RESOURCE MOBILIZATION FOR HEALTH CARE PROJECTS IN HARGEISA, SOMALIA

BY

ZAINAB ABDIRAZAK ALI

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DECLARATION

I Zainab Abdirazak Ali, declare that this thesis is my original work and has not been submitted for any other award of a degree and published at any institution of higher learning.

..... 3Th / 11 / 2016

Signed **Date**

APPROVAL

This thesis has been submitted to the department with my approval as supervisor.

DR. WANDIBA AUGUSTINE (PHD)

Supervisor

..... 04 / 11 / 2016

Signed **Date**

DEDICATION

This thesis is dedicated to my dear parents without whose help, i would not have produced this piece of work. May the almighty Allah bless you abundantly.

ACKNOWLEDGEMENT

It has been a struggle finishing this work, there has been great support from different individuals and institutions without which it wouldn't have been possible. It is therefore, essential to recognize their contribution.

First, I would like to express my sincere gratitude and appreciation to my almighty Allah for enabling and guiding me through my academic life.

I am grateful to Kampala International University for the academic enrichment they have offered me through this master's program.

My vote of thanks goes to my supervisor, Dr. Wandiba Augustine who patiently guided me throughout the entire work.

I am so grateful to my brothers and sisters, aunts and uncles who have supported me in one way or another, up to this level.

Special thanks also go to the administration of Hargeisa, Somaliland for sparing their time to fill in questionnaires, without all of them, this research would not have been done.

May almighty Allah reward you abundantly

LISTS OF ACRONYMS AND ABBREVIATIONS

GNP	GROSS NATIONAL PRODUCT
NGO	NONE-GOVERNMENTAL ORGANIZATION
NHAS	NATIONAL HEALTH ACCOUNTS
SHI	SOCIAL HEALTH INSURANCE
UN	UNITED NATIONS
UNICEF	UNITED NATIONS INTERNATIONAL CHILDREN'S EMERGENCY FUND
USAID	UNITED STATES AID
WHO	WORLD HEALTH ORGANIZATION
KIU	KAMPALA INTERNATIONAL UNIVERSITY
HOD	HEAD OF DEPARTMENT
SPSS	STATISTICAL PACKAGES FOR SOCIAL SCIENTIST

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ABSTRACT

The topic of the study was resource mobilization for health care projects in Hargeisa, Somaliland. The problem was poor performance of health care projects in Hargeisa Somaliland. The objectives of the study were: to determine the resource allocations from government revenue for the health care projects in Hargeisa Somaliland; to establish the public revenue-raising efforts to improve health service delivery in Hargeisa Somaliland and to examine the usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland. The research employed both qualitative and quantitative research approaches, with descriptive and survey designs, the target population was 420, the sample size was 205 and the researcher used simple random sampling technique to come up with the sample. The findings revealed the following: most of the individuals in Hargeisa, Somaliland females than males, fall under the age of 20-30 years, attained education qualification such as secondary level, primary level and vocational qualification, followed by those with diploma qualification, most of them are married couples and that most of the workers in the health sector in Hargeisa, Somaliland have working experience 1-3 years in that field; the findings also reveal that resources are properly allocated in the health sector for health care projects in Hargeisa, Somaliland; public revenue raising efforts improves health service delivery in Hargeisa, Somaliland; and health insurance is a major mode of resource mobilization for health care projects in Hargeisa, Somaliland. The researcher concluded that respondents in Hargeisa, Somaliland were more of females than males, most of them fall under the age of 20-30 years, most of them attained secondary level, primary level, vocational qualifications and most others attained diploma as their highest qualification, most of the respondents are married couples, and with working experience of 1-3 years; resources are properly allocated in the health sector for health care projects in Hargeisa, Somaliland; public revenue raising efforts improves health service delivery in Hargeisa, Somaliland; and health insurance is a major mode of resource mobilization for health care projects in Hargeisa, Somaliland. The researcher recommended to the government as follows: to look for other ways of mobilizing for resources, not specializing on only insurance as a major mode of resource mobilization for health care projects; to continue putting more efforts in raising of public revenue since this results into success of health care projects; the government should continue to properly allocate resources in the health care projects, this is because health is an important department in every government or state. The researcher recommended to the public of Hargeisa Somaliland as follows: to look at health care projects as their project and therefore, they should actively get involved in the activities of the projects, and this will result into success of these projects and to join the insurance companies for the betterment of their health.

CHAPTER ONE

1.0 Introduction

This covered the background of the study, problem statement, purpose of the study, objectives of the study, research questions, scope of the study and significance of the study.

1.1 Background of the Study

This section covered historical perspective, theoretical perspective, conceptual perspective and contextual perspective.

1.1.1 Historical Perspective

Worldwide, countries differ greatly in their social policy frameworks with consequent impacts on social development and well-being. In United States and Germany, governments initiate policies such as education and health services as well as welfare provision, however we know little about how the sources of revenue and the way resources are mobilized affect policy priorities of decision-makers. Today, the population in most industrial countries (except Mexico, Turkey, and the United States) enjoy universal access to a comprehensive range of health services that are financed through a combination of general tax revenues, social insurance, private insurance, and charges (Preker 2011).

