliland is an aggravating factor to all aspects of the health worker shortage. The World Health Report 2006 shows that countries with fewer than 2.3 health care professionals (doctors, nurses, and midwives) per 1,000 people fail to achieve essential public health targets such as efficient immunization coverage or adequate level of skilled birth attendants (WHO, 2006, p 11). Somaliland is in every aspect far behind these public health targets.

An additional shortage and imbalance of physicians' services between public and private services is obvious. Participants state that while they are employed by the government, they do not serve more than two to three hours per day in public hospitals. The situation in their private sector facilities is the opposite: here they are usually available from the afternoons until late evenings.

Most participants highlight their own importance and relevance of their private health care services by comparing themselves with the services provided through the public sector. The general agreement is

that both, the physicians and the Somaliland population do not trust the public services. Despite these sentiments, many of the physicians with private facilities continue to work parallel in the public sector. One physician explained it openly: *"- - - there are patients who prefer private; I mean to see private hospitals, because they think that the government hospitals are not well served. But they forget the same people who are working in the private are also working in the government."* – male, age 58, [interview 19].

The quality of care is perceived as high in private facilities; those working there are considered to be responsible, available and accessible. These attributes stand in stark contrast to the work ethic witnessed in public services. There the majority of staff is unmotivated due to low salaries and an insufficient infrastructure. Most of the physicians employed in a dual working situation are complaining about scarcity of all essential resources in the public services. This is not so in private services where physicians and auxiliary staff are committed to provide good quality of care. The physicians' believe that their unfavourable perception of public services is also confirmed through their patients' health seeking behaviour: Given the choice, all patients prefer private health care if available.

Most participants emphasize their greater responsiveness towards their private patients and services. In his publication *"Public health care under pressure in sub-Saharan Africa"* Streefland (2005) confirmed that the same or similar problems in public health care sector exist in most SSA countries. In Somaliland the major problems in the public health system are related to inadequate procurement systems, non-accountable service delivery and ineffective supervision. The public sector administration is not empowered to standardize bureaucratic processes, such as regulating tariffs or controlling work performances. Even the presence of active health workers in hospitals cannot be assured. As a consequence, the Somaliland population seeks health care in the private sector (Mazzilli and Davis, 2009).

For most participants a feeling of ownership marks the difference: In their private facilities they regulate and structure the working processes to their liking, this leads to a favourable outcome. Their perception that private care is more effective and efficient cannot be supported by Basu et al (2012), who conducted a systematic review about performance comparison of public and private health care in low and mid income countries. For them private facilities demonstrate only a more efficient customer support and timeliness. Specific studies about quality of care in fragile country settings have not been conducted up to date.

Most interviewees express a lack of trust towards the services provided by mid or low level health workers. Health care provision in general seems to be mainly physician oriented and patients mainly value their accessibility. This is confirmed by the physicians own perception about the health seeking behaviour of Somaliland's population. The results published in *"Somaliland Immunization Coverage Report"* (UNICF, 2008) further validate the notion of a physician centred approach: Somalis in general prefer to be consulted by medical doctors. UNICF reports low utilization of Mother Child Health (MCH) facilities when services were provided by nurses, contrary to days when physicians were available for out-patients consultations: then women queued to be seen (UNICEF, 2008). Somalis' mistrust of mid-level (nurses, midwifes) health care workers does not hold up against researched evidence. It has been proven that appropriately trained nurses are able to provide high quality health care equal to that of medical doctors (Laurant et al, 2004).

For most participants the importance of the private sector is found in the provision of sophisticated diagnostics and treatment options. Major investments in the health care sector for expensive high technique diagnostic devices (e.g. CT and MRI) are not feasible without financial risks and familiarity of the private sector. *"Before we were sending to Addis Ababa which is one thousand kilometres west and more than one thousand five hundred dollars paid by the patient, / for costs of the air, / costs for the CT scan, now we can get the CT scan for one hundred fifty dollars - - - just in Hargeisa- - -"* – male, age 29, [interview 24].

The innovative capacity of the private sector to provide services otherwise not available is based on resulting financial profits as confirmed by current literature (IFC, 2009). It is expected that a major contribution to the health care investments related to infrastructure and sophisticated diagnostics will be made by the for-profit private sector in low-income countries in the coming years (IFC, 2009)..

