

A Comprehensive Study of Health Gaps and Needs in the Mandera Triangle

The Cross-Border Health for Peace Programme

**This project is made possible thanks to
the generous financial contributions from**



**Foreign, Commonwealth
& Development Office**

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Interpeace's peacebuilding efforts
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Acronyms and Abbreviations

| | |
|-----------------|---|
| AIDS | Acquired immunodeficiency syndrome |
| ANC | Antenatal clinic |
| ART | Antiretroviral therapy |
| ARVs | Antiretroviral drugs |
| ASRH | Adolescent sexual and reproductive health |
| AWD | Acute Watery Diarrhoea |
| CBHI | Community-based health insurance |
| CBMP | Cross-border mobile population |
| CBMP | Cross-border mobile populations |
| CBN | Community-based nutrition |
| CD4 | Cluster of Differentiation 4 |
| CEWARN | Conflict Early Warning and Response Mechanism |
| CEWERU | National Conflict Early Warning and Response Unit |
| CHMB | County Health Management Board |
| CHMT | County Health Management Team |
| CHV | Community health volunteer |
| CHW | Community health worker |
| CO | Clinical officer |
| COVID-19 | Coronavirus disease of 2019 |
| CPHO | Chief public health officer |
| EDHS | Ethiopia Demographic and Health Survey |
| ESCRH | Elwak Sub-County Referral Hospital |
| FGC | Female genital cutting |
| FGD | Focus group discussion |
| FGM | Female genital mutilation |
| FGS | Federal Government of Somalia |
| FP | Family planning |
| GoE | Government of Ethiopia |
| GTP | Growth and Transformation Plan |
| HC | Health centre |
| HEP | Health extension plan |
| HIV | Human immunodeficiency virus |
| HP | Health post |
| HSDP | Health sector development plan |
| HSNP | Hunger Safety Net Programme |
| I/C | In charge |
| IDP | Internally displaced person |
| IDSR | Integrated disease surveillance and response |
| IGAD | Inter-Governmental Authority on Development |

| | |
|---------------|--|
| IOM | International Organization for Migration |
| KEMSA | Kenya Medical Supplies Authority |
| KEPI | Kenya Expanded Programme on Immunization |
| KMTC | Kenya Medical Training Centre |
| LMIS | Logistics Management and Information System |
| MCH | Maternal and child health |
| MCRH | Mandera Country Referral Hospital |
| MDGs | Millennium Development Goals |
| MNS | Mental, neurological and substance (use) |
| MO | Medical officer |
| MOH | Ministry of Health |
| NDMA | National Drought Management Authority |
| NGO | Non-governmental organization |
| NHE | National health expenditure |
| NHIF | National Health Insurance Fund |
| OWNP | One Wash National Programme |
| PAR | Participatory action research |
| PFSA | Pharmaceutical Fund and Supply Agency |
| PHC | Public health care |
| PHU | Primary health unit |
| PMTCT | Prevention of mother to child treatment (of HIV) |
| PTSD | Post traumatic stress disorder |
| RHB | Regional health bureau |
| RSCRH | Rhamu Sub-County Referral Hospital |
| RVF | Rift Valley Fever |
| SCH | Sub-county hospital |
| SGBV | Sexual and gender-based violence |
| SHFS | Somalia High Frequency Survey |
| SHI | Social health insurance |
| SRH | Sexual and reproductive health |
| SRHR | Sexual and reproductive health and rights |
| SRS | Somalia Regional State of Ethiopia |
| STI | Sexually transmitted infection |
| TB | Tuberculosis |
| TSCRH | Takaba Sub-County Referral Hospital |
| UNICEF | United Nations International Children's Emergency Fund |
| UNSCR | United Nations Security Council resolution |
| URTI | Upper respiratory tract infection |
| UTI | Urinary tract infection |
| WASH | Water, sanitation and hygiene |
| WHO | World Health Organization |

Foreword

This report has two sections, i) Comprehensive health study on the health gaps and needs in Mandera Triangle ii) Analysis of gaps existing on cross border health policies and practices. The report will better inform Mandera triangle regional administration, the health sectors providers, regional and international institutions supporting health providers such as the World Health Organisations, UNFPA, other UN agencies and IGAD among others, in the three cross border regions on the health needs. The report also aims at ensuring an all-inclusive rights-based approach to health service delivery through proper institutionalization of policies and practices, good governance, effective community participation, and systems coordination. Recommendations to ensure adequate and timely interventions for prevention, detection, and response to diseases of public health concern through collaboration have also been registered.

The Mandera Triangle occurs at the convergence of Kenya, Somalia, and Ethiopia. It is largely inhabited by Somali communities who have close cross-border social, economic and development connections. The Triangle provides essential corridors for commerce and livestock trade for the entire region. A significant proportion of the population is Cross-Border Mobile Populations (CBMPs), who include mobile pastoralists looking for pasture, refugees, seasonal cross-border labourers, persons engaged in cross-border economic activity, undocumented migrants, Internally Displaced Persons (IDPs), and communities hosting refugees and IDPs.

In terms of health, the region is characterised by malnutrition, cross-border disease outbreaks such as Chikungunya, Dengue Haemorrhagic fever, Rift-Valley Fever (RVF) among others due to transboundary movement of persons and animals, mental illness, and high rise of drug and substance abuse, especially among the youth. This situation can be linked to the Triangle's long history of the conflict as well as its poor access to health-care, low economic growth, food insecurity, limited water, and the absence of adequate sanitation and hygiene. Conflict and violent incidents cause deaths and injuries among both combatants and civilians and high levels of mental disability.

In addition to the clan and ethnic militias, Al Shabaab operates in the Triangle. Its activities have had an enormous impact on service delivery in the region. Skilled health-care providers have been forced to flee and the resulting shortage of medical personnel has reduced the range and quality of healthcare and nutrition services. In addition, various state security agencies and the African Union Mission in Somalia (AMISOM) have stationed large forces in the area, which has increased mistrust.

Each country has different health policies, administratively, each of the public health providers in the triangle is currently managed by devolved units that historically have been weakly supported by their respective central governments with limited investment in several specialised health needs. CBMPs travel within and across the triangle to obtain health services. The recent worsening of conflict and tighter border security has restrict-

ed their ability to do this, which has split communities and made it harder for CBMPs to meet their health needs.

Links with the central government remain weak. Communities living in the Triangle have limited access to social services because they are so distant from their capitals. On top of state neglect, social and economic inequalities mean that many CBMPs are also marginalised locally. This creates conditions that favour the formation and activities of militias. International development actors and companies are also less active in this isolated region known for its insecurity.

The population faces many challenges in accessing health services ranging from lack of adequate infrastructure, inadequate skilled personnel due to poor attraction and retention of skill mix, essential medicines and supplies including life-saving vaccines and poor cross-border coordination mechanisms.

This has resulted in most health facilities being unable to meet the local health needs of the population's high demand for health services.

Perennial conflicts across borders have also affected health services directly often leading to civilian casualties requiring specialised treatment in the neighbouring referral facilities such as Mandera County Referral Hospital (MCRH). In addition to forcing health personnel to flee health facilities, the destruction of communication masts disrupts mobile coverage and the ability to respond to health emergencies, while referrals cannot be made, and ambulance services cannot operate when roads are blocked or become dangerous. In addition, people cannot trade or pursue their livelihoods, with the result that communities become more isolated.

The persistence of conflict in the area has generated high rates of mental disorder, that unemployment, economic and social stress, and substance abuse exacerbate. In general, the region lacks facilities that can care for patients suffering from Post-Traumatic Stress Disorder (PTSD), psychotic disorders (schizophrenia) or bipolar disorders.

Girls and women are most directly affected by conflicts. Sexual violence is a significant problem, but few cases of rape are reported for fear of stigma in most communities. Unwanted pregnancies have risen, putting victims and their families under stress. The region has no one-stop facilities to protect survivors of sexual violence, provide counselling or test for sexually transmitted diseases, etc.

Stricter border restrictions have hindered people from crossing into neighbouring countries to access medical services, but many cannot obtain treatment because they lack legal documents to prove their identity or money to pay for medical services privately.

Efforts have been made in the past to improve disease surveillance and control, but these have been difficult to implement because the region is divided by borders, communities are marginalised and mobile, and infrastructure is insufficient and thinly spread.

Interpeace has played an important role to promote linkages between health and peace in the Democratic Republic of Congo (DRC), Ukraine among others in the past. It has tried to bridge the gap between international health providers and the population by building trust and helping to realign the population's health priorities with international efforts to control disease outbreaks such as Ebola. It has encouraged international health provid-

ers and institutions to integrate peacebuilding into their health programmes. in Mandera county and several other frontier counties, Interpeace is strengthening local resilience for peace. This report emphasises the need to strengthen health systems in the region by improving the quality of services and access to them, as well as administrative and management functions, financial systems, and health information management.

More still needs to be done. Referral systems and cross-border coordination of health services need to be strengthened. Synergies between health, peace, and livelihoods, needs to improve, across borders. The regions need to be able to share economic opportunities and services and strengthen regional cooperation and partnerships. In this, partners such as the Inter-Governmental Authority on Development (IGAD) and the African Union (AU) play an important role in facilitating dialogue between the three countries and addressing the impacts of conflict on health. It will be critical to widen awareness of the need to strengthen health systems and address the needs of local populations and CBMPs throughout the Triangle, strengthen cross-border peace and security coordination, and build relationships, including through inter-community peace committees and peace dividends projects, such as water facilities and markets.

The overall aims of Interpeace are to create conditions for peace, safety, and health, to leverage health in support of peace and vice versa, and to ensure that regional institutions such as IGAD support cross-border health initiatives. The COVID 19 pandemic showed that even the most developed countries were ill-prepared for a health emergency and that we need to invest in regional health hubs. Mechanisms are also needed to address the many forms of marginalisation that kill the resilience of communities like those in the Mandera Triangle.

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Liaison for IGAD/AU Relations*

Comprehensive Health Gaps and Needs

Part I

Executive Summary



Executive Summary

This study was commissioned by Interpeace and conducted during February and March 2021 in Mandera County, Kenya, the Dollo Ado and Mubarak zones in Ethiopia, and the Belet Hawa and Elwak Districts of Somalia. It examines the health dynamics, systems, and actors in the Mandera Triangle and their linkages to conflict dynamics. The study seeks to clarify the specific health and peace needs of cross-border mobile populations (CBMPs) in the Mandera Triangle, and inform future interventions that are designed to boost the health security and resilience of households and communities and contribute to sustainable peacebuilding efforts in the region. Besides providing a basis for new programming, a better understanding of this complex system will help to reshape health and peace policies that are expected to improve access to healthcare services.

The study employed a variety of tools. The team reviewed secondary data on the region and on the linkages between peace and health. It collected primary data, using semi-structured interviews with stakeholders and key informants, focus group discussions, visits, and interviews. It observed 28 health facilities in the Triangle. The team also compiled case studies from the three countries.

Overall, the healthcare infrastructure varies across the three countries, as it does in all the IGAD countries. However, all three lags regarding most health indicators and access to healthcare is a major bottleneck. Sixty per cent of the population in South-Central Somalia has no access to healthcare. Few people use and few people have access to quality health services, rates being lowest in Gedo Region compared to Mandera County and Mubarak and Dollo Ado. Because they are distant from each country's specialised hospitals and health budgets are limited (dominated by out-of-pocket expenditure), the population depends on lower-tier facilities that provide a limited range of services. Key features in all three countries include: scarcity of facilities; a poor health infrastructure; limited funding; absence of regional collaboration and coordination policies; population displacement; insecurity; and lack of technical and human resources. Because health professionals are in short supply, in all interviews, but particularly in Somalia and Ethiopia, respondents cited lack of staff to explain why access to quality health services was restricted. The public services rely on humanitarian assistance to deliver their mandate. Private actors and NGOs operate hospitals, clinics and pharmacies in the major towns. Primary healthcare activities, such as vaccinations, are better managed. International partners, including the CORE Polio Group, provide funding and coordination. However, gaps in care existed in several areas, including physical disability; mental health care; sexual and gender-based violence; reproductive health; the elderly; special needs; and malnutrition.

Cross-border mobile populations (CBMPs) face major barriers when they try to access basic healthcare because the public health system responds socio-politically in a complicated way to cross-border migration and mobility. While it is easy for clinical and public health workers to meet the health care needs of a static population, it is often hard both to deliver health care to CBMPs and monitor outcomes. Though it is difficult to obtain clear

data, anecdotal evidence suggests that a significant number of ‘medical travellers’ move between Mandera, Gedo region, and Mubarak and Dollo Ado districts. Because Mandera County’s infrastructure is relatively more developed, people move from Dollo and Gedo to Kenya to access markets, hospitals, and schools. Movement from Mandera to neighbouring cross-border districts also occurs. According to health service providers, movement has increased: more and more patients now seek medical treatment in countries in which they do not live. Providers expected the numbers to increase further, both because health services have improved, particularly in Mandera County, and because users perceive that some Ethiopian hospitals provide superior services, notably orthopaedic services in Wollaita and gynaecological services in Shashamane.

It appears that two categories of patient seek healthcare in neighbouring districts: (1) those who temporarily move across the border solely to obtain medical assistance and return home upon treatment; and (2) those who have permanently moved and live in a host country. They do have same privileges as citizen in accessing health services. The overwhelming reason given for cross-border movement of patients was to seek services that were not available in their own country. A few better-off patients were said to be dissatisfied with the services in their own country and sought services in better well-equipped facilities across the border. In most cases, such patients used private healthcare facilities. For less-privileged patients, the key motive for crossing the border is to find care that is less expensive. Healthcare professionals interviewed also noted that some patients sought medical care across the border for medical conditions that attracted stigma or because they needed anonymity for other reasons. For example, it was safer for HIV/AIDS patients to seek anti-retroviral drugs across the border because they were likely to be identified and stigmatized in their local environment. As for barriers to health care, factors that were identified included: poor physical access to facilities; cost; shortage of skilled workers; the absence of referral systems; stigma; language barriers; lack of trust or confidence in the capacity of medical professionals (as a result of past medical errors); and non-possession of legal documents that the country concerned requires for identification and travel.

The research found clear linkages between health outcomes for the population and the incidence of conflict in the Triangle. The districts in the Mandera Triangle have experienced multiple conflicts and security concerns that have affected the population’s health. As highlighted in the *Voice of the people: challenges to peace in Mandera County* (2017), a prolonged conflict between the Gare and Degodia communities after November 2015 caused the loss of at least 77 lives, displaced over 18,000 households, and destroyed large amounts of massive property. Two additional factors have separately heightened insecurity in the area: the presence of Al Shabab; and longstanding political disagreements between Jubaland State and the Federal Government of Somalia that have led to frequent fights between their security forces. These conflicts have caused deaths, injuries, displacement, blocked vital supply routes, and destroyed livelihoods. Over the long term, these conflicts increase rates of both physical and mental disability. In addition, they increase the risk of disease, disrupt health care systems and the medical supply chain, undermine social norms, and obstruct the free movement of health workers. Unfortunately, except for the Gare-Degodia conflict, conflict in the Triangle is worsening in scale, nature and complexity as more non-state groups and regional and international actors become involved, making it less amenable to political resolution.

The impact of Al Shabab on service provision has been enormous in the region. The disruption sometimes occurs intermittently depending on escalation or de-escalation of attacks. The escalation affects all aspects of lives and livelihood including health sector in the region. In previous episodes of attacks, most skilled healthcare and education workers from other regions of Kenya posted to Mandera elected to leave the Mandera county. Because of uncertainty and unpredictability of security situation, most of these workers are usually reluctant to return to the region. This continues to affect the availability of quality education, healthcare and nutrition services. This is further impacted by frequent clan conflicts that stretches the ability of county government to provide peace, security, education and health services. The departure of many professionals affected the delivery of services in most health centres. Other effects of conflict and insecurity included the destruction of communication masts, which disrupted mobile coverage and slowed responses to health emergencies. NGO and government vehicles were unable to travel along the Lafey Road, which disrupted referral systems because ambulances were not able to operate in certain areas. Cases of youth training themselves on basic health skills are common. The 'local medics' are known to prescribe drugs for malaria, attend to home-based childbirth, and treatment of snake bite as well as the treatment of minor motor bike related injuries. Given that it has the skills, relationships in the Triangle, and convening power, Interpeace could mediate some of these issues particularly where inter-clan conflicts could be lessened or 'permanently' resolved. Healthcare initiatives can and should assist peacebuilding interventions because caring for the sick and injured is considered both a neutral activity and a universal good. Health is often seen as a shared goal by all sides in a conflict, and can therefore realign warring factions in support of a shared interest. The fair and balanced delivery of health care and other social services is also crucial in conflict-affected settings because inequitable access can be a key trigger or driver of conflict. Interpeace and WHO have been working together to leverage their respective expertise in a manner that will advance health and peace across their work, from policy to programming.

Based on the findings of this assessment, we recommend that actors should plan interventions that address urgent issues affecting CBMPs. Any intervention in the Triangle should consider integrated action, and should promote regional collaboration at policy level and institutionally, as well as investment to improve health services in the three countries. Given that the cross-border areas are prone to conflicts that have direct impacts on health, peace stakeholders should strengthen collaboration on cross-border management and conflict prevention. Stronger bridges and links between services are also critical. As detailed in the recommendation section, we propose key actions to: strengthen regional cooperation and partnerships; improve programmatic synergy between health and other sectors, including peace and livelihoods across borders; address the impacts of conflict on health; strengthen the capacity of health systems to address local needs in each region and the needs of CBMPs; address the specific challenges that face CBMPs who seek health care in neighbouring countries; and improve access to mental health and psychosocial services. Future programmes and interventions that implement some of these recommendations can be expected to enhance service delivery, improve disease prevention and curative care, modernise and transform the health infrastructure, and attract sufficient health personnel to the triangle to meet the health needs of the mobile community.



Background and Context

Background and Context

The tri-border area where Kenya, Ethiopia and Somalia converge, also known as the Mander Triangle, is almost entirely inhabited by Somali communities with close cross-border social, economic, and development connections. It provides corridors for commerce and livestock trading that are critical to the entire region. Cross-border mobile populations (CBMPs) compose a significant proportion of the population: mobile pastoralists, refugees, seasonal cross-border labourers, persons engaged in cross-border economic activity, undocumented migrants, internally displaced persons (IDPs), and communities that host refugees and IDPs. These populations move across the border to access social services and market their livestock, crops, and other products. However, they find it difficult to access basic health care because the public health system responds socio-politically in complex ways to migration and cross-border mobility. For clinical and public health workers it is straightforward to meet the health needs of a static population, but difficult to deliver care to CBMPs or monitor their health outcomes.

As noted by the World Bank (2020), border areas present several development challenges. The Mander Triangle is isolated, poor and insecure; it has limited infrastructure, thin social services, and offers few livelihoods; the movement of people, goods, and services is frequently restricted for security reasons; and local governance arrangements (a mixture of traditional and secular systems) are weak and hybrid. The health and nutritional status of the population is marked by chronic malnutrition, disease and high morbidity. This is because access to health-care is limited; the population lacks socio-economic and civil security; food insecurity is widespread; childcare practices are poor; and the water, sanitation and hygiene (WASH) infrastructure is inadequate. These factors are compounded and influ-

enced by persistent cycles of conflict. In addition to inter-state conflicts, the region has experienced several bouts of communal violence, especially between local Somali clans. The disputes are over political power, representation in local and national assemblies, access to water and other resources, and trade. Terror groups like Al Shabab also cause instability. In Gedo, factional fighting between sub-clans has been a feature of local politics; but the situation has been worsened by recent clashes in Belet Hawa between the armed forces of Jubaland and the armed forces of the Federal Government of Somalia (FGS).

These conflicts have had a great impact on the population. They have caused deaths, injuries, mental stress, grief, displacement, kidnapping of medical professionals, blockade of supply routes, destruction of communication masts, suspension of health outreach programmes and ambulance services, closure of health facilities. People have been prevented from reaching medical facilities, and inflows of IDPs from conflict zones have strained the capacity of urban utilities. There is growing evidence too that conflict has affected the mental health and psychological wellbeing of many people. Studies of the long-term effects of war on mental health in Somalia show that mental disorders have risen after conflicts.¹ The prevalence of diseases and epidemics has also increased. In addition, conflicts disrupt education, social norms, and the free movement of health workers. As of February 2021, several health facilities in Belet Hawa were not accessible because of clashes between Jubaland and FGS forces. Similarly, the Mander Triangle-Lafey Road remained very insecure, disrupting movement and access to services, and hindering referrals from sub-counties and neighbouring villages in Somalia. Lack of access to adequate healthcare services can itself fuel conflict. For specific ethnic, regional, or religious

¹ Odenwald, M., Lingenfelder, B., Schauer, M. et al. 'Screening for Posttraumatic Stress Disorder among Somali ex-combatants: A validation study', *Conflict and Health*, 1, 10 (2007).

groups, lack of access to health services exacerbates feelings of exclusion and perceptions of unfair treatment by the government or other groups. Exclusion can also be self-generating, especially where pa-

tients elect to be treated by medical professionals from their affiliate clan and avoid facilities staffed by professionals from rival clans.

A Comprehensive Study of Health Gaps and Needs in the Mandera Triangle

Interpeace is an international peacebuilding organization, headquartered in Geneva, Switzerland. It aims to strengthen the capacities of societies to manage conflict in non-violent, non-coercive ways by assisting national actors in their efforts to develop social and political cohesion. Interpeace also strives to assist the international community (and in particular the UN) to play a more effective role in supporting peacebuilding efforts around the world by understanding and supporting local actors and local capacities. Interpeace is currently running a programme in the Mandera Triangle that will clarify the needs of CBMPs and identify the connections between health and conflict, with the aim of

strengthening cross-border coordination between key health and political actors in the three countries and developing and implementing policies and approaches that expand access to health care services. This study focuses on health dynamics, health systems and health personnel in Mandera County, Kenya, Dollo Ado and Mubarak zones in Ethiopia, and Belet Hawa and Elwak districts in Somalia, and their linkages to conflict dynamics in the region. The aim is to understand the specific health and peace needs of local populations, so that future interventions can boost the health security and resilience of households and communities in the region while contributing to overall peacebuilding efforts.

The objectives and significance of the study

Because of their mobility, it is difficult to provide healthcare services to CBMPs or monitor outcomes. Past initiatives to monitor disease and control pandemics have been hampered by the cross-border character of local communities. To address these challenges effectively, it will be necessary: to understand the unique needs of CBMPs and the interconnections between their health challenges and causes of conflict; to establish effective cross-border coordination between key health and political actors in the three countries; and to apply policies and approaches that expand access to and provision of health care services. The primary aim of this study is to identify, confirm and rank major health gaps and needs and their links to peace needs and priorities in the Mandera Triangle. It seeks to identify the health needs of mobile communities in a region plagued by regional and communal conflicts, the constraints that face health personnel and the health infrastructure, and gaps in service and delivery that need to be met. The findings are of interest to health ministries in Ethiopia, Kenya and Somalia, the Intergovernmental Authority on Development (IGAD),

the National Cohesion and Integration Commission, Interpeace, peacebuilding actors, and international donors and policymakers active in the region.

A better understanding of this complex system will make it easier to reshape health and peace policies and may provide the basis for new programming that modernizes and transforms health care services in the Triangle, thereby improving the health of communities and accelerating growth and development. The study involved:

- A consultation/inception meeting to introduce the programme to all relevant stakeholders and invite them to support it.
- A joint cross-border inception meeting with health staff in Ethiopia, Kenya and Somalia, in the presence of Interpeace and IGAD, to discuss the research process and appoint a cross-border coordination forum to support the consultants undertaking the study. The forum took the lead in involving stakeholders and agreeing with

them how identified cross-border issues should be coordinated.

- A consultative research process in specified areas of the three countries to study comprehensively health care delivery and associated issues.

- A joint technical validation workshop at regional level.

- A joint stakeholders' validation workshop with cross-border communities.

Approach and Methodology

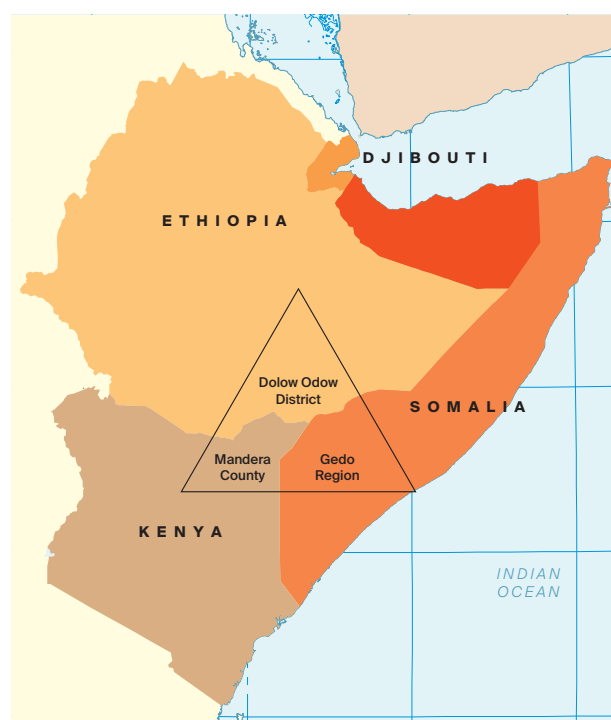
The study looks at both health needs and health gaps that exist in the region and their influence on the delivery of health services. Health needs assessment is a systematic method for reviewing the health issues a population faces, in order to set priorities and allocate resources in a manner that will improve health outcomes and reduce inequality. A 'gap' occurs when local resources, infrastructure, or processes are at variance with current national or institutional best practice. In the gap and need analysis, results of interest included: (1) health outcomes, such as the

prevalence and incidence of disease; (2) gaps and needs in health services, in terms of availability, accessibility, comprehensiveness, etc.; (3) gaps in the health workforce; and (4) the extent of coordination across borders. Other key domains under review included: (1) mental health services; (2) the integration of mental health services in primary health care; (3) human resources for primary healthcare and mental health services; and (4) public education and its links with other sectors.

The study areas: the Mander Triangle

The study focuses on the Mander Triangle (Figure 1), which covers the borderland areas between Kenya, Somalia and Ethiopia. It is entirely inhabited by Somali communities who have cross-border social, economic, and development connections. The region's health and nutrition status are characterized by high malnutrition, high rates of disease, and high rates of morbidity and mortality. Factors associated with poor health conditions in the region include: limited access to healthcare, low economic growth, food insecurity, limited water, poor sanitation and hygiene, and persistent and recurrent conflicts and insecurity.

Figure 1. Map of the Mander Triangle



The study's approach and collection of field data

In accordance with the terms of reference (Annex 7),

the assessment team conducted an in-depth study

using a mixed-method approach. After reviewing relevant secondary documents for context, the team prepared an inception report that outlined its approach, methods, data collection tools, and deliverables. This was presented to Interpeace and stakeholders and validated by them. A joint cross-border inception meeting was held on 10 February 2021 with health staff in Kenya, Somalia and Ethiopia, and representatives of Interpeace and IGAD, to discuss the research process and nominate a cross-border coordination forum to support the consultants during the research process. On the basis of the inception report and consultative meeting, the team conducted a comprehensive analysis of health care delivery and health issues in the three areas studied, using a consultative research process. The team collected primary data in stakeholder consultations and interviews, observed facilities, surveyed health workers, and held focus group discussions (FGDs) with the target population.

The team made field visits to cross-border communities and health facilities in February and March 2021, to obtain the views of health experts and community leaders, assess facilities, and gather health statistics and indicators. Stakeholders and key in-

formants targeted for consultation included the leadership of the Ministry of Health in the three regions, facility managers in Mandera County, Dollo and Mubarak zones, and Belet Hawa and Elwak Districts, and community leaders, including health committee members, elders, and religious leaders. Interviews with health experts helped the team to identify health needs and gaps in the target areas, prioritize those needs, and suggest strategic actions to resolve them. In focus group discussions with community health committees and male and female community members, the team gathered general information about health facilities, staffing, equipment, communications, ambulances and transport, power supply, infection control, obstetric and new born care, maternal deliveries, etc. The team also observed health facilities, including their availability, the quality of the infrastructure, transport systems for emergencies, and specific services (for example, mental health care). The aim of these discussions and observations was to identify the most significant community health concerns and unmet needs. Table 1 sets out, for each country, the number of meetings held, case studies completed, and facilities visited during the assessment.

Table 1. The assessment's evidence base

| Data collection tools | Persons and facilities | Number | Locations |
|--|---|--------|------------------------------------|
| Stakeholder and key informant interviews | MOH senior officials at central level | 7 | Ethiopia 2, Kenya 3, Somalia 2. |
| | MOH officials at district/regional level. Included the Chief Public Health Officer, Regional Medical Officer, District Medical Officer, Primary Health Care Coordinators, managers, mental health in charge (i/c), clinical nurse consultant. | 37 | Ethiopia 12, Kenya 14, Somalia 11. |
| | Community leaders: the Community Health Committee chair, secretaries, influential religious and clan leaders. | 9 | 3 in each country/region. |
| Focus group Discussions | Community members: religious, elders, women, MCH staff, youth, facility staff, mental health patients. | 19 | Ethiopia 6, Kenya 4, Somalia 9. |
| Facility interviews | Hospital director, nursing/hospital manager, nurse i/c, mental health i/c, maternity i/c, Chief Public Health Officer, clinical nurse consultant. | 28 | Ethiopia 8, Kenya 9, Somalia 11. |

| Data collection tools | Persons and facilities | Number | Locations |
|---------------------------|---|--------|----------------------------------|
| Case studies | Mothers with complications, SGBV survivors, mental health patients, RVF survivor, victim of conflicts | 11 | Ethiopia 3, Kenya 2, Somalia 6. |
| Field observations | Wards, outpatients, water and sanitation, buildings, transport, drainage system, staff, etc. | 28 | Ethiopia 8, Kenya 9, Somalia 11. |

Limitations of the study

The study was conducted as planned, but faced some limitations. Key informants were selected based on their knowledge and experience of the region; this influenced the degree to which the data is representative and the degree to which findings based on them can be generalised. Regarding the general population, field data were collected from a largely homogenous community that shares similar socio-cultural and economic characteristics. Unfortunately, some senior government officials, whose policy perspectives could have been important, were not available at the time of the research. Most of the senior officials we did interview were reluctant to dis-

close certain information, particularly on the quality of services available at their facility, on budgets, and on patient feedback and complaint systems. The study did not collect data on the health care access of non-mobile communities and the study therefore lacks a benchmark or comparator; its conclusions apply only to cross-border communities. The report would have been enriched by a detailed household survey. Finally, lack of time and security concerns limited the team's access to certain facilities.

