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“Getting the most out of it: Nomadic Health Care Seeking and the State in Southern Somalia”

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Getting the Most Out of It

Nomadic Health Care Seeking and the State in Southern Somalia

Bernhard Helander

He was perhaps twenty-five years old and gave a very shy impression as he was trying to avoid the strong light from the petromax lantern by standing in the doorway to the pharmacy. His clothes and style of hair revealed that he was a camel herder on a temporary visit in the town. He tried, unsuccessfully, to call the attention of the pharmacist. His "psst-psst" drowned in the noise from the street, and finally he stretched out his stick and tapped lightly on the counter. "What do you want?" the pharmacist retorted. The boy hesitated first and looked down at his sides. Eventually he said: "ten pieces of the medicine for malaria and pain, and four of that blue and white one". He handed over the money and put the ampicillin capsules and the aspirins in a small plastic bag that he slipped into his army belt and disappeared in the darkness outside the pharmacy...

To approach state-nomad relations is a challenge for medical anthropologists. While political economy approaches have recently seen renewed applications in the field of primary health care (Donahue, 1989; Morgan, 1989); the other level, that of local people, is easily left out. The real difficulty is to concentrate on the linkages, the channels of communication and the various perceptions that actors on different levels have of one another (Dahl & Hjort, 1984; ISCS, 1988; Scheper-Hughes, 1989).

Medical anthropology focussed on the interaction of different health systems and development of primary health care, has over the past ten years or so, generated several shared assumptions, many of which have been proven empirically sound. One of these assumptions, that has a direct bearing

on issues I shall bring up here, is explicitly formulated by Arthur Kleinman as a shift of focus away from the idea that governmental agencies and authorities are the ones who organize health care for people (Kleinman, 1980). Rather, he says, it is people themselves who activate the health care resources they want to make use of and who discard other facilities that they see no need for. Thus, the perspective put forth by Kleinman and many others (e.g. Bloom, 1985), is one that attributes a considerable amount of agency to local people. There is little in agreement between this picture and the traditional view of the health care system in a developing country, with the Ministry of Health at the top of a neat diagram that branches out in different sub-departments and offices with the health workers at the bottom.

However, as health care is assuming the character of an international commodity (Elling, 1981; Justice, 1986) a perspective that only gives attention to the lowest level of a health care system, easily overlooks factors that lie outside the realm of rural peoples' control. In this paper, I shall therefore attempt to maintain a dual perspective: to see the local events in the light of national patterns of health care, and conversely, to use rural patterns of health seeking to shed light on problems in the organization of national health. I shall do so by presenting case material from southern Somalia, and in particular the agro-pastoral population of Bay region.¹ More specifically, I shall discuss some of the factors that affect the character of health services for nomadic pastoralists, e.g., the spatial dispersion of the population, the seasonal mobility, and the special difficulty of establis-

hing workable reach-out mechanisms for a continuously shifting population (cf. Haraldsson, 1979; Mayer, 1985). While my emphasis throughout the presentation is on grass-root events and the micro-politics of health care, I shall, as mentioned, try to frame my discussion of the local level, by a consideration of the national environment of health policy guidelines and the political and economic constraints within the public health sector.

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The State And Health Care In Somalia

As primary health care became the catch-all for health development towards the end of the seventies, Somalia adapted its health policy to the new donor situation that emerged. It has been remarked how some of the poorest countries were those that most rapidly and completely sought to approach the Alma-Ata declaration in their national health designs. It has also been suggested that this fact not necessarily reflects the strength of primary health care as a strategy, but is more an indicator of the dependency of foreign aid and the need to adapt to what is held fashionable within the donor community (cf. Justice, 1986:61; ISCS 1988:5). With or without primary health care as a leading concept for Somalia's health policies, the centralization of resources to the hospitals of the capital, Mogadishu, has remained throughout the eighties (Bushkens, 1986).

The Public Health Sector

Several factors have contributed to the extremely poor state of primary health care facilities in Somalia. In Somalia, as elsewhere, it has been very hard to convince physicians to work outside of the capital or major urban centres. While, for a while it appeared that nurses were more willing to take up rural assignments, there are many examples of how they found trying to cope with the workload that would have required two physicians, unbearable. A very orthodox educational system for the doctors also bears some responsibility for the acute shortage of doctors outside the capital (Farah & Bushkens, 1987). The faculty of medicine is paid for largely by Italian aid. Part of that deal is that nearly all teaching and literature is in Italian, a language uncomprehended by a majority of the students at the commencement of their studies.