5.2 Motivation

Physicians' motivation can be divided into intrinsic factors based on internal personality characteristics and extrinsic factors related to external characteristics of the health care system they work in (Franco et al, 2002). The motivation to serve in private institutions is based on the requirements to fulfil their financial obligations. The low salaries in governmental services (between 100 and 300 USD per month) do not allow for a decent standard of life. I asked one participant how much his estimated living costs are: *"I am married but I only have one child, // my expenditures is around nine hundred fifty per month, because this is the cost of the rental, / the electricity, / internet and / water. Because of water scarcity you have to pay twenty five dollars every ten days to get the water, // you have to pay fifty dollars for the*

light, // two hundred dollars for the rent. All the food vegetables, meat and this and you have to pay another water, which is qualified to drink, so this costs for me, my wife and only one child are nine hundred fifty dollars." – male, age 29, [interview 24]. This responds exemplifies why a satisfying standard of life, based on governmental employment seems to be impossible; clearly additional income sources are necessary. All participants report that without private business opportunities, a good life is not feasible for a physician in Somaliland. A typical statement: *"If the government provides ///, gives me a good salary I can close here (his private facility)."* – male, age 28, [interview9]. Additional extrinsic factors related to better infrastructure and organizational structure in private are relevant as well, however not expressed as major reasons to serve in private.

They express a perception of intrinsically motivated determents as their primary motivation to work in the private sector: They all report a high ambition to help and treat their Somali people. *"The first motivation is towards my people, = helping my people and helping Somaliland people - - -"*– male, age 32, [interview 4]. Most participants see themselves as altruistic individuals who work for the best of their patients. Leaning from their Somali culture they describe themselves as pro-socially motivated health workers. These aspects are highlighted when it comes to health care provision for the vulnerable and poor: *"You know we are Somalis we always look after the poor. - - - every doctor is like that."* – male, gage 55, [interview 20]. The physicians believe that their professional obligations and their love to serve their communities are central. They have clear perceptions about values and behaviours concerning their profession as medical doctors.

Perceived respect, appreciation of the patient population they serve and a clearly defined position within the clan's ranking system are other major sources of intrinsic motivation. *"- - - in the Somali context, doctors, teachers and religious leaders that three is very respected. We are like the top of the clan - - -*." – male, age 29, [interview 24]. Willis-Shattuck et al. (2008) confirms these intrinsic aspects to be major motivation factors in the SSA context. Financial incentives are only one of several aspects of health care worker motivation, and they are usually not the leading ones. In general, increased salary does not directly improve health service quality and outcomes. Satisfaction with the services offered, sufficient infrastructure, as well as adequate resources are considered to be as important in order to maintain work motivation. Intrinsic motivations are essentially related to an environment which provides opportunities to deliver higher quality of care; Brock et al (2012). For participants both aspects, intrinsic and extrinsic, are more often attained through the private sector. There, opportunities to organize and structure a health care facility, including human resource management are provided. *"I said to myself, better to do yourself*

*and organize your private clinic. Here I have no inpatients, because it is hard to, because we don't have good nurses, // *it is a disaster if the patient is going to die from you*."* – male, age 60, [interview 15].

5.3 Access

All interviewees acknowledge that user fees affect accessibility to health care. The physicians emphasize that user fees are charged equally in public and private health care sectors, and that problems to come up with the needed money are witnessed in both. However, fees in the governmental sector are lower. The consequence of malady related user fees for major population groups in Somaliland, living on 1 to 2 USD per day, is dramatic. Life of these groups is characterized by typical poverty driven problems (Kaplan, 2008). This is comparable to many other regions of SSA. The African Development Bank Group (2012) stated that nearly 50% of the population in SSA must sustain their living on less than 1 USD a day. Additionally SSA is characterized by extreme wealth distribution inequity.

In lieu of these circumstances all participants highlight their very low user fees. Regardless, it has to be assumed that consultation fees between 1 and 7 USD present severe financial obstacles to access private care for major population groups in Somaliland. It is general practice to pay out of pocket for all health care services. *"- - - there are some variations, but nothing is for free even in the public."* – male, age 53, [interview 13]. Expenditures for diagnostics, treatment and prescribed drugs need to be paid in addition to consultation fees. It seems that this is the source where many facilities generate most of their income from; conveniently almost all facilities are directly affiliated with pharmacies and laboratories (personal observations, June/July 2013). Malpractice related to superfluous tests or prescription of unneeded medicine to augment income cannot be excluded.

In specialty treatment procedures like surgeries, interventions can increase the costs dramatically. For instance, costs for a caesarean section can add up to 500 USD in private hospitals, despite an average income per capita and year of 250 to 350 USD in Somaliland (personal observations, June/July 2013). According to Ronsmans et al (2006) due to socioeconomic inequities in SSA large segments of the population have no access to potentially life-saving surgery interventions, such as caesarean sections.

Because the poor have only limited access of health care, the typical beneficiaries of private health care services are described as follows: *"- - - people who have availability, anybody who have the capability to pay the things we provide. - - - most people who have a job or who are working come to our hospital - - -"* – male, age 29, [interview 1].