Synthesis and Findings of the Assessment

Synthesis and Findings of the Assessment

In this section, we define the population who inhabit the Mandera Triangle, focusing on mobile populations who are engaged in cross-border economic activities or who seek services in neighbouring countries. Considering that health care is among the services for which there is most demand, we discuss health systems in the three countries, highlighting similarities and differences in access.

The findings focus on: the cross-border population; the services in highest demand; why patients move, and where they move; barriers that obstruct access to health services; and health service referral and coordination systems in the region. Finally, the report identifies and prioritises the needs of populations in the region, and gaps in provision, and makes recommendations for addressing these.

The Populations Defined

Demographic characteristics in the Mandera Triangle

Mandera Kenya is one of the largest sections of the Triangle. According to the 2019 Kenya Population and Housing Census it hosts a population of 867,457, at a population density of 33 per square kilometre. The population is largely distributed across seven major sub-counties: Mandera East, Mandera West, Banisa, Mandera North, Lafey, Mandera South, and Kutulo. Though the county has historically lagged in terms of development, there are signs that the situation is changing under the devolved governance system. Most of the county's population is pastoralist (85%); the rest are agropastoralists, urban residents, or IDPs. The Gedo region of Somalia is estimated to have a population of half a million people. Gedo has six districts: Elwak, Bardhere, Belet Hawa, Dollow,

Garbaharey, and Luuq. Administratively, the region falls under the Jubaland regional government, headquartered in Kismayo. According to the UN, the population of Somalia is 35% rural, 29% nomadic, and 21% urban; 15% are IDPs.² In Ethiopia, the districts of Mubarak and Dollo Ado fall within the Somalia Regional State. Though no official census exists, they are estimated to have a population of 100,000 and 73,000, respectively. The Health Team in Mubarak estimated that 86% were pastoralists, 10% agropastoralists, and 6% urban dwellers. 18% of the residents of Mubarak were classified as IDPs. Table 2 summarizes the population's characteristics and the challenges they face in accessing healthcare.

² UN Habitat, Working Paper and Spatial Analysis for Urban Planning Consultations and Durable Solutions for Displacement Crises (a series of papers on districts of Somalia), 2018.

Table 2. Characteristics of the population of the Mandera Triangle; obstacles that impede their access to health.

| Category | Characteristics of the population | Obstacles that impede access to health |
|------------------|---|--|
| Urban population | <p>Represent about 6-10% of the population. They live in urban centres and engage in a range of economic activities.</p> <p>Have access to public and private health facilities. They enjoy reasonable access to water and sanitation facilities and to the health care system.</p> <p>Are diverse socially and economically and in the way they are accessing healthcare.</p> <p>How they access health care services is a matter of choice, influenced by distance, income levels, and preferences.</p> <p>Are more aware of health issues and seek treatment early enough.</p> <p>Interaction with pastoralists and IDPs may expose them to some forms of disease.</p> | <p>Often have lifestyle-related health issues.</p> <p>Economic status determines their health care.</p> <p>Because of congestion in markets and schools, diseases can spread rapidly.</p> <p>Limited access to ambulance services.</p> <p>Those coming to Kenya for treatment may face barriers of language and lack legal documents.</p> <p>Funding of health facilities is limited; the number of skilled professionals is limited, especially female obstetric staff.</p> <p>Funding is limited in both Somalia and Ethiopia.</p> <p>Patients treated for mental illness or SGBV face stigma.</p> |
| | <p>Are the largest group in the Triangle (65 to 85% of the population).</p> <p>Are highly mobile and delay seeking healthcare.</p> <p>Have livestock wealth but rarely sell animals to obtain health care.</p> <p>Rely heavily on traditional and spiritual forms of treatment.</p> <p>Are exposed to the weather, conflicts and disease.</p> <p>Have limited access to health care because they are far from facilities.</p> <p>Are periodically involved in communal conflicts over resources and boundaries.</p> <p>Principally at risk from cholera, dysentery, malnutrition, STIs and mental disorders.</p> | <p>Lack access to outreach or mobile units.</p> <p>May face complications when they delay treatment.</p> <p>Have few local health facilities, and cannot easily reach health facilities in towns.</p> <p>Few health professionals operate near to where they live.</p> <p>No ambulance services are available for emergencies.</p> <p>Persons with HIV and mental health conditions may be stigmatised if they seek treatment.</p> <p>Language barriers may inhibit them from seeking treatment.</p> <p>Many lack legal identification documents.</p> |
| Pastoralists | | |

| Category | Characteristics of the population | Obstacles that impede access to health |
|-------------------|---|--|
| Agro-pastoralists | <p>Live close to rivers, grow crops and keep animals. 10-15% of the population.</p> <p>Live in smaller towns; have access to larger towns.</p> <p>Are somewhat conscious of health but delay seeking treatment.</p> <p>Can afford relatively cheaper health services.</p> <p>Are exposed to farm-related accidents; workers may acquire STIs.</p> <p>Are exposed to disease through interaction with pastoralists and urban people.</p> <p>Have relatively secure livelihoods (subject to occasional floods).</p> <p>Have access to health facilities in both rural and urban settings.</p> <p>Experience frequent shocks (locusts, COVID-19, RVF).</p> | <p>Health centres may lack specialised services.</p> <p>Substance abuse and mental health issues are common.</p> <p>Lack adequate funds to access services.</p> <p>Lack ambulance services and supplies.</p> <p>Face language barriers when they access services from Kenya and lack legal documents if they are referred.</p> <p>Face stigma if they seek treatment for STIs or mental related needs.</p> |
| | <p>They represent 3-5% of the population. In Somalia, most IDPs came from Bay and Bakool. In Kenya, most came from Wajir and settled in Rhamu. In Ethiopia, most came from Nagele and settled in Mubarak.</p> <p>Live in shelters provided by government or NGOs or insecure temporary shelters.</p> <p>Sometimes, are survivors of conflict and SGBV, and may have mental health disorders.</p> <p>Have livelihoods based on farm leasing, farming and other work.</p> <p>Supported by local NGOs and INGOs, but face hostility from locals.</p> <p>Face insecurity.</p> <p>Subject to frequent outbreaks of cholera, diarrhoea, and malnutrition.</p> | <p>Likely to lack money to pay for services that are charged.</p> <p>Face stigma if they seek services.</p> <p>Lack security if they move about;</p> <p>Have access to fewer health services.</p> <p>Have limited access to transport.</p> <p>Face stigma if they seek treatment for mental health or SGBV issues.</p> <p>Lack medicines.</p> <p>Face language barriers if they seek services in Kenya; lack legal documents if they are referred.</p> |

The cross-border populations in the Mandera Triangle

A sizeable proportion of those who live in the Mandera Triangle are classified as cross-border mobile populations (CBMPs). Traversing the international borders and playing an important role in the local economy, CBMPs include people living on and across borders, labourers who cross borders for employment, traders who move goods across frontiers, and pastoralists who cross frontiers in search of pasture or to trade. These communities are highly mobile and, although they may have access to various social and health services in the three countries, they are highly exposed to disease because they are so mobile and interact with people in different places. CBMPs may be culturally and sometimes religiously distinct from host communities, and local communities may resent them or associate them

with the spread of certain diseases. For instance, health officials in Mandera associated the spread of sexually transmitted diseases (STIs) and drug consumption in Mandera with the arrival of Ethiopian border communities. These communities were also excluded from health facilities in Mandera because they lacked legal travel documents (passport, visa, ID). As a result, cross-border programming is increasingly essential, particularly in the areas of peace and health. Humanitarian organizations have provided cross-border immunization and disease surveillance to address the needs of the CBMP population. Recently, interventions targeting cross-border communities have recommended better coordination, communication and collaboration to combat outbreaks of disease.

Health Systems in the Mandera Triangle

Health care infrastructures within the Triangle vary in each country. In common with all IGAD countries, Somalia, Ethiopia and Kenya lag regarding most health indicators (Table 3). Meeting the needs

of persons with physical disabilities and mental health issues remains a challenge, many old people need special protection and assistance, and malnutrition is widespread.³

Table 3. Health indicators in Kenya, Somalia and Ethiopia

| County/Region | Kenya | Somalia | Ethiopia |
|--|----------------------|------------|----------------------|
| Rate of maternal mortality per 100,000 live births | 488 | 1,200 | 420 |
| Antenatal care attendance (%) | 92 | 42 | 97 |
| Contraceptive prevalence (%) | 46 | 4.7 | 56.2 |
| Skilled birth attendance (%) | 46 | 44 | 23 |
| HIV prevalence | Women 8% Men 4.3% | Women 0.9% | Women 1.9% Men 1% |

Source: IGAD, *State of the Region* (2016).

The Kenyan health system: Mandera County

Organization of the health system

Kenya's health sector is one of the 14 devolved units managed by the country's 47 county governments, as provided in the Fourth Schedule of the 2010 Constitution. Based on the types of service they offer;

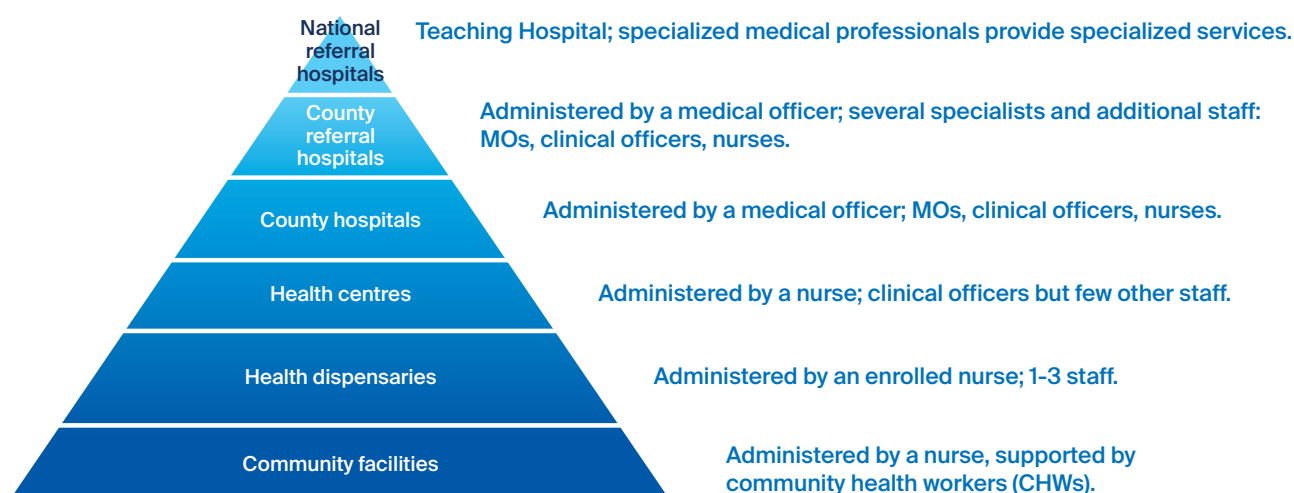
the country's health system is divided into six levels in line with the National Health Sector Strategic Plan 1 and Strategic Plan 2 (NHSSP). (See Figure 2.)

³ IGAD, *State of the Region* (2016).

- Level 1. Community services.
- Level 2. Health dispensaries and clinics.
- Level 3. Health centres and maternity and nursing homes.
- Level 4. County and sub-County hospitals.
- Level 5. County referral hospitals.
- Level 6. National referral hospitals.

Mandera's healthcare structure conforms to the national system. There are six Level 4 facilities in the county, nine level 3 facilities, and 24 Level 2 facilities, as well as six nursing homes and 60 private clinics. The doctor/population ratio is 1:114,000; the nurse/population ratio is 1:25,000.⁴

Figure 2. Organization of the health system in Kenya.



Source. *Somalia Health Policy* (2014).

Governance of health care in the devolved system

The County Executive Committee for Health (CEC Health) leads the health system in Mandera. Its role is to plan and implement health and health-related policies in the county. The Chief Officer is the accounting officer for the Department and below this level are two Directors: The Director for Medical Services and the Director for Public Health. There is a Health Planning and Monitoring Unit. The Director for Medical Services oversees the management of county hospitals and primary health facilities while the Director for Public Health oversees the delivery of programmes on disease control, family health, environmental health, health promotion, and com-

munity. Oversight of facility-level operations lies with County Health Management Boards (CHMBs) and Health Management Teams (CHMTs), which coordinate public health care provision through the network of primary and comprehensive health centres and hospitals. Their responsibilities include human resource development (continuous training and supervision) and management, distribution of medicines and medical supplies, communication of order requests and health information reports to the central level, and maintenance of infrastructure and equipment.

⁴ Mandera County Government, County Integrated Development Plan 2018-2022 (2018).

Healthcare financing in Mandera County

Devolution has changed how healthcare is governed and financed in Kenya, particularly in marginalised border counties such as Mandera. The national government allocates 15% of government resources to the devolved functions, and counties now manage all aspects of health care. County managers increasingly take decisions on expansion, revitalisation, and improvement of facilities. Decentralisation has also increased community participation in health-care decisions. As a result, the sector has become more responsive to needs, is more accountable to the public, and is more equitable.⁵ The national govern-

ment continues to support investments to improve health systems at county level. In Mandera County, the budgetary allocation to the Health Department averaged KES 23 billion in the last five years and has grown steadily since devolution (Table 4). These investments are improving the infrastructure (physical, equipment, transport, ICT). Four more referral hospitals have opened at sub-county level that can provide specialised medical services. This has helped to reduce the travel time for patients who seek health care.

Table 4. The budgetary allocation of Mandera County government to the Health Department (Kenya Shillings)

| Financial Year | Mandera | Per capita | Annual increase (%) |
|----------------|---------------|------------|---------------------|
| FY2016/2017 | 18,000,000.00 | 20.75 | - |
| FY2017/2018 | 22,000,000.00 | 25.36 | 22.22 |
| FY2018/2019 | 23,000,000.00 | 26.51 | 4.55 |
| FY2019/2020 | 24,000,000.00 | 27.67 | 4.35 |
| FY2020/2021 | 29,000,000.00 | 33.43 | 20.83 |
| Average | 23,200,000.00 | 26.74 | 12.99 |

Source. Prepared on the basis of information supplied by County health officials.

The health system in Gedo region, Somalia

Organization of the health system in Gedo Region

Health care facilities in Somalia are in one of four levels, depending on their locality and the services they offer.

- Level 1. Regional hospitals.
- Level 2. Referral health centres.
- Level 3. Health centres (HC).
- Level 4. Primary health units and health posts (PHU/HP).

All provide some essential health services (Figure 3). Health centres offer at least some preventive and curative services, focused on women and children, together with basic health services for the general

population, particularly people living in rural areas. Primary health units (health posts) provide limited curative and preventive services at community level, but many do not operate properly because they lack qualified staff and infrastructure. Hospitals do not provide the full range of secondary or higher-level care services, and most of the regional hospitals offer limited services only. Across Somalia, it is estimated that the density of health facilities is 1.1 and the average hospital bed density is 1.1 for every 10,000 in the population.⁶ However, key informants reported that the density in Gedo Region is even lower than this.

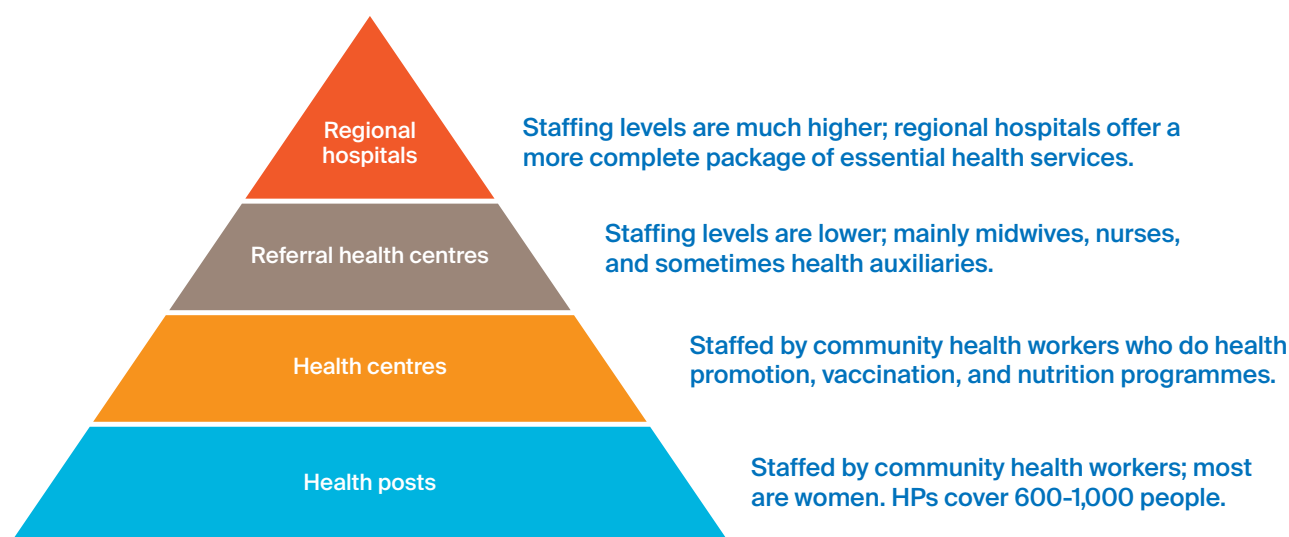
⁵ McCollum, R., Limato, R., Otiso, L., Theobald, S. and Taegtmeier, M., 'Health system governance following devolution: comparing experiences of decentralisation in Kenya and Indonesia', *BMJ Global Health*, 2018, 3(5).

⁶ WHO, *Strategic Review of the Somali Health Sector: Challenges and Prioritized Actions* (2015).

The Federal Ministry of Health (FMoH) is constitutionally mandated to regulate the health sector in Somalia, but governance also follows the country's federal system. Facilities in each region report to the district, regional and then state Ministry of Health (MoH). In consequence, the healthcare facilities in Gedo region fall under the Jubaland State of Somalia and are managed by the Regional Medical

Officer of Health for the Gedo Region. This said, decentralization faces significant challenges, partly because local capacity is limited but also because the federal system is unstable. Administrative problems impede service delivery. Resources to improve institutional capacities are concentrated centrally, at the Federal Ministry of Health in Mogadishu.

Figure 3. Organization of the health system in Somalia.



Source. *Somalia Health Policy* (2014).

Health financing in Gedo Region

In Gedo, public expenditure on health is about USD 10-12 per person per year. This increases the financial burden on poorer people who may incur high out-of-pocket expenses.⁷ Although few data are available on health financing in Gedo Region, the health system is predominantly funded by patients and by donors and development partners. Public services depend on humanitarian assistance to deliver their mandates. Development assistance is received at Federal level, and the financing of State, regional and district health services is not proportionate, though it is where services are most constrained.

The public system for supplying medicines collapsed during the civil war. Since then, NGOs have provided medical supplies to health facilities. Gedo Region has benefitted from global health initiatives, for example the Global Alliance for Vaccine and Im-

munization, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Polio Eradication Initiative. Most drugs and supplies for public health facilities are provided by humanitarian actors, including UNICEF, WHO, Trocaire, the CORE Group Polio Project, among others. Access to drugs and other supplies for public hospitals is a key concern, current arrangements are not sustainable and it is not known how long humanitarian assistance will continue. Data on how the population uses Gedo's health services and the demands that are placed on the system are also scarce. Somalia has a private pharmaceutical sector, but it is poorly regulated, especially in cross-border regions. As a result, there are concerns that treatment may be of poor quality and that consumers and patients pay more than they can afford for private care, which may generate adverse health outcomes.⁸

⁷ WHO, *Strategic review of the Somali health sector: challenges and prioritized actions* (2015).

⁸ Health and Education Advice and Resource Team (HEART), *Assessment of the Private Health Sector in Somaliland, Puntland and South Central* (2015).

Ethiopia's health system: Mubarak and Dollo Ado

The structure of Ethiopia's health system

In line with the Ethiopian Health Sector Development Plan (HSDP), the country has a three-tier health system. The second and third tiers are general and specialized hospitals; the first tier is composed of primary health care units (health posts and health centres) that are the foundation of the health care system (Figure 4). National referral hospitals provide specialized services; regional referral hospitals provide general referral services; and prima-

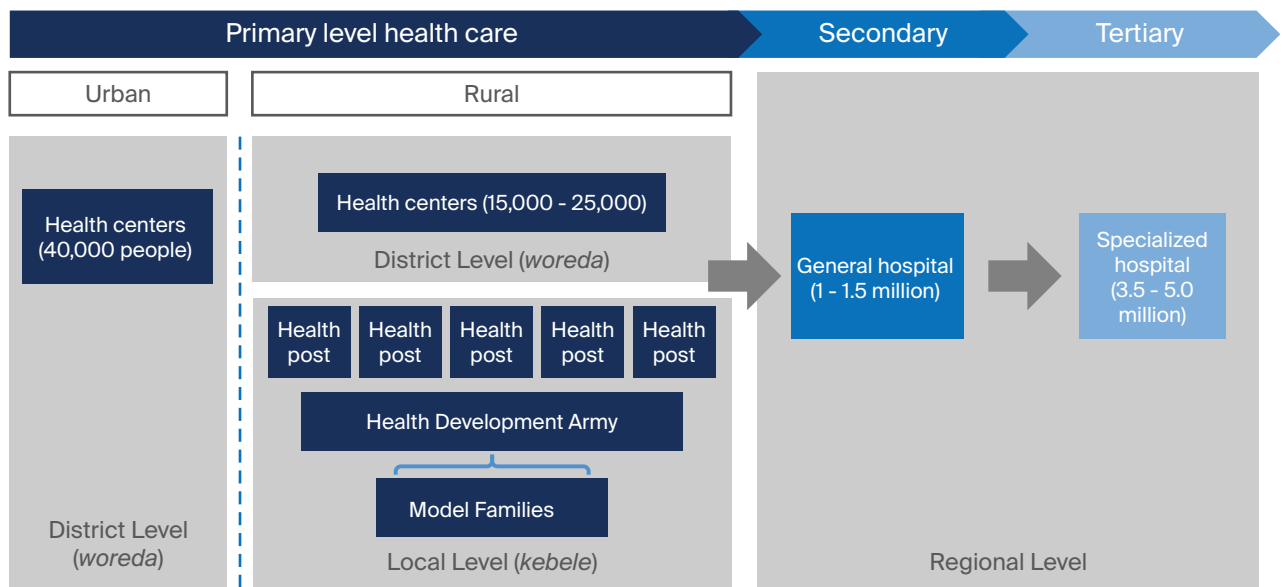
ry health care units (PHCU), operating in *woreda* (district) and *kebele* (the lowest level of administration), provide primary health care services to communities. The management, coordination, and distribution of technical support at every level is the responsibility of *woreda* district health offices and regional health bureaus (RHBs); the Federal Ministry of Health sets policy and takes significant decisions.

Organization of the health system in Mubarak and Dollo Ado

Ethiopia's health system is federally decentralized to the nine regions. Health services in Mubarak and Dollo Ado are managed by the Somali Region's regional health bureau. Primary health care in Mubarak and Dollo Ado includes a primary hospital, local health centres, and rural health posts. In addition to these public facilities, several private clinics and hospitals are run by faith-based and non-governmental organizations, mostly in larger

settlements such as Mubarak and Dollo Ado. The decentralised health system is implemented by health extension workers who deliver basic primary care services (contraception, immunization, treatment for common childhood illnesses, etc.), monitor local levels of health and disease, and deliver health education advice to the public. More serious cases are referred to health centres or the primary hospital.

Figure 4. The structure of Ethiopia's health system.



Source. Ethiopia Health Sector Development Plan.

Health financing in Mubarak and Dollo Ado

Financing is primarily the responsibility of the Government of Ethiopia (GoE). Regional governments, donors and non-governmental organizations, and patients provide additional resources. Unlike Kenya, Ethiopia's health system includes an insurance plan that covers patient medical costs. However, patients in Mubarak and Dollo Ado pay themselves for services that are not free at health facilities. The Pharmaceutical Fund and Supply Agency (PFSA) manage the supply chain for drugs and other medical supplies, and also decides how medicines are distributed across the country. At *Woreda* and *Kabele* level, health extension workers play a key role in mobilizing the public. They train ‘model families’ to help spread health education and raise awareness in the larger community. Model families make up the ‘Health Development Army’, which aims to “engage the community, identify locally salient bottlenecks that hinder uptake of services, and scale up best practices”.⁹

The country has developed a health financing strategy based on social health insurance (SHI) for the

formal sector, and community-based health insurance (CBHI) for citizens in the informal sector and agriculture. (The informal sector is composed of self-employed people and private-sector employers with fewer than 10 employees.) However, regional states have been slow to implement the strategy. As in other parts of the country, public financing for healthcare in both Mubarak and Dollo is very low, and the health relies for essential resources on the Somalia Regional State, external development assistance, and patient contributions. Though good data on health financing are not available at district level, key informants estimated that Mubarak is allocated some ETB 1.67 million, which amounts to USD 20 per capita, slightly below the national average of USD 24.5 (Table 5). Though the HSDP and HEP recommend that these resources should be managed by health facility governing boards, which were expected to meet monthly in both districts, few facilities have appointed boards and, where these exist, they have not met regularly. In addition, federal decentralisation of health to *woreda* levels has been slow.

Table 5. Budgetary allocations to Mubarak district 2020/2021 (USD)

| Item | Mubarak (Birr) |
|-------------------|----------------|
| Salaries | 1,083,857.23 |
| Recurrent | 192,500.00 |
| Operation/capital | 412,698.78 |
| Total | 1,689,056.00 |

Source. Chief District Medical Officer.

Healthcare Access in the Mandera Triangle

Access to healthcare in the Triangle is generally low. It is least good in Gedo Region, somewhat better in Mandera County and in Mubarak and Dollo Ado. In South Central Somalia, it is estimated that 60% of the population have no access to healthcare because of displacement, insecurity and obstacles to travel.¹⁰ The research for this study found that a large number of problems affect the condition of facilities in the Triangle and their supply chains. All

the respondents said that lack of health staff limited public access to good quality health care. They observed that, unlike in other health services, few non-state actors provided mental health and psychosocial care in the Triangle’s health system. As Table 6 shows, cross-border health facilities suffer particularly from shortages of personnel, drugs and other supplies.

9 Ethiopian Federal Ministry of Health, *Health Sector Transformation Plan (2015-16 to 2019-20)* (2015).
10 WHO, *Strategic Review of the Somali Health Sector: Challenges and Prioritized Actions* (2015).

Table 6. Number of health professionals in selected cross-border health facilities in the Mandera Triangle

| Designation | Country /County | Population | Doctors | Nurses/clinical nurses | Clinical Officers |
|---------------------|-----------------|------------|---------|------------------------|-------------------|
| Khalalio | Mandera | 7,948 | 0 | 4 | 2 |
| TSCRH | Mandera | 21,517 | 2 | 13 | |
| RSCRH | Mandera | 35,644 | 2 | 4 | 5 |
| MCRH | Mandera | 87,692 | 19 | 148 | 17 |
| ESCRH | Mandera | 60,732 | 5 | 15 | |
| Elwak Somalia | Somalia | 30,958 | 1 | 6 | 2 |
| Samarole HC | Somalia | | 0 | 3 | 0 |
| Damasa | Somalia | | 0 | 2 | 0 |
| Khalil | Somalia | 138,000 | 1 | 19 | |
| Gawido | Somalia | | | 6 | |
| Dollo hospital | Ethiopia | 80,000 | 1 | 44 | |
| Boryale health post | Ethiopia | * | 0 | 3 | |
| Suftu health centre | Ethiopia | 25,059 | 0 | 38 | |
| Mubarak | Ethiopia | 86,000 | 0 | 6 | |
| Megag health post | Ethiopia | * | 0 | 2 | |
| Total | | | 31 | 313 | 26 |

Source. Field survey, county census reports. * Records could not be established.

All the centres we visited in the Triangle reported a common pattern of disease. Malaria, malnutrition, skin diseases, diarrhoea, cholera, dysentery, respiratory tract infections/URTI, urinary-tract infections (UTIs), and sexually transmitted infections (STIs) were the most common. Chronic mental health issues were frequently reported. Based on our discussions with health staff and previous health studies, common and conflict-related conditions are

prevalent in cross-border communities, including injuries, psychological illnesses and communicable diseases. While psychological problems were reported to be on the increase, health personnel said that they lack the skills and the time to provide appropriate support; very few health professionals are trained and equipped to treat patients with psychological or mental health problems.

Healthcare access in Mandera County, Kenya

Relatively, communities in Mandera County have much better access to health services than neighbouring communities in the Triangle, although the county lags on most health indicators compared to other counties in Kenya. Mandera County has the highest mortality rate in the world a recorded death rate of 3,795 per 100,000 live births, over seven

times higher than Kenya's national average (488). This is attributed to poor health infrastructure, an unskilled health workforce, and cultural practices that discourage hospital delivery. Maternal mortality has also been rising, due to poor health practices, cultural values that do not permit women to be attended by male health workers, and the distances

women must travel to reach hospitals.¹¹ In addition, county referral hospitals in Mandera do not yet meet approved standards for referral hospitals.

Most rural dwellers have access to health centres, dispensaries and clinics, while residents in sub-county headquarters and Mandera town have access to the sub-county referral hospitals in Rhamu, Elwak, Lafey, Banisa, Takaba and Kutulo as well as the Mandera County Referral Hospital. With some support from clinical officers, nurses run the majority of rural facilities. In most cases they offer outpatient preventive care, including immunization for mothers and children, family planning, and curative care for common diseases. They refer patients with more serious problems to the sub-county referral hospitals or to Mandera County Referral Hospital, where they can access a fuller range of services.

Mandera County Referral Hospital provides specialized services and receives referrals from sub-county hospitals and other centres in Ethiopia and Somalia. The county has the largest share of health professionals in the Triangle. After devolution, the County Government of Mandera invested in health care. It upgraded some facilities to provide surgical services, and posted adequate staff to them. The hospitals in Takaba, Rhamu, Elwak and Banisa were upgraded to the level of sub-county referral hospitals and now provide some specialized services, including general, obstetric and specialized surgery. Lafey, Kutulo and Dandu can now offer caesarean delivery. Some health centres and dispensaries in rural areas also serve cross-border communities. (See Table 7 for cross-border health facilities in Mandera County).

