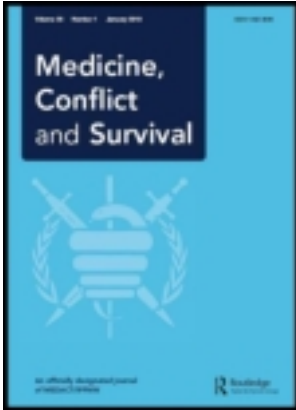


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COMMENTARY

Post 9/11 Somalia: the strategic role of health systems strengthening in global security

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Introduction

The events of 9/11 precipitated a reappraisal of international policy in almost every field of practice and in every corner of the globe. Much of the publicized consequences has been of the military agenda of the United States, United Kingdom and the NATO coalition in Iraq and Afghanistan. However, elsewhere in other fragile states international intervention and its impact on health have been profoundly shaped by 9/11 but often in a less militaristic fashion.

Somalia is a country of particular international significance in the post 9/11 era, as a hotbed of Islamic fundamentalism, the cradle of international maritime crime and a seat of some of the most horrific parameters of human ill-health (WHO 2010). In view of the strategic importance of Somalia for international terror networks there has been sharpening of the global focus on development and stability in the region since 9/11. It is against this backdrop that we analyse the significant incremental improvements in healthcare in Somaliland to see how 9/11 impacted on Somalia's place in the international policy arena, what influence this has had on health and to reflect on the possible impact of health systems strengthening in the region on future global security.

Many commentators considered the situation in Somalia to be amongst the most intractable in the world. Al Shabaab's withdrawal from Mogadishu in early August 2011 therefore was as much of a surprise to governments as to NGOs. The insurgents, for years the controlling force in economically

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important parts of the capital, left the city under fire from the African Union (AU) in trucks in the manner of a withdrawing army. The situation remains unclear today, though Al Shabaab claim to have made a tactical withdrawal for longer term strategic purposes. Indeed, at the time of writing (August 2011) the AU were yet to take full control of the area evacuated by the insurgents. The withdrawal comes at a time when East Africa is facing what many suggest may become one of the worst famines in modern times. At the same time, security experts note that Al Shabaab's financial stream is under pressure. Recently, Al Shabaab has struggled to respond to the famine. The insurgents prevented international NGOs gaining access to the areas they control, and without credible plans to alleviate hunger, their popularity has dwindled.

Somalia's future remains in the balance, but one part of the country – Somaliland – gives a glimmer of hope for improvement. Before we explore this in more detail, we will give a brief overview of the variety of issues that create this instability in Somalia.

Political stability

Kilcullen (2009), an anthropologist, soldier, and former head counter-insurgency advisor to the US military, describes a model for the transmission of insurgency between disparate peoples. As with the pre-9/11 world, in his model insurgencies typically develop for traditional, locally generated reasons. However, globalized communications and media facilitate remote transnational agitators infecting the area, and transposing a radical global narrative onto the local problems. Foreign fighters bring with them expertise in fighting, propaganda and access to supply chains for the arms and technology of guerrilla warfare. Moreover, these globalized insurgents have an agenda to export their insurgency further afield.

The Somali experience fits this model closely. Post-independence Somalia has experienced a series of complex violent conflicts, most often arising through inter-clan rivalry, with a large number of governance, economic, resource-based, militarized regional conflict drivers (The World Bank 2005). Over decades the nature and composition of the principal protagonists in these conflicts has changed. Somalia has suffered from a lack of functioning government since 1991. Poor civil infrastructure, the threat of violence, an extensive internally displaced population, and the failure of the AU to run an effective peacekeeping mission in Mogadishu have created a power vacuum (The World Bank 2005). After 9/11 up until August 2011, the Islamic Courts Union (ICU), later succeeded by Al Shabaab, established theocratic rule in significant parts of Puntland and South Central Somalia, including the capital Mogadishu (The World Bank 2005).

Global threat

Post 9/11, the situation in Somalia has led to a number of individuals from the country committing acts of terrorism in countries throughout the East African region, often specifically against the West. Al Qaeda has claimed the acts were committed in support of its regional and global strategic objectives (BBC 2010). The impact on international trade networks and Somalia's role as an incubator and exporter of terrorists and transnational insurgents, means that Somalia's future, and that of other failed states, is of global importance. Whilst the burden of human suffering alone may not have been sufficient to permeate the consciousness of international policy-makers, the economic threat of piracy and, since 9/11, the safe haven for fundamentalism provided by Al Shabab, have refocused global attention.

Piracy

Piracy is estimated to have cost the global economy between \$7 and \$12 billion in 2010 (Bowden 2010). Off the coast of Somalia, these costs extend to the payment of \$238 million dollars in ransoms in 2010, deployment of expensive security vessels (\$2 billion per annum), insurance excess (\$460 million to \$3.2 billion per annum), diversion costs (\$2.4 to \$3 billion per annum) and a reduction in trade for countries in the region (\$642 million, estimated cost to Egypt). Moreover, despite the palliative attempts of the international military in Somali waters, this is a problem which is unlikely to disappear until stability is achieved on land.