Further problems regarding health care access are related to geographical aspects and the misbalanced allocation of physicians in Somaliland. About 190 of 205 accredited physicians are living and serving in the three cities I assess in July 2013. About 160 of them are living and serving in the capital area of Hargeisa (Dr Muuse, MoHL, personal interview by Dirk Grothuesmann, 13th July 2013). The infrastructure in these urban centres is good, and the majority of customers have a regular income and are able to afford the fees. Communities in remote areas have almost no physician based health care. Lack of transportation often creates additional problems and a trip to reach a physician in one of the distant urban centres is impossible for many. Almost none of the participants address these obstacles, but they are quick to volunteer the information that patients (who can afford it) travel from far to utilize the physicians' services: *"They are coming from every Somali speaking region of the horn."* – male, age 56, [interview 12]. The Somali speaking regions encompass the Republic of Somalia, Djibouti, northern parts of Kenya and major south east parts of Ethiopia (Figure II). This means people are travelling up to thousands of kilometres to access private health care in urban centres of Somaliland. The perceived attractions are specialty services and the high quality of care offered in private facilities. Statements like this are common: *"- - - almost eighty percent of my clients come outside of Somaliland ///. "* – male, age 60, [interview 15]. Even from war-torn parts of southern Somalia and focus of insurgencies like Mogadishu, patients are recruited regularly. Due to the oral society structure the contacts are mainly based on transmitted narratives of personal patients' experiences. Different modern media are utilized as well, here is another typical example: *"- - - the Somali community is an oral society, if one patients comes to your clinic and got there, = they go back to their community and tell them, // I was in that hospital and I improved there. So we although do some advertisement from the radio and from the TV about this set-up. - - - "They just call us and we tell them how to come here."* – male, age 55, [interview 20]. (male 20). Themes related to physical safety and security, direct/indirect financial costs of the travel related expenditures are not addressed.

5.3.1 Access for the poor

Access for the poor is depending on physicians' own contributions. One such charity is free of charge consultation hours on certain days of the week. Of course, many of those in need are unable to access the free of charge consultations due to the burden of travel distances and cost. In addition they would often not be in a position to sustain a suggested treatment and are frequently unable to pay the remaining costs of diagnostics (laboratory and medical devices) and surgeries if needed. The remaining costs for laboratory and drugs are explained by the physicians: *"- - -we try to minimize to help them to pay half of*

it and they pay only the laboratory but for me as a doctor I mostly see patients free of charge //."* – male, age 31, [interview 7]. Here is a typical scenario: *"- - - doctors might not be able to give them what they need all the time. Sometimes they may offer, sometimes they may say when they are reaching their saturation point; can you talk to someone who can help you and I see you freely."* – male, age 30, [interview 23]. It seems that physicians feel that fees for laboratory and diagnostic procedures are be easier justified than the rather intimate source of consultation fees (personal observations June/July 2013).

Free of charge treatments for certain patient populations with specific health problems, such as females with post obstetrical uro-genital fistulas, is offered in established private centres. One physician explained the process of gaining access to the needed financial expenditures as follows: *"- - - services we are already providing to the people, // we just put a small amount on it, for each service we are doing, providing to the community. So that amount we give, and with that amount we support the fistula."* – male, age 55 [interview 20]. He continues: *"- - - we use, our principles says that take it from the rich and give it to the poor."*

Feelings of responsibility and availability to the most vulnerable in their community are communicated to be high intrinsic motivation factors for most participants. Major aspects of the strong social cohesion are related to powerful clan structures and related family networks in Somaliland (Kaplan, 2008). Each clan fosters interests in controlling and regulating the available resources (e.g. social, financial and available infrastructure) and to share them with the members. Clan related interests rank above individual interests and clan membership defines the identity of the individual within the Somali society. Each clan is responsible for its members. The clan membership guarantees protection, livelihood assurance and certain political influence (Gundel, 2009). Medical doctors are highly respected and perceived as stakeholder of the clan. To maintain this respect and position they have to serve and contribute with their professional skills.

Clan based customs influence health providing and health seeking behaviour. Strong social cohesions to Somaliland tradition mandates that family members are supported emotionally as well all financially: One participant describes it like this: *"- - - my father and my neighbours and like this all the surroundings are poor, poor people here, because this country more people come from immigration here, they come from other counties, = they come from other towns. They want to have money but they have nothing, because I am the chairman of this place, I collect some money and give them for these people like this ///."* – male, age 40 [interview 11]. The clan system is an essential aspect to understand

the Somaliland's health care provision. *"- - - the clan system is in every aspect of the Somali society, it still effects the way doctors communicate with another, the clan system even effects medical students. It exists everywhere and it is very strong in the Somali society and of cause doctors are all among the Somali society, they are not from Jupiter."* – male, age 30, [interview 23]. The same participant explained why clan related issues are not more frequently addressed:*"- - - the people never, never ever talk about this topic; this is the hidden secret of Somaliland."* – male, age 30, [interview 23]. Instead most participants preferred to speak about the overall Somali identity: *"You know we are Somalis we always look after the poor. - - - every doctor is like this"* – male, age 55, [interview 20].