Table 7. Major cross-border health facilities in Mandera County, Kenya

| Health Facility | Description of the facility |
|--|--|
| Mandera County Referral Hospital (MCRH) | Established in the 1970s, the MCRH is the largest health facility in the Triangle and has expanded significantly since devolution. It has 200 inpatient beds, 11 consulting rooms for outpatient services, and 380 medical staff, including 19 consultant doctors and 148 nurses (when the assessment took place). The facility is well equipped, runs specialist clinics, provides mental health services, has an ambulance service that covers the county, and receives referrals from all the smaller facilities in the Triangle. Few cases from this facility are referred to Nairobi. Some cases are self-referred to health services in Somalia or to Shashamane and Wollaita in Ethiopia. |
| Khalalio Health Centre | This facility serves residents, pastoralists and the cross-border farming community. It provides outpatient, laboratory and maternal and child health clinics and is staffed by eight clinical officers and nurses. 30-40% of the patients are CBMPs. Diseases commonly reported included acute watery diarrhoea, upper respiratory tract infections, gastrointestinal conditions, and vector-borne diseases such as malaria. Because of its proximity to Mandera town, the population had access to ambulances from MCRH, to which most referrals were made. |
| Rhamu SCH | Established in 1972, this facility was recently classified as a sub-county referral hospital and its facilities and staffing have been upgraded. The facility serves residents but also CBMPs, mainly from Ethiopia. A quarter of the patients who visited the facility were classified as members of a cross-border community. Supported by (erratic) supplies from MCRH, the facility has 24 beds, a work force of 26 that includes two doctors and four nurses, and two ambulances that transport referrals to the MCRH (15-20 patients per month). The facility lacks specialized clinics and does not have a radiography machine or similar equipment. |

11 Mandera County Government, 2018. County Integrated Development Plan 2018-2022

| Health Facility | Description of the facility |
|--------------------------|--|
| Elwak SCH | Established in the 1970s, the Elwak SCH has been classified and upgraded as a sub-county referral hospital. It serves residents, accepts referrals from other sub-county health facilities, and takes cross-border patients from Elwak in Somalia. It has 102 in-patient beds, two consulting room for outpatients, and 108 staff including five doctors and 14 nurses. The facility lacks specialized clinics, facilities for treating mental health cases, or a safe house for victims of SGBV. It refers such cases to MCRH using a stand-by ambulance. |
| Takaba SCH | Like the Elwak and Rhamu SCHs, this facility was established in the 1970s and was upgraded from a health centre to a sub-county referral hospital after devolution. It provides outpatient and inpatient services, physiotherapy, dental services, and ultrasonography, and has a chest clinic. The facility serves residents and takes referrals from Mandera West Sub-County as well as CBMPs from neighbouring Ethiopian villages. It has a staff of 49 that includes two doctors and 13 nurses. It lacks specialized clinics. Patients who need those services are referred to MCRH, Kenyatta National Hospital, or Kijabe Hospital. |
| Kiliwehiri Health Centre | This health centre provides limited primary health care services. Due to its proximity to the Ethiopian border, a significant number of CBMPs use it. When the research was done, it had a staff of eight, headed by three nurses, and was supplied (erratically) by MCRH. It makes referrals to Banisa and Takaba SCHs; some patients also travel to MCRH; some also go to Awasa in Ethiopia, a facility that patients considered to be cheaper and well-equipped to provide some specialized services. |

The services provided in health facilities are in line with service norms in the national health system. Curative and preventive services are provided nearly every day in referral hospitals, and for six days a week in smaller facilities. When the facilities were observed, they seemed to be used extensively and doctors reported that the workload was so heavy that it was difficult to cope. Curative services mainly handle common diseases endemic in the county. The most common reported by health centres include upper respiratory tract infections, gastroenteritis, skin infections, and a few non-communicable diseases. Preventive care is an important activity for primary health centres and includes programmes to vaccinate children and pregnant women, and family planning. Access to services is free for some preventive services, including antenatal and postnatal clinics for pregnant women, family planning, and vaccinations. Medicines and laboratory/radiology are also free to the public in county facilities. The main vaccines available are for polio, measles, tetanus, and the Bacillus Calmette–Guérin vaccine (BCG). However, few facilities have functioning cold storage for drugs and vaccines. This affects the potency of drugs and vaccines and limits their availability.

An elaborate system captures health information. In rural areas, information is collected and registered on (paper) registers. Data are sent regularly to the Department of Medical Records, which analyses and compiles information from all county health facilities. As indicated, Kenya's National Health Insurance Fund (NHIF) allows contributors to access medical services, some even in private facilities. In practice, the insurance fund is restricted to government employees and those working in the humanitarian sector, because the incomes of most people are not sufficient to sustain the regular payments required. As an alternative, local communities rely on relatives and donations from Good Samaritans, especially when they need emergency treatment. Since decentralization, budgeting and disbursement have been a responsibility of the county government, and procurement, resource mobilization, and emergency allocation have been done faster than before. Compared to both Somalia and Ethiopia, the staffing of health facilities in Kenya appear to be relatively adequate. Staffing levels in Mandera county have risen since devolution, though the number of staff and their key competencies still fall below WHO standards. Data show that Northern Kenya (including Mandera, Wajir, Garissa, Tana River, Lamu, Tur-

kana, Samburu, Marsabit and Isiolo) had the lowest percentage of health professionals. According to the 2012 Human Resources Assessment report in Northern Kenya carried out by the Ministry of State for the Development of Northern Kenya and other Arid Lands (MONDKAL) and IntraHealth International, Northern Kenya suffer from acute shortage of health workers at all levels. For example, out of the entire health workers in the country, there are only 2% of doctors, 2% nurses, and 5% clinical officers working the local population (2.3 million; 6.4% of nation population). In contrast, Nairobi province with a population of 8.2 million (22% of Kenya) has 25% of doctors and 6.6% of the nurses working in the country. Although Mandera has the largest population in the province (22%) it has far less total health workers (6%) compared to Garissa (13% of the population) with 18% of health workers in the province.¹²

Several factors contribute to low staffing in the region. First of all, the region is considered to be harsh, volatile, and insecure. As a result of insecurity and Al Shabab attacks on public transport, Mandera County's health sector has high staff turnover and it has proved difficult to contract and retain non-locals. These problems are compounded by the county's poor road network and harsh climate, the absence of physical and social amenities (such as staff housing), and lack of incentives (including attractive remuneration). In addition, the region faces a similar problem in education. This has depressed the quality of educational institutions and as a result, the high school graduates from the region cannot easily compete for entry to higher institutions. Most higher education institutions are also located in other parts of the country, making access to them even harder. To address this challenge, the county government, in partnership with the national government, opened a Kenya Medical Training College (KMTC) campus in Mandera. It is hoped that this will increase the number of students trained in the county and lift standards. With regional collaboration, the Mandera KMTC can potentially meet the

healthcare training needs of the Triangle. Overall, the low quality of education and health services in the county, and the underperformance of other sectors of the economy, continue to negatively affect the lives and livelihoods of Mandera's people. Youth unemployment makes young adults vulnerable to recruitment by militia groups, exacerbating the Triangle's insecurity.

With respect to the availability and management of drugs, we found that most essential drugs were available at the referral hospitals, but relatively few were available in smaller health facilities. The situation has nevertheless improved tremendously since devolution, because it was previously common for county health facilities to experience systemic shortages. The Kenya Medical Supplies Authority (KEMSA) is the only body mandated to deliver drugs and supplies to county governments in Kenya. A state corporation under the Ministry of Health, it is legally authorized to procure, import, and distribute supplies to public medical facilities. Though KEMSA works in partnership with the government, its procurement processes are lengthy and supplies are frequently erratic. Shortages also occur. Where particular drugs are not available in public health facilities, patients are asked to buy them from a private pharmacy. The private sector can take a more flexible approach to stocking medicines because it is not obliged to follow the lengthy procurement procedures of the public sector. Kenya's vibrant pharmaceutical industry can meet the local demand of private hospitals, clinics, and pharmacies for drugs and supplies. However, the majority of the population cannot easily afford the high cost of medicines sold through private facilities and most opt for the free services offered by public health facilities. If medicines are unavailable, patients prefer to delay treatment. The health facilities we visited observed high standards of hygiene; they applied sterilization and infection control procedures, met waste management standards, uses safety boxes for needles, etc.

¹² Kenya Ministry of State for the Development of Northern Kenya and other Arid Lands (MONDKAL) and IntraHealth International, *Human Resources for Health (HRH) Assessment in Northern Kenya: An overview of health workforce distribution across 10 counties* (2012).

Healthcare access in Gedo Region, Somalia

Somalia has some of the worst indicators. Ongoing insecurity, the lack of government access, and the limited coverage of health services, combined with an absence of essential health, nutrition and WASH facilities, mean that only half the population have access to essential health care. The density of health facilities is low throughout the Gedo Region. Rural populations in Gedo only have access to prima-

ry health units or health posts; urban populations in Dollow, Belet Hawa, and Elwak Somalia can access Dollow Referral Hospital, Belet Hawa General Hospital, Belet Hawa Health Centre, and Elwak Hospital. However, all of these lack specialized medical treatment and surgical units. Several of the facilities in Gedo Region also serve cross-border communities in Kenya and Ethiopia (Table 8).

Table 8. Cross-border health facilities in Gedo Region, Somalia.

| Health Facility | Description of the facility |
|--------------------------------|--|
| Damasa MCH | Supported by the NGO Human Development Concern, this facility is staffed by two nurses and provides mother and childcare support to residents and CBMPs. The facility receives medical supplies every 90 days. Complicated cases are referred to Elwak Sub-County Referral Hospital (Kenya). |
| Elwak PHU | Owned and operated by the Somalia Red Crescent Society, this and the Elwak District Hospital are the only medical facilities in the vast Elwak Somalia District. The facility receives supplies from Mandera and Nairobi, and provides basic curative services for diarrhoea, skin diseases, injuries, snake/insect bites, etc. It refers more complex cases to Elwak SCH (Kenya) and Elwak District Hospital. |
| Samarole Health Centre | Like the Damasa MCH, this facility is supported by Human Development Concern, restocks its medical supplies every 90 days, and refers complex cases to Elwak SCH (Kenya). It is staffed by two nurses and a midwife. |
| Elwak District Hospital | Established in 1978, Elwak District Hospital is a major facility. Supported by Human Development Concern, it offers laboratory services, vaccination, minor surgery, delivery, and accepts inpatients and outpatients. Its staff includes a doctor, six nurses, ten auxiliaries and two midwives. It is supplied every 90 days from Nairobi and sometimes from Mogadishu. It refers cases of hepatitis, cancer, physical injury, hypertension, complications in delivery, and mental health patients to Mandera hospital, or to hospitals in Nairobi or Mogadishu. |
| Khalil Hospital | Founded 50 years ago and supported by Trocaire, this facility provides laboratory, maternity and immunization services, accepts outpatients and inpatients, and treats cases of acute malnutrition. Its staff of 55 include a doctor, a matron, 19 nurses, and auxiliary staff. Equipped with adequate supplies and possessing a cold chain for vaccines, the facility receives its supplies from Kenya and Ethiopia every 90 days. For specialized treatment and surgery, it refers patients to Mandera hospital, or to hospitals in Nairobi or Mogadishu. |
| Gawido MCH | Established in 2012, this facility is locally managed with support from HIRDA, a local NGO. Run by a nurse, its auxiliary staff offer basic services including immunization. Supplies are provided by UNICEF through HIRDA every 90 days. It refers more complex cases, including cases of diabetes, TB, asthma, and hypertension to other hospitals in Kenya, Somalia and Ethiopia. |

A number of private sector actors operate hospitals, clinics, and private pharmacies in the major towns. Across Somalia, the number and density of doctors, nurses and midwives is less than 4 per 10,000 of the population (well below the minimum threshold of 23 per 10,000¹³), and the situation in Gedo Region is worse. Observation, as well as interviews with health staff, confirmed that services and facilities are of much lower quality than in Kenya. We noted in addition that the referrals from Dollow and Belet Hawa to Mandera County Referral Hospital (Kenya), and from Elwak Somalia to Elwak Sub-County Referral Hospital (Kenya), were informal; coordination between the health system in Gedo and the health systems in Kenya and Ethiopia is poor. Most health facilities in Gedo possess no transport to carry referred or emergency patients. The situation is made worse by the tensions that exist between Kenya and Jubaland State, and between the Federal Government of Somalia and the administration of Gedo Region.

Health systems in the region face a variety of challenges. Most relate to the fact that the technical and human resources available are insufficient to provide essential services. During our health facility assessment, we observed that the infrastructure was everywhere inadequate (Figure 5), and that most facilities lacked equipment and essential drugs. Most of the facilities provided outpatient consultations for common conditions such as upper respiratory tract infections, gastroenteritis, skin infections and some non-communicable diseases. We also observed that staff levels were too low and staff lacked equipment and a formal health information system. Especially in rural areas, most health facilities had no electricity and were not connected to the internet, while the primary health units also lacked transport for patient referrals and emergencies. Further, the facilities depend financially on development assistance and contributions from patients. During FGDs, respondents said that poorer households preferred to use health facilities that are cheaper or managed by NGOs, because the larger facilities in major towns charge them.

Figure 5. The condition of health facilities in Somalia.



The dire state of healthcare in the region is largely due to the fact that health systems in Somalia have been in disarray since the collapse of the national government; and that currently the Ministry is still too weak to fulfil its obligations. In addition, the Regional and State authorities are too weak to facilitate and develop the health sector fully. The key challenges facing the Somali health system are: (1) the burden of disease is persistently high; (2) institutional capacity is limited and the Ministry of Health's stewardship falls short; (3) financing arrangements are insufficient, unpredictable and un-

sustainable and depend too much on the direct contributions of patients; (4) the health workforce lacks training, is insufficient, and is not well-distributed or well-managed; (5) access to essential health services is limited and unequal, and the services themselves are of poor quality across all levels of care; (6) the procurement and supply system is inadequate and the use of essential technologies and medicines is irrational; (7) national surveys and census, and birth and death registration are lacking, and operational research and disease surveillance are insufficient; (8) the humanitarian response and health sys-

13 WHO, *Strategic review of the Somali health sector: challenges and prioritized actions* (2015).

tem are not working together; and (9) insufficient action is taken to address the social determinants of health.¹⁴

The Federal Government and States have limited resources but these have rarely been allocated to rural health facilities; and revenue collection has been limited. In the absence of strong national governance, multiple actors, including the Federal Government, local authorities, private entities, international development partners and international NGOs, fund or offer healthcare services. This has implications for how healthcare is financed and managed

“Despite improvements in revenue collection over the past four years, the government’s fiscal position remains highly constrained and the economic impacts of Covid-19 have created further pressure. As a result, Somalia’s health sector has faced chronic shortfalls in capacity, equipment, infrastructure and medical personnel (Warsame, 2020), while medical supply chains have been disrupted. This has seriously impacted maternal and child health. The World Health Organization has identified the key building blocks for strengthening health systems in Somalia, and the government’s focus remains on primary healthcare. However, the 2020 Somali Health and Demographic Survey results have clearly shown that recent investments have not delivered.” (Directorate of National Statistics, 2020.)

Poor governance and insecurity compound the dire health situation. Most of the rural areas of Gedo Region are occupied by Al Shabab, which restricts access to public services and humanitarian interventions in the region. The region also suffered a prolonged dry season, which it was feared could lead to drought. Stakeholders noted that Gedo Region is one of the most volatile and conflict-prone regions of Somalia. At the time of the assessment, political tensions between Gedo Region and Jubaland State had led to clashes between their armed forces, causing deaths and displacements in Belet Hawa. Conflicts obstruct health care provision in Somalia but also prevent local people from moving across the border to obtain treatment in Kenya. People have been deterred by fear of reprisals by Ken-

ya’s anti-terror units and lack of the travel documents they need to enter the country. We were told that some people with gunshot wounds had not received treatment, that patients with gunshot wounds had been detained by border police, and that some patients from border communities had disappeared after arrest.

Box 1. Synopsis of health system challenges in Somalia

- A persistently high burden of disease.
- Limited institutional capacity; the Ministry of Health does not exercise its stewardship role well enough.
- Financing is insufficient and unsustainable. Patients are expected to contribute too much of the cost of their treatment.
- The health workforce is short of personnel; allocation is not balanced or well distributed. Staff are not motivated, are not well managed, and lack an appropriate mix of skills.
- Access to essential health services is limited and unequal. The services provided are of poor quality across all levels of care.
- The procurement and supply system is inadequate. Essential technologies and medicines are used irrationally.
- The humanitarian health response does not work closely with the national health system.
- Inadequate action has been taken to address the social determinants of health.
- Not enough national surveys are undertaken. Census collection, birth and death registration are weak. There is little operational research or disease surveillance.

There is optimism that the situation will improve as Somalia slowly rebuilds its institutions and receives more support from the international community. A stabilized Somalia is expected to develop more responsive and stronger institutions that can offer better health care to its population. Until then, the Ministry will rely on donor support to provide services. The WHO and UNICEF have continued to support critical areas of health, including immunization. They supported the most recent distribution of monovalent house-to-house oral polio vaccine type 2 in the central and south regions of the country in Oc-

¹⁴ Op. cit.

tober 2020. Preliminary results suggest that 96.1 per cent (1,337,974) of the target population had been

vaccinated, including 9,792 children who had previously never received a polio vaccine.¹⁵

Healthcare access in Mubarak and Dollo Ado, Ethiopia

Ethiopia has a substantial disease burden from infectious diseases and faces challenges to reproductive, maternal, neonatal and child health.¹⁶ Basic health coverage is low, as is use of health services, and access is very unequal: urban dwellers have more access than rural, and differences in regional and subregional coverage are evident.¹⁷ Respondents noted that the Ethiopian Health Sector Development Plan (HSDP) and the Health Extension Program (HEP) have improved access to health care in Ethiopia, and that health facilities have been upgraded, health personnel trained, and community outreach extended;¹⁸ however, the situation for populations in Mubarak and Dollo Ado remains less favourable.

Residents of Mubarak have relatively less access to healthcare than residents of Dollo Ado. This is because Dollo Ado is an older and bigger settlement than Mubarak and has a higher number of private clinics and pharmacies. These private facilities supplement and complement the services offered by government-managed facilities. Mubarak is a relatively new *woreda* and is served by three health centres (at Mubarak, Yara and Chilako) and 13 health posts. Because Mubarak's facilities lack capacity, cases are frequently referred to Kenyan hospitals. Most patients are sent to Banisa and Takaba; some go to Moyale (150 km. from Mubarak) which has only a few specialists, or Awasa, which has more. In contrast to Mubarak, Dollo Ado General Hospi-

tal serves Dollo Ado town; and several health centres and health posts serve the rural population in the Dollo *woreda*. Being close to refugee camps, where health facilities are supported by humanitarian agencies, Dollo Ado shares its facilities with the refugee population. Across the two *woreda*, several facilities that serve the local population also serve cross-border populations from Kenya and Somalia (Table 9).

Staff density across the region is very low. Compounding this, the level of education of most of the staff responsible for primary healthcare in these *woreda* is also low. Because they lack skills, they cannot provide the desired services. As noted earlier, the healthcare system lacks resources, is over-reliant on patient contributions, and applies the resources it has inefficiently and inequitably, narrowing health care coverage.¹⁹ The number of health facilities in both Mubarak and Dollo Ado is inadequate, most facilities are ill-equipped, and they are unable to meet the healthcare needs of CBMPs. The two *woreda* are also far from Jigjiga, the regional city of the Somali Regional State (SRS) of Ethiopia, where the largest referral hospital in the region is located. The condition of their facilities and their distance from Jigjiga mean that the populations of these *woreda* rely for more complex health care on Mandera County Referral Hospital and regional referral hospitals in the Oromia Regional State of Ethiopia.

15 OCHA, Somalia Humanitarian Bulletin, 2020.

16 Misganaw A., Melaku Y. A., Tessema G. A., et al, 'National disability-adjusted life years (DALYs) for 257 diseases and injuries in Ethiopia, 1990–2015: findings from the global burden of disease study 2015', *Population Health Metr*, 2017, 15:28.

17 Federal Democratic Republic of Ethiopia, Ministry of Health, *Health and health related indicators, 2008 EFY* (2015).

18 Memirie S. T., Verguet S., Norheim O. F., Levin C., Johansson K. A., 'Inequalities in utilization of maternal and child health services in Ethiopia: the role of primary health care', *BMC Health Services Research*, 2016, 16(1):51.

19 Eskinder Eshetu Ali, *Health Care Financing in Ethiopia: Implications on Access to Essential Medicines* (2014).

Table 9. Cross-border health facilities in Mubarak and Dollo Ado

| Health Facility | Description of the facility |
|-----------------------------------|---|
| Megag Health Post | This facility provides free immunization and some curative services to both pastoralists and residents. Staffed by nurses, it refers patients who need further investigation and specialized treatment to other facilities in the countries. |
| Jara Health Centre | Established five years ago, this facility is staffed by eight health professionals. It provides free laboratory services and outpatient consultations. Other services include: deliveries, nutrition, ante-natal care, family planning, and immunization. It serves the local population, pastoralists and cross-border communities. It is reliant on ambulances from Mubarak, but refers more complex cases to the sub-county hospitals in Moyale and Takaba. |
| Eymole Health Post | This post, staffed by two nurses, provides some maternity services for cross-border communities and pastoralists. Because it is close to the border, patients cross into Kenya to obtain treatment at Eymole (Kenya), Kiliweheri and Takaba SCH. |
| Boryal Health Post | This facility provides immunization and curative services free to residents and pastoralists, as well as some numbers of cross-border communities. It lacks specialized clinics. Referrals were made to Eymole (Kenya), Kiliweheri and Takaba SCH. |
| Mubarak Health Centre | Established in 2001, this is the largest facility in the Mubarak District. It is supplied by the regional government in Jigjiga and sometimes by UNICEF. It serves patients from all 11 locations in the district and also mobile communities. The staff of 20 includes six clinical nurses. The facility has 4 inpatient beds and serves outpatients. Services include maternal and child health, laboratory tests, and nutrition. An ambulance transports referral patient to Takaba, Moyale, Banisa and Mandera hospital. |
| Suftu Health Centre | This facility provides an outpatient service, ante-natal care follow-up for mothers, TB treatment, laboratory services, and nutritious food for malnourished children. It serves residents and pastoralists. Because it is close to Mandera, Dollo Ado and Dollow, it refers more complex cases to the larger health facilities in these towns, in most cases to Mandera hospital. |
| Dollo Ado General Hospital | This is the biggest public facility in the Dollo Ado District. It serves a variety of patients from Somalia, Ethiopia, and even Kenya. The facility provides an outpatient service, and services in maternal and child health, general investigation, radiology, and obstetrics (including delivery). It serves pastoralists, local communities and cross-border communities. The most common diseases are malaria, dengue fever, water-borne diseases, common cold, blood infections, and bacteria-caused diseases. The facility receives most of its supplies from the regional government and some from NGOs. Supplies are insufficient and erratic. It refers more complex cases, including open fractures and cardiac problems. Most referrals are to Awasa, Addis Ababa and Wollaita. |

Healthcare Access for Cross-Border Mobile Populations

The Mandera Triangle is a dynamic trading zone that supports the livelihoods of thousands of people. The population is highly mobile. While free movement stimulates the economy and social development, it also facilitates the spread of disease. To address this, it is paramount to ensure that mobile health services are available along migration routes, in addition to static clinics. Although some improvements have been made and informal systems exist, health systems in the Mandera Triangle are not designed to meet the needs of CBMPs. Formal cross-border links are weak, and procedures

for cross-border referrals and patient tracking do not exist. Though it is difficult to obtain clear data, anecdotal evidence suggests that a significant number of ‘medical travellers’ move between Mandera, Gedo region, and Mubarak and Dollo Ado districts. Because infrastructure in Mandera County is relatively more developed (as detailed above), people move from Dollo and Gedo to Kenya to access markets, hospitals, and schools. Movement from Mandera to neighbouring cross-border districts also occurs.

Provision of health services to marginalized and vulnerable cross-border mobile populations in the region is often neglected and is not regarded as a priority. The quality of medicines available in cross-border facilities is also an issue. Informal traders move medicines across the porous borders between Kenya, Somalia and Ethiopia but these medicines are not quality-assured. The bulk are illegally important from Somalia. A regional survey

of the quality of medicines in cross-border areas showed that 21% of the oxytocin injection samples tested did not meet quality specifications. In addition, the relevant national medicine regulatory authority had not registered 72% of the oxytocin injection products, 30% of the amoxicillin dispersible tablet products, and 26% of the amoxicillin suspension products that were collected.

Mapping cross-border crossing and health facilities

A mapping by the CORE Group Polio Project found 22 cross-border health facilities, 53 cross-border crossing points, and 124 cross-border villages in the seven sub-counties of Mandera. In the four cross-border districts of Gedo Region, it located 14 cross-border health facilities, 14 cross-border crossing points, and 67 cross-border villages.²⁰ As shown in Tables 7 to 9, our assessment reviewed 28 cross-border health facilities in Mandera, Gedo Region, and Mubarak and Dollo Ado districts. Because the Mandera County's health services and infrastructure are more developed, its services attract a particularly large number of people from neighbouring cross-border districts. As discussed below, visitors most often sought clinical consultations or care and treatment for gynaecological conditions (difficult births, caesarean section), specialised surgery, sexual and reproductive problems, and mental health issues.

How CBMP seek healthcare depends on several fac-

tors, including their access to identification documents, the cost of the health services they need, and transportation. The main healthcare patterns include:

- Patients with access to Kenyan and Ethiopian identification documents often seek treatment in these countries.
- Patients who lack identification papers either delay seeking health services or use alternative medication, including the Quran.
- Some seek treatment from more expensive private facilities in their own country, especially when security deteriorates or in situations of emergency.
- Others use informal border-crossing points to access health services in neighbouring countries.
- For mental health services, FGD respondents reported that they tried a number of solutions before they approached health services.

Priority health services for mobile cross-border populations in Mandera Triangle

People in the Mandera Triangle have not started to seek treatment from health facilities in neighbouring countries recently. When healthcare services in one district have been poor, CBMPs have always sought treatment in neighbouring districts that have better facilities. However, health service providers said that more patients now seek medical treatment in countries in which they do not live; and they expect the numbers of cross-border patients to rise fur-

ther as health services improve, particularly in Mandera County. CBMPs also believe some hospitals in Ethiopia provide superior treatment: they value orthopaedic services in Wollaita, for example, and gynaecological care in Shashamane.

Gender-based violence against women and girls is reported to be common across the Triangle. Regional and clan conflicts and the displacements associ-

20 Arale A., Lutukai M., Mohamed S., Bologna L., Stamidis K. V., 'Preventing Importation of Poliovirus in the Horn of Africa: The Success of the Cross-Border Health Initiative in Kenya and Somalia', *American Journal Tropical Medicine and Hygiene*, 2019, 101(4_Suppl), 100-106.

ated with them have made women and girls more vulnerable to sexual violence. Use of gender-based violence as a weapon in conflicts has been reported in Mandera; medical professionals also reported a rise in cases of rape and other forms of violence against women and girls. The number of teenage pregnancies has also risen. The situation is made worse by local practice: after a rape or when an unmarried woman becomes pregnant, the perpetrator's family traditionally negotiates an arrangement with the victim's family under which perpetrators agree to marry the victim or go free after paying a small fine.

Aisha [not her real name] is a 16-year-old girl whose family lives in Belet Hawa outskirts. She was admitted on 17th February 2021 after complaining of loss of appetite, vomiting and generalized weakness. Following admission to an inpatient facility in Belet Hawa and, after a medical examination, Aisha was informed that she was pregnant. Aisha's mother is divorced, and Aisha lives with her father and stepmother. Because she was afraid of her father, and worried about her ability to keep the child, Aisha decided to induce an abortion. Her mother opposed the abortion but agreed to it in view of the shame associated with teen pregnancy. Aisha and her mother went to a facility across the Kenya-Somalia border. [Narrated by Bulla Hawa medical superintendent.]

FGD participants reported cases of sexual exploitation of mentally-challenged individuals. Because of the stigma associated with rape, victims of sexual violence are often murdered by their aggressors. In

the past, such cases were not widely reported. However, the recent establishment of a law court in Mandera and increased media coverage has raised the profile of SGBV nationally. For example, the *Daily Nation* reported the attack by a Boda Boda transporter on a 13-year-old girl. ("Boda boda rider denies defiling girl, 13, in Mandera, at <https://nation.africa/kenya/counties/mandera/boda-boda-rider-denies-defiling-girl-13-in-mandera-3323418>.) Local media reported a similar incident, and human right activists and law enforcement officers in Mandera have started to address the issue.

Women and human right activists stage a protest outside Maendeleo ya Wanawake offices in Mandera County to demand justice for a 14-year-old girl with mental disorder who was allegedly raped by an officer of the National Police Reservists. The protests came as Mandera Commissioner Onesmus Kyatha issued a stern warning to area community leaders who are still using 'Maslah' to resolve rape cases. (https://www.youtube.com/watch?v=Oq-8fRdd1Q6c&ab_channel=KBCChannel1).

The medical professionals who reported a rise in rape cases and other sexual and gender-based violence observed that most facilities do not have specialized SGBV services; no specialized shelter or accommodation is available for SGBV survivors. During an FGD discussion with a group of women, we were told that survivors were accommodated in the general wards. Such arrangements do not provide privacy and are not well-equipped to provide a healing environment for SGBV survivors. In search of privacy, some victims sought treatment and care across the border.

Mental health services

Mental health services remain an important priority for populations in the Triangle. The region's frequent conflicts and displacements have had many health-related effects, including deaths, physical injuries, and mental problems. Mandera County has witnessed waves of violent clan conflicts and terrorist attacks in the recent past that claimed dozens of lives and displaced hundreds of families. Interviewees informed us that, apart from Mandera Referral Hospital, Mandera Wellness Centre and a private fa-

cility in Belet Hawa, few services can address mental health or the effects of sexual and gender-based violence. In addition, donor agencies and governments are keener on forms of medical care that visibly save lives, such as sanitation, malnutrition and vaccination programmes, and reproductive, maternal, neonatal and child care. Partly because their outcomes can be measured easily, such programmes attract resources.