In this cursory glance at the primary health care system of Somalia, it certainly also pertinent to mention the fragmentation which has resulted from the donors' division of the country into regions of primary concern. The country is literally a chessboard where every region has its own particular donor. Populationwise, these regions are little more than lines on the map, so the reasons for this division remain obscure. Now, primary health care is not supposed to suffer from lack of coordination. Primary health care is, in essence, supposed to be synonymous with decentralized, non-bureaucratic, local health initiatives. However, in practice, much would be easier if one organization had at least a basic understanding of the agenda of the other. For one thing, it would be easier for staff on intermediate levels to take up work in other regions if the systems for filing reports and ordering equipment were similar within the different organizations.

What Elling refers to as "brain-drain" is increasingly becoming an effect of foreign aid at all levels of the Somali governmental health system (Elling, 1981). Scholarships to American and European universities are necessary to develop a national medical research potential. However, in periods of political crises the most important aspect of scholarships is that they offer a one-way air ticket. After 7-8 years of involvement at a

foreign university, and with chances of continuing a burgeoning academic career, few MDs feel prepared to go back to an uncertain future.

The instability of Somali financial politics has also had a more direct impact on health projects. During the mid 80s, a successful Essential Drug Programme was begun in several regions throughout the country. The idea was that the sale of a limited number of drugs would help finance import of new drugs. Although the retail system set up by UNICEF in cooperation with other donors worked smoothly, the programme was halted due to the lack of foreign exchange in the banking system (cf. Snell, 1986). The fact that, in 1986, only 1.3 percent of the recurrent government expenditure was on health care, is another aspect of financial politics with a direct and negative effect on health care (LaPin, 1987).

The Private Health Sector

What I have given attention to thus far only amounts to a tiny fraction of the structural and political constraints that inhibit the development of a primary health care system in Somalia. There is yet another type of problem to consider: practically no one employed in the public health sector can make a living from their salary. The effect of this is that the disintegrating public health sector is becoming replaced by a vibrant private health sector; where mother-child health centres are literally falling to pieces, fully equipped private clinics grow up in the same block; where a PHC-nurse (Primary Health Care, ass. ed. comm.) has struggled for years to have a building to receive patients, a privately run pharmacy all of a sudden offers that possibility; when under-staffed government laboratories have to stop receiving samples by noon every day, the private laboratories become a viable alternative. The people employed in these private enterprises are largely the same as those employed in the public health sector. Many of them are able to use their public employment to recruit patients to their private clinics. They work, say, during the morning in the government clinic, and they inform the patients that the clinic is badly equipped and lacks the proper pharmaceuticals, statements that in

most cases are true. Instead, the patients are encouraged to come to visit them in their home or private clinic in the afternoon or evening. The system works largely in the same way both in large cities, like Mogadishu, as it does in rural towns like Baydhabo or Beled Weyn.

There is much to be said about the growing private health sector. Its growth is certainly uncontrollable and, at present at least, it does not seem to offer an organizational structure that could be of interest to foreign donors. On the other hand, it is self-sustaining and does actually offer health care to people who otherwise would not have any. One should also be careful to underline that private clinics do not overcharge their clients, nor do they generate huge profits. Furthermore, without the existence of the private health sector, the public health sector would be jeopardized. Unless health workers were able to generate some income from their skills elsewhere, most government clinics would probably have to close completely. In a way, therefore, the private health sector is what guarantees the continued existence of the public health sector.

One may wonder why public health workers bother at all to remain publicly employed. That they can convince patients to visit them privately cannot be the only reason. Certainly in the case of physicians the ambition to maintain academic ties are important. For other types of health workers their reasons for remaining in the public health sector are different.² I suspect that the considerable prestige that goes with simply saying "I am a government employee", (*dowleddaan u shaqeeya*) is at least part of the answer. In a way, to be employed by *dowledda* (the government) is also to have a share of their power.

The Medicinalization Of Rural Health Care

As I have indicated, privatization in the forms I have described are mainly phenomena of urban centres. While private initiatives in health care seems to be gaining ground in rural areas, too, the sentiments against a misuse of a "government position" seems to be stronger there. The social control of health workers that are neighbours with their patients seems to counteract

anything like a full privatization of their services.