The physicians' efforts to provide the poor with access to health care is a recurring theme during the interviews: *"- - - it is my role for the clinic, if the patient cannot afford the consultation fees, it comes to me free. Every day we have three to four patients without fees or free consultation. Some of them // we pay the laboratory charge and sometimes we pay even the drugs."* – male, age 45 [interview]. The decision making process is based on Somali cultural context and on individual cases: *"When you are Somali you can understand in our culture who can pay or not."* – male, age 29 [interview 1]. "- - - we figure out the patients who are really very needy and find the patients out who can really not afford. = We tell them and if they really cannot pay they get for free." – male, age 32 [interview4]. In these situations where patients and family members are unable to collect the requested amount of money to pay, free services might be available. *"That is the time we sometimes / we discuss and the director gives them free of charge - - -"* – male, age 29, [interview 1].

Various international aid projects facilitate free access to private health care services for some patient groups. Internally displaced people (IDP) are amongst those who are given the opportunity to receive free private care. Caused by the on-going civil war, mainly in south and central Somalia, thousands of IDPs have settled in Somaliland where they cluster in and around urban areas. International NGOs like Health Poverty Action have projects in Somaliland that allow IDPs access to public and private health care (Health Poverty Action, n.d.). *"- - - for very few patients, those who have nothing and for some of those it is paid by NGOs - - - the people who are internal displaced people, who are maybe very much in Hargeisa and surroundings. They are the worst hit by this system, - - - when they go there the NGO sometimes pays the private hospitals."* – male, age 53, [interview13].

So far no health insurance system has ever been implemented in Somaliland. Examples from Nigeria, Ghana and Ruanda show a positive tendency towards universal health care and equitable financing mechanisms (Odeyemi and Nixon, 2013; Saksena et al, 2011). Private health care without direct

payment is only offered to employees of certain international NGOs. These NGOs have special arrangements with some of the hospitals in Somaliland: *"There was some international NGOs who is having insurance in our hospital. We threat them // than they will pay us later. They take the little insurance card, the letter,- - - then they pay the hospital later. It works like insurance. - - - It is there staff international NGOs, their staff."* – male, age 29, [interview 1].

The opportunity to access health services for the poor is in accordance with the research presented by Yoong et al (2010), who described increased private health care participation reduces both, urban-rural and rich-poor disparities in access and availability of health care facilities in many regions of SSA.

5.4 Health sector regulations

5.4.1 Regulatory bodies

National Health Professional Council

Controlling mechanisms to regulate Somaliland's health care sector were established, but as of today they are not enforced. The National Health Professions Council (NHPC) is acting as a statutory body to control and regulate the different levels of health care professions. The act to establish the NHPC passed in 1999. In 2001 the agency was constituted, but related to several constraints and difficulties; it remained completely ineffective until 2011. The objective of the council is to register, control and accredit health professionals and educational institutions. On their homepage the mission is described as follows:

"Act as a statutory body with a mandate to regulate the health professions, their education and practice, as well as the facilities where they practice, and to provide guidance to the health professions, policy makers, employers and the public on the practice, education, ethics and other professional issues in order to improve healthcare standards." (NHPC Somaliland, n.d.).

The situation started to change in 2011. Funding given by international NOG allowed for the establishment of a functioning infrastructure, as well as the development of a strategic framework. The NHPC works in cooperation with the MoHL and other organizations in the health sector, such as different professional associations (physicians, nurses, pharmacologists, laboratory technicians). In January 2013 the President signed an amended *Health Professionals Committee Law (Law No. 19/2001)* to enforce the implementation of further health sector regulations (Somaliland law, n.d.).

Somaliland Medical Association

SMA's main task is the advocacy of Somaliland physicians' professionalism. SMA is a member on the decision making board of the NPHC, where they aim to establish certain standards regarding accreditation, quality of care and integrating of regulatory processes for foreign doctors (Somali Medical Association, n.d). As of now, the SMA has not fulfilled its objectives; reasons are financial limitations and enforcement problems of the mandated regulatory processes. SMA aims to establish self-regulation based on a regulatory framework and guidance on the accreditation of physicians. The approach for effective governance and institutional regulators is not sufficient.

Typical problems related to self-regulation of medical-profession described in the literature are: assuring to maintain the professional competence, taking appropriate action once a problem situation with an individual practitioner has been raised up, and regulating conflicts of individual and group interests (Cruess and Cruess, 2005). All of these problems are validated by one or the other study participant.

Informal regulation efforts

Related to the problems expressed, national physicians are trying to establish some informal regulating mechanisms with collaborating providers. Their efforts are mainly directed toward a better management of the influx of foreign doctors to control the competition faced. An example describes the situation:*" The last two, three years there are too many doctors from foreign countries, / from Russia, / from Tajikistan, / Pakistan. So now five hospitals they cooperate, they said, // if a foreign doctor comes we talk about the salary, if he works for that hospital he cannot work for another hospital. If he finishes that contract, he has to go back to his country, not to another area another hospital. Aeh // also something like that, there is a good cooperation starts for the last five month. "*– male, age 28 [interview 9].