Interviewees told us that the main factors associated with mental health problems are conflict and displacement. Those affected include IDPs, refugees, cross-border communities, and pastoralist populations. Youth substance abuse in urban settlements is also an issue. Some 15-20% of Kenya's population suffer from some form of mental health problem. In Africa, Kenya has among the highest rates of mental, neurological, and substance use (MNS) disorders.²¹ A situational analysis of mental health in Somalia conducted in 2010 estimated that approximately one third of the population suffered from mental health problems.²² Recurring intra- and inter-clan conflicts and regional conflicts put individuals, families and communities under significant psychological and social stress. The responses to stress vary with their cause. Mental disorders in Kenya are attributed to inherited and bipolar disorders and substance abuse; in Somalia people suffer primarily from conflict-related trauma and depression.

Because many patients and families explain mental disorders in spiritual and traditional terms, most families turn to faith healers and traditional practices (Quran reading) to treat them. FGD participants discussed the effects on mental health of the war in Somalia that caused them to flee with their children. They said that such situations are very likely to cause psychosocial problems, particularly among adults.

A man more than sixty years old living in Elgolicha lost his most beloved son during a cross-border clan conflict. This greatly affected his social and personal life. In response, he moved away from the village and no longer grazes his animals close to the scene of his son's death and burial site. Neighbours reported that he rarely talks to people and appears

to be mumbling alone every time he approaches areas in Elgolicha to find water for his livestock. Apparently elders in the villages have advised him to participate in social activities and not to isolate himself because this could further affect his life. He appears to fear people and places. There is no professional mental expert in the whole of North and South Mandera to diagnose this kind of problem and help such patients.

Mental health services in the Triangle are insufficient in number, lack proper equipment, and are not able geographically to cover all the region's needs. During our visit, we noted that, with the exceptions of Mandera County Referral Hospital and Mandera Wellness Centre, no health facilities in the Triangle can handle mental disorders. In Mandera CRH, two professionals serve the entire region; the private Mandera Wellness Centre offers services for a fee. Table 9 shows that the main mental disorders treated in the two facilities include depression, post-natal depression, anxiety and neurosis, disorders associated with substance abuse, and bipolar disorder. The two centres jointly handle patients from Kenya, Somalia and Ethiopia. During our visit, about one hundred mental patients were present at the Mandera County Referral Hospital facility, 10% of whom were from Somalia. The centres provide counselling and medicines free, but psychotropic drugs, essential for medical treatment and for managing the most acute and initially aggressive cases, are not always available. No specialist inpatient services are available, but patients who are in a critical state are sedated and housed in the normal general ward. Outpatients come to the centre to receive medication. Recovered patients are followed up, but this cannot always be done if staff do not have transport to make home visits.

21 Meyer A. C., Ndeti D., *Providing Sustainable Mental Health Care in Kenya: A demonstration project*. In: Forum on Neuroscience and Nervous System Disorders; Board on Health Sciences Policy; Board on Global Health; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine.

22 WHO, *A Situation Analysis of Mental Health in Somalia*.

Table 9. Description of mental patients at private and public facilities in Mandera

| Item | Mandera wellness centre | Mandera County Referral Hospital |
|-------------------------|--|---|
| Disorder/needs | Schizophrenia, bipolar disorder, depression, drug abuse. | Depression, post-natal mothers, anxiety, bipolar disorder, conflict-related trauma, drug abuse. |
| Payment | Covered by NHIF. | Free services. |
| Patient type | Inpatient. | Outpatient, followed up at home. |
| Number, age and gender | 40, age 18-54, male. | 100, all ages, male. |
| Origin | Kenya (mostly from Rhamu); Somalia; Ethiopia. | Mandera; referred from other county facilities; Somalia (10%); Ethiopia. |
| Duration | Minimum 6 months. | Continuous until recovery. |
| Patient characteristics | The four we met included an ex-soldier, a bank worker, a teacher. | Data not available. |
| Services /amenities | Medicine, tagged uniform, food, entertainment/TV, security, Quran teaching, laundry. | Medicines; inpatient care in serious cases. |
| Outreach /follow up | Home-based care and treatment; radio-based mental health education. | Home visits; outreach to families. |
| Number of staff | Four technical staff, four security staff. | One professional staff. |
| Gaps | No space for female patients. | Space is limited. |
| | No female staff to care for female patients. | Professional staff lack complete training. |
| | The staff are not adequately trained. | Female staff not available. |
| | Not all patients can access NHIF. | No female staff for female patients. |

Kenyan interviewees reported that the county does not prioritize financing for mental health. A recently-constructed mental health facility has been converted into a COVID 19 isolation centre. The Chief Psychiatrist at Mandera County Referral Hospital said that the hospital did not meet basic criteria for a mental health facility. It is located in the town, in a noisy neighbourhood, and is not designed to meet patients' needs, lacking space and amenities and having no playground. In addition, the hospital has only two mental health professionals, both male, who cannot adequately attend female mental health patients for cultural and religious reasons. Overall,

both at the level of Mandera county and nationally, less than 1% of the health budget is allocated to mental health.²³ The funding shortfall largely explains why more competent psychological and psychiatric healthcare staff have not been hired.²⁴

Due to prolonged conflict in the country, mental health disorders have increased in Somalia. Data on mental health are not available but a report on Somalia's health system and immigration data suggest that about one third of the whole population have some sort of mental disorder. Several studies have predicted that this proportion will rise. The main

23 Getanda, E. M., Papadopoulos, C., Evans, H., 'The mental health, quality of life and life satisfaction of internally displaced persons living in Nakuru County, Kenya', *BMC Public Health*, vol. 15, 755. <https://dx.doi.org/10.1186/s12889-015-2085-7>.

24 Kiima, D., Jenkins, R., 'Mental health policy in Kenya—An integrated approach to scaling up equitable care for poor populations', *Int J Ment Health Syst* 4, 19 (2010). <https://doi.org/10.1186/1752-4458-4-19>.

causes are extended conflict, unemployment, economic and social stress, and substance abuse (particularly *khat*). No site we visited on the Somalia side of the Triangle offered specialist treatment for mental disorders. As in Mandera, mental illness continues to attract stigma and communities are generally unwilling to share information on the subject. Some community elders we interviewed reported that mentally ill people were historically mistreated, put in chains or cages. Abusive treatment on people with mental disorders has declined as mental disorders are now recognized as a health issue, and the people suffering from such disorders are also considered to have rights. Interviewees reported that preferred treatments include traditional healing and reading of the Quran. We did not observe a specialized facility in the public sector that dealt with mental patients.

Farah Bare, a father of four children, used to sell ice bags in the street, and lived with his family in Bulla Hawa town. During the war, he witnessed sad events and the heavy sounds of sophisticated weapons affected him mentally. One day he started shouting, "Please don't kill us, don't kill people, stop fighting!" The family started continuous Quran recitation to help him overcome his fear and anxiety. However, his situation deteriorated further, and he died seven days after the incident. He could not obtain medical treatment across the border in Mandera because of travel restrictions. [Report by a relative.]

On 25th of January 2021, five children from the same family were killed during a battle between federal and Jubaland forces in Belet Hawa after a mortar shell landed on their house. Though Abdiweli Turmak, the father of the children, survived, he cannot stay in his house in Belet Hawa. He said that he cannot stand to see the place where his children died. Abdiweli once told the media, "We are living in

a state of constant fear. The conflict is taking a toll on our mental health."

It is difficult to describe the mental suffering you see when you go to a conflict zone and meet people who have been affected. Abdiweli is one such victim of war. He said, "War trauma leaves physical marks. War is hell ... Its mental effects persist for a long time and victims rarely come out of their state of confusion, depression, and fear. The problems become lifelong. These disorders often impair their ability to function – so access to care isn't just about improving mental health, it can be a matter of survival. The uptake of mental health care during conflicts and other emergencies, in countries where such support has been limited, can cause people to be tied to trees, confined in cages or hidden away from society because of stigma. "War is terrible and beyond the understanding and experience of most people," Abdiweli concluded. He lost all his children during the recent fight between Jubaland and FSG in Belet Hawa. To avoid memories and flashbacks, he now avoids returning to his house and has moved to Mogadishu to start a new life, although he is still full of sorrow and anxiety.

On the Somalia side, Belet Hawa Mental Health and Rehabilitation Hospital is the only centre that provides mental health services in Gedo Region. Established in 2013, this private facility receives over 800 patients annually from Somalia, Kenya and Ethiopia. The most prevalent mental disorders reported at this facility are post-traumatic stress disorder (PTSD), psychotic disorders (schizophrenia), mood disorders (depression and bipolar disorder), anxiety, and epilepsy. At the time of the assessment, the facility had 22 in-patients and 38 outpatients. Its capacity is limited by lack of skilled workers and financial resources.

Specialized surgeries and consultations

Health professionals we interviewed suggested gynaecology-related emergencies are among the most common cases referred to Mandera County Referral Hospital from across the Triangle. They attribut-

ed this, among other factors, to the fact that 98% of women experience female genital mutilation (cutting), which causes serious obstetrical and gynaecological complications. Because most facilities in the

Triangle are not equipped to do specialized surgery or consultation, most cases are referred to Mandera County Referral Hospital; some patients self-refer to institutions in neighbouring countries. Professionals reported that reproductive health care poses a second key challenge. Women in Mandera prefer to be treated by traditional birth attendants in Bulla Hawa because they do not want to be treated by male

nurses or male clinicians. A third issue for medical staff was the need to shelter and protect survivors of sexual violence. Female victims are uncomfortable sharing their experiences with male medical professionals during counselling. This is a problem because women are under-represented in medical institutions in all three countries.

Management of cross-border disease outbreaks

Outbreaks of several diseases occurred in the Mandera Triangle in 2020-2021, including cholera, acute watery diarrhoea (AWD), Chikungunya, and dengue, among others. Our assessment coincided with outbreaks of Kala Azar in Mandera South and Rift valley Fever (RVF) in Mandera North. According to the World Health Organization, as of February 2021, 32 human cases (14 confirmed positive) of RVF led to 11 deaths (CFR 34%) in four counties in Kenya, including Mandera. In Mandera, cases of RVF in humans and animals have been documented (<https://www.who.int/csr/don/12-february-2021-rift-valley-fever-kenya/en/>). The porous borders between Somalia, Kenya and Ethiopia make it hard to contain the spread of diseases. In addition, surveillance procedures, quarantine regulations, coordination and enforcement are weak in all three countries; and the lack of a tracking system to monitor the movement of people hampers efforts to eliminate pathogens. Managing these outbreaks requires appropriate interventions in key areas. Measures are required to

establish a cross-border coordination mechanism, to improve prevention, surveillance and control systems, and to strengthen treatments. To achieve these goals, more staff need to be trained, and health facilities need to be better equipped to manage communicable diseases. This in turn will require improved regional coordination and the creation of specialised facilities (to manage zoonotic diseases, for instance), probably at Mandera Country Referral Hospital.

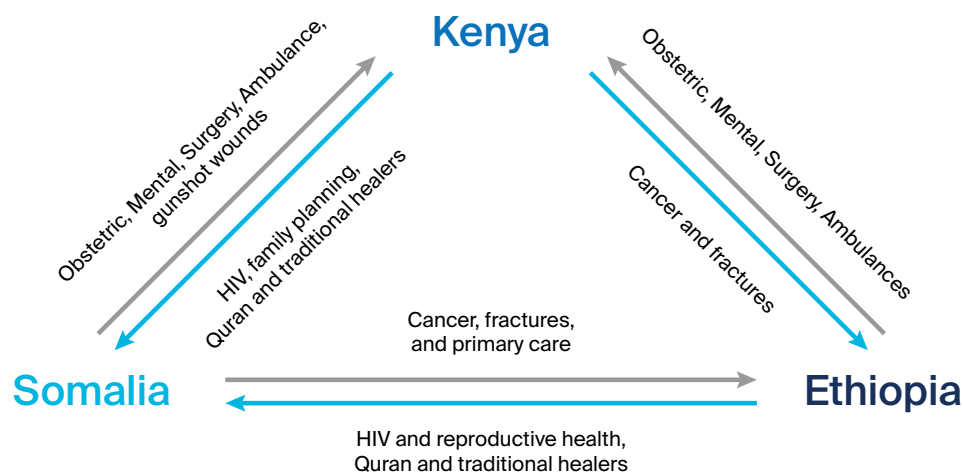
A patient from Kalmalab village, Mandera North subcounty, fell ill after he took part in the slaughter of four sick camels. He was evacuated to a hospital in Nairobi with haemorrhagic symptoms on 18 January 2021, and later admitted to the intensive care unit with multiple organ failure. A diagnosis of RVF was confirmed on 21 January at the NVL. The patient died on 22 January.

The direction and drivers of movement of patients across borders

We sought to understand what pushes people to move and what incentives they have to move, as well as the directions in which they move for medical treatment and the medical treatments they seek. The assessment showed that medical travellers or patients move for several reasons and various services (Figure 6). While patients who can afford to pay for treatment are likely to seek better quality healthcare, less prosperous people, including most CBMPs, are obliged to look for inexpensive health care in neighbouring countries. Easily the most fre-

quent reason that interviewees gave for crossing the border was to obtain services that were not available in their own country. A few better-off patients said they crossed the border because they were dissatisfied with the services offered in their own country and could find better care abroad. Such patients in most cases sought services in private health care facilities. For less-privileged patients, the key driver for crossing borders to seek medical services was to find less expensive health care.

Figure 6. Direction taken and services sought by cross-border medical travellers.



Health professionals interviewed also noted that patients sought medical attention across the border when they wanted anonymity or to treat medical conditions that are stigmatized. For example, it was safer for HIV/AIDS patients to seek anti-retroviral drugs across the border because their condition might be discovered more easily if they used a local facility and this might cause them to be stigmatized in their community.

Because Mandera County is better equipped, its medical services attract cross-border patients, putting pressure on resources. Because of devolution, it also has more resources to invest on expanding and modernizing its health facilities; additional cross-border demand is therefore an encouragement to expand and further improve the County's facilities, to meet the needs of citizens and cross-border

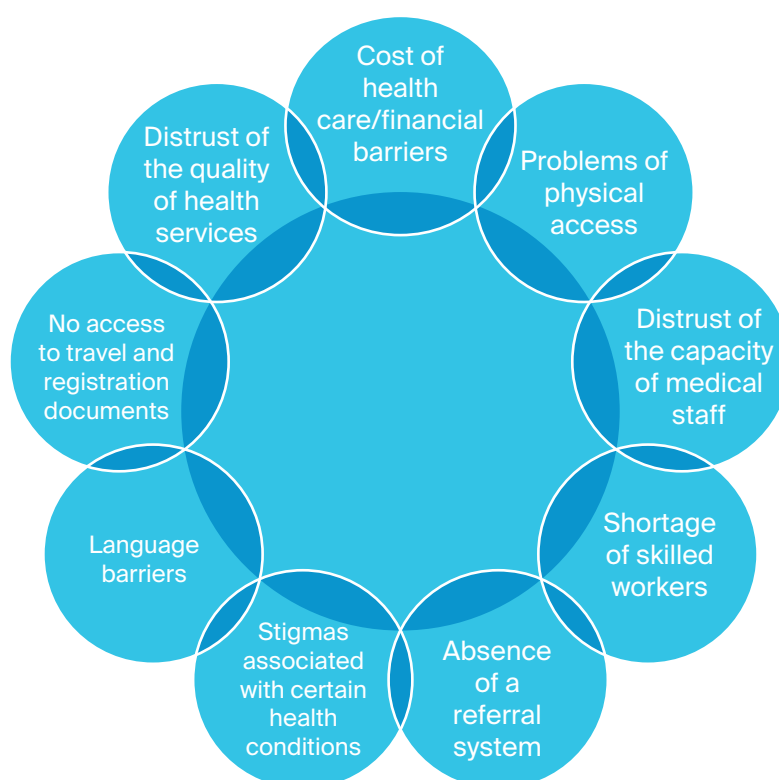
populations. Similarly, knowing that patients from Mandera go to Shashamane in Ethiopia for treatment is likely to encourage the county government to make those services available locally. Healthcare workers expressed concern that, although foreign patients (who rarely identify themselves as foreign) make financial contributions, a rising demand on public facilities could eventually force public as well as private healthcare services to increase their costs, overburdening the population. They noted that in all three countries sick people deferred decisions to seek treatment because of the cost. This was particularly their response to mental illness. Families tried other remedies, including religious therapies and traditional healers, before they sought conventional treatments. This did not benefit patients and could affect the outcomes of treatment.

Barriers to accessing healthcare services

Cross-border communities find it difficult to access healthcare services for several reasons. They include: distance or other problems of physical access to health care facilities; the cost of health care; shortages of skilled workers; the absence of effective referral systems; stigmatization; inability to speak local languages; lack of trust; lack of confi-

dence in the capacity of medical staff; lack of legal documents that are required to travel or stay abroad. Figure 7 lists some of the main barriers faced by cross-border populations who try to access health services in the Triangle.

Figure 7. Barriers that hinder cross-border populations from accessing health services.



Health facilities in the Triangle are far apart. Most are located in towns and small urban centres. The region is vast and the pastoralist lifestyle takes CBMPs to places distant from urban centres. The isolation of rural communities is worsened by the underdeveloped road network. Roads are almost impassable during the rainy season. A report by IGAD and the UN found that poor roads and transport increase the cost of health services and limit access to them. In this respect, progress in health delivery as well as livelihoods in the Triangle is likely to be driven by improvements in transport infrastructure. Governments in the region can work together on this. Better transport would bring important benefits for mothers, children, and victims of conflict. Sam Wafula, in a study of the factors that restrict access to maternal health care, reported that over 96% of households in Mandera County did not have a means of transport to a health facility and that 93.4% of women who gave birth did so at home.²⁵ In the Somalia context, a report by the World Bank found that it is difficult to provide health and social services to ru-

ral residents, pastoralists and mobile communities. These reports match the responses from our FGD discussions and interviews with key informants across the region.

Adding to the difficulties of road transport, it is a challenge to cross the borders from Somalia and Ethiopia into Kenya. The Kenya government demands proof of citizenship to enter the territory. In most cases, patients from Somalia lack legal documents they can use to enter Kenya. Some patients therefore find unconventional ways to enter the country. We were informed during our visits that some visitors to Mandera hospital's mental health section prefer not to reveal their nationality, in order to be able to obtain services but also for fear of victimization or arrest.

Those seeking health services across a border must also pay for transport to the facility, for their treatment, including perhaps their medicines, for the cost of hospital admission, and for their own upkeep and

²⁵ Wafula, Sam W., Individual and contextual factors affecting maternal health care utilization in Mandera County in Kenya: a mixed methods analysis (preliminary paper, unpublished).

the upkeep of accompanying relatives. FGD participants complained of the cost of transport and the long distances they had to cover to reach cross-border facilities. For example, patients referred from Mubarak travel up to 150 km. to reach the Banisa Sub-County Referral Hospital. The cost of private health care is high, and higher still for patients who are not formally referred, because they have to pay additional fees for registration and consultations. FGD participants reported that it helps cross-border patients enormously to have relatives who live near the health facility. Patients who have local relationships receive more support and have better access to public services.

Interviewees complained about the quality of care that public facilities provide. Their concerns included: the limited range of drugs available; their mistrust of the drugs dispensed (especially in Somalia, where drugs and supplies are not well regulated); the narrow scope of services (particularly in facilities in rural Ethiopia and Somalia); insufficient and insufficiently-skilled staff; and lengthy waiting times. We were told that mental health services, in particular, are not prioritized and are therefore unavailable in most facilities. During our own visits to facilities in the Triangle, we found that access to transport and ambulances is a key determinant of access to health services for border communities. People postpone seeking specialized treatment for serious diseases or disorders because hospitals are distant and transport is unavailable or expensive. In the region under review, only Mandera County has recently invested in ambulance services. Currently, twelve ambulances have been placed in the MCRH and sub-county hospitals. In the entire Mubarak district of Ethiopia, only one ambulance serves a population of approximately 80,000. Mubarak is almost 650 km. from Mandera and it is futile to make an urgent referral to

Mandera hospital, given the distance, the insecurity, and the poor state of the roads. This said, a medical worker at Banisa hospital in Kenya said that the hospital does sometimes respond to cross-border patient calls from inside Ethiopia.

“There are cases of maternal health death because of the vastness of the areas. For example, recently, a mother from Samarole district in Elwak, Somalia, some 30 km. to Elwak, died because of bleeding during home childbirth. Two more women died from birth related complications in Damasa and Elwak town in Somalia. [Narrated by the facility manager.]

The community leaders and women’s group in Kenya that we interviewed said they were delighted to have access to ambulances. These generally respond only to cases of obstetric complications and sometimes snakebites. Patients far from hospitals can wait for eight hours for an ambulance to respond. Ambulance managers also prioritise call outs and locations. Most mothers opt to deliver at home despite the unhygienic conditions in many homesteads. They are assisted by community health volunteers and traditional birth attendants. The latter are now commercializing their expertise despite their limited skills. In many instances, their interventions put patients at risk in situations that medical staff could handle easily. As noted, some patients seek medical care across the border to obtain anonymity or because their medical conditions are stigmatized.

Finally, although the Triangle is mostly inhabited by Somalis, language and dialect can be barriers. This problem is compounded by mistrust of people who are not known locally. Unknown persons may be suspected of belonging to Al Shabab, especially if they do not have identification documents.

Priority Health Needs in The Mandera Triangle

Based on the assessment, we list below priority areas for investment to meet the health needs of populations in the Triangle.

Strengthen country-level support to the health system

In all three countries, measures should be taken in the Mandera Triangle to strengthen the health systems, improve the quality of essential services, and increase access, in order to better serve the local populations and CBMPs. Key interventions that we have identified include:

- Strengthen administrative and management functions, including financial systems and health information management, to enhance efficiency, accountability and decision making.
- Increase the number of essential health staff to ensure that access to health services improves in the short term.
- Strengthen the health sector's preparedness and capacity to respond effectively to health emergencies.

There is a particular need to strengthen mental health care in the Mandera Triangle. Currently, capacity is weak whereas the population continues to have numerous mental health disorders that are due to conflict, displacement, and other predisposing factors.

The weaknesses we identified include: lack of mental health policies; inadequate financial support from the government for mental health activities; poor availability and accessibility of psychotropic drugs; weak or absent human rights legislation; an overall lack of adequate well-structured facilities, including inpatient and outpatient units; lack of services specifically designed for adolescents and children; lack of services specifically for women, whose access to essential services is restricted by social norms; lack of communication between traditional

healers and modern health practitioners; lack of services specifically for prisoners; health practitioners receive insufficient training in mental health, and mental health refresher training is not available for medical professionals; absence of treatment protocols; mental health is not integrated in the primary healthcare structure; inadequate staffing at every level, including psychiatrists, psychologists, social workers, nurses, and support staff; lack of consumer and family associations; absence of effective data collection and research on mental health and mental health services; lack of health education campaigns promoted by government; lack of legislation to provide for and protect people with mental disorders; lack of collaboration between mental health departments and other organizations.²⁶

To address these deficiencies, a regional mental health facility should be established in the Triangle to treat mental health cases; and a regional rehabilitation centre should be established in the Triangle to treat survivors of sexual and gender-based violence. Other priorities for action include:

- Improve financing of mental health services in the region.
- Improve the organization and capacities of mental health services in the region. Increase the capacity of facilities, and the availability of skilled personnel and medicines.
- Provide training in mental health care to primary healthcare professionals.
- Train professionals in mental health to raise the number of mental health staff in the sector.
- Run public education programmes to raise awareness of mental health.

²⁶ WHO, *WHO-AIMS report on the mental health system in Somaliland region of Somalia* (2009).

Ease administrative and other challenges that CBMPs face when they try to obtain health care.

Low-level health facilities do not handle certain diseases. On some occasions, the medical professionals at these centres refer patients to more specialised facilities in Mandera, Awasa, Wollaita, Mogadishu, Jigjiga, and Nairobi. These patients face administrative hurdles that prevent them from travelling easily to obtain treatment. Lowering these hurdles will

significantly increase the access of CBMPs to health care. Specific measures include: waive the need to possess registration documents if patients can show they have been officially referred; provide community support during travel; provide travel waivers for CBMPs who seek health services in neighbouring countries.

Strengthen the referral system and improve cross-border coordination of health services.

Multiple stakeholders help to coordinate the national health sector, including the government, donors and NGOs. Regionally, this coordination system is constituency-based. For example, Somalia has a cluster-based coordination mechanism, but it has been difficult to link the cluster system with health sector coordination.²⁷ With respect to medical referrals, these are not officially communicated to receiving institutions, but issued in the form of advice to patients and families. Patients also refer each other

to hospitals; for example, the hospital in Awasa is a popular destination for patients diagnosed with cancer because patients believe its services are relatively inexpensive services and has accommodation. Overall, few ambulances are available to transport referrals and during the rainy season roads are impassable. It is important to strengthen the referral system and improve cross-border coordination to address these challenges.

The Nexus Between Health Gaps and the Peace and Security Situation

The Mandera Triangle has experienced numerous security crises and conflicts that have affected the health of its populations. As highlighted in the *Voice of the people: challenges to peace in Mandera County*,²⁸ a prolonged conflict between the Gare and Degodia communities in 2015 caused the death of at least 77 people, displaced more than 18,000 households, and caused massive destruction of property.²⁹ Two additional factors have heightened insecurity more recently: the presence of Al Shabab, and longstanding political disagreements between the Jubaland State Government and the Federal Government of Somalia. The latter has led to frequent fights between the forces from these institutions. The Kenya Government's decision to host the Jubaland Security Minister, Ahmed Janaan, made the situation worse: he has fought relentlessly with the Gedo re-

gional armed forces and Somalia National Army to recapture Belet Hawa.

Health and peace are inter-related (Figure 8). In the words of the Director-General of WHO, Dr Tedros, "there cannot be health without peace, and there cannot be peace without health".³⁰ Conflict in the Triangle has multiple consequences: among other effects, it causes deaths, injuries, displacement, blocks vital supply routes, and destroys livelihoods. In the longer-term it leaves behind it physical disabilities and mental disorders. In addition, it facilitates the spread of disease, disrupts health care systems, ruptures the medical supply chain, subverts social norms, and impedes the movement of health workers. Unfortunately, although the Gare-Degodia conflict was settled, conflicts in the area are grow-

27 WHO, *Strategic review of the Somali health sector: challenges and prioritized actions* (2015).

28 NCIC and Interpeace, *Voice of the people: challenges to peace in Mandera County* (2017).

29 Crisis Group Africa Briefing N°114, Kenya's Somali North East: Devolution and Security, 17 November 2015.

30 <https://www.who.int/initiatives/who-health-and-peace-initiative>

ing in scale and complexity as a result of the involvement of more non-state armed groups and regional and international actors. A political resolution is increasingly difficult.

The impact of the Al-Qaeda-linked Al Shabab jihadist group has been enormous on service provision in the region. It has limited humanitarian access to most parts of Gedo region and to parts of Mandera County. Schools have been closed, private investments suspended, and most skilled healthcare and education workers have had to leave the area. Because of the risk, teachers and medical professionals refused to resume their duties in Mandera: as a result, healthcare, nutrition and education services fell in quality and became less accessible. Access to health care in Mandera County was especially affected, because health facilities closed for lack of staff. The departure of many professionals has affected services in most health centres.

"Problems of security are still there. We have challenges. Al Shabab was the problem that has made our teachers, colleagues from other regions to flee this county", Kulo Mohamed, Mandera Teachers' Union Representative said.³¹

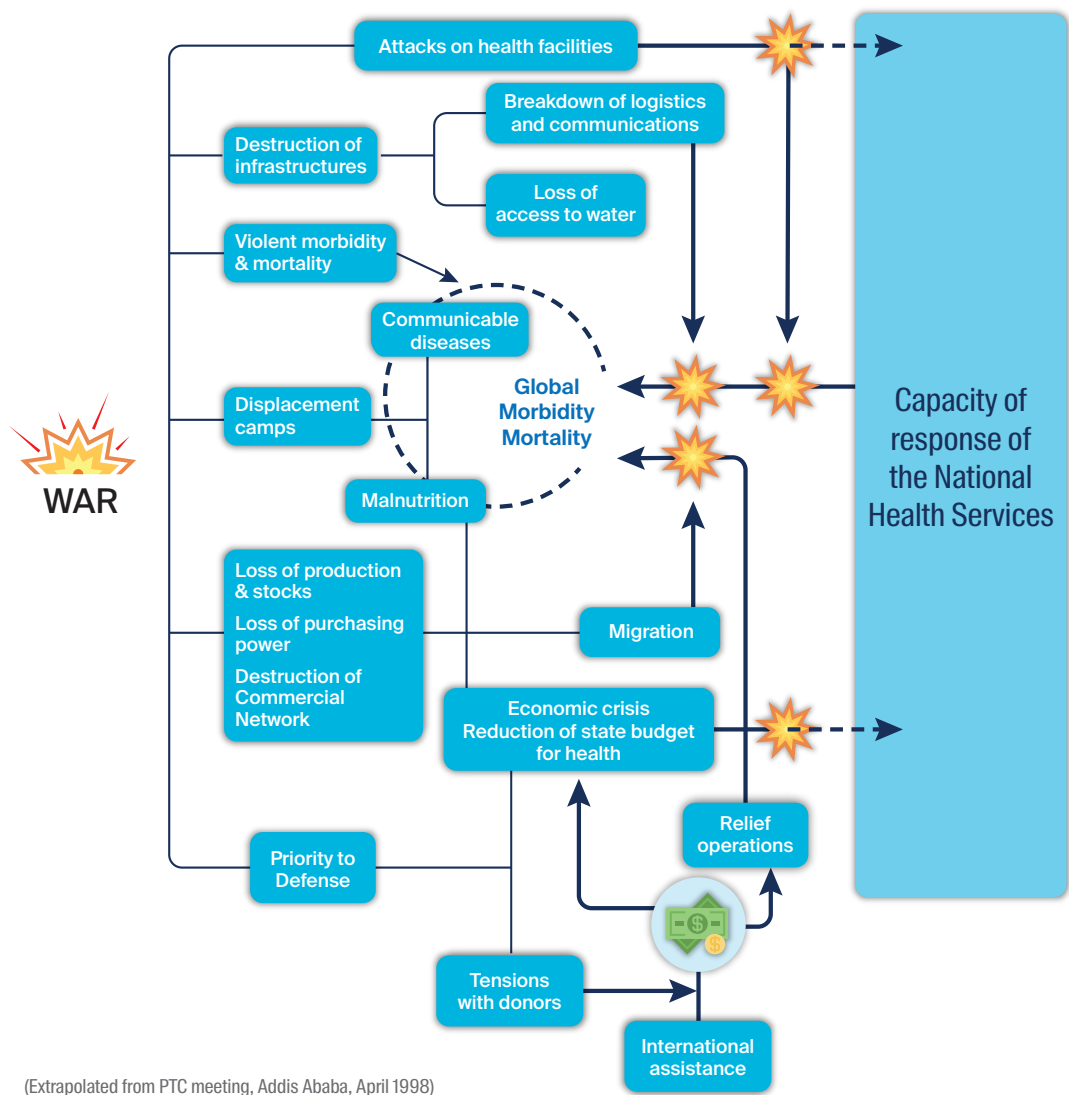
In Mandera County, Al Shabab has continued to become more powerful. The Governor of Mandera has accused the government of "failing miserably" to stop them. To meet the shortfall in medical personnel, in June 2018 Kenya deployed 100 Cuban doctors to different counties. Two of them, posted to Mandera CRH were subsequently kidnapped by Al

Shabab and were only released after three years in captivity. A large exodus of non-local workers out of Mandera caused shortages of workers in medical and education facilities. The Yedo Medical Centre on the Kenya-Somalia border was closed for over 6 months in 2020 due to insecurity. Many IDPs ended up in temporary emergency camp. The influx of people into urban centres put the water, sanitation, health and power infrastructure under strain. Medical professionals we interviewed told us that conflict and displacement increased the incidence of STIs, communicable diseases, and mental disorders. Faced by high demand and lacking staff, most health facilities were not able to handle all their cases. Compounding this already difficult situation, the complex internal Somali political crisis not only entangled the Kenya Government but led to episodes of fierce fighting on the frontier. In December 2020, clashes between the forces of Somalia's federal government and the forces of Somalia's Jubaland State spilled over the border into Kenya and 12 people were injured when a missile hit a house in Mandera.