Unfortunately, the form of private health initiative that spreads most rapidly in the rural areas appears to be of the least wanted and the least needed kind: the uncontrolled sale of pharmaceuticals. The reasons for that involves the local attitudes to modern health care, and I deal with them in a separate section below.

However, another reason is to be sought in the booming pharmaceutical retail business of Somalia. Every donor that has operated health projects in the country has apparently felt it necessary to set up their own supply system for drugs. Eventually, as projects terminate, only the drugs remain and, in the end, they find their way into the open market. Needless to point out, this has created an enormous surplus of drugs, a sure sign of which are the comparably low increases of drug prices during the past five years.

Black marketing is not the only source of pharmaceuticals. As the illicit khat trade increasingly becomes concentrated to fewer and fewer hands and the army involvement in it increases, the legal import of drugs from Kenya has begun to stand out as an attractive, and less risky, alternative. People seem to have come into the drug trade from other types of business, too. One extremely successful pharmacist in Baydhabo, for instance, is a former livestock trader who claims to have entered the business because of the increasing difficulties on the livestock scene.

Pharmacies that ten years ago used to found only in urban centres, are now spreading into the countryside (LaPin, 1987; Lore, 1985). In Bay region alone, there has been a 400 per cent increase of pharmacies between 1980 and 1988 (Helander, 1989a). Pharmacies have also begun to develop into more complete health centres. Many of them cooperate with physicians who receive patients in an adjoining building. They also offer laboratory facilities, sometimes surprisingly advanced. Pharmacies in rural towns with a small stable population and a continuous influx of nomadic herders and visitors from agricultural villages in the region, have also come to serve as means of innovation in how rural people think about health and disease (Helander, *in prep.*;

Serkkola, 1990). Towns like Baydhabo have strong rural ties. Daily life within them, evolves around the livestock market and the markets for agricultural produce. A visit to the market tends to be combined with other types of purchase - including a visit to a pharmacy. For rural visitors, the competence of pharmacists is not restricted to human health. *Kabsuls*, i.e. various types of antibiotics, are seen as equally effective for animal diseases, and they are frequently obtained for such purposes. Townspeople have large assortments of jokes about rural peoples' attitudes to medicines. They regard some of the rurally invented names for popular drugs as particularly funny. Tetracycline capsules, for instance, are called *Abu Fullay* by the nomads, suggesting that this red and yellow capsule is the fruit of the slightly reddish Fullay tree.

The booming medicine business is also affecting the practitioners of traditional medicine. Somali traditional doctors are increasingly looking towards their successful colleagues in the pharmacies, and at least one traditional surgeon in Baydhabo does, himself, keep a small supply of drugs.

The picture I have painted of the public-health sector may seem gloomy. However, the economic constraints and political problems do not seem to be conducive for any development of primary health care.³ Adding to that the possibility that Somalia may have jumped on the PHC-train too quickly to allow the necessary transformation of medical education and infrastructure, the pessimism appears warranted. To be sure, the private health sector offers alternatives, but their commercial character and emphasis on curative treatment, and in particular the focus on drugs, corresponds badly with the preventive aims and self-help profile of primary health care proper.

Health Care In The Country Side

The Character Of Rural Health Services

There are few rural areas of Somalia where primary health care functions according to intentions. In theory, every local communi-

ty should have a health committee that organizes logistics for the local health post, arranges the salary of the health worker and transportation for pharmaceuticals and for patients that are referred to district or regional facilities. I have personal knowledge of two southern Somali regions where the health committees have run into similar types of problems. While the idea of community financed health care is basically sound and would appear implementable in southern Somalia it has not been attempted on any larger scale. The effect of that is that communities have remained dependent of outside, primarily state input. Many people have, therefore, come to regard Primary Health Care as yet another one of an endless series of projects that foreign governments and the Somali state have come to offer them. Since PHC has a low-budget profile and focuses above all on preventive health measures without any expensive equipment and with a minimum of input of drugs, it gives PHC projects a rather scrappy appearance, in particular, when compared to more expensive-looking projects carried out simultaneously. An enormously successful TB programme, for instance, is set up as a referral system, parallel to, but independent from, the PHC structure. It is also funded differently through a bilateral agreement between FINNIDA and the Somali government, while the PHC programme in the same regions is run and funded by WHO.⁴

There are many reasons why health committees have failed. A basic problem is that they are entirely absent in most cases, and in other places have misunderstood their functions. In one village, one of the elders told me that a group of men had been assembled by a visiting team from the ministry of health. The group had been rather haphazardly assembled, but as many of the participants had been men with a recognized standing, they had thought this was the reason they were called upon. They had been told that they should form a health committee (*guddiga cafimaadka*) to help the PHC nurse that was coming to the village. Apparently they had not conceived of that responsibility as something which extended beyond the context of that meeting.⁵ During the meeting they allocated a piece of land for the house that was

needed, but they have not assembled again never since. The non-existent nature of this particular health committee was a continuous complaint that the PHC nurse in question had.