A number of low-income countries (such as Sri Lanka, Malaysia, Zambia, and Costa Rica) have tried to follow a similar path, but the quest for financial protection against the cost of illness in middle- and low income countries has been a bumpy ride. Many of the world's 1.3 billion poor still do not have access to effective and affordable drugs, surgeries, and other interventions because of weaknesses in the financing and delivery of health care, (ILO 2009). In Zimbabwe, there are six main sources of health sector financing in Zimbabwe: (i) the Ministry of Health and Child Welfare; (ii) other government departments; (iii)local government, including municipalities and rural district councils; (iv) donors and voluntary organizations, including the members of the Zimbabwe Association of Church Related Hospitals (ZACH); (v) employers; and (vi) individuals, through both direct payments and private health insurance (Medical Aid Societies) , (ILO 2009).

In Uganda, we provide the historical context of, and trends in, resource mobilization (domestic and external revenue) and social spending in post-independence Uganda in 1986. After years of

civil war, mismanagement and general decline, Uganda turned a page in 1986 when NRM (National Resistance Movement) came to power.

During the 1990s and early 2000s, Uganda was a prototypical donor-dependent country with aid constituting more than half of government revenue. During this period, the government, in partnership with donors, focused spending on targeted pro-poor development programs, including primary education and basic health care, (WHO 2009).

While priority of these social sectors has led to some improvements in social development outcomes, the quality of education and health care is still disappointing and social protection programs remain neglected.

Moreover, domestic resource mobilization has not improved considerably which points to issues of weak institutional capacity as well as the contested nature of taxation. Trends in recent years show an increasingly strained relationship between the government and its traditional donors, piecemeal and ad hoc tax reforms, promise of increasing revenue from oil, and a move in policy priorities away from human capital development to spending on infrastructure and expansion of productive sectors, (WHO 2009).

In Somalia, health care projects are seen as important since Universal access to health care is an ideal goal for all nations. In Somalia, provision of health care services was also driven by this principle, and delivery of services was publicly funded like other social services, such as education. However, that goal was never achieved and the health status indicators for Somalia, even before the collapse of the central government, showed grim statistics, (ILO 2009).

Health care services in Somalia were shaped by various administrations that adopted different policies, priorities, and health care service approaches, often influenced by local and international paradigms and resolutions, (ILO 2009).

The parliamentary government in the 1960s and the military government in the 1970s to 1990s shared common deficiencies in their national plans. Development plans were driven by institutional history, political interest, and personal desires, instead of need and resource capacities based on empirical evidence.

Both administrations failed to maintain established health care delivery infrastructures or sustain their core operations, let alone expand services to the rural population and other vulnerable groups or modernize the system and improve its quality. As a result, health care facilities in many districts collapsed and were unable to provide even the minimum required clinical and preventive services.

In addition, high population growth, environmental degradation, desertification, frequent droughts and famines, urbanization and haphazard settlement, poverty and a weak economy, and poor governance created an unbearable burden of health problems that overwhelmed the nation's staggering health care system and its coping mechanisms.

These problems stifled the health care system and contributed to the poor health status of the Somali people. The Ministry of Health (MOH) never developed a core health care services package nor gauged the extent of resources and infrastructure needed to deliver them, (WHO 2009).

It could have saved wasted resources and eased its management burden if sound leadership had been practiced. As a result of poor leadership, the needs of the health care system and its effective operation were misconceptualized. Furthermore, the type and competencies of health manpower for the provision of a core health care services package, at different levels of delivery points, were never determined.

Development of a national health plan with such attributes could have traced an efficient and progressive path for the Somali health care system. A prominent weakness of the Somali health care system was the lack of a strong regulatory body on drug importation and utilization. Disappointing outcomes of treatable diseases, such as tuberculosis, malaria, typhoid, and dysentery, were mainly attributed to the poor quality of imported drugs. As a result, many patients succumbed, in addition to those who fell victim to provider negligence and ignorance, (WHO 2009).

The currently flourishing drugstores across the country could dangerously worsen an already dire health situation. There were several milestones in the history of health care services in Somalia. In 1966, a nursing school was established in Hargeisa, and another one in Mogadishu in 1970. In 1973, a faculty of medicine and surgery was set up in Mogadishu, (WHO 2009).

These training institutions boosted the human resources for health. The smallpox eradication campaign in the mid-1970s, and introduction to primary health care (PHC) and new tuberculosis (TB) treatment regimens by the Finnish International Development Agency (FINIDA) in the 1980s, brought in massive external assistance.

It established PHC training institutions and opened the door for medical specialty training in TB and lung diseases. These inputs expanded access to health care services and improved the quality of care, particularly with regard to TB. However, the massive resources injected into the health care system were not used properly and their contributions faded soon. Another landmark was the formation of a semi-autonomous refugee health unit (RHU) in the Ministry of Health to serve the refugees from Ethiopia in 1977, which attracted massive foreign aid and expatriate health professionals, (WHO 2009).

The RHU introduced sound health care planning and effective operations, which positively influenced the overall MOH functions and operations. The RHU staff gained valuable experience and knowledge about public health concepts and practices. This produced competent public health professionals and raised the awareness and practice of public health in Somalia. Also in the 1980s, research in medical sciences was initiated by the faculty of medicine, in collaboration with several universities in Sweden, through the National Academy of