Other impacts should be mentioned. The destruction of communication masts disrupted mobile coverage and hindered responses to health emergencies. NGOs and government vehicles, including ambulances, no longer travelled along the Lafey Road., disrupting medical referral arrangements and emergency care for victims of the hostilities and their relatives. The disruption of transport also harms community life and economic activity, because goods as well as people are not able to move around. Communities are more isolated and excluded from government services.

³¹ <https://www.africanews.com/2021/02/10/frustration-mounts-in-northern-kenya-as-al-shabaab-threats-grow/>

Figure 8. The relationship between conflict and health.³²



*Voices of the People: Challenges to Peace in Mandera County*³³ identified four thematic areas that underpin peace in Mandera County: (1) social cohesion; (2) security and the rule of law; (3) governance and politics; and (4) cross-border dynamics. These themes also underpin health and peace in the Mandera Triangle. Extrajudicial killings and human right abuses cause physical injuries, trauma and mental illness. The governance and political system influence the quality and availability of health care. *Voices of the People* noted that the larger clans use their numerical advantage to secure privileged access to resources. The County Government has been accused of isolat-

ing certain areas and limiting their access to health-care and social services. Clan tensions and identity also affect health care. Youth activist told us that teachers and health officers cannot work outside their perceived clan homelands. This affects who provides and who receives health services and potentially also restricts opportunities to use health to promote peace and reconciliation.

The impacts are most severe in sub-counties in Mandera that border Somalia and in villages in Gedo that are under the control of Al Shabab. There, insecurity has also affected humanitarian services in a

³² WHO. *Health as a potential contribution to peace: 'Realities from the field: what has WHO learned in the 1990s'* (no date), pp. 6.

³³ National Cohesion and Integration Commission (NCIC) and Interpeace, *Voices of the People: Challenges to Peace in Mandera County* (2017).

region where aid helps to ease the burden of drought and mitigate the inadequacy of health, education and other essential services. Informants reported that fear and insecurity are pervasive in these areas, causing increasing psychological problems. At night, people are afraid to seek medical assistance and ambulances do not operate. FGD participants also complained about the conduct of the security forces when they responded to Al Shabab attacks. They reported extra-judicial killings, enforced disappearances, beatings and arrests. The community's trust in the security forces has fallen away. Women and girls are – and feel – particularly affected by insecurity and these conflicts. They are exposed to sexual and gender-based violence, including forced early marriage and rape. With little access to justice and protection, sexual violence cases are usually dealt with by traditional courts (*maslaha*) rather than the formal justice system.

Because Interpeace has competency, legitimacy, a web of relationships in the Triangle, and convening power, it is in a position potentially to mediate some of these issues. Health interventions that promote peacebuilding should be developed because caring for the sick and injured is considered to be a neutral activity that is also a universal good. All sides in a conflict can frequently agree that health is an aspiration; it is capable of aligning warring factions towards a shared goal. The fair and balanced delivery of health care and other social services is also crucial in conflict-affected settings because inequitable access can retrigger or prolong conflict. Interpeace has been working with WHO to combine their respective expertise in ways that will advance health and peace across their agendas, in both policy and programming.

Conclusion and Recommendations



Conclusion and Recommendations

Although the Mendera Triangle is principally occupied by Somali communities which have cross-border social, economic and development connections, other groups are also present. They include: urban populations settled in Mendera, Belet Hawa, Mubarak, Dollo Ado, and neighbouring districts; agropastoralists, riverine, and rural communities settled in rural villages in cross-border districts; and pastoralists who cross borders frequently to market their livestock, obtain goods, or find water and pasturage. A large population of IDPs also reside in urban cross-border districts of the Triangle. Healthcare services are made available to these populations by the governments of Kenya, Somalia and Ethiopia, and by the humanitarian community: to a significant extent, nevertheless, the health and psychosocial needs of cross-border populations in the Mendera Triangle remain unmet. Although an elaborate health structure exists in each country, it does not meet all the health care needs of the populations and as a result many people move to neighbouring countries to obtain treatment. The health deficit is most acute for pastoral populations, for rural communities that live in settlements without healthcare facilities or access to health and humanitarian workers, and for communities whose services cease to function due to insecurity and conflict.

The health care infrastructure varies in each country. In common with all IGAD countries, most health indicators for Kenya, Ethiopia and Somalia lag, notably for disability, nutrition, and protection. Structurally, each country has an established healthcare structure that manages budget allocation, sets investment priorities, personnel deployment, and the supply chain. Currently, the governance system in Mendera County is closest to the grassroot communities; and the Somali structure is most directly administered by the federal and regional governments. This difference explains why more has been invested in healthcare in Mendera than in Ethiopia and Somalia. At the same time, the populations cannot fully meet their basic healthcare needs because the public health system's response to migration and cross-border mobility is socio-politically complex. Our study revealed numerous problems related to the state of facilities and the supply chain. To deliver efficient and decent health care to people living in the Triangle, basic changes and improvements need to be made to the physical infrastructure of health facilities, because some do not meet the minimum standards required to promote and protect for health and wellbeing. Problems include: power cuts; insecure fencing and perimeter walls; insecure facilities; lack of space to treat patients; poor water quality; lack of staff housing; lack of morgues; an erratic drug supply system; insufficient and unsanitary toilets and laundry facilities. Broadly speaking, health facilities need to be upgraded and improved, and their number needs to rise if the healthcare system is to meet the needs of communities in the Triangle.

In particular, although some improvements have been made, and some informal systems of care exist, the health systems in the Mendera Triangle are not designed to meet the needs of CBMPs. Formal cross-border linkages are weak, and procedures for cross-border referrals and patient tracking do not exist. Though it is difficult to obtain clear data,

anecdotal evidence indicates that a significant number of ‘medical travellers’ move between Mandera, Gedo region, and Mubarak and Dollo Ado districts. [The overwhelming reason that patients gave for crossing the border was to obtain services that were not available in their own country. Because of stigma, some HIV patients cross to maintain anonymity. Several major barriers make it difficult for CBMPs to obtain health care outside their own country. They include: insecurity and conflict; the unavailability and cost of transport; the cost of health care; shortages of skilled medical staff; the absence of referral systems; stigmatisation; language barriers; lack of trust; lack of confidence in medical professionals; and lack of identification documents.

Conflict and displacement are common in the Triangle. Our research showed that health is very strongly linked to peace and security in the region and that conflicts have had repercussions on all aspects of the health system and society. Although Ethiopia, Kenya and Somalia have distinct governance structures, across the Triangle the population is largely the same, and their health profile, as well as the profile of conflicts, shares many characteristics in common. Conflicts have caused displacement which has disrupted access to health facilities. Health supplies and resupply routes have also been disrupted or severed, leading to a lack of essential medicines. Because of the risks, medical workers have left conflict areas, leading to the closure of critical health services. Closures and staff relocation have deprived mobile communities along the border of medical services. As a result, individuals with conflict injuries were sometimes untreated, and some resorted to traditional treatments. Many civilians have been displaced to urban centres, or become residents in

temporary emergency camps as IDPs. These arrivals have added to the demands on water, sanitation, health and power systems, which has sometimes led to the spread of disease. It is reported that STIs, communicable diseases, and mental health have all worsened in the Triangle as a consequence of conflict and displacement. The destruction of communication masts by militias has disrupted communications, rupturing mobile networks and preventing medical workers from responding to emergencies or running health outreach programmes. When insecurity closed off major roads (like the Lafey road), large numbers of people lost their ambulance service, and local facilities could not resupply drugs and other medical equipment. Disruption of transport also affected community and livelihoods, by hindering the movement of goods and reinforcing the isolation of communities who could no longer obtain government services.

Our research showed that Mandera County Referral Hospital is the only public health facility that treats mental disorders. One professional medical staff (plus one private clinic) is responsible for providing mental health care to the entire Mandera Triangle. The great majority of the population must rely on traditional healers and spiritual leaders. Numerous people suffer mental illness in silence. To make matters worse, the stigma associated with mental illness means that few come forward to seek help. This situation significantly decreases the quality of life of individuals suffering from mental disorders, and is the more concerning because there is a high and rising incidence of mental illness in the Triangle due to the stress and trauma associated with conflict, displacement and SGBV.

Recommendations

Comprehensive interventions are required to deal with CBMPs complex healthcare needs. Our assessment showed that their health needs are intertwined with a large number of challenges, including conflict and insecurity, restrictions on cross-border movement, and administrative obstacles. We recommend below a number of interventions that will address these problems. Any interventions in the Triangle should be integrated. Regional collaboration between governments and partners should be

encouraged at the level of policy, institutional organization, and delivery. All three countries should increase investment to improve health services. Recognizing that cross-border areas in the Triangle are particularly prone to conflicts that have direct impacts on health, investments should be made in collaborative border management and conflict prevention. It is important to create strong bridges and linkages between services.

Strategic recommendations and actions for the health sector in the Manderia Triangle

- Strengthen regional cooperation and partnerships. Given that actors such as IGAD and the African Union play an important role in facilitating dialogue between the different countries in the Manderia Triangle, actors that deliver health services for CBMPs will need to work closely with those institutions. Cooperation at high level will help to reduce duplication of activities in the region and encourage adoption of a unified approach to address health and conflict-related challenges.
- Improve the programmatic synergy between health and other sectors, including peace and livelihoods across borders. Because border communities share economic opportunities and services, strengthening sectors that facilitate social contacts will help build and strengthen relationships.
- Address the impacts of conflict on health by raising awareness and sharing information. This work should accompany a strategy to: strengthen cross-border peace and security coordination and relationship building; bolster inter-community peace committees; support activities that promote peace (such as markets, water facilities and health facilities); and localize IGAD policies on cross-border peace and security.

Integrate peace and conflict considerations in health policies, to harness the ability of health systems to create inter-group relationships and address the needs of marginalized groups

Improving access to healthcare will help to bridge ethnic, political, and religious differences. Simply bringing people from different communities to the same physical space and encouraging contact is unlikely to improve intergroup relations. By conferring equal status and respect to all communities, however, health systems can meet health needs better and strengthen social relations. The WHO Peace and Health Initiative describes how technical interventions can help to sustain peace. Interventions in the health sector can address the causes of conflict, such as grievances against state institutions (for example, over lack of access to health care), or social divisions (for example, the legacy of intergroup mistrust). Health facilities and services can also promote collaboration across conflict divides. As noted in the WHO's theory of change, "if individuals and groups enjoy equitable access to health services, fulfilling their rights to physical and mental health interventions that promote trust and dialogue, and communities are empowered to cope with violent conflicts, then health coverage is universal, grievances can be heard and addressed to generate trust around emergency health concerns, affected communities are more likely to make meaningful contribution to peace and reconciliation, and resist incite-

ment to violence".³⁴ The WHO's Health and Peace initiative provides a menu of possible health and peace interventions, some of which will be useful in the Manderia Triangle. For example:

- Improve citizen-state cohesion by delivering healthcare services that partner with affected communities. Ensure that dissatisfied populations are reached. Facilitate participatory exchanges between communities, health practitioners and state officials in conflict affected areas.
- Encourage cross-border cooperation in health. Facilitate dialogues that bring together health professionals from across border and conflict areas; promote health mediation, joint healthcare training programmes, and service delivery across borders and conflict lines.
- Promote health and well-being through dialogue and inclusion. Meet the needs of marginalized groups and people with disabilities. Implement group interventions focused on mental health. Expand the number and coverage of services that provide mental health care and psychosocial support.

34 WHO, *Health and Peace Initiative* (2020).

Strengthen health systems to address local needs in each region, particularly the needs of CBMPs and pastoralists

In the Mandera Triangle, mobile pastoralists and CBMPs represent an important proportion of the population but the public health system does not meet their basic healthcare needs well because it has difficulty responding to migration and cross-border mobility. Pastoralists are not just mobile; they inhabit remote environments, frequently at great distances from healthcare facilities, and often from roads and transport as well. Whereas clinical and public health workers are comfortable treating stable populations, they find it hard to provide health care to CBMPs and pastoralists or measure the outcomes of treatment. To meet the needs of mobile pastoralists and CBMPs, formal health services must adapt their health delivery systems. In addition, the following interventions are recommended:

- Improve health infrastructure across the Triangle and remove barriers to access. Match staffing to need. Improve staff training and capacity. Improve immunization, and the cold chain system.
- Improve the capacity of health management committees. Bolster the resources provided for outreach services, especially those that cross-border health facilities offer pastoral populations.
- Strengthen the health system generally, to improve access and the quality of services for local populations as well as CBMPs.
 - a. Upgrade the status of health facilities. Strengthen administrative and management functions, financial systems, and health information management, in order to enhance efficiency, accountability, and decision making.
 - b. Increase the number of essential health staff to improve access to health services in the short term.
 - c. Strengthen the health sector's preparedness and capacity to respond effectively to health emergencies.
- Enhance the institutional and governance capacity of the Ministry of Health in each country to cooperate and coordinate.
 - a. Establish a cross-border coordination mechanism. Hold joint planning meetings for all the relevant stakeholders.
 - b. Develop shared case definitions. Collect and share health information and data; ensure data are mutually compatible.
 - c. Establish a regional technical working group for integrated disease surveillance and response (IDSR). Convene meetings periodically to review progress and implementation.
 - d. Facilitate intercountry collaboration and coordinate cross-border responses to disease outbreaks.
- The Medical College in Mandera is potentially a regional resource. Discuss and promote its use as a regional facility. Develop the health infrastructure and invest in staff capacity in parallel.
- Improve communication between health facilities on the borders. Build an effective referral system for patients that will reduce their need to move long distances to find treatment.
- Strengthen the frameworks that regulate private healthcare providers and the market in pharmaceuticals.
- Instil good practices in social service provision for pastoralists. Combine mobile and static health service approaches. Establish a joint animal and human vaccination services. Employ community health workers alongside traditional birth attendants.

Address specific factors that impede CBMPs and pastoralists from obtaining health care in neighbouring countries.

Health officials are in a position to mitigate several of the specific factors that impede CBMPs and pastoralists from obtaining health care. They include: certain physical obstacles; the cost of health care; shortages of skilled staff; the absence of referral systems; stigmatization; language barriers; lack of confidence in the capacity of medical staff; and lack of legal identification documents. To address these problems, the study recommends:

- Strengthen the capacity of current cross-border health services: enable them to meet the demand of the increasing number of CBMPs who cross borders to seek treatment.
 - a. Work with partners to raise resources to support regional health plans that meet the needs of CBMPs.
 - b. Raise the skills of healthcare staff who work in cross-border facilities. Strengthen health management information systems at these facilities.
 - c. Improve the quality and capacity of laboratory services in cross-border health facilities.
- Establish an effective referral system.
- d. Create a regional forum to share information and good practice on IDSR.
- Ease administrative and other burdens on CBMPs.
 - a. Ease administrative barriers. Remove a strict requirement for identification papers for persons who have been officially referred for health care.
 - b. Provide waivers at cross-border health facilities for CBMPs, especially individuals exposed to specific risks, such as women, children, victims of SGBV, persons with disabilities, and people who have a mental illness.
- Strengthen the relationships between cross-border administrations. Develop policies on access to cross-border health facilities.
- Ease immigration procedures; establish a one-stop facility for CBMPs.

Strengthen mental health and psychosocial services in the Manderla Triangle.

There is growing evidence that conflict is affecting the mental and psychosocial health of people living in the Manderla Triangle. Odenwald et al.³⁵ showed the long-term effects of war on mental health. The Manderla Triangle is prone to conflict and insecurity, which cause a wide range of mental disorders (depression, stress, PTSD, etc.). The estimated prevalence of mental disorders in the Triangle, particularly in Somalia, is higher than the average in low-income war-torn countries. Many determinants explain the high rate: overall insecurity (displacement, violence), war trauma, poverty, unemployment, substance abuse.³⁶ This situation is made worse by the fact that mental health has been neglected and under-funded in the Triangle. The en-

tire burden is borne by families and communities. Individuals with mental disorders are stigmatized, discriminated against, and socially isolated. Until recently, degrading and dangerous cultural practices (such as restraining with chains) were widespread, being socially and medically accepted. Traditional healers play an important role; but they are not involved in medical rehabilitation or the health system. It is therefore essential to expand the number and capacity of mental health facilities and train and appoint more mental health staff. Further, community support systems need to be strengthened so that communities can better address the effects of conflicts and insecurity on their members. Our specific recommendations are:

35 Odenwald, M., Lingenfelder, B., Schauer, M., Neuner, F., Rockstroh, B., Hinkel, H. and Elbert, T., 2007. Screening for posttraumatic stress disorder among Somali ex-combatants: a validation study. *Conflict and Health*, 1(1), 2007, 10. DOI:10.1186/1752-1505-1-10.

36 WHO, *A situation analysis of mental health in Somalia* (2010).

- Develop community-based mental health services for people who have mental disorders. For example, support households that care for mentally impaired persons; provide ambulance support; extend treatment services, etc. This will mitigate the shortage of mental health facilities and the effects of unequal access to them.
- Strengthen existing facilities. Enable facilities to provide inpatient treatment and provide culturally appropriate treatment, including drug rehabilitation.
- Raise public awareness of the relationships between conflict and mental health, and other predisposing factors such as consumption of Khat and other drugs. Explain the value of culturally appropriate treatment procedures, including drug rehabilitation.
- Strengthen regional and cross-border cooperation with respect to mental health care and psychosocial support services in the region.

The study found that current peacebuilding, reconciliation and justice systems do not adequately address psychosocial care. On their own, neither le-

gal compensation nor prosecution of perpetrators secures effective justice. These outcomes do not necessarily help individual survivors, or the community, to heal.³⁷ In addition to mental disorders, many other psychological consequences are reported by survivors. The death or disappearance of family members leads to grief and anxiety, especially in collective societies. Efforts to achieve restorative justice must therefore include mental health and support services. In addition, the direct consequences of displacement and conflict may include harmful living conditions, malnutrition, sexual violence, injury and other effects that require immediate access to health services. We therefore recommend that, when initiatives to secure justice are considered, health care services, including mental health care services, should have a role. Psychotherapy and psychosocial support to survivors can be an important support and make a therapeutic contribution in these processes and can help survivors to find their voice. An inter-disciplinary approach is necessary when efforts are made to address the effects of conflict on an entire society as well as on individuals.³⁸

Sexual and reproductive health rights, gender-based violence prevention and response, and youth participation

In a thematic paper for the 2020 Peacebuilding Architecture Review, UNFPA noted that programming can help to address long-term drivers of conflict, such as inequitable access to services, gender inequality, gender-based violence, and youth marginalization. Programming can contribute to peace by improving access to justice, facilitating reconciliation, fostering community social cohesion and resilience, reducing violence, enhancing state legitimacy and promoting an inclusive social contract.³⁹

Governance in the Mandera Triangle has serious shortcomings, in the delivery of essential services, the provision of sexual and reproductive health, the fulfilment of human rights, and meaningful participation of women and youths. These gaps in protection help to drive cross-border movement of people. To give just one example, gynaecological emergen-

cies are among the most common referrals from abroad to Mandera County Referral Hospital. Regional and clan conflicts and displacement have increased the exposure of women and girls to sexual violence; medical professionals report an increase in cases of rape and other forms of sexual violence. More widely, nearly all women in the Triangle undergo female genital mutilation (cutting), which increases the risk of serious obstetrical and gynaecological complications. The risks to which women and girls, are exposed is made worse by stigmatization of teenage pregnancies. Young adults are also frequently marginalized, at risk of harassment if they lack registration documents, and repression if they are perceived to be a threat to peace or to be extremist. Our recommendations are:

- Create a broader understanding among stake-

37 Brounéus, K., The trauma of truth telling: Effects of witnessing in the Rwandan Gacaca courts on psychological health.

38 Kizilhan, J. I. and Neumann, J., The Significance of Justice in the Psychotherapeutic Treatment of Traumatized People After War and Crises, 2020.

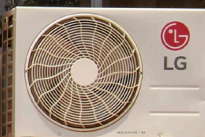
39 UNFPA, UNFPA's Role in Peacebuilding and Sustaining Peace (unpublished paper).

holders of the importance of programming for women and girls and youth, and programming to prevent discrimination, stigmatization and SGBV. Highlight the contributions that women and youth make to wider peace building efforts in the region.

- Take steps to ensure that health systems provide fair and equal access to basic services for everyone. Improve the capacity of service providers to offer psychosocial and clinical support to survivors of SGBV. Develop a sound referral system for such cases.
- Support access to justice. Take steps to increase community cohesion and resilience. Provide facilities and budgets to shelter and protect victims of sexual violence.
- Support traditional and religious efforts to stop and prevent the systemic use of violence as a tactic in clan conflicts. For example, impose severe legal and traditional penalties on perpetrators of such crimes.
- Address the root causes of violence. These are likely to include social and gender norms, including norms of masculinity and norms regarding the status and behaviour of women and girls. Protect and promote women's sexual and reproductive health and the rights of women and children.
- Work with youth in the Triangle to address sources of conflict. Facilitate youth consultations; foster youth participation and leadership; explore their peacebuilding and other capabilities. Put them at the centre of programming.
- Improve youth access to civil registration. Make sure in particular that young people are able to obtain national identification documents, birth certificates, and marriage registration. These confer proof of identity and can help youth to access resources, own property, move freely within their country and across borders, and obtain access to justice and social services. ■



MANDERA COUNTY MOLECULAR LABORATORY



Annexes

Annexes

Annex 1. List of Documents Reviewed

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Annex 2. Facility Checklist for Somalia

| Facility | Referral for what | Some unique diseases | Group accessing | Services | Suggested health needs | Challenges/Constraints |
|--------------------------------|--|---|--|--|--|---|
| Damasa | Dental. Mental. HIV. | Hydatids. Leptospirosis. | Pastoralists and residents | Vaccination. Delivery. Family planning. Pre- and postnatal care. | Nutrition. TB. Immunization. Obstetrics surgery. | Funding. Equipment. Low community participation. Lack of transport. No access to obstetric care. |
| Elwak district hospital | Hepatitis. Cancer. Physical injuries. Hypertension. Labour complications. Mental health. | Accidents. Pesticide poisoning. Snake and insect bites. Zoonotic diseases. Skin diseases. Respiratory diseases. Oral disorders. | Pastoralists, cross-border patients. | Lab services. Minor surgery. Vaccination. Labour. Inpatient and outpatient services. | Mental health. Cholera Treatment Centre to treat cholera and other diarrheal diseases. | Inadequate and dilapidated infrastructure. Funding. Staff shortages. Lack of equipment. Poor supply. Lack of transport. No specialist medical staff. |
| Elwak PHU | Diabetes. TB. Asthma. Hypertension. | Diarrhoea. Skin diseases. Physical injuries. Snake/ insect bites. | Pastoralists and residents. | Outpatient services. Nutrition services. | Pregnancy care. HIV/AIDS. SGBV emergency unit. Mental health. TB. Laboratory. | Shortage of first aid kits. Lab service. Essential drugs supply. Inadequate funding. Lack of staff. WASH. Lack of vaccines. No transport. Poor infrastructure. |
| Samarole Health Centre | Emergency surgery. Mental health. HIV/AIDS. Cancer. Diabetes. | Throat. Ears. UTI. Bronchiolitis. Common cold. Bacterial sinusitis. Cough. | Pastoralists, residents. | Diagnosis. Treatment. Health promotion. Prevention. | Mental health. SGBV. Chronic diseases. Health education. | Poor infrastructure. Lack of staff. No ambulance. Roadblocks delay supplies. Low salary. Lack of vaccines. |
| Khaliil hospital | Fractures. Cancer. Renal diseases. | RTIs. UTIs. STIs. Nutrition. Physical injuries. TB. Mental health. | Pastoralists, residents and cross-border patients. | Lab services. Outpatient services. In-patient services. Maternity. Immunization. Acute malnutrition. | Disease prevention. Diagnosis. Treatment. Rehabilitation. Terminal care. | Poor infrastructure. Lack of staff. Patient overload. Low salary. Lack of career opportunities. |
| GAWIDO MCH | Diabetes. TB. Hypertension. Asthma. | Physical injuries. Burns. Bites. Skin diseases. Scabies. | Pastoralists and residents. | MCH. | Expansion of facility buildings. Increased medical supplies. | Lack of staff. Unreliable drug supply. Inadequate facilities. No ambulance service. |
| Jubba Hospital | Surgical cases. Malnutrition. Immunization. | Diarrhoea. Malaria. Pneumonia. Dengue fever. Skin diseases. Infections. Physical injuries. Animal and snake bites. | Pastoralists, residents and cross-border patients. | Outpatient services. Inpatient services. Ophthalmology. Lab services. Dental services. Delivery. | Delivery. HIV/AIDS. SGBV. Mental health. TB laboratory. | Roadblocks. Poor road infrastructure. Lack of incubators. Lack of mental health. No paediatric unit. Lack of staff. Inadequate safe water and sanitation. No blood banks. |
| Tulo-Amin dispensary | Emergency obstetric care. Mental health. Blood transfusions. | | Pastoralists and residents. | Diagnosis, treatment and care of people with health problems. | Maternity. Counselling. HIV/ AIDS. SGBV. Surgery. | Lack of staff. Lack of funding. Lack of safe water and sanitation. Supply of vaccines. Other supplies. No ambulance. |

Annex 3. Facility Checklist for Ethiopia

| Facility | Some unique diseases | Group accessing | Services | Suggested health needs | Challenges/Constraints |
|----------------------------|--|--|---|--|--|
| Megag Health post | | Pastoralists and residents. | Vaccination. Basic medicine. | Pharmacy, outpatient services. Immunization. Drugs. Lab services. Nutrition. Radiology. | No ambulance service. No electricity supplies. Lack of staff. Delays in drug delivery. Lack of radiology and lab services. |
| Boryal Health post | | Residents and pastoralists. | Vaccines. | Pharmacy, outpatient services. Immunization. Drugs. Lab services. Nutrition. Radiology. | Delayed drug deliveries. Lack of transport. Lack of water. No beds. Lab services. Lack of staff. No trained social worker to handle SGBV. |
| Suftu health centre | Malaria. Diarrhoea. Malnutrition. Pneumonia. Dengue. STIs. TB. Mental health. SGBV. | Residents, cross-border communities and pastoralists. | Outpatient MCH. TB. Lab services. Nutrition. | | Shortages of drugs. Lack of electricity. Lack of professional staff. Lack of radiology. No transport. No oxygen services. No blood bank services. |
| Dollo Hospital: | Malnutrition. Malaria. Mental health. Respiratory diseases. | Pastoralists, residents, cross-border communities, and refugees. | MCH. Outpatient service. General investigation. Radiology services. Obstetrics and delivery. | Mental health. MCH and reproductive health. Disease prevention. Cross border facilitation. | Absence of coordination in the Triangle. Lack of facilitation across the border. Budget shortage. Roads. Drug shortage. |
| Jara HC | Pneumonia. UT. STIs. Gastroenteritis. Worms. Malaria. Renal problems. Common cold. Arthritis. Mental health. SGBV. TB. | Cross-border communities, pastoralists. | Laboratory services, outpatient services, Nutrition, ANC. Family planning. Immunization. | Ambulance service. Increase in wards/beds. Waste management. Mental health care. Public health; toilets. Oxygen. | Lack of infrastructure (wards, power, electricity, waste, fencing). Lack of ambulances. Limited water sources. No specialized mental health services. No SGBV specialist. Budget is limited. |
| Eymole health post | | Cross-border communities and pastoralists. | Flu. Diarrhoea. Cholera. Zoonotic diseases. Malaria. Eye problems (rampant). SGBV. Mental health. | Ambulances. Lab services. Delivery services. | No delivery services. Poor infrastructure. No water storage. Lack of skilled staff. Solar power system unreliable. No waste disposal system. Facility dilapidated. No ambulance services. |
| Mubarak | Occasional disease outbreaks. AWD. Cholera. Measles. | Residents, agropastoralists, pastoralists, IDPs, and cross-border communities. | | Radiology. Blood bank. Orthopaedic services. Dental services. Ambulance. TB treatment. Wards. | No blood banks. No radiology service. Only one ambulance (for a radius of over 700 km.). Erratic drug supply. Poor facility. Poor road infrastructure. No specialist staff in mental health or SGBV. Low infrastructure standards. |

Annex 4. Facility Checklist for Kenya

| Facility | Some unique diseases | Group accessing | Services | Suggested health needs | Challenges/Constraints |
|------------------------------|---|---|--|--|---|
| Mandera County Referral Hosp | In addition to all diseases, patients visit facility for cancer, TB, HIV, mental issues and SGBV | Residents of three countries including pastoralist, urbanite, and agropastoral | Vaccination, inpatient, outpatient, specialized services, lab and outreach | Increase number of ambulances, expand wards to cater for special needs of mental and SGBV victims | No established agreement with facilities in Ethiopia and Somalia. Being the largest and most equipped, the facility is often overpopulated, and staff are stretch particularly during conflicts and disease outbreaks. No sufficient mental specialist and patients do not have access to ward suitable for mental patients |
| Khalalo Health Centre | Acute watery diarrhoea, upper respiratory tract infections, gastrointestinal conditions, and vector-borne diseases, farm related accidents | residents, pastoralists and the cross-border farming community | outpatient, laboratory and maternal and child health | Ambulances, Wards, specialists | Space is limited to cater for both local and cross border community, there are no specialized facilities and specialist, no ambulance |
| Rhamu SCH | In addition to all the diseases in the region, this area has high rate of mental patients who are referred to either Mandera, Nairobi or spiritual healers | Residents, pastoralists, Agropastoralist and cross border community | Ambulances services, inpatients, outpatients, outreach and lab services | Specialists for different ailment, ambulance, wards, fencing, electricity/backup, Mortuary | Limited bed capacity, limited access to ambulance, erratic supplies, no radiography machine, mental care specialist and facility is missing |
| Elwak SCH | Maternal disorders. Cirrhosis, Lower respiratory infect, HIV/AIDS, Maternal disorders in addition to common diseases in the region | It serves residents, accepts referrals from other sub-county health facilities, and takes cross-border patients from Elwak in Somalia | outpatient and inpatient services, physiotherapy, dental services, and ultrasonography, and has a chest clinic | Additional specialist, additional ambulance, safe house for victims of SGBV, facility for treating mental health cases | The facility lacks specialized clinics, facilities for treating mental health cases, or a safe house for victims of SGBV |
| Takaba SCH | HIV, SGBV, water borne disease outbreaks, injuries from clan conflicts in addition to other common diseases | Outpatient and inpatient services, physiotherapy, dental services, and ultrasonography, and has a chest clinic | Residents and referrals from Mandera West Sub- CBMPs from Ethiopian | Improve on supply chain, | Serves wider area with limited ambulance, frequent power outage, erratic supplies, no facility for mental and SGBV care, limited of specialists and specialized surgery |
| Kiliwehiri Health Centre | Diarrhea, cholera and zoonotic diseases. Because of cross border interaction and conflicts, this area is reported to have high incidences of sexual and gender-based violence (rape cases) and mental issues. | Residents and cross border community from Ethiopia | Some limited primary health care services. | Improve outpatient services, ambulances, improved supplies, deploy personnel | No specialized services, lack of inpatients services, lack of ambulances, lab services are missing, |

Annex 5. Terms of Reference

Comprehensive study on the health gaps and needs in the Mandera Triangle - Interpeace Kenya Programme

Interpeace is an international organization for peacebuilding, headquartered in Geneva, Switzerland. Its aim is to strengthen the capacities of societies to manage conflict in non-violent, non-coercive ways by assisting national actors in their efforts to develop social and political cohesion. Interpeace also strives to assist the international community

(and in particular the UN) to play a more effective role in supporting peacebuilding efforts around the world through better understanding and response to the challenges of creating local capacities that enhance social and political cohesion. For more information about Interpeace, please visit www.interpeace.org

Background

The Tri-border area where Kenya, Ethiopia and Somalia converge, also known as the Mandera Triangle, is almost entirely inhabited by Somali communities with close cross-border social, economic and development connections. The significant portion of the population is cross-border mobile populations (CBMPs) which are composed of mobile pastoralists looking for pasture; refugees; seasonal cross-border labourers, persons engaged in cross-border economic activity; undocumented migrants; internally displaced persons (IDPs) and communities hosting refugees and IDPs. CBMPs face major barriers to access to basic healthcare needs because of the complex socio-political dynamics of the public health system in migration and cross-border mobility. While it is easy for clinical and public health workers to provide healthcare needs to a static population, the health outcomes for CBMPs are often difficult to monitor and implement.