I must pause here to point out that there is an implicit delusion in the perspective I have advanced. By, thus far, portraying the problems of health care as if they were only problems that could be solved by re-organization, better salaries, smoothing the coordination of different donors etc., I have also assumed the perspective that is most readily available to those with the decision-making power within the state apparatus and within agencies. To put it differently, problems in health development are usually treated as if they were problems that could be solved with minor organizational adjustments or administrative skills.

In one of the most penetrating anthropological studies that has been made of health care planning, both in a national and international context, Justice has recently pointed out that the question is rarely what sort of socio-cultural information that might be needed to address a particular problem, instead "social scientists are hired to fulfill policy mandates and not because senior officials have a real commitment to them or their potential contributions" (Justice, 1986:137).⁶

Yet, there is another perspective that can and must be advanced: that of the users of health care. It is erroneous to assume that people in the rural areas, whether they are nomadic or settled, are just passive recipients of health care and that they will just gladly receive whatever is given to them. On the contrary, people in the villages and in the pastures make an active selection among the output of health resources. Their perception of their own needs and their estimation of the ability of various alternatives to respond to that perception, is what in the final instance determines the outcome of health programmes. To appreciate that point, we need to dive into the processes of decision-making within communities and families and outline the various factors that affect peoples' health seeking behaviour.

The People Of Bay Region

Bay region lies in the central part of sout-

hern Somalia. Ethnically it is populated by two groups of Somali clans, the Digil and the Rahanweyn, that speak a type of dialects often referred to as Af-May. The total population of the region can be estimated as being around a million. My primary concern here is with the people of one clan of the Rahanweyn clan cluster who call themselves Hubeer after their founder, or use the name of their locality, the people of Ooflaawe. The Hubeer, in similarity to the majority of Rahanweyn clans, practice a special combination of agriculture and animal husbandry. Around their villages they grow sorghum, maize, some fruit, and beans. Their livestock, consisting of camels, cows and small stock, are for the most part of the year herded southwards in the Dooy pasture that the Hubeer have to share with a large number of other clans, and even farther away in the Shabeele river valley.

However, not all people migrate with the animals. The most frequent arrangement is that one part of the family, e.g., a younger brother and his family, or the sons of one wife, has the primary responsibility for the animals. Another section of the family will then have the farm as their principal responsibility. The effect of this type of arrangement is that even herders who engage in long-cycle herding activities that may keep them away from their villages for a year or more, still regard the village where the family field lies as their "home".⁷

The Process Of Health Seeking

I have, thus far, paid considerable attention to PHC and private health care facilities. Yet, the primary decision that people make is not whether they should utilize the PHC system or not (cf. Thomas, 1982). The decision to seek *any* kind of assistance outside of the family is preceded by a series of activities that involve a widening sphere of family-members, neighbours, relatives and experts. There are studies from the USA indicating that more than 90 per cent of illness episodes take place outside of contact with medical professionals (Kleinman, 1975). For developing countries like Somalia, and in particular among nomadic portions of the population, this figure is by necessity much higher. In this section, I shall attempt to summarize some of the general

tendencies in health seeking. I must also point out that while my presentation here is in sequential, almost chronological form, in reality things are, of course, much more complex.

There is no uniform pattern of health seeking that all families resort to. On the contrary it matters a great deal who the sick family member is and what the family's circumstances are. One thing, however, is obvious; whatever steps that are later taken they are always preceded by discussions that involve all adult members of a household.⁸ The decision-making power may be differently allocated between husbands, wives and grandparents in different families. Yet, it is this sphere of people that assigns a tag, or illness label, to the symptoms that have been identified. If later on one decides to seek some form of professional assistance, the illness is presented by the illness label, not by giving a detailed account of the symptoms. Occasionally an illness label is constructed by singling out one of the symptoms that appears particularly important, like fever or diarrhoea.