5.5 Present Situation

In July 2013, the situation seemed to be unchanged despite the above described legislative improvements and efforts. In the capital, private providers are taking advantage of the lack of regulations. Thousands of providers try to engage in the lucrative health care sector, independent of their educational qualifications and work experience, (Mazilli and Davis, 2009; Pavignani, 2012). The governmental has not been able to control this scenario. Almost all physicians interviewed for this research perceive this unregulated work force as a constant threat to their livelihood, as well as to the overall population. Many express their perceptions in dramatic words: *"If they don't check who work in private sector, / who works there, / it will be zero, it will be a disaster."* – male, age 60 [interview 15].

In addition, it is almost always impossible to clarify whether a facility belongs to a formal or informal provider: *"There are so many famous doctors here in Somaliland //, here who are no doctors. They have never ever been to medical school and you see there are lines and lines of people who are lining up for them- - - "*– male, age 53, [interview 13]. Two major concerns are voiced: in the first place is the competition from these pseudo doctors and following are the complications related to the inappropriate treatments which then need to be corrected by formal doctors: *"- - - in Somaliland, you drop your bag and you start practicing, so there is no law, no law is regulating, so that is why we have people who come from all over, who we do not know who they are and start doing whatever they want. They even charge high fees."* – male, age 53, [interview 13].

One deplorable consequence of unregulated physician activities is the complete imbalance of geographically distributed health care services in Somaliland. Skilled health services provided by accredited physicians are almost all exclusively available in the three urban hubs: Hargeisa, Boorama and Berbera. Only 15 (7%) of the total 205 physicians are serving the remaining 2.7 million citizens (73%) who are living in smaller towns and remote areas.

The interviewees and my observations explain this:

- Experienced physicians are running lucrative facilities almost exclusively in major urban centres.
- The government has cancelled the internship program due to money constraints and salary imbalances (internship doctors got a higher salary than permanently employed physicians).
- There are almost none maintained and functional public facilities in remote areas.
- Remote areas are not, or much less attractive locations to establish private facilities.
- The standard of life in remote provinces doesn't compare to what is offered in more urban settings.

Almost all participants expressed that urban areas offer higher monetary and non-monetary compensation for their services compared to rural areas. One participant summarized the situation: *"- - - like in all other developing countries, the doctors who graduated stick to the big towns, they don't want to go to the smaller towns"* – male, age 53, [interview 53]. Especially since the governmental internship program has been cancelled, job opportunities are almost all exclusively available in the private sector, and the private sector is clustered in the main cities. This situation has led to an oversupply, especially of young newly graduated doctors in urban areas. One participant describes the present situation in Hargeisa: *"They are trying to get in a private hospital, or they are working in some pharmacies, sitting*

there seeing outpatients and getting minimum money maybe around one dollar per patient. Some of them are working in this way." – male, age 32, [interview 2].

Foreign doctors are further competition; they come from all over the world and start their private business in Somaliland. Frequently these doctors are recruited by national businessmen in order to run their newly established health facility (personal observations, June/July 2013). For all involved, the scenario is usually based on financial interests and not on ethical medical attitudes: *"She came here because some local people sponsored her. They sponsored her so that she can make money and he can make money and that how it is."* – male, age 53, [interview 13]. The perception of the participants about these services is in accordance with the available literature about the Somalia and Somaliland health care situation: often health care services are shaped by commercial forces and not by health or welfare considerations (Pavignani, 2012; Newbrander, 2006).

6. Conclusion

The interviewed physicians perceive the contributions of their private services toward the overall health care in Somaliland as supreme endeavours. Their importance is explained by noting the historical context: since the declaration of independence (e.g. first functioning facilities after the civil war) until now (e.g. innovative investments in several health sector segments) health care in Somaliland has been depending on private run facilities. Furthermore, private health care provided by physicians of Somali origin is deeply integrated into the overall social, political and cultural context of Somaliland. The impact of physician based private care can be validated by the population's preference for private services. The perception of superior care in private facilities depends, amongst other things, on motivated staff that are supervised by committed and accessible physicians. The physicians themselves describe private ownership, direct influence on the decision making processes, infrastructure, supply chains and collaborations with other providers as essential factors.

The interviewees appear to be highly motivated by extrinsic and intrinsic factors. Major motivating aspects are related to country specific characteristics, such as strong clan ties and vibrant family networks. Physicians are highly respected members within Somaliland's society and its clan based structure. Because of this, their intrinsic motivation drives them to excel for the benefit of their "people". Physicians depend on their reputations and the appreciation of their communities in order to succeed in the private health care market. Extrinsic factors, such as a decent income is important to secure a certain standard of life, but not for personal financial gain. All participants are burdened with

huge financial commitments toward their own families, extended relatives and other clan members. They meet their obligations only by partaking in the competition-driven, private health care sector.