Several factors influence the health and nutritional status of the populations in the Mandera Triangle, which is marked by chronic malnutrition and disease movement and morbidity. These include limited access to healthcare, poor socio-economic and civil security, food insecurity, poor child-care practices, population, and limited water, sanitation and hygiene (WASH) infrastructure. These factors are compounded by and influence persistent cycles of conflict and insecurity in the region. Sev-

eral efforts to address disease surveillance and control of pandemics have been made, but with difficulties because of the scope and borderline nature of the communities.

Addressing these challenges requires a thorough understanding of the unique needs of CBMPs and the interconnections between the health challenges and conflict drivers; effective cross-border coordination between key health and political actors in the three countries and developing and implementing policies and approaches that expand access to and provision of health care services while contributing to building sustainable peace in the region.

Interpeace, in partnership with the Inter-Governmental Authority on Development (IGAD) thus seek a consultant/research team to undertake a study on the health dynamics, systems and actors and their linkages to conflict dynamics in the Mandera Triangle, specifically in Mandera County of Kenya, Dollo and Mubarak zones of Ethiopia and Belet Hawa and Elwak Districts of Somalia. The aim of the study is to better understand the specific health and peace needs of the populations of the Triangle and to inform future interventions to boost household and community health security and resilience while contributing to overall peacebuilding efforts in the region.

Service or Assignment Description and Objective(s)

The main objective of the study is to identify, validate and prioritize the major health gaps, needs and their linkages to peace needs and priorities in the identified areas of each of the three countries. The study will be of interest to the ministry of health in the regions, IGAD, National Cohesion and Integration Commission, Interpeace, the peacebuilding actors in the region as well as to international donors and policy makers engaged in the region.

The study will involve:

- County consultative/ inception meeting to introduce the programme and bring on board all relevant stakeholders to ensure the buy-in of the programme.
- Joint cross-border Inception meeting with health staff in Kenya, Somalia and Ethiopia with Interpeace and IGAD to discuss on the research process and nominate a cross-border coordination forum that will support the consultant undertaking the study. The forum will also lead on engaging the stakeholders on how the identified cross-border issues can be coordinated.
- A comprehensive study of health care delivery/ issues through a consultative research process across the specified areas in the three countries
- Joint technical validation workshop at regional level
- Joint stakeholder's validation workshop by cross-border communities

Scope of work

The anticipated duration of the evaluation is 25 days with a minimum of 10 days to be spent in the Mandera Triangle (Mandera County of Kenya, Dollo and Mubarak zone of Ethiopia and Belet Hawa and El-

wak Districts of Somalia). The anticipated start date is 20th January 2021 with submission of the final draft by end of February 2021.

Activities, Deliverables and Timeframe

The consultant will carry out the following duties:

- Development of the protocol for the assignment: the consultant will develop a checklist tool for the collection of relevant documents and information. This protocol will be reviewed by Interpeace and the cross-border health technical team prior to the implementation of activities.
- **Documents review and field visits:** The consultant will carry out the following activities:
- **Desk review:** The consultant will collect and review the relevant documents for the assignment through the developed tool
- **Country visits:** -The consultant with the support of staff seconded from the ministry of health of the three respective countries and through our partner IGAD to conduct interviews with key stakeholders in the health sector and communities at the cross-border. These visits will serve collection of relevant country document and interview with the relevant government institutions
- **Development of draft study report:** Based on findings of the study and desk review, the consultant will draft a report which will be discussed and enriched through regional validation workshop.
- **Validation workshop:** The consultant will facilitate a three-day workshop that bring together member states ministries and partners to present the findings/outcome of the study and to refine the recommendations developed by the consultant.
- **Preparation of final report:** The consultant will incorporate comments and contributions from participants and develop the final report including proposed recommendations.

Methodology

The consultant is expected to use participatory methodologies which may include but are not limited to, contribution mapping/contribution analysis, interviews, focus group discussions etc. The methodology used should also be gender, youth and conflict sensitive. The consultant is expected to present, agree upon and apply a conceptual framework of analysis consistent with Interpeace peacebuilding and participatory approach. The study will be both an objective and a consultative/participatory exercise, and is expected to involve the following elements:

- Initial planning process: in conjunction with IGAD, Ministry of health from the three countries, Interpeace and partners, finalize the methodology, guiding questions, indicators, and workplan.
- Documentary review: a review of relevant documentation, including the review of existing literature and relevant official reports, data and information, including past national, regional and global health reports, national overarching policies, strategies and medium-term plans.
- Stakeholder interviews and focus group discussions: including with employees of IGAD health department, ministry of health, NCIC; stakeholders and beneficiaries in Kenya, Somalia and Ethiopia border; and external experts from academia, civil society, etc.
- The consultant is encouraged to suggest a comprehensive methodology that includes these elements and others that the deem fit for meeting the study objectives. The methodology for data collection should be described in the inception report.

Reporting and feedback

The consultant will provide:

- A brief inception report (no more than 5 pages) at the end of the initial planning phase, setting out a timetable for the study, an overview of the final agreed upon methodology, the names of people and groups to be interviewed, a detailed workplan and a list of documents to be reviewed. Data collection tools are expected to be reviewed by and finalized together with IGAD, Ministry of health and Interpeace.
- The consultant will provide a brief progress report and presentation at the end of the fieldwork phase (no more than 10 pages) summarising the progress of the study, highlighting any changes to the study schedule, and providing tentative findings.
- The consultant will submit a draft report within 15 days after completing the fieldwork.
- They will provide a final report taking into account comments on the draft report within 5 days of receiving such comments.

The study report will include a main text of no more than 30 pages with findings and recommendations. The consultant will hold a feedback meeting (or meetings) for the IGAD, ministry of health and the Interpeace East and Central Africa office and invited stakeholders. This will be an opportunity to debrief on the study, and to exchange views on preliminary findings and recommendations.

Qualifications

The consultant will be expected to have the following skills and experience at a minimum:

General professional experience

- Solid knowledge and understanding of key Health challenges in the Mandera Triangle region
- Strong knowledge in peacebuilding
- Minimum of 7 years' experience in health research/ assessments (or collaboration with a person or group with extensive evaluation experience)
- Graduate degree in public health, international and global health and any other similar health related degree.
- Experience working in the conflict or post-conflict environments, with preference given to Mandera Triangle specific experience
- A willingness to travel to the Mandera Triangle region

- An ability to work within tight deadlines
- Good analytical and report writing skills
- Good communication and facilitation skills
- Good interpersonal skills
- Good computer literacy

Specific professional experience: The consultant should be a highly knowledgeable person on health research and analysis

Interpeace and its partners will be responsible for:

- Providing a focal point for the study, who may or may not travel with the consultants (time and funds permitting)
- Providing logistical support within the Mandera Triangle region
- Providing standard Interpeace security support for the Consultants (responsibility rests with the consultants)
- Arranging meetings with stakeholders

How to apply

For consideration for this opportunity, please submit an expression of interest (no longer than 5 pages and inclusive of the proposed budget and CVs for the proposed consultant by January 15th, 2021 (midnight Nairobi time) via email to: ECA@interpeace.org and copy nderitu@interpeace.org. Applicants, if short-listed, will be required to subsequently submit work samples in English.

Interpeace values diversity among its staff and aims at achieving greater gender parity in all levels of its work. We welcome applications from women and men, including those with disabilities.

Cross Border Health Policy and Practice

Part II

Background

Background

Executive summary

This publication presents the findings of a study of health policy and practice in the Mandera Triangle conducted on behalf of Interpeace. The main objective was to analyse cross-border policies and platforms with a view to improving these, promoting effective cross-border coordination between health actors, and enhancing health services in a manner that will address the specific health and peace needs of Mandera Triangle's population. Mandera Triangle is a border area where Kenya, Ethiopia and Somalia converge (see Map, p. 32). Cross-border mobile populations (CBMPs) represent a significant portion of the population, which is almost entirely composed of Somali communities with close cross-border social, economic and development connections. CBMPs face major obstacles when they try to obtain basic healthcare because, for complex socio-political reasons, the public health system finds it difficult to deal with migration and cross-border mobility. The problems are compounded by persistent conflict and insecurity in the region.

The study found obvious old and new gaps that need attention at country and regional level. While each country has control over its borders, people are constantly in movement across them in search of better or more affordable health care. For instance, people from Ethiopia and Somalia cross into Kenya for free maternity services, and people from Somalia and Kenya travel to Ethiopia's Awasa hospital to receive specialized orthopaedic services. A glaring gap is the absence of public mental health facilities along the borders in all three countries. State financing of public health is meagre and medical services continue to depend for complementary funding on humanitarian donors and patient contributions. Stigma, religious beliefs and traditional customs are

also factors that hinder access to and use of health services. At regional level, the study found that resources are not mobilized to resolve common health issues and that border control and movement are not coordinated. It recommends the creation of a regional rehabilitation centre.

The report makes specific recommendations to State agencies in all three countries at national level, and to IGAD at regional level. In particular, it recommends: development of a regional approach to resource mobilization for shared health-related services; and establishment of a regional rehabilitation centre for drug addiction and abuse, to reduce the incidence of mental health disorders. It recommends that IGAD should work with the three countries to operationalize the Regional Coordination Committee. At country level, it recommends that the Government of Kenya should establish a Mandera County Mental Health Unit and complete and adopt the Draft National Disaster Management Policy and Draft National Migration Policy (2017). It recommends that the Federal Government of Ethiopia should establish one-stop recovery centres along its borders to provide care to survivors of sexual and gender-based violence (SGBV); and introduce a livestock insurance programme to cushion pastoralists from the shocks of drought and famine and enhance food security and nutrition. It recommends that the Federal Government of Somalia should develop guidelines for traditional midwives and Community Health Workers (CHW); introduce a livestock insurance programme to cushion pastoralists from the shocks of drought and famine and enhance food security and nutrition; and approve and introduce its Mental Health Care Bill, its Mental Health Policy, and other policies on WASH and HIV/AIDS.

Study problem and rationale

The Mandera Triangle is almost entirely inhabited by Somali communities with close cross-border social, economic and development connections. A significant proportion of the population are cross-border mobile populations (CBMPs) composed of: mobile pastoralists looking for pasture; refugees; seasonal cross-border labourers; persons engaged in cross-border economic activity; undocumented migrants; internally displaced persons (IDPs); and communities hosting refugees and IDPs. CBMPs face obstacles when they try to obtain basic health care because, for complex socio-political reasons, the public health system is unable to cope with migration and cross-border mobility. Clinical and public health workers find it straightforward to serve static populations but struggle to provide health care to CBMPs or measure outcomes.

The health and nutritional status of populations in the Mandera Triangle is marked by chronic malnu-

trition as well as high rates of disease and morbidity. Several factors explain this state of affairs. They include: limited access to healthcare; socio-economic and civil insecurity; food insecurity; poor child-care practices; and a limited water, sanitation, and hygiene (WASH) infrastructure. These factors are compounded by, and influence, persistent cycles of conflict and insecurity in the region.

To address these challenges, it is necessary to understand the unique needs of CBMPs and the interconnections between factors that drive threats to health and factors that drive conflict. Health and political actors in the three countries need to introduce effective cross-border coordination and develop and implement policies and approaches that will expand access to and enlarge the provision of health care services, while helping to build sustainable peace in the region.

Objectives

The main objectives of this study were to analyse cross-border policies and platforms with a view to improving them, foster effective cross-border coordination between health actors, and enhance health services to address the specific health and peace needs of the Mandera Triangle population. More specifically, it aimed to:

- Conduct a desk review of existing health protocols, in order to identify and analyse gaps in health delivery to CBMPs and links to conflict dynamics in the Triangle.
- Identify and analyse the practices of health actors in the Triangle.
- Consult key stakeholders to establish how policies on cross-border health can be developed or refined to respond better to the specific health and peace needs of people living in the Mandera Triangle, especially CBMPs.
- Develop a draft situation analysis that includes policy options to strengthen cross-border health policies and make them more responsive to the health and peace needs of CBMPs.

Study setting

In each region of the Mandera Triangle selected for review, the study undertook policy analysis, observed health facilities, interviewed key informants, and reviewed secondary literature. The study sites chosen were: Mandera County, Kenya, which has an area of 25,797 km² and a population of approx-

imately 867,457; Somali Region in Ethiopia (Dollo and Mubarak) which has an area of 327,068 km² and a population of approximately 15.65 million; and Gedo Region in Somalia (El Wak District, Belet Hawo District, and Doolow District), which has an area of 85,000 km² and a population of 509,000.²¹

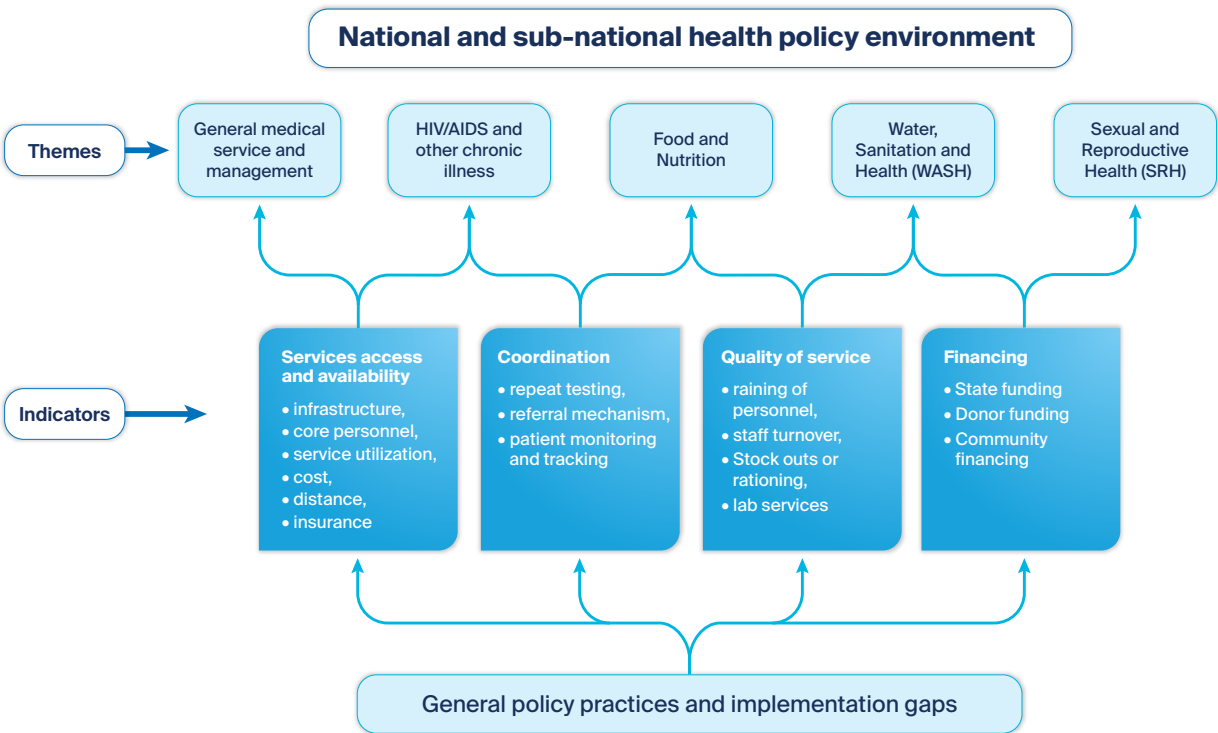
Methodology

The study adopted a dual approach that involved thematic analysis and qualitative research, including key informant interviews. The thematic analysis framework identified six policy areas: maternal and child care; HIV; sexual and reproductive health (SRH); water, sanitation and hygiene (WASH); food and nutrition; and mental health. It further identified four indicator areas: access, availability and use; quality of service; coordination; and financing.

To document practice, the team conducted key informant interviews with representatives of selected

health facilities situated on the borders, INGO staff, and local government officials. Key informants were selected on the basis of their functions. Both senior and subordinate officials were interviewed. Data provided by government officials was triangulated with direct observation of health facilities. A total of 67 key informants were interviewed. In each health facility visited, the researchers interviewed the matron or officer in charge, a medical officer, and a community health worker. See the conceptual framework in the figure below.

Conceptual framework showing the interplay between health policy and health practice.



1 See OCHA, *Somalia - Subnational Population Statistics*. Accessed in March 2021 at: <https://data.humdata.org/dataset/somalia-population-data>.

Study limitations

Every study has limitations that arise from its design, the methods used to collect or validate findings, or the impact of unforeseen circumstances. In this study, two limitations should be mentioned. The first is the small sample size of the data collected. This is not a major drawback because the study is primarily qualitative and field data were used essentially to validate the findings of desk research and interviews. The second is that the study looked pri-

marily at health policy and reported practice; further research should be considered to confirm actual health gaps in the Mandera Triangle. Finally, the study mainly focused on CBMPs' access to health care as opposed to the static populations' access to health care thus a baseline was not established to compare CBMPs' access and the average access in the three countries.

Summary of key findings

Policy on cross-border health is not coordinated

Kenya, Somalia, and Ethiopia do not coordinate their approach to common issues of health and cross-border movement of people. Many key informants said they were unaware of any inter-State agreements on these issues and considered that, if policies in fact exist, they might be tucked away unimplemented in the capitals of the three countries. For specialized orthopaedic services, people in Mandera County (Kenya) depend on Awasa hospital in Ethiopia, whose services are considered to be of good quality and affordable. People in Ethiopia's Dolow Ado District and Somalia's Gedo Region, on the other hand, go to Mandera hospital in Kenya for maternity services because they are free of charge. People in Ethiopia and Mandera Coun-

ty (Kenya) favour drugs from Somalia's Gedo region because they believe these are imported from the West whereas drugs in Kenya are imported from China. There is also a constant movement between all three countries as people travel abroad for certain services (such as HIV/AIDS treatment and family planning) for fear that they might be stigmatized or face violence from their families if they seek those services at home.

Respondents from Belet Hawa in Somalia's Gedo region complained that the Kenya government acted unilaterally when it closed the Kenya-Somalia border and deployed heavy security forces following incidents on the border.

Health budgets in the Mandera Triangle are low

The governments of all three countries have promised to increase funding for health. In Kenya per capita health expenditure increased from USD 38 per person in 2013/14 to slightly above USD 45 per person in 2019/20, which is still below the recommended World Health Organization (WHO) target of USD 64 to provide a basic package of healthcare. In Somalia, per capita public expenditure on health is approximately USD 10–12 per person per year, which is far below that target. Very low public expendi-

ture increases the financial burden on poor people, because they contribute more of the cost from their own pockets. In Ethiopia, National Health Expenditure (NHE) increased from USD 16.09 per capita in 2007/08 to USD 30.77 in 2019/21, still half WHO's target. Data suggest that external humanitarian funding in all three countries has been falling, which has serious implications for the region in view of its fragile situation and the weak capacity of the public sector.

Inequitable access to health facilities and human resources

The region has not met public aspirations for equitable access to a health care system staffed by qualified medical staff. Most of the health facilities we visited in Kenya reported that they were understaffed, lacked essential equipment and medical and non-medical supplies, and that a poor and unsafe working environment undermined staff morale and productivity. In Somalia, there are very few public facilities for the population served, and the size of the country exacerbates problems of access. There is a grave shortage of qualified health workers, especially midwives and reproductive health professionals. In rural areas, public services rely on aux-

iliary staff, most of whom are not well trained and not well paid. In Ethiopia, staff attrition, high turnover, absenteeism, lack of incentives and lack of motivation have also caused staff shortages. The number of trained mental health professionals is wholly inadequate to provide services to Ethiopia's population; there are no public mental health facilities along its borders in the Mendera Triangle. Due to broken machines, lack of trained technicians, or power cuts, laboratory services are frequently disrupted, particularly CD4 testing in antiretroviral therapy (ART) sites.

Irregular and inadequate supply of drugs and equipment

In Somalia, health facilities are irregularly supplied with an inadequate selection of drugs through a kit system (meaning that every month wastage and stock-outs occur). In Ethiopia, respondents report-

ed that procurement and management systems to deliver supplies and maintain equipment do not function well.

Gaps in law and policy

There are huge policy and legal gaps in the health sector. In Kenya, the government has not yet adopted the Draft National Disaster Management Policy (2009) or the Draft National Migration Policy (2017). Somalia has not yet enacted the Mental Health Care Bill (2007), or the Draft WASH Sector Policy (2019). The government has no agreed policies or legislation on WASH, mental health, HIV/AIDS, national migration, or female genital mutilation (FGM). So-

malia continues to rely on policy documents and instruments provided by international development partners. Ethiopia has not yet enacted legislation on mental health, sexual reproductive health, or regional migration.

These legal gaps have important and dangerous effects on health and cross-border movement that the main findings of this report describe.

Health Policy and Practice in Mandera Triangle

Health Policy and Practice in Mandera Triangle

Introduction

This section describes health policies and health practices in the Mandera Triangle, and the legal context. The information is set out by country. Key highlights and policy/practice gaps are noted, as well as best practices. The section also discusses links between health and conflict. Discussions and findings are grouped under the four indicator areas of the conceptual framework (see above).

Kenya

Policies and legal framework

| Sector | Laws and policies |
|-------------------------|--|
| General health policies | <p>The Constitution of Kenya (2010) affirms that every person has the right to the highest attainable standard of health, which includes the right to health care services (Article 43). The Fourth Schedule states that the County Government is in charge of county health services, including, in particular, (a) county health facilities and pharmacies; (b) ambulance services; and (c) promotion of primary health care. Article 20(5)(a) states that it is the State’s responsibility to show that resources are not available. Article 20(5)(b) states that, when allocating resources, the State will give priority to ensuring the widest possible enjoyment of rights and fundamental freedoms, having regard to prevailing circumstances including the vulnerability of particular groups or individuals. Article 204 states that the Government will use the Equalization Fund only to provide basic services to marginalized areas, including health and mental health facilities, to the extent necessary to bring their quality to the level generally enjoyed by the rest of the nation, as far as possible.</p> <p>Kenya Vision 2030 recommends the revitalization of community health centres, referred to as Community Health Units, through implementation of a community health strategy.</p> <p>The Kenya National Health Policy (2014–2030) calls for progressive realization of universal access to services that prevent and treat mental disorders and communicable diseases. The policy further states that both national and county health services will improve the professional quality of health workers by: (a) identifying training needs and providing training opportunities; (b) providing scholarships; (c) ensuring that staff receive their salaries during training; (d) redeploying health workers appropriately when they complete their training; and (e) establishing appropriate arrangements for continuous professional development and career progression.</p> <p>The Kenya Community Health Strategy (2020–2025) sets out to strengthen community structures and systems, improve implementation of community health actions and services at all levels, and strengthen the delivery of integrated, comprehensive, community health services of good quality to all population cohorts.</p> <p>The National Hospital Insurance Fund (NHIF) Strategic Plan (2018–2022) seeks to promote universal health coverage by providing affordable, accessible, sustainable and good quality health insurance through strategic resource pooling and healthcare purchasing in collaboration with stakeholders.</p> |

| Sector | Laws and policies |
|--------------------------------|---|
| Mental health | <p>The Mental Health Policy (2015-2030) and the Mental Health Act (Sections 9 and 20) state that the government will ensure that mental health systems remain affordable, equitable, accessible, sustainable and of good quality. In addition, they require health facilities to be equipped to provide outpatient and inpatient mental health services. Under the policy, cross-border disasters and conflict-related mental health needs are to be managed by intergovernmental mechanisms. However, the Act states that, where it is necessary to admit a person suffering from a mental disorder from a foreign country into a mental hospital in Kenya for observation or treatment, the Government or other relevant authority of that country must apply in writing to the Board to approve the admission, and that no mental hospital is to receive a person suffering from a mental disorder from a foreign country without the Board's written approval.</p> <p>Mandera County Health Services Act (2019) states that the County Government will provide the highest attainable health services to citizens, and will provide a mental health unit in the county.</p> |
| Maternal and child health care | <p>National Policy Guidelines on Immunization state that the government will ensure that children under the age of five have access to free immunization in all government health facilities.</p> <p>Kenya's Primary Health Care Strategic Framework (2019-2024) recommends the introduction of innovative financing mechanisms at national and county levels of government to secure sustainable domestic financing for public health care (PHC). It proposes: a county-based healthcare financing scheme for public health care; scaling up the community health workforce, and financing their work through income-generating activities; innovative tax regimes to increase domestic financing for primary health care; and the adoption of results-based financing for public health care.</p> <p>The Newborn, Child and Adolescent Health Policy states that the government: will ensure that medical facilities: initiate breastfeeding immediately after birth (without recourse to artificial forms of breast milk); and promote prevention, early detection and treatment of common non-communicable diseases and conditions among children, including asthma, disabilities, cancers, obesity, diabetes and cardiovascular conditions.</p> <p>The National Reproductive Health Policy (2007) aims to increase at all levels of the health care delivery system: the availability, accessibility, acceptability, and use of skilled attendants during pregnancy, childbirth and the post-partum period; and access to quality maternal and neonatal health services.</p> |
| Food security and nutrition | <p>The National Food and Nutrition Security Policy, and the Food and Nutrition Security Policy Implementation Framework (2017-2022) introduce programmes and actions designed to ensure adequate access to food and nutritional services. The strategy sets up a national early warning system to provide essential information promptly in cases of potential food insecurity and malnutrition, in addition to free feeding programmes in marginalized areas. It also mandates the government to establish a livestock insurance scheme to cushion pastoralists from the impact of drought and famine. The policy harmonizes and strengthens inter-agency efforts to monitor and control the safety and quality of food and minimize overlaps.</p> <p>The Agricultural Sector Development Strategy (2010-2020) affirms that the government will explore the possibility of providing a livestock insurance scheme for producers in arid areas.</p> <p>The Draft National Disaster Management Policy has remained in draft form since 2009. The policy would put in place an integrated and coordinated disaster risk management mechanism to prevent or reduce the risk of disasters, mitigate their severity, improve preparedness, provide a rapid and effective response, and promote recovery. The draft policy envisages a Directorate of Early Warning and Disaster Risk Profiling that would detect and monitor drought-related risks. To improve management of disasters, it proposes to harmonize the Humanitarian Disaster Fund, the National Drought Disaster Fund, and the National Disaster Management Contingency Fund.</p> |

| Sector | Laws and policies |
|--------------------------------|--|
| Water, sanitation and hygiene | <p>The Kenya Environmental Sanitation and Hygiene Policy (2016) addresses WASH policy. It states that schools must have an adequate and safe water supply and satisfactory environmental sanitation at all times; and that schoolchildren must have a healthy learning environment, and access to water and clean child-friendly hand-washing and environmental sanitation facilities. It states that public health departments must ensure that health facilities: instal sanitation and healthcare/medical waste management arrangements to prevent the release of waste and ensure its safe disposal; and that, from inception, they have a reliable water supply, environmental sanitation and hygiene facilities. The policy envisages a comprehensive programme to mobilize the resources required to secure universal access to improved sanitation, and affirms that the government and management bodies will supply skills training to maintain the quality of services.</p> <p>Other policies with similar provisions include the National Water Master Plan 2030 and the National Water Services Strategy. Mandera County Public Works and Water Services Act sets out provisions for storm water management, county water services and sanitation.</p> |
| Sexual and reproductive health | <p>The National Reproductive Health Policy (2007) sets out to reduce unplanned births, socio-economic disparities in access to and use of contraceptives, and the unmet need for family planning (FP), by increasing FP services and funding for them.</p> <p>The National Adolescent Sexual and Reproductive Health Policy (2015) seeks to promote adolescent sexual and reproductive health (ASRH), by: making available high quality, adolescent-friendly information and services; providing medical, legal and psychological services at all levels, including rehabilitation for adolescents exposed to drug and substance abuse; and reducing the adolescent incidence of SGBV, drug abuse, and harmful traditional practices such as FGM.</p> <p>The National Guidelines on Management of Sexual Violence advise health and security practitioners on management of sexual violence in Kenya. They underline that, in both normal and humanitarian contexts, services must meet the medical and also the psychosocial and legal needs of survivors of sexual violence.</p> <p>The Kenya National Action Plan for Advancement of UNSCR 1325 on Women, Peace and Security (2020-2024) calls for interventions to build community awareness of SGBV and promote community participation in preventing conflict and all forms of violence against women and girls.</p> |
| HIV and AIDS | <p>Mandera County HIV and AIDS Strategic Plan (2016–2019) and Kenya’s AIDS Strategic Framework (2020–2025) set out plans to: appoint an adequate complement of competent staff at national and county levels to deliver HIV services as part the essential health package; strengthen community service delivery of HIV prevention, treatment and care services at national and county levels; find innovative and sustainable HIV financing options by establishing an HIV trust fund; and create an effective HIV co-ordination mechanism at national and county level.</p> |

Summary of health policy and practice gaps

- Mandera County has no mental health unit/facility.
- Kenya’s National Migration Policy (2017) and National Disaster Management Policy (2009) have not been enacted or implemented, although they could make vital contributions to management of cross-border movement and food security.
- Water quality and supply are poor in most schools and some health facilities and sometimes not available at all.
- Some laws and policies (such as the Mental Health Act) obstruct cross-border coordination and restrict services to CBMPs.