It is essential to underline that individual family members regard the consultation with one another as a necessary step in combating illness. For instance, a young woman that I asked what she would do if her child got sick and neither her brother or husband was around, responded that in that case she would just sit idle until her child was dead. Her response was exaggerated because women are all the time faced with crucial health decisions that they have to act upon without other family members. Yet, they are never completely alone, but belong either to a village neighbourhood or a herding camp with other women to ask for advice. However, I do not think that a man would have answered in the same way. Although I have seen a large number of men who, when they fell ill, were completely dependent on their wives, the cultural ideal of a man's role, in the context of illness as well as in anything else, is that he should display decisiveness and ability to act independently.

In the initial stages of a detected illness, it is very common to apply different forms of dietary treatment. These may vary from the simple elimination of a kind of food, like salt or fresh milk, to more elaborate

diets like eating the meat of porcupines or soup from the backbone of camels. During the period when such treatments are applied, neighbours and relatives often come by to give suggestions about particular aspects of the diet or to express their sympathy. It is when dietary and other forms of home treatment fail that outside expertise may be called in. In the illness stories that I have collected, there were principally three different ways to consult with traditional and biomedical experts.

One way is to go to a healer who happens to have a relation with the family. He will be informed about the illness label that the family has agreed upon, but it has a subordinate role for the selection of therapist. What matters is that he is someone known and trusted by the patient and the family. His response will naturally vary depending on what type of therapeutical tradition that he represents. However, in the case of herbalists and religious healers, they will as friends or relatives of the family offer some treatment without charging anything. If the contacted person is a pharmacist or has some other type of connection to modern medicine, it is less likely that the treatment will be free. I should add that I came across some cases where a family had not turned to a healer although he was a close relative. The reason for this appeared to be that they regarded themselves as being in debt to that person because of previous favours he had given them. To offer him money was out of the question as it would have been considered rude.

There is another way to approach healers where the illness label has a more guiding role. There are some categories of illnesses that suggest their own therapy, as it were. If the family believes that the illness is due to an attack of spirits, for instance, it is likely that a religious healer will be contacted. For many of the most common infectious diseases it is herbalists instead that one consults primarily. In the case of some respiratory disorders, it is, instead, a so-called "Somali doctor", i.e. a traditional surgeon, that one turns to. Conversely, for wounds, cuts and fractures modern medicine is extremely appreciated. In the records from the hospital in one district centre it turned out that for the past two years no other type of illness had been trea-

ted. There is a variant of this approach to healers that, increasingly common, consists of purchasing pharmaceuticals from a drug vendor or pharmacy. In such cases the request will simply be for medicine against "malaria" or "pneumonia", or whatever the illness label might be.

A third way of seeking help from experts is to present the expert in question with the patient, account for the history of the illness and then hope that something will come out of it. It is interesting to point out that this is the way that, for instance, Swedish patients normally approach medical care. However, in my data this only occurred when everything else had failed or when one felt completely at a loss about what to do.

The Problem Of Distance

Even during such long periods of absence, the herding portions of families are never completely out of touch with those who remain behind. Verbal messages and letters are frequently carried to and from the home villages and the pastures by neighbours, friends and relatives. To what extent these channels of communication are utilized to pass on health messages is difficult to determine. I know of some cases where herders sent messages to their family that one of them was sick. Correspondingly, families may occasionally call back a young herder when a family member is severely ill.

However, in most cases, distance to home villages has a clearly negative effect on the health care facilities open to herders. It is extremely rare to terminate grazing just to allow for a sick member of the herding encampment to return to the home. Often this is simply not possible because as waterholes begin to dry up towards September-October, the routes open for migration are limited to more densely populated areas with drilled wells. Taking a herd of animals through such an area, while avoiding upsetting farmers by having one's animals walking astray, is hardly an ideal task if one of the herders is sick. Rather, consultation with PHC facilities are postponed until it is necessary to return, anyway. By contrast, it is interesting to note that I have come across some cases where herds were being returned to home villages because an

animal was sick.

The reasons for this do not only relate to the distances that may separate a herding encampment from health workers. Rather, as far as modern health care facilities are at all being considered, all herders that I have discussed this with, stated that they would primarily turn to those available in the home village or its vicinity. Naturally, it also happens that when they graze in areas where other close relatives live, these may be consulted and asked to assist in approaching a doctor or nurse. Yet, to go on one's own to a PHC in the vicinity of where one is grazing does not really seem to be an alternative. It is extremely significant that this hesitance to seek active professional assistance outside of one's home area, is not paralleled by similar reservations to purchase drugs. On the contrary, herders tend to be well-equipped with pharmaceuticals and frequently apply these both to themselves and to their animals.