The interviewees' general clientele earns a regular income and live in an urban setting, close enough to access to the private facilities. The physicians are aware that their system: 'out of pocket cash for service' excludes the poor from their health care system, but in their perception the poor population groups (living on 1 to 2 USD per day) are still benefitting from their services. Therefore, although it is almost near impossible for poor rural inhabitants to reach physician staffed health care facilities, this issue has not been broached by the participants. Due to the imbalanced geographical distribution of physicians, almost 2.7 million people in different provinces remain without physician based care.

Health care provision for the poor depends on individual solutions; they range from free consultation days to extensive free-of-charge treatments. A selection process, considering cultural context and the poor person in question, determines if free services are granted. Even though physician's consultation might be gratuitous, the fees for diagnostics, drug therapies and treatment (surgical) procedures are seldom waived. The inability to come up with user fees for live saving surgery, like a caesarean section, poses a treacherous problem to major population groups.

The participants' frustration regarding the lack of regulatory and accreditation frameworks is palpable in all interviews. In their perception, the present situation threatens to destabilize everything that has been developed over the last two decades. Non-regulation of private health care in combination with uninformed patients (illiteracy rate about 70%), provides the matrix for unscrupulous providers to flourish in both, the formal and informal health care sector. The study participants fear that uncontrolled, detrimental services might prevail over reliable health care provision. Foreign doctors entering the private health sector contribute to the problem. The regulatory body, NHPC in cooperation with the MoHL and the SMA, does not have the financial means or infrastructure to enforce the recently amended regulatory laws. All physicians express the desire to cooperate with the responsible actors in order to improve the lawless situation. They welcome the implementation of regulations and executive power as they believe that the resulting changes will be for the benefit of all stakeholders: Unskilled providers won't be able to practice and the health care seeking population will have access to a more supervised and quality controlled private sector; consequently patients will be treated by qualified physicians.

Keeping the specific Somaliland context in mind, solutions are urgently required. Unified, health care access strategies for the poor need to be developed. The dramatically imbalanced, geographic distribution of physician based services has to be reversed.

The participants accept their leading role as health care providers. This, coupled with extended cooperation with the public sector (as exemplified in the public-private mix TB program) are necessary prerequisites for all solutions. All interviewees have a clear grasp on the current situation and they are willing to accept changes in form of self-regulation and by welcoming a national solution. These attitudes can be applied toward the implementation of better regulations and improved health care distribution.

For a reform to be successful, it is essential that key components such as adequate financial means, close cooperation between public and private sectors, and integration of the communities, are given. If these targets can be met in a problematic part of the world, such as the horn of Africa, adequate and accessible health care can be supplied everywhere in the world.

7. Suggestions for further research

Further research is recommended in order to explore how better regulations can optimize access and utilization of the available resources. National and local self-regulation processes should be included. Concerning Somaliland, the typical clan related power structures and customs, and their impact on the health sector should always be included.

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9. Annexes

Annexe I
Interview guide

All interviews are conducted face to face in Somaliland. The interviews are recorded by using a portable handheld recording device. At the beginning of the interview I introduce myself and explain my professional background and the master program I participate in. The objective of my study is explained once again. Informed consent is given by all interviewees at the beginning of the interview. The Interviewees are informed about handling and storage of interview recordings. All interviews are recorded anonymously. The recordings will be deleted after my thesis had been graded.

Background information: age, gender, nationality, education (areas of expertise, numbers of years practicing, national, international experience)

- Why do you to provide private services, can you describe your journey to this point?

- Can you explain your offered private services?

  Outpatient care

  Inpatient care (including primary care),

  Preventative care

  Diagnostic services

  Do you provide services which are not offered by public services?

- Who are your main customers and where do they come from?

  What other customers do you have?

- How are your services paid? (cash, insurance, salary)

- Can you describe the major differences between private and public healthcare? Please describe concrete situations and examples?

- What is private health care for in Somaliland? (Past, presence, challenges?

  Out of your experience what are the benefits of private health care for Somaliland?

  Can you reach lower-income and/or rural population with your offered services?

  Examples how this can be done?

Do you collaborate with public services and strategies to improve health services for the poor, can you give examples?

- Are you working for the public (governmental) health system as well? If so what proportion of time do you spend in public and in private?

  In your experience what are advantages of public and advantages of private?

  What are disadvantages of public and disadvantages of private?

- Can you describe what are the major obstacles and difficulties for private health care in Somaliland, can you give examples out of your experience?

- Does collaboration between the private and the public system exist?

  For example do you treat patients in your clinic who are sent by the public services or do you send patients to public services?

- Out of your experience, do you influence the public services with your private health care (examples of positive and negative aspects)?

  Is there competition within the private sector as well as between private and public sectors?

- Out of your experience what can be done by the government to improve the situation for you and your services offered (examples)?

  What can be done by the private sector to improve the situation?