- Most health facilities report that they do not receive an adequate supply of medicines, commodities and supplies.
- Mandera lacks one-stop SGBV recovery centres that provide an integrated service.
- Most of the health facilities visited reported that they were understaffed; lacked essential equipment and medical and non-medical supplies; and that poor and unsafe working conditions lowered staff morale and productivity.
- Due to inadequate specialised services i.e. orthopaedic services, Mandera residents occasionally cross the borders to access orthopaedic services in Awasa in Ethiopia.
- Due to stigma propagated by religion and culture, Mandera residents are occasionally compelled to visit Somalia and Ethiopian facilities to access HIV/AIDS and family planning services
- Most family planning health facilities do not consider men to be potential clients.
- Though prohibited, harmful traditional practices such as FGM and early forced marriage continue to be practised.

Discussion

In Mandera, drug and substance abuse remain a major problem for young people. Most State agencies expressed the fear that drug addicts could be radicalized and recruited by terror groups if the State does not act in good time to provide rehabilitation services. Despite the need for such services, no drug rehabilitation or counselling programmes for adolescents exist in Mandera. The county still has to establish a mental health unit as provided by county law.

Devolution has enabled Mandera County to invest more in health. More facilities and services have become available. Before devolution, the county operated 18 facilities and employed about 157 health staff; it now runs 64 active health facilities plus two mobile clinics, and employs more than 557 health workers. However, only eight facilities offer anti-retroviral therapy (ART); 25 offer prevention of mother to child transmission (PMTCT) and 18 offer TB and HIV services. Government documents confirm a general increase in the number of health-care personnel, and that in 2020 there were 20.7 doctors and 159.3 nurses for every 100,000 persons. This is slightly below the WHO recommended minimum target ratio of 21.7 doctors and 228 nurses per 100,000 people. Despite this progress, most health facilities reported that they were understaffed, did not receive enough medicines or supplies, and that the roll out of KEMSA's Logistics Management and Information System (LMIS) has been weak.

Since devolution began in 2013, Kenya has gradually increased expenditure on health. It is one of the Big Four Agenda. Government documents report per capita expenditure on health has risen from USD 38 in 2013/14 to slightly more than USD 45 in 2019/20, still below the WHO recommended target of USD 64 to meet a basic package of healthcare. Investment in sanitation remains a low priority: it stood at 0.2% of GDP, below the WHO recommended standard of 0.9%. The National Hospital Insurance Fund (NHIF) contributes one tenth of health sector financing and has 7.6 million members nationally (about 17% of the population).

Harmful cultural practices, including FGM, SGBV and early and forced marriage, continue to have a direct impact on reproductive health in Mandera. Despite an obvious need for them, Mandera County still lacks one-stop integrated SGBV recovery centres to which SGBV survivors can go to report complaints, be examined and treated, receive emergency contraceptives, obtain STI and HIV tests, and take long-term protection measures (for example, manage HIV through ARVs).

In Kenya, Mandera County has the second highest incidence of stunted growth (31-39%). Positively, Kenya offers an index-based livestock insurance scheme to pastoralists (including in Mandera County) that cushions their risks from drought and famine. Mandera also benefits from Kenya's national school feeding programme and Hunger Safety Net

Programme (HSNP), an unconditional cash transfer programme implemented through the National Drought Management Authority (NDMA) in four of Kenya's poorest and arid counties: Turkana, Wajir, Mandera, and Marsabit. These programmes are part of Kenya's effort to implement social protection policies on food security. In partnership with IGAD's CEWARN, Kenya runs an effective national early warning system, through National Conflict Early Warning and Response Units (CEWERUs), which provide crucial information promptly on cases of potential food insecurity and malnutrition.

Stigma against family planning and HIV/AIDS make it difficult for women and girls to access treatments for these conditions in their local health facilities; many women therefore opt to cross into Ethiopia to obtain family planning and HIV/AIDS services. Most family planning health facilities do not consider men to be potential clients and design their services and programmes exclusively for women. As a result, few men use these services. In addition, male contraceptive methods, such as vasectomy, are stigmatized culturally. There is low awareness of cancer and other diseases of the reproductive organs, particularly in older populations.

Somalia

Policy framework

| Sector | Laws and policies |
|-------------------------|---|
| General health policies | <p>Article 27 of the Constitution of the Federal Republic of Somalia sets out the right to health care. It affirms that every person has the right: (1) to clean drinkable water; (2) to health care; and (3) to full social security. No one may be denied emergency healthcare for any reason, including lack of resources.</p> <p>The UNICEF Somalia Health Strategy Note 2018-2020 affirmed that women and children should have access to government-led public and community services of good quality and recognizes that much work is required to strengthen government health systems. It reported that UNICEF would continue to support EPHS only in certain priority areas, focusing on the hardest to reach nomadic populations and groups that are socially excluded.</p> <p>The Somalia Social Protection Policy (2019) states that the Somalia Government will progressively establish a social protection system that by 2040 will deliver predictable assistance throughout life.</p> <p>The Somali Health Policy (2014) sets three key objectives: (a) to strengthen reproductive, maternal, neonatal, and child health and nutrition; (b) to prevent and control the spread of certain communicable diseases, thereby reducing morbidity, mortality, and disability; and (c) to move towards universal health coverage by increasing the government's allocation to health, "while mobilizing the participation and financial contributions to different health interventions of regions, local governments and grass root communities, supported by transparent collective oversight and monitoring of the resources".</p> <p>Under its disaster mitigation and response objective, the National Disaster Management Policy (2017) will work to make households, communities, and institutions resilient to acute shocks from natural hazards and climate change. Under its recovery objective, it will work to prevent erosion and support livelihood creation.</p> |
| Mental health | <p>The Mental Health Care Bill (2007) provides that every individual in need will be assured mental health care, particularly patients who live in provinces without health facilities. The Bill further affirms the rights of mental health patients, their family members, and other caregivers. It states that members of the general public are competent to act as guardians to assure the wellbeing of persons with mental illnesses. The Bill also describes voluntary and involuntary admission procedures and finally sets out the conditions of accreditation of mental care professionals and mental care facilities.</p> |

| Sector | Laws and policies |
|--------------------------------|---|
| Maternal and child health care | <p>The priorities of the Comprehensive Multi-Year Plan (2016-2020) and National Immunization Policy include: increasing immunization coverage and thereby reducing disease; stopping wild polio virus and eradicating polio; improving the quality, efficiency and sustainability of immunization programmes; and making the public aware of the importance of immunization.</p> <p>Strategic objective 3 of the WHO Country Cooperation Strategic Agenda (2017-2019) for Somalia encouraged the government to: coordinate all partners around a single plan to develop and implement Somalia's maternal, neonatal, child health programme; improve the availability and quality of maternal, neonatal and child health services and access to them; strengthen community health services, especially for new-borns; and improve the availability and quality of obstetric care services and access to them. Strategic objective 1 encourages the government to: build up immunization as a core element of the health system; increase the coverage and equity of routine immunization; increase surveillance and improve the monitoring and reporting of immunization services; and increase the sustainability of immunization financing.</p> <p>The UNICEF Somalia Health Strategy Note (2018-2020) set for itself several relevant outcomes: 75% of health facilities and 90% of community health workers were to increase their capacity to provide maternal, child and new-born health services of good quality, including HIV care in the most vulnerable areas; 80% of service providers were to be able to provide quality care for children and maternal services; and 95% of caregivers were to have increased their knowledge and skills of health-seeking behaviour and home care. By 2020, all health policies, strategies, plans and evidence were also to be available for planning and decision making. In 2021, however, Somalia still lacked maternal and child health policies and continues to be guided by the policies of external intergovernmental institutions.</p> |
| Food security and nutrition | <p>The National Nutrition Strategy (2011-2013). The goal of the first and second Strategic Plans for 2011-2016 was to "improve micronutrient status among children and women of reproductive age in Somalia", with a focus on children under 60 months. Special emphasis was placed on children under 2 years of age and pregnant and lactating women, since micronutrient deficiency is malnutrition's most serious effect, and lasting damage occurs during pregnancy and the first two years of life.</p> <p>In terms of food security and livestock, the National Development Plan (2020-2024) recommends mobilizing resources for large-scale investments in watershed management and infrastructure to mitigate the impact of extreme cycles of rainfall, flood and drought. These policies are of critical importance to Somali pastoralists who rely for their livelihoods on livestock, and also to efforts to re-establish the National Rangeland Agency and enforce policies and laws to rehabilitate and manage rangelands. The NDP affirms that the principle of leaving no one behind and reaching out first to those furthest behind should guide health interventions that support poverty reduction. Strengthening health sector coordination and health information systems will identify populations that most need support.</p> |
| Water, sanitation and hygiene | <p>The National Development Plan (2020-2024) sets out to enhance the public's access to clean water, sanitation and hygiene (WASH). Specifically, it asserts that the government will provide WASH services (including drainage, sewage and solid waste management) to vulnerable communities, including under-served schools and health clinics. It will also build human and institutional capacity to provide sustainable water supplies.</p> <p>The Draft WASH Sector Policy (2019) presents a framework for improving the delivery of WASH to households, communities, health centres and schools. The government undertakes to ensure that all schools and health facilities have handwashing facilities with water and soap available at all times; and to integrate hygiene promotion in infant and young child feeding interventions at health facilities and in communities.</p> <p>The UNICEF Somalia WASH Strategy Note (2018-2020) stated that by 2020 more people in rural areas, small towns and urban centres, as well as schools and health centres, especially women and girls, would have access to safe and affordable drinking water. People affected by emergencies, especially women and girls, would receive lifesaving WASH support. No policies and plans of action directly address water and sanitation in healthcare facilities and in primary schools.</p> |

| Sector | Laws and policies |
|--------------------------------|---|
| Sexual and reproductive Health | <p>The Family 2020 Commitments of the Federal Government of Somalia. In 2017, the Government of Somalia made six commitments: (1) to put in place legal policy frameworks for FP by 2020; (2) to identify barriers that impede access to FP and demand for it, and to increase uptake by 2020; (3) to raise the proportion of facilities that offer FP services, including in emergency and crisis settings, from 50% in 2017 to 80% in 2020; (4) to decrease stock outs by 30% by 2020 by supplying FP products reliably; (5) to explore and advance public-private partnerships in FP service delivery by 2018; and (6) to strengthen monitoring of FP programmes.</p> <p>The Essential Package of Health Services will enable rural populations and the poor to receive a health package that will improve reproductive and emergency obstetric care services. Institutional capacity will rise as a result of staff training, policy development, and health sector reform.</p> <p>The National Reproductive Health Strategy sets out a path to: provide family planning, birth spacing and infertility services of good quality; eliminate harmful traditional practices; protect and promote adolescent reproductive health; and detect early and manage cancers of the reproductive system.</p> |
| HIV and AIDS | <p>The Strategic Framework for the Somali AIDS Response envisages specific interventions for cross-border mobile and humanitarian populations. It plans tailored prevention, treatment, and care services, coordinated regionally, targeting important spaces along the borders. Programmes are to improve emergency preparedness and mobilize resources to strengthen the capacity of civil society organizations that provide services in IDP settlement areas. The HIV response will establish guidelines for delivering counselling and testing services, including services to test for HIV among TB and other patients. The framework recommends initiatives to increase the acceptability and use of condoms by the Somali population.</p> |

Summary of health policy and practice gaps

- Despite high rates of mental illness in Somalia, the country is unable to provide even basic care to those in need. The country has no law or policies on mental health.
- Immunization records are frequently lost during conflicts. Health facilities rely on mothers or parents to provide such information. Many illiterate women who have lost their immunization cards do not know which immunizations their children have received.
- The government has not integrated traditional birth attendants in the national health system although traditional midwives remain popular among rural and cross-border populations.
- Somalia has no clear policy or plan of action for delivering clean water and sanitation in health-care facilities.
- No national health insurance scheme is available to the people of Somalia.
- HIV and sexually risky practices are strongly stigmatized in Somalia. Combined with deeply-rooted cultural taboos, it is therefore difficult to discuss or address HIV/AIDS or sexual and reproductive health issues. Women are compelled to cross into Kenya or Ethiopia to obtain FP services safely and without stigma.
- Health services cover only a small proportion of the population. In terms of staffing, procurement, supply management, and monitoring and evaluation, the capacity of the health systems is weak.
- In rural areas, public services rely on auxiliary staff, most of whom are ill-paid and inadequately trained for their jobs. Salaries are too low to attract professional staff.

- Public facilities are insufficient to meet the needs of the population served. The size of the country exacerbates problems of access.
- No integrated one-stop SGBV centres exist in border areas to provide care and protection to survivors of SGBV.

Discussion

Use of health services is generally very low and even lower for PMTCT, ART, TB and HIV services, FP, condom programming, STI care, counselling, and testing services. Estimated use rates are one contact every eight years. Health facilities are irregularly supplied, and receive an inadequate selection of drugs through a kit system (which implies monthly stock-outs and wastage). This is partly because the number of public facilities is inadequate for the population they serve. The size of the country exacerbates problems of access.

Qualified health workers are in very short supply, especially qualified midwives and reproductive health professionals. In rural areas, public services rely on auxiliary staff, most of whom are inadequately trained and paid very little. The number of skilled health workers (approximately four professionals per 10,000 citizens) is well below the minimum ratio of 23 per 10,000 recommended by WHO.

According to a recent baseline study, the Government spent less than one per cent of its total expenditure on health in 2017; patient per capita expenditure on health was between USD 6 and USD 7.4.² Another qualitative study found that, because Somalia has virtually no tax base, the health system is highly dependent on donors. According to a demographic and health survey in 2020, 48% of households reported that they paid their health expenses from their income; 25% said that family or friends paid, 14% had to borrow money, and 11% were obliged to sell assets to cover health costs. No national health insurance scheme is available for people in Somalia. People either seek out health services that are free of charge at government or NGO-run facilities, pay

privately from their own pocket, or defer treatment.

Traditional safety net structures are important in Somali society; they protect the poor and those who are vulnerable from economic shocks. Religious contributions such as *zakat* and *sadaqah* are important supplements to poor households, especially in urban areas. Fewer of the households that receive remittances are poor (35%) than households that do not (56%). Remittances are often sent from the diaspora and channelled through family networks. Contributions are governed by cultural norms and distributed via local institutions or social networks. These traditional safety nets are an important coping mechanism in times of crisis. However, they do not work equally well for everyone; certain communities and vulnerable households from marginalized groups tend to be excluded.

Somalia has no mental health policy; nor has it developed a mental health strategic plan or an emergency/disaster preparedness plan for mental health. Some 86 staff work in the Department of Health's mental health facilities (a ratio of 0.95 per 100,000). No psychiatrists or primary health care doctors work in mental health. Six nurses provide mental health services to the entire country (a ratio of 0.066 nurses per 100,000).³* The Ministry of health does not allocate a budget to mental health. Mental illness is generally denied and mentally ill people face discrimination and stigmatization. Psychiatric or biomedical health care is not usually considered until a person becomes very ill and, for example, suffers a psychotic attack and cannot cope. Yet Somalia's protracted war and conflict have created a situation in which one in three Somalis is estimated

2 HIPS and City University of Mogadishu, *Somalia's Healthcare System: A Baseline Study and Human Capital Development Strategy* (2020), p. 19. At: <http://www.heritageinstitute.org/wp-content/uploads/2020/05/Somalia-Healthcare-System-A-Baseline-Study-and-Human-Capital-Development-Strategy.pdf>

3 See WHO-AIMS Report on Mental Health System in Mogadishu and South/Central Somalia, WHO and Ministry of Health, Mogadishu, 2009. Available at https://www.who.int/mental_health/mogadishu_south_central_somalia_who_aims_report.pdf

* All the rates per 100,000 stated in this report are based on the population estimate of entire Somalia. Please note that these rates may be an underestimation of the actual situation in S/C Somalia

to be affected by some form of mental illness. This rate is far higher than the incidence of mental illness (one in five) that the WHO expects to find in war zones.

With respect to maternal and child health, women along the borders have to cover on average a minimum of 20 km to access maternal services. This reduces access to ante-natal and post-natal care. The poor quality of maternal health services is due to lack of supplies and equipment, understaffing, inadequate training and supervision, negligence, unethical practices, and weak referral systems. Most women still rely on traditional midwives for support services and delivery. Many parents do not know which immunizations their children have received because they are illiterate, or immunization records have been lost in the course of conflict. Illiteracy and the region's isolation also explain why public awareness of the health risks of pregnancy and childbirth is low and scarcely informed by modern medical practices. There is poor demand for, and mistrust of, preventive services such as vaccination and birth spacing.

The Federal Government has not yet adopted a national gender policy, which has been in draft form for years, despite the fact that up to 98% of women undergo FGM, and many experience SGBV or early or forced marriage. The Government continues to rely on the penal code, which is not robust on FGM or SGBV. No SGBV recovery centres have been set

up along the borders that would give survivors protection and enable them to report complaints, obtain treatment, be tested for STIs and HIV, etc.

Somalia's High Frequency Survey (SHFS) found that fewer than half of schools and health clinics have access to clean water and sanitation. Rural, nomadic, and IDP populations have very low access to clean water and sanitation. Because skilled WASH staff are lacking in both the public and the private sector, water supply systems are badly constructed and maintained. Somalia's State agencies continue to rely heavily on external funding to deliver sustainable WASH services in urban environments and in humanitarian contexts.

The stigma associated with HIV/AIDS and family planning constricts access to care and compels some patients to cross into Kenya and Ethiopia to obtain treatment. Respondents reported that recent unilateral decisions by the Kenyan Government prevented people in the Gedo region from obtaining such services. Due to very tight border security, patients were unable to access health facilities in Kenya. The Government of Somalia has not adapted its reproductive health services to the cultural norms of pastoralist and Somali communities, or removed misconceptions in the community about the safety and efficacy of modern contraceptives.

Ethiopia

Policy framework

| Sector | Laws and policies |
|-------------------------|--|
| General health policies | <p>Article 35(4) of The Constitution of the Federal Democratic Republic of Ethiopia affirms that the State will enforce the right of women and eliminate harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited. Article 35 affirms that the State will prevent harms arising from pregnancy and childbirth and that women have the right to FP education, information, and support.</p> <p>The Ethiopian National Health Quality Strategy (2016-2020) sets out to improve the quality of the healthcare system, from prevention to palliative care, with special emphasis on five public health areas: (1) maternal, neonatal and child health, with a specific aim to reduce maternal and neonatal mortality; (2) malnutrition, especially prevention and management of severe acute malnutrition; (3) communicable diseases, particularly malaria, HIV, and TB; (4) prevention and management of non-communicable disease, particularly diabetes, cancer, cardiovascular diseases, mental health, and chronic respiratory diseases; and (5) clinical and surgical services, aiming specifically to improve the timeliness of care.</p> <p>The Health Sector Transformation Plan (2016-2020) set ambitious goals to improve the equity, quality, coverage and use of essential health services, and enhance the health sector's implementation capacity at all levels. It stated that services would be accessible without undue barriers of cost, language, culture, geography or any other factor; and that Ethiopians would have access to high quality, safe, effective and affordable essential medicines. An undertaking was made to increase health sector budgets.</p> <p>The National Health Policy emphasises human resource development. It foresees training of community-based and mid-level health workers to lift professional standards, and recruitment at regional and local level; training of trainers; and training of managerial and support staff, aligned with health service objectives. With respect to equipment and procurement, it proposes to list essential and standard drugs and equipment throughout the health system; and increase the nation's capacity to produce drugs, vaccines, supplies and equipment.</p> <p>The five-year Growth and Transformation Plan (GTP) aims to attain rapid economic growth (14.9% per annum) and to expand both health and education, thereby attaining the MDGs and ensuring the welfare of youth and women by building capacity and good governance.</p> |
| Mental health | <p>The National Mental Health Strategy sets several targets. Mental health services will be accessible to all and will be free or affordable. Mental and general health services will be of equal standing. Efforts will be made to ensure that people with mental illnesses and substance abuse disorders no longer suffer discrimination and stigmatization, by educating the general population, healthcare workers, teachers, professionals, patients and families, and other groups. Emergency, short-stay, in-patient stabilization treatments will be provided in dedicated wards, staffed by specialist mental health workers. The government will develop a National Institute of Mental Health (NIMH) whose mandate will be to guide, direct and supervise the overall development, implementation and monitoring of the strategy.</p> |

| Sector | Laws and policies |
|--------------------------------|--|
| Maternal and child health care | <p>The Health Sector Transformation Plan (2016–2020) set out to provide universal access to maternal, neonatal and child health services; scale-up maternity care in all health facilities; eliminate obstetric fistula and clear cases of fistula and pelvic organ prolapse; and implement the routine immunization improvement initiative.</p> <p>The National Health Policy sets out to: ensure that maternal health care is adequate and that cases of high-risk pregnancy can be referred; expand and strengthen immunization services, and optimize their use and access to them; and encourage early use of health care facilities to manage common childhood diseases, particularly diarrheal diseases and acute respiratory infections.</p> <p>The National Strategy for New-born and Child Survival in Ethiopia (2015–2020) stated that the government would: ensure that community and health facilities provide essential health care of high quality to mothers, new-borns and children; increase community empowerment; improve new-born and child survival interventions; promote key family and community care practices; improve procurement of essential medicines and commodities; and provide counselling and care of mentally ill patients at home and health posts.</p> |
| Food security and nutrition | <p>The Health Sector Transformation Plan (2016–2020) set out to: scale up the community-based nutrition (CBN) programme and the First 1000 Days initiative; implement the Seqota declaration on ending child undernutrition; and implement the baby-friendly hospitals initiative in all hospitals.</p> <p>The National Health Policy sets out to: establish principles of appropriate maternal nutrition; maintain breast-feeding; and promote home preparation of weaning foods as well as their production and distribution at affordable prices.</p> |
| Water, sanitation and hygiene | <p>The National Hygiene and Environmental Health Strategy (2016) sets out to protect and promote the health of the population; create a friendly and healthy environment by controlling environmental factors that directly or indirectly cause the spread of disease; and increase access to sustainable sanitation services and safe water. It envisions the formation of WASH Committees or Kebele Sanitation Committees responsible for supporting household and communal sanitation. The Strategy committed to achieve the following results by 2020: all Ethiopians would have access to adequate and equitable sanitation; basic hygiene behaviour to control communicable diseases would improve; safe water would be supplied from point of source to consumption; and all institutions would meet basic WASH standards.</p> |

| Sector | Laws and policies |
|--------------------------------|--|
| Sexual and reproductive health | <p>The Health Sector Transformation Plan (2016–2020) set out to: achieve universal access to FP information and services; scale up postpartum FP services to all <i>woreda</i> and villages; strengthen reproductive health services for adolescents and youth.</p> <p>The National Guideline for Family Planning Services in Ethiopia (2011) makes commitments to promote the health of women and families and reduce maternal, infant, and child mortality. Specifically, it sets out guidelines for: counselling; provision of contraception; screening for cancers of the reproductive organs; prevention, screening, and management of STIs, including HIV prevention; and management of infertility.</p> <p>The National Reproductive Health Strategy emphasises family planning. It states that the goal of FP is to reduce unwanted pregnancies and enable individuals to choose the size of family they desire. It lists the following action points: delegate provision of forms of FP (especially long-acting and permanent methods) to the lowest service delivery level possible without compromising safety or quality of care; increase access to FP services and their use, especially by married and unmarried young people and those whose families are the size they desire; create acceptance of and demand for FP, focusing on populations who are made vulnerable because of geographic dispersion, their gender, or lack of resources.</p> |
| HIV and AIDS | <p>The National HIV/AIDS Policy (1998), The National Strategic Plan HIV (2015–2020) and The National comprehensive and integrated prevention of Mother-to-Child Transmission of HIV (PMTCT) Guidelines aspires to increase HIV services for women (who accounted for 53% of HIV tests in 2019). The policy documents further provides that the government will: reduce early marriage, FGM, and widow inheritance; expand income-generating schemes for vulnerable women; raise women’s awareness to adopt safe sexual practices and methods to prevent and control STIs and HIV/AIDS; increase STI testing and counselling; improve the availability in universities and colleges of youth-friendly HIV and reproductive health services (STI, counselling, HIV testing, etc.); enhance coordination and leadership of condom programming nationally and regionally; enhance efforts to reduce stigma and discrimination; and increase domestic allocations to cover the implementation costs of priority interventions.</p> |

Summary of health policy and practice gaps

- 65% of those who attend mental health service have free access to the essential psychotropic medications. For those paying out of pocket, the cost of antipsychotic medication is 3% of the daily minimum wage. However, Ethiopia has no social insurance for mental health patients.
- The budgets allocated to WASH remain low even though government policies say that adequate allocations should be made. External actors still fund 90% of WASH costs in humanitarian settings in Ethiopia.
- Half of women currently give birth in a medical facility. This reduces the risk of death from complications during delivery. But the quality of treatment, and ensuring that women can reach facilities in time, remain challenges.
- Ethiopia has no public mental health facility along its borders.
- The health sector lacks one-stop integrated SGBV recovery centres on its borders to which survivors of SGBV can go to report complaints, get examined and treated, receive emergency contraceptives, obtain STI and HIV tests, and receive longer-term treatment and support.

- As a result of policy and the Federal Government's efforts, most financial institutions have designed credit products for pastoralists. However, virtually none of them are suitable for pastoralists.
- Ethiopia has the highest rate of malnutrition in Sub-Saharan Africa: 40% of the country's children are affected.
- The public usually attribute mental illnesses to spirit possession, bewitchment, the evil eye or other supernatural influences, rather than to biomedical or psychosocial causes. As a consequence, affected individuals and their families tend to seek help from religious and traditional healers rather than health facilities.

Discussion

In recent decades, the Somali Region of Ethiopia has experienced different forms of cyclical conflict, between clans, within clans, and between the State and insurgents. Research has shown that armed conflicts stall disease control programmes by disrupting the health system and preventing patients from obtaining health care.⁴ This largely accounts for the partial and inequitable distribution of health facilities in the country. Patients in conflict zones are likely to spend significantly longer before their diseases are diagnosed, and to self-treat more, than patients from non-conflict zones.

Respondents indicated that SGBV is frequent, including FGM, early and forced marriage, and rape. Nearly three-quarters of women (74.3%) were victims of FGM. However, the regional government of the Somali region has not yet established integrated one-stop SGBV recovery centres to which SGBV survivors can go for protection and to report complaints, be examined and treated, obtain emergency contraceptives, STI and HIV tests, and longer-term care, etc.

Most of the health facilities visited were not able to procure supplies or maintain equipment reliably. Most were also short-staffed due to attrition, high turnover, absenteeism, or poor incentives. The number of trained mental health professionals is wholly inadequate for Ethiopia's population. The country has no public mental health facilities along its borders in the Mendera Triangle. Laboratory services were inadequate. We observed frequent disruptions, particularly of CD4 testing at ART sites, due to broken machines, lack of trained technicians, or power cuts. Maintenance of HIV-related equipment is centralized but the centre lacks the capacity to maintain equipment promptly.

According to government documents, national health expenditure per capita increased from USD 16.09 per capita in 2007/08 to USD 30.77 in 2019/20. This is still well below the minimum recommended by WHO (USD 63). State insurance usually complements the Government's efforts to mitigate the costs that patients pay directly for health services. Ethiopia runs a community-based health insurance (CBHI) for the informal sector and a social health insurance scheme (SHI) for the formal sector.

⁴ Richards, S. and Gezu Bekele, Conflict in the Somali Region of Ethiopia: Can Education Promote Peace-Building? (2011). At <https://fic.tufts.edu/assets/Conflict-Somali-Ethiopia.pdf>.