Another, and perhaps even more important reason why herders abstain from health care, relates to what I described above about how families discuss health matters internally before taking any contact with healers. Cut off from those expected to assist with advice, postponement of any action probably appears most rational. Distance is also a problem relative to the time of the year (Chambers, 1979). Thirty kilometres is not far to walk in the light showers of July, but during the heavy rains of May, even three kilometres can be exhausting. If one is driving animals, there are areas with soil that simply cannot be traversed in the rainy seasons.

The problem of distance is also sometimes a problem of transportation. To arrange to have a sick person taken to hospital involves some costs. It happens that truck drivers refuse to take on sick persons or demand a higher fee for these, because if they are lying down they will take up positions that could be filled with more passengers. Also, the costs involve more than just paying for the ride to the hospital. Someone has to accompany the person there, and they need to bring their own food for the time they estimate to be staying there.¹⁰ Preparing sorghum for the consumption of two persons during two weeks is heavy

work when it has to be carried out in addition to other chores. Moreover, not only the labour of the sick person will be lost for the family, but also that of the person who accompanies him.

The Importance Of Personal Relations To Health Workers

Herders' hesitance to rely on remote health facilities is also understandable in view of the pattern being the same even among the sedentary population in the villages. The attitude is not restricted to PHC facilities, but is essentially the same when it comes to various forms of traditional healing. Few people are prepared to visit a herbalist they had no previous knowledge of, nor would they consult with a sheikh unless they regarded him as "their" particular sheikh.¹¹ In one case there were two sisters in the same village who both had sick infants. Their respective husbands were both living elsewhere. The two sisters acted differently to their children's illness. One of them went with the child to Baydhabo, where her husband had a sister who knew somebody that worked in the hospital. The other sister did absolutely nothing, and she explained that this was because she did not know either the local pharmacist or any of the other health workers. When I asked why she had not accompanied her sister to the hospital, she frowned. Affinal relations, particularly distant ones, can often lead to the development of considerable strain and unease and in this case that was evidently so.

The emphasis put on personal knowledge of medical practitioners is understandable also from the perspective of how social relations work in everyday life. Few people among the Hubeer enter into any kind of exchange or communication with people they do not know. This is one of the reasons why ambulatory health services will not be a solution to the health care of Somali nomads. Strangers who appear for a few days in the grazing-lands will not appear particularly approachable, unless they are preceded by favourable rumours. Given the current state of Somali public health care facilities, that appears unlikely.

In the case of modern health services there is a further dimension of personal knowledge involved. As one woman put it

when asked about her impressions from the Baydhabo hospital: "those people and we don't have the same language". Certainly patients' feelings of estrangement due to the esoteric language of biomedical practitioners, is found widely also in our part of the world (Hahn & Kleinman, 1983). In southern Somalia it is also common among practitioners of traditional medicine to apply a highly sophisticated and oblique idiom in dealing with illness. Yet, as I have argued elsewhere (Helander, 1989b), when religious healers and herbalists do that, it is usually within the range of patients' expectations. However, in meetings with modern medicine the information they receive may be completely out of range, as it were. Familiar conceptions about health and disease may find themselves being contradicted by what a doctor has said. A Hubeer man returning from the regional hospital in Baydhabo described his disappointment with the test results: "I know my blood is very small because I feel so weak and without strength, my heart beats heavily all the time. Yet they told me that my blood is too much, how can it be so?" Others may find themselves in agreement with the physician's diagnosis, yet disagree with the treatment they are offered. A man who had discontinued the treatment for his TB said: "they told me I needed to take those small tiny red pills every day, but I had already been given 13 injections [by a relative], so it couldn't help me." Others complain over the visibly low standard of health posts and that leaking roofs and cracking walls do not help to gain patients' confidence. "Everything they have there is expired", as one man phrased it.

Experiences like these do not remain restricted to the family of the sick person. On the contrary they spread rapidly in local communities and contribute to building up public opinions about government health services. Even among people without any personal experience of modern health care, one often comes across the attitude that in order to visit the regional hospital you need to be "sick enough". A woman that had been severely ill and had been within reach of the hospital explained why she had not gone there by saying "the disease had not yet spread into the whole of my

body".