Annexe II

Boorama Trip Arrangement 4th July2013

Logistic preparation

1. Vehicle check-ups - Road is tarmac and smooth no rough
2. Security – Expats need escort
3. Weather – If raining it is difficult to pass some of the valleys between cities
4. Communication – Antenna is working very well
5. Transport
6. Escort per diem
7. Food (Lunch) – No booking required if arrived before 10am
8. Rental cars with valid road tax
9. Drivers with licence

Expenditure

Item	Cost	Remarks
1 rental Vehicles (Land cruiser)	120 USD /Car	
Lunch	4 /Person	Fish with Drinks and rice or pasta
SPU	1 /Soldier	SPU –Escort
Estimated cost	**160 USD**	

Annexe III

Berbera Trip Arrangement 3 July 2013

Logistic preparation

1. Vehicle checkups - Road is tarmac and smooth no rough
2. Security – Expats need escort
3. Weather – If raining it is difficult to pass some of the valleys between cities
4. Communication – Antenna is working very well
5. Transport
6. Escort per diem
7. Food (Lunch) – No booking required if arrived before 10am
8. Rental cars with valid road tax
9. Drivers with licence

Expenditure

Item	Cost	Remarks
1 rental Vehicles (Land cruiser)	120 USD /Car	
Lunch	4 /Person	Fish with Drinks and rice or pasta
SPU	1 /Soldier	SPU –Escort
cost	**160 USD**	

Annexe IV

Transcription conventions

Italic speech assigned for the interviewee

/ a hearable pause from speech (less than a second)
// a pause longer than previous (more than a second)
/// a pause that is noticeably prolonged

= overlapping words

Bold speech that is hearably louder than encompassing speech

e::::i degrees of expansion of the prior sound; the more colons, the more expansion

silent distinctly more silent speech

.hah. stated laughter

((comment)) furthermore comments from the transcriber, e.g. about stated detail of context

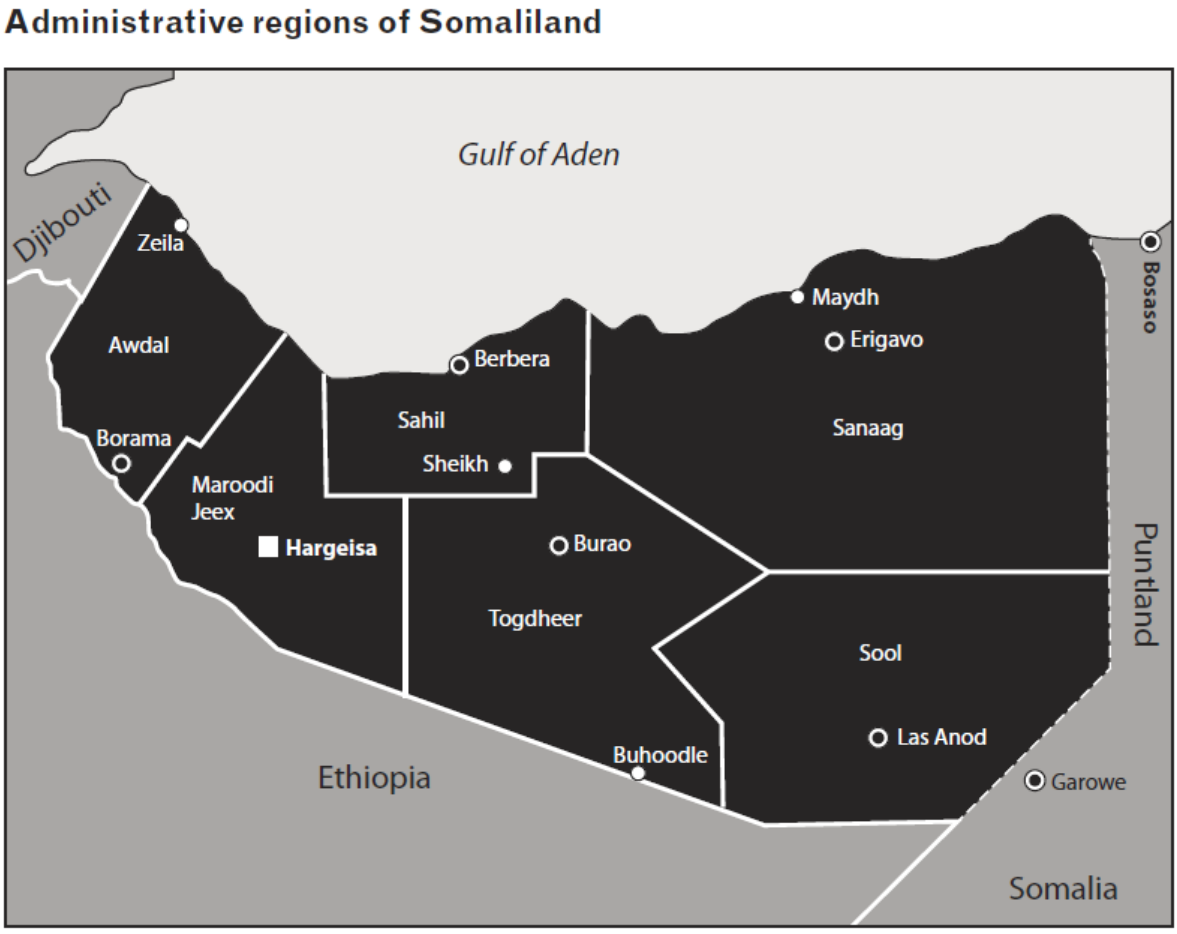
(sound) short comment or sound from the interviewer in the middle of interviewees response