Understanding the Linkages Between Health Gaps and Conflict in the Mandera Triangle

Understanding the Linkages Between Health Gaps and Conflict in the Mander Triangle

Introduction

The main aim of a public healthcare system is to avert avoidable morbidity and mortality. When a country, city, town, or village becomes engulfed in a political, civil, communal or religious conflict, the health system cannot function well, placing the population in a precarious situation.⁵ Conflict is a direct threat to life. Many people around the world are trapped in a vicious circle of armed conflict and poor health.⁶ In the Mander Triangle, insurgency, inter-community conflict, and political or election violence have disrupted health programmes and harmed health workers, caused loss of life, physical injury, displacement, and widespread emotional distress, created conditions for the outbreak of communicable diseases, and exacerbated malnutrition (especially among children). According to WHO, conflicts in the Mander Triangle have also increased risks associated with pregnancy and childbirth.

National and local health systems, fragile to start with, have been further incapacitated by lost assets, missed investment, collapsed cost-recovery, financial shortages, and loss of human resources. Information is scanty because record-keeping systems are imperfect, records have been lost, and many systems have been disrupted. Community coping strategies are exhausted. Planning the health system's recovery therefore requires careful analysis, of the state of health in the region but also the impacts of conflict on health. How does displacement influence access to safe water and health care? How well do health financing schemes accommodate the region's economic evolution? Experience suggests that planning for reconstruction should start as early as possible.⁷

Health consequences of conflict

It is important to note that, while conflict and war may lead to the breakdown of health facilities and reduce both access to health services and their quality, experts have not reached a consensus about the degree to which health inequalities generate conflict. The discussion below reviews the relationship

between conflict and the state of health.

Health infrastructure. Morbidity increases during and in the aftermath of conflicts because health infrastructure has been damaged or destroyed: systems for supplying healthy food and clean water,

5 Singh, S., Orbinski, J. J., Mills, E. J., 'Conflict and health: a paradigm shift in global health and human rights', *Confl. Health* 1, 2007,1, <https://doi.org/10.1186/1752-1505-1-1>.

6 WHO, EURO, PAR, *Peace Through Health: Summary of WHO peace building experiences, principles and strategies in Bosnia and Herzegovina* (1999).

7 Pavignani, E., *The Reconstruction Process of the Health Sector in Mozambique - A messy affair with a happy end?* (1999, unpublished).

public healthcare services, sanitation and hygiene systems, communications, transport, energy supply and distribution, etc. In Mandera, terrorist attacks and conflict that spilled across from Somalia led many health workers and teachers to leave the area, creating large gaps in the health, education and food sectors. This exacerbated the effects of a long history of central government neglect, which was itself an effect of the constant conflicts within and between clans. In Somalia, it is reported that more than 300 health facilities have been destroyed by violent conflicts since 1991. It has few health facilities and many healthcare professionals have fled. Most mobile clinics are operated by international organizations, lack essential drugs and skilled staff, and do not operate in active conflict zones. Ethiopia's health infrastructure has suffered from conflicts that date back to the 1970s, when it relied heavily on 'barefoot' doctors and community volunteers.

Displacement. Large-scale displacement is another effect of war. Displacement in the Mandera Triangle is enmeshed in the region's health, politics, security, and economy. Refugees and displaced populations are particularly at risk from malnutrition and infectious diseases. Their presence complicates access to, and puts strain on, health services and can be regionally destabilizing. The Kenyan Government, for instance, has constantly expressed concern at the security risks it believes are created by Somali refugees in Kenya. Refugees and IDPs often find themselves in competition for resources with host communities. At present, more than 870,000 Somalis are registered as refugees in nearby countries, and over 2.1 million people are displaced within the country.⁸ Reports of high morbidity and mortality rates in refugee camps are linked to deficiencies in food supply and distribution systems, crowding and poor sanitation, insufficient water supplies and inadequate access to medical and health services. Ethiopia's seven Somali regions host 260,000 refugees and more than a million IDPs, which puts additional pressure on their natural and financial resources and on the government's capacity to provide essential services, including medical care.

Sexual and gender-based violence and HIV.

SGBV is more likely to occur in zones of violent conflict because the civil population is more unprotected and those who commit sexual crimes are more likely to escape punishment. Militias and undisciplined armies often treat women and girls as trophies of war, sometimes leading to widespread, even systematic rape. Impunity worsens the incidence of SGBV. SGBV harms survivors physically and mentally; in addition, for psychological or social reasons (shame and fear of stigma, for example), survivors may feel unable to seek help, from doctors, mental health carers, lawyers, the police, or security forces, or their families and community.⁹ In conflict zones, the exposure of women and girls to SGBV increases the spread of HIV. A sizeable literature now links SGBV and HIV infection. Sexual violence can lead to HIV infection directly because trauma increases the risk of transmission. Indirectly, victims of childhood sexual abuse are more likely to be HIV positive and to exhibit high risk behaviours. SGBV perpetrators are also at risk of HIV infection, if their victims have been victimized before. In the Mandera Triangle, a rise in HIV infection rates has been linked to a rise in SGBV. HIV prevention policies should recognize the direct and indirect effects of SGBV on HIV, the need to reduce SGBV, and the importance of understanding and tackling the behaviours of perpetrators.

Mental health. Experts agree that conflicts traumatize populations and damage health.¹⁰ Due to the protracted violence that Somalis have experienced, it is believed that one in three Somalis in the country are affected by some form of mental illness, a far higher rate than the average one in five persons that WHO expects to experience mental illness during conflicts. Many of the refugees and IDPs in Ethiopia's Somali region, who in addition face difficult living conditions, suffer from distress and mental disorders. According to the International Medical Corps, most Somali refugees who develop mental health problems do so because they have lost family members, personal effects, jobs and livelihoods, or have witnessed or suffered extreme violence. In Kenya, Somali victims and witnesses of conflict and

⁸ See more at <https://reliefweb.int/report/somalia/war-and-hunger-somalia>.

⁹ See: https://www.jica.go.jp/jica-ri/research/peace/l75nbg00000bwayb-att/GBV_pamphlet_A4_ENG_print.pdf.

¹⁰ See IRIS (2015), at: <https://www.iris-france.org/wp-content/uploads/2016/11/ENG-Observatoire-Prospective-Huma-NORTHEasternKenya-12-2015.pdf>.

human rights abuses have also been cut off from work and hope of self-reliance, and live in squalid conditions that amplify their trauma. Mandera respondents said that mentally depressed young men are easily radicalized and recruited by extremist groups. In addition, threats of attack against mentally ill persons are likely to elicit an aggressive response from the person's clan which can in turn trigger new conflict.

Malnutrition. Children, girls, and women are particularly at risk during conflicts because of their vulnerable status in society. According to UNICEF, malnutrition persists in Somalia due to prolonged conflict, the collapse of basic social services, and the progressive erosion of resilience. In 2018, more

than 1.2 million children suffered from malnutrition. Field data show that humanitarian actors find it difficult to reach IDP camps in some highly insecure areas of Somalia. In Mandera, conflicts between clans over access to scarce rangeland resources contributed to food insecurity in the region, which was exacerbated by displacement. Many people lost their livelihoods, which worsened malnutrition and caused them to adopt negative coping mechanism (such as charcoal burning). According to UNICEF, many people in Somali region experience chronic food insecurity: this is reflected in high rates of malnutrition in children under five. The 2019 Ethiopia Demographic and Health Survey (EDHS) reported that 21% children under five were wasted - the highest percentage in Ethiopia.¹¹

Confronting health and conflict dynamics: food for thought

Restoring the previous health system is not necessarily the right choice. It can be argued that a health system that was in place before a conflict is likely to have been a factor behind that conflict. Post-conflict rehabilitation should avoid reproducing previous inequities. To be equitable and accessible, for instance, a health service should meet the needs of groups and minorities that were previously under-served. A medical metaphor is applicable: all illness, even an asymptomatic infection, leaves behind an immunological scar. Similarly, disasters, especially violent conflicts, leave behind 'scars'. Human infrastructures are destroyed, demographic patterns changed, new social structures formed, new economic directions taken. Even the natural environment may be permanently changed (for example by landmines). People will have new and perhaps greater expectations, and objective new needs.

Investing in health is investing in peace. Investments in health can reduce the risk of a future conflict as well as mitigate the impact of a conflict that has ended. The governments of countries in the Mandera Triangle have an opportunity to design health systems that can withstand crises and to de-

velop forms of preparedness planning that help prevent conflict. Pushing social services up the political agenda helps to maintain social stability, which can reduce any slide towards militarization in situations where the risk of violent conflict is high. Investing in the health sector makes good sense for conflict prevention as well as socio-economic development. Empirical evidence suggests that health can also promote peace operationally: health services and assets are widely understood to be a shared and universal good, and this means that for conflicting parties health can often be the subject of a positive discussion.

Challenges and commitment. Conflicts clearly present many challenges for government. However, the sheer burden of illness and death that conflicts cause requires governments to strive for peace. It is now a widely accepted principle that, in any crisis, governments must continue to function and be ready to adopt the most suitable operational tools. These include the development of early health intelligence, strengthening technical programmes and capacity, and working through NGOs or beneficiary communities to support pockets of stability.

11 See EDHS (2019) at: <https://www.unicef.org/ethiopia/reports/2019-ethiopia-mini-demographic-and-health-survey>.

Emerging Issues

Emerging Issues

Introduction

This section presents emerging issues that have implications for health policy and practice in the region. They include the COVID 19 pandemic, and regional migration and its coordination by IGAD.

Implications of the COVID-19 pandemic on health practices in the Mandera Triangle

The world is currently experiencing the worst pandemic in recent memory, COVID-19. In the Mandera Triangle, many people do not seek treatment or services, either because some health facilities have been converted into isolation centres, or because the public are afraid of catching the disease in health facilities or have been told not to visit health facilities unless it is an emergency.

Like other countries worldwide, the three countries have taken measures to mitigate the spread and impact of COVID-19. Measures range from closing schools and academic institutions to traveling across borders. School closures stopped the delivery of nutrition programmes in Kenya and Ethiopia; border closures prevented CBMPs from accessing cross-border health facilities.

Governments have been compelled to increase spending in the health sector. However, the additional resources mitigate the impact of the COVID 19 pandemic and do not help to meet other health sector needs. This said, health facilities and schools have introduced additional WASH practices. All three countries are in the process of strengthening WASH programmes in their health sectors. Additionally, Kenya's economic stimulus package (which increased the allocation to the HSNP) will enhance

food and nutrition security among vulnerable populations in Mandera.

The pandemic exposed weaknesses in the health sector in all three countries. It made apparent: severe shortages of skilled staff; inadequate health facilities and equipment; inadequate coordination between health sector actors; and the huge financial challenges that national governments and local and regional and county governments face. In Kenya, extra medical personnel have been hired to bridge the gap but more are still needed. The government also established a national task force to coordinate government programmes to manage the pandemic. All three governments have had to borrow externally to cope with the demand for resources.

At regional level, it is positive that a testing centre has been established in the Mandera Triangle. It can be hoped that this will set a precedent for further regional cooperation on health issues.

All three governments nevertheless face the possibility that their health sectors, already weak, will be overwhelmed by the pandemic. They must act decisively to protect the sector as the region faces a third wave of infection.

Regional migration and coordination

In 2012, IGAD member States adopted the Regional Migration Policy Framework. Among other things, the framework acknowledges the link between cross-border movement/migration and health. It mandates IGAD to address the health concerns of cross-border migrants and other CBMPs, including IDPs and refugees. It recommends that IGAD should facilitate migrants' access to health care services, by: granting them unrestricted access to national healthcare systems; removing cultural or linguistic barriers that prevent migrants from seeking or obtaining treatment, especially for pregnancy, STIs, TB and HIV/AIDS; ensuring refugees and IDPs have adequate access to healthcare even in camp settings; and encouraging governments to include migrants and the needs of mobile populations in national

health policies. It also establishes a Regional Migration Coordination Committee, mandated to coordinate the smooth cross-border movement of CBMPs. IGAD is expected to lobby member States to review and harmonize their labour and migration laws to facilitate free movement of people, pastoralists, and labourers.

At country level, Kenya has started to integrate the Framework in domestic law by drafting a National Migration Policy (2017). However, three years later, the draft law has not yet been adopted. Ethiopia is in the process of reviewing and amending its labour and migration legislation and policies.

Prioritization of Issues/ Recommendations

Prioritization of Issues/ Recommendations

Introduction

This section summarizes the key recommendations of the consultative phase of this investigation. It outlines the main health practices identified by the technical team and other stakeholders, and the priorities they propose for achieving sustainable health services in the region. The findings were validated by Technical Validation and Stakeholder Validation forums held at the Red Sea Hotel in Mandera town from 22 to 26 March 2021. A total of 9 technical team members and stakeholders gathered to hear, discuss and validate the findings. Those who attended included representatives from Somalia, Ethiopia, and Kenya, including senior health practitioners, other officials, representatives of IGAD's Conflict Early

Warning and Response Mechanism (CEWARN), and staff of the Red Cross and international NGOs.

The objective of the forum was to enable the technical team and stakeholders to collectively identify and prioritize gaps in health policy and practice in the Mandera Triangle, and kick start participatory drafting of agreed recommendations. The forum marked the conclusion of the consultative phase of the study, which ran from early February to early March 2021. The technical team and stakeholders at the forum reached agreement on the main health gaps in policy and practice in the Mandera Triangle.

The validation process

To make the process effective, validation was divided into two parts, technical and stakeholder. Technical validation was undertaken by health practitioners and technical members of the team who led field data collection. Stakeholder validation was led by community leaders. The analysis was presented

country by country, since most findings were country-specific. The findings were discussed in lecture and plenary formats. When participants had reached agreement on issues, they posted their views on theme charts. Breakout groups were avoided to mitigate the risk of spreading COVID 19.

Prioritization of issues

The participants and technical team members agreed that the issues below should be prioritized at regional and country level.

| Thematic areas | Short-term Priorities | Priorities |
|---|--|--|
| Cultural and religious practices. | Develop guidelines for traditional midwives and community health workers to improve access to health services in Somalia. Raise awareness among CBMPs of the importance of SRHR and HIV/AIDS medication. | |
| Cross-border coordination and learning. | IGAD should continue to encourage the countries of the Mander Triangle to translate the Regional Migration Policy Framework into domestic law and operationalize the Regional Coordination Committee. Governments, INGOs and other actors should increase cross-border learning from research that has been done. | Develop a regional approach to resource mobilization for common health-related services. |
| Governance and marginalization. | | Construct adequate health facilities and appoint sufficient qualified health staff to run them. |
| Mental health and general well-being of conflict survivors. | Establish Mander County Mental Health Unit. Complete drafting of and adopt the Mental Health Care Bills, and mental health policies in Somalia and Ethiopia. Campaign to increase the enrolment of Mander CBMPs into the Kenya NHIF. | Develop a regional rehabilitation centre for drug abuse victims and/or a regional mental health facility. Establish integrated SGBV recovery centres to which SGBV survivors can go to report complaints, be examined and treated, receive emergency contraceptives, obtain STI and HIV tests and participate in long term prevention measures such as HIV management through ARVs. |
| Women, youth, and participation of vulnerable and marginalized groups. | Involve women and other marginalized groups in policy processes and decision making. | Finance the collection of gender-sensitive statistics in health planning and policy development. |

Recommendations

The following are selected key recommendations from the study.

Improve community–State relations through health

For citizens, the delivery of health care and other basic services is often the most tangible manifestation of national authority and an important factor in State legitimacy. When health care and other services are delivered unequally, State legitimacy can be undermined and the risk of violence increases – especially if particular groups consider that inequities in cov-

erage reflect intentional exclusion, marginalization and neglect by the government. Communities in the Mander Triangle have experienced historical injustices exacerbated by political and socio-economic marginalization. In some areas, lack of access to basic services, including health, has encouraged recruitment into violent extremist groups; in others,

inter-community conflicts have occurred because one community has been marginalized whereas another has benefited from State services.

To restore lost trust, governments need to **increase the quality of health services, and access to them, by increasing the number of health facilities and employing more well-qualified staff**. This outcome implies continuous training of health personnel, and supplying adequate drugs and laboratory equipment, especially to the border regions.

Most respondents, including stakeholders at the validation forum, emphasized that the government needs to adopt a **community-led approach to needs assessment and programming**. This will improve access to health services, as well as their quality and use. Although the regional/county and national/federal governments collect statistics, they tend to be State-led and to lack community ownership. This partly explains why relatively few people use health services and why so many go across the border to obtain services they perceive to be better.

Promoting the mental health and psychosocial well-being of conflict victims

As noted already, conflict causes mental stress and illness as well as psychosocial problems for SGBV survivors. Health experts argue that, if community members are offered opportunities to participate in healing processes they can voice their grievances safely and constructively, and can join inclusive dialogues to overcome social divisions and the physical and mental scars of war, they will become more resilient, able to contribute constructively to reconciliation processes.¹²

To do this, the governments and stakeholders must implement an array of services and initiatives. Stakeholders need to appreciate that complementary approaches are required, using both clinical interventions and psychosocial interventions. The two must be implemented side-by-side. Clinical interventions focus mainly on physical injuries and diagnosis; psychosocial interventions promote mental stability, acceptance and re-integration in the community.

States should run **participatory dialogues** with communities, health practitioners and officials in conflict-affected areas, to understand patients' needs, grievances and perceptions of the health system. **Policy dialogues** should generate **recommendations** to ministries of health on issues of concern to the public and support should be made available to implement them. Specifically, campaigns should be held in the Mendera Triangle to raise public awareness of social health security systems, such as the national health insurance scheme. To address community dissatisfaction, laws and policies on WASH, nutrition and maternal/child health care should be developed and implemented.

The governments should adopt a **community approach to public education**, to address sensitive issues such as family planning, male cancers, HIV/AIDS, and mental health. Campaigns should counter traditional narratives that stigmatize services that treat sexual and reproductive health and rights (SRHR) and HIV/AIDS.

With respect to clinical interventions, it is recommended that the countries should establish:

- Mental health units, fully-equipped with laboratory services and staffed by an appropriate number of qualified well-remunerated personnel, in line with WHO recommendations. The services they offer should be culture-friendly.
- A well-equipped national or regional training institute for mental health.
- A rehabilitation centre for drug addicts and ex-militants, as part of a broader repatriation and reintegration strategy.

With respect to psychosocial interventions, the governments should **introduce sustainable group-focused mental health treatments**, such as interpersonal group therapy or community healing dialogues. In addition, stakeholders in all three

¹² See: <https://www.who.int/initiatives/who-health-and-peace-initiative>.

countries should **promote mental health and psychosocial support by building the capacity** of national mental health networks. To achieve this, the States need to review or adopt laws or policies on mental health that reflect the regional context and extend clinical services to include mental health.

This would mean that services focus also on SGBV survivors, survivors of torture, persons with disability, and victims of drug abuse. The States should establish safe centres in which continuous community dialogues can take place.

Increase the agency and inclusion of women, youth and other vulnerable groups in policy dialogues and decision making

A range of institutional, social, religious, cultural and personal barriers impede women and adolescent girls from participating meaningfully nationally and locally. Without bodily autonomy (the right and agency to make decisions about their bodies, health and reproduction) women and girls cannot control their lives, take part in public life, benefit from sustainable health practices, and contribute to peace and recovery. The exclusion of youth and other marginalized and vulnerable groups from health governance processes can generate feelings of injustice and frustrates their desire for independence and a sense of purpose. It can lead young people to become politically engaged, sometimes in support of violent causes. It is therefore important to **initi-**

ate women-led and youth-led health dialogues, not only to enhance community participation and ownership but to convey clear messages to actors who can influence conflict and peace dynamics, because women and youth represent a larger proportion of society. In its report *Women and Health: Today's Evidence, Tomorrow's Agenda* (2009), WHO advocated **women-led policy dialogue and action in four areas**: (1) to build strong leadership and institutional responses; (2) to make health systems work for women; (3) to leverage changes in public policies (for example, to include women's health in all policies); and (4) to build better evidence and information systems for monitoring progress in women's health.

Conclusion

Conclusion

The Mandera Triangle has a long history of cyclical conflict and insecurity. Years of constant civil war, inter- and intra-clan tensions, and State repression, have severely marked its health sector. The conflict has destroyed health infrastructure, reduced access to essential health services, and exposed an already vulnerable population to high rates of disease and malnutrition. It has also created additional health problems, including high rates of mental illness and SGBV, and a legacy of physical injuries. With limited State funding, the three countries have continued to grapple with policy challenges in the health sector. These challenges have been sharply exacerbated by the COVID 19 pandemic, which forced governments to close their borders and re-allocate scarce health and other resources to tackle it.

Despite these difficulties, some practices in Ethiopia, Kenya and Somalia can be emulated by others. For instance, Ethiopia offers community-based insurance which the majority of Ethiopians can access. It has reduced the direct payments that Ethiopians have to make for health care. Kenya's livestock insurance scheme cushions pastoralists from economic shocks. It allows pastoralists to obtain compensation for livestock that are lost to drought and famine. Kenya also has a hunger safety net program which enables poor and vulnerable people in Mandera and other counties to obtain food and nutrition.

Somalia continues to benefit from traditional social protection practices, directed by traditional and religious leaders.

With respect to policy, Kenya and Ethiopia seem advanced compared to Somalia, which is still grappling with post-war reconstruction. Despite the policy frameworks in place, however, Kenya and Ethiopia experience continued challenges in the health sector. There are gaps or deficits in funding, staffing, the supply of drugs and medicines, and the placement of health facilities. At regional level, IGAD supports the three countries with early warning and detection of potential droughts and conflicts at country level and across the borders. In addition, IGAD adopted a Regional Migration Policy Framework in 2011, and an associated cross-border coordination committee. The committee is not yet operational.

This report makes a number of recommendations at country and regional level. These indicate that health and conflict practitioners and government agencies can still do a lot to enhance equitable access to health services and address cross-border mobility in the Mandera Triangle, recognizing that in the absence of a strong health sector it will be harder to secure stable and sustainable security in the region.

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Kenya Vision 2030

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 Somalia National Reproductive Health Strategy
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 Strategic Framework for the Somali AIDS Response
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 UNICEF Somalia WASH Strategy Note (2018-2020)
 WHO Country Cooperation Strategic Agenda (2017-2019) for Somalia
 Ethiopia
 Constitution of the Federal Democratic Republic of Ethiopia
 Ethiopian Health Sector Transformation Plan (2016-2020)
 Ethiopian National comprehensive & integrated prevention of Mother-to-Child Transmission of HIV (PMTCT) Guidelines
 Ethiopian National Health Policy
 Ethiopian National Health Policy Five-year Growth and Transformation Plan (GTP)
 Ethiopian National Health Quality Strategy (2016-2020)
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 Ethiopian National Mental Health Strategy
 Ethiopian National Reproductive Health Strategy
 Ethiopian National Strategic Plan HIV (2015-2020)
 National Guideline for Family Planning Services in Ethiopia (2011)
 National Strategy for New-born and Child Survival in Ethiopia (2015-2020)

Figure 1. Map of the Mander Triangle.

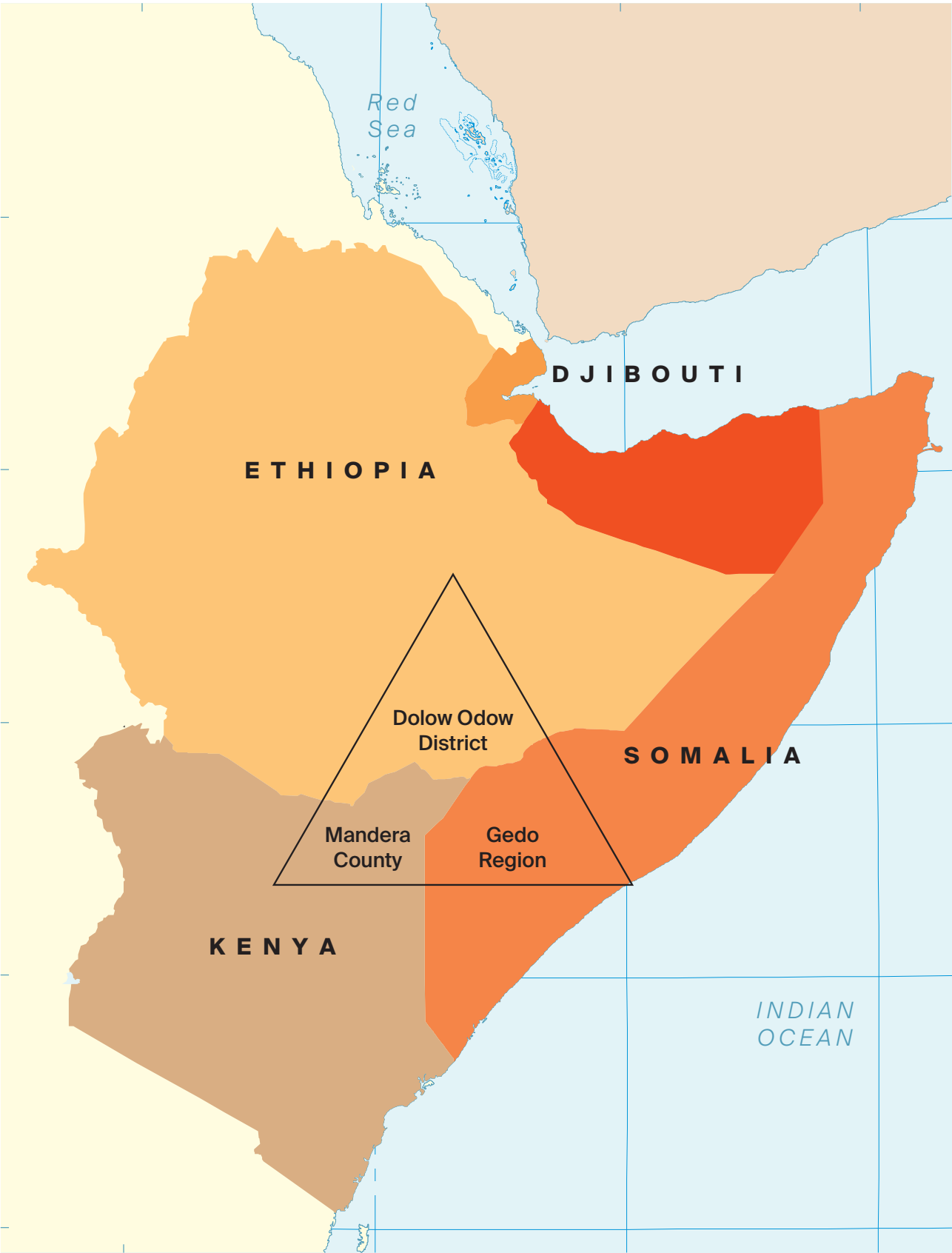


Table 1. List of health facilities visited.

| Ethiopia (Dollo) | Ethiopia (Mubarak) | Somalia (Dolo) | Somalia (Elwak) | Somalia (Belet Hawa) | Kenya (Mandera) |
|---|-----------------------|------------------------|--------------------------|----------------------------------|-------------------------------------|
| Dollo District Primary Hospital (Dollo Ethiopia) - CB | Mubarak Health Centre | Dolo RHC | HDC – Health Centre | District General Hospital (Town) | Mandera Wellness Hospital (private) |
| Kola Health Centre | Jara Health Centre | Ged Wawe Health Centre | SRCs -MCH | | Mandera County Referral Hospital |
| SUF Health Centre - CB | Eymole health post | Reveri mobile outreach | ARD – MCH | McH (Town) Belet-Hawa | Neboi dispensary |
| Wadahuba Health Centre - CB | Mubarak health post | Kokey PHU | Dhibayu HP -cross-border | Belet Hawa mental health | Burabor dispensary |
| Rhama Health Centre CB | | Dec Rebe PHU | Dhoqa HP - cross-border | | Shafshefey Health Centre |

Annex: Questionnaire

INTERPEACE

Consultancy to Conduct Cross Border Health Policy and Practice Analysis in Mandera Triangle

QUESTIONNAIRE FOR KEY INFORMANTS

Note to Data Collection Enumerators:

- Uphold ethical considerations at all times during the exercise
- This questionnaire is meant to collect data from key stakeholders in health sector, including national, international and inter-governmental organizations working on health

Interview Partner (Name, Position):

Institution:

Country and region:

Contact Details (Address, Phone, E-mail):

Primary Role of the Institution:

Note for the Interview Partner:

Use of data: This questionnaire is used to collect important data to find out the general gaps in health policy and practices in responsiveness to the needs of CBMDs and the conflict dynamics in Mandera Triangle. The collected data will be analysed and summarized in a general final report.

Confidentiality: Your information will not be used for any other purpose than for this study and your name will not be revealed in connection with this interview.

1 What is your main area of service?

| | |
|---|--|
| 1 | General medical service and management |
| 2 | HIV and AIDS |
| 3 | Food and Nutrition |
| 4 | Water, Sanitation and Hygiene (WASH) |
| 5 | Sexual and Reproductive Health (SRH) |

2 Are you aware of any policy that guides your work/interventions? If yes, name the policy document(s).

3 What infrastructure is in place for your services? Are they adequate? If no, explain

4 Which among following the cross-border mobile populations (CBMPs) does your institution serve?

| | |
|----|--|
| 1. | mobile pastoralist looking for pasture; |
| 2. | refugees; |
| 3. | seasonal cross-border laborers, |
| 4. | persons engaged in cross-border economic activity; |
| 5. | undocumented migrants; |
| 6. | internally displaced persons (IDPs) |
| 7. | Communities hosting refugees and IDPs. |

5 Do you consider the cost to the services affordable to the target population? Explain

6 Do you consider the services accessible in terms of distance and sensitivity to vulnerable groups? Explain

7 Does your institution/facility have core personnel needed to render services? Explain

8 What is your experience working with government officials / CSOs from neighbouring countries on service provision?

9 Is there any policy or guidelines that you rely upon in joint operations with neighbouring countries? If yes, name the guidelines/policies/strategies etc.

10 How do you manage referrals from and to other countries?

11 How do you coordinate on patient repeat testing, tracking and monitoring from one country to another?

12 Do you or your staff undergo regular trainings on handling your target population/CBMPs? If yes, explain how regular and types of trainings?

13 Do you have equipment for testing samples? Explain.

14 How do you manage constant supply or drugs/services/stock?

15 Are you aware of any inter-country cross-border coordination policies or agencies?

16 Are there any occasions when you receive and attend to patients from neighbouring countries?