External investment

In part because of these threats, international aid to Somalia is significant. The UK's Department for International Development (DFID) currently has 44 active projects in Somalia, at a total cost of \$100 million – a level of spending which has been fixed until 2015 (UKAID 2011). USAID spent \$228 million in Somalia in 2008 alone (Global Humanitarian Assistance 2011). Both countries prioritize funding projects which encourage the development of stable government over humanitarian and health projects. Stripping inflation from the figures, total aid to Somalia has risen significantly from \$103 million in 2001 to \$683 million in 2009. This equates to \$75 per Somali citizen, making Somalia amongst the top 10 largest recipients of aid on the planet.

The security situation in South and East Somalia has severely limited the overt non-military options available to external governments to influence the development of Somalia. In South Central Somalia and Puntland, Al Shabaab has declared war on the UN peacekeeping mission and the small number of NGOs that operate in the area (Anderson 2009). Unfortunately, South Central Somalia is heavily reliant on committed programmes of

healthcare delivery from Médecins Sans Frontières (MSF) (Médecins Sans Frontières 2009). In view of the precarious security situation MSF, UNICEF and other international organizations rely mostly on local Somali staff supported remotely by colleagues in Nairobi.

Health

The result of all this means that health inequalities in Somalia, even compared to other parts of sub-Saharan Africa, are profound. Average life expectancy is 48 years; one in seven children can expect to die before their fifth birthday, and maternal mortality is amongst the highest in the world at 1044 per 100,000 (UNICEF 2009a). There are fewer than 0.5 physicians per 10,000 population (WHO 2010). The problems are compounded by the migration of the already limited healthcare workforce, and the perpetual security risk to the healthcare infrastructure for delivering services.

Health systems strengthening

However, there is a glimmer of optimism. Somaliland, a relatively stable autonomous region in the northwest of Somalia, is a paradigm for hope in the country and a rich source for learning how the situation could be improved. Somaliland has held recent free and fair elections and has relative economic and political stability. Within the health sector, two new medical schools have opened within the last decade, a strong Nursing and Midwifery Association has been developed, five functioning nursing schools created, and a new internship programme to support the first locally trained doctors in the region's history has begun (Leather 2006). Its relative security makes Somaliland a rare attractive prospect amongst fragile states for the international health systems strengthening effort. As a region which is sufficiently stable for NGOs and foreign governments to support capacity building, major external investments and substantive bi-lateral partnerships have formed.

In healthcare, this relative political stability has taken place in three principal pillars: strengthening health institutions, delivery of an essential package of health services and training of qualified healthcare professionals (Leather 2006). The WHO has created a strategy for mental health; worked towards the provision of sexual health services for internally displaced people; and created a landscape map of the health system architecture in the region (Ahmed 2002). UNICEF continues to run operations for health, nutrition, sanitation and child education in the region (UNICEF 2009b).

The creation of health-related links has played a vital part with the formation of partnerships with local health or education institutions at the Ministry of Health, the Somaliland Medical Association, and the medical schools at Amoud and Hargeisa universities (Leather 2006). The

King's – THET (Tropical Health and Education Trust) Somaliland Partnership has worked for a decade to apply the expertise of a network of northern partners to local problems in a responsive collaboration with local people. Funded by DFID, the internship programme for government sector doctors is now in its fourth year (and has trained 36 doctors); the nursing schools have increased their capacity (124 nurses trained at Hargeisa Institute of Health Sciences alone) and the medical schools continue to grow. Recently, innovative technology has been applied to support collaborative educational partnerships focused on the sustainable transfer of clinical knowledge between the UK and this fragile state (Finlayson 2010). For over two years, an international faculty has logged on to deliver weekly live 'simulated' bedside clinical tutorials to every graduating doctor in Somaliland, and separately to every final year medical student at Boroma and Hargeisa Universities. The weekly rotation of medicine, surgery, psychiatry, obstetrics and gynaecology and paediatrics provides the only structured postgraduate education in the country. These programmes perhaps go some way to responding to calls for the western healthcare workforce to repay the debt of gratitude for the influx of healthcare workers to western health systems (Crisp 2007). Nevertheless, residual problems with the (prohibited) loss of workers to the private sector, postgraduate training deficiencies and lack of sustainable funding will require new solutions in the coming decade.

Conclusion

Somalia's problems are of substantial global importance in the post 9/11 world. Moreover, 9/11 created the political impetus to support the rebuilding of Somalia. Regional differences in stability have facilitated the implementation of some international long term attempts to strengthen the health system in parts of the country with some degree of success. Such strategic health capacity building is seen as one of the essential cornerstones of recovery in a post conflict country (Collier 2008). As such, there is some hope, given the geographic, linguistic and cultural proximity of Somaliland to the rest of Somalia, that emerging best practice can spread from its foundations in Somaliland into perhaps the most precarious healthcare system in the world.

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