- - - deleted text

[ ] the start and end of overlapping speech

Male 13 coding for the interviewee: - male, age 53, [interview 13]

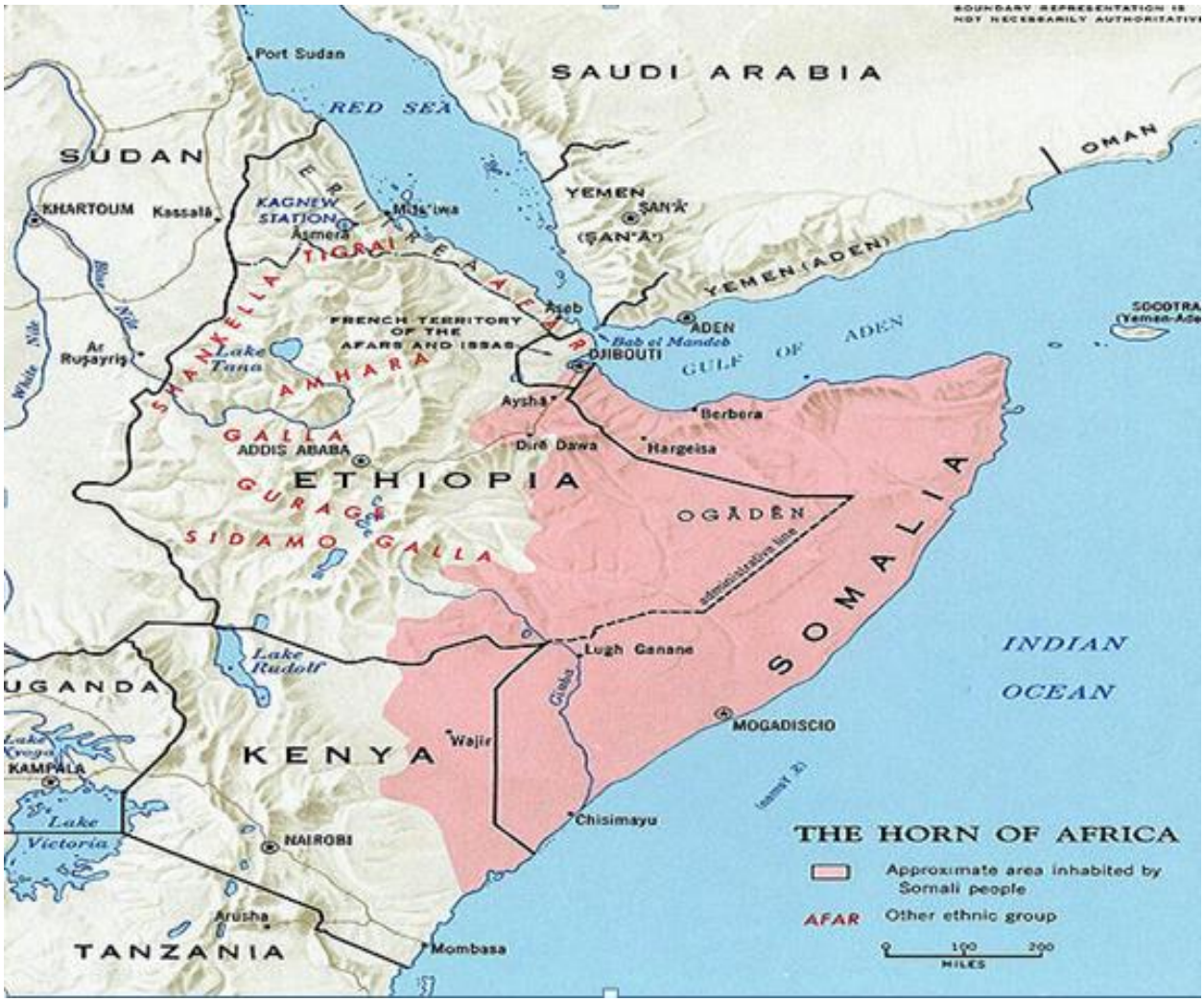
Figure I



Ismail M F, 2011. Patience and care. Rebuilding nursing and midwifery, in Somaliland. African Research Institute, London page 2

Figure II

Somali speaking regions Horn of Africa



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