Conclusion

In health care there is always the question of supply and demand. There is also the question of needs which is a more complex issue. From the perspective of the nomads, the government measures to supply health care amounts to just a tiny fraction of the resources they perceive that they need. This demand has set free an enormous enterprise potential in the form of privately organized "health care". This output hits the nomadic population exactly where the demand is highest: it offers comparably cheap and fast solutions to health problem for which no other solution has been found and for which there is no time to search. It comes in a form that is not disturbed by social anonymity, but that can be put in the pocket and taken back to the camp: pharmaceuticals.

The Somali state is not an isolated actor on the world scene for it, too, is subject to pressures of supply and demand. Health aid comes earmarked for primary health care, and whatever a handful of people in 2-3 ministries may think about it, that is what the money must be used for. The same handful of people may privately think that this is not what nomads or rural people in general demand, but they subscribe to the idea that it is what people need.

When things do not work out exactly the way they were intended, it is easy to look for organizational and administrative means to correct them. In this paper I have pointed to a number of such weak points in the way that primary health care is organized in Somalia. Yet, I have also attempted to show how each one of these points are intertwined with the concerns and agendas of rural people, in the light of which they look quite different. If, as I have suggested, PHC is regarded as just one of the many places to which one goes to ask for treatment for a disease that one has already decided upon, then the quality of the training that the health worker has received is of little import. Similarly, if the local PHC looks scrappy and underequipped, then it does not matter how good sanitary advice the health worker can offer, because people

will go to the local pharmacy instead.

For PHC to have a future in rural Somalia it must be constructed in such a way that it actually comes to benefit from the extent health resources. There are hundreds of drug traders and pharmacists that must count as such resources and become officially incorporated into the public health system. Unofficially, pharmacies are already a cornerstone in what Serkkola has called the "communication and control network of self-medication" (Serkkola, 1990:22). However, their role in the total medical system could be much further expanded, as could be that of traditional experts. Involving a few herbalists here and there is not enough (Velimirovic, 1984), but the structure for information about health needs to be mapped out much more carefully than I have been able to do in this short paper. The family character of decision-making in health matters is also crucial, and since social relations between health worker and patient are so important, it underlines the need to recruit all health workers locally. Moreover, if these are to remain faithful to their training they need incentives through their salaries. If PHC is to become regarded as anything more than a complement to traditional healing, its capacity for curative treatment must be increased.

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Notes

- 1 Most of the data in this paper comes from my most recent fieldwork in Somalia, during November-December 1988 that was funded by SAREC, UNICEF and WHO. However, I have also benefitted from experiences during my earlier field work in 1983-1985. I thank Saadia Muuse Ahmed for her comments on an earlier version of this paper.
- 2 It has been suggested to me that private practitioners are compelled by law to work in the public health if they are to be allowed to maintain private practices. However, I do know of some exceptions to this.
- 3 An alternative subtitle to this paper could be "nomadic health seeking and the state of southern Somalia".
- 4 WHO officials hold that this is unusual as they should only step in as a direct implementing agency in exceptional cases.
- 5 This is understandable. Many other projects also approach villagers and encourage them to form committees for various purposes. The modern Somali word for committee, *guddi*, is itself of rural origin but does not have the same character of permanency as the English term. Rather, it suggests a temporary assembly for a particular purpose.
- 6 Actually, Justice is cautious not to cast the whole blame on the category of "planners". She also adds that if occasionally a report would actually reach the right person in a health bureaucracy and in time to have a fair chance of actually affecting the program under planning, another problem is that short-term social scientists have a tendency to litter their reports with scholastic terms and academic language that distracts the potential interest of decision-makers.
- 7 The local term is *iddo*, meaning literally "persons".
- 8 In the case of infants, however, there is usually a period of time during which the mother alone is seen as being responsible.
- 9 Health has its natural place in every Somali greeting. A conversation, or a message, usually starts by the mutual assertion of good health even if, later on, that information is modified.
- 10 Food is officially said to be free in all hospitals. When I confronted a doctor in the Baydhabo hospital with the many patients that were cooking their food outside the buildings he suggested that this was because rural people did not appreciate the spaghetti which was on the hospital menu.
- 11 The Somali expression "my sheik" refers to the Qur'anic school teacher one had as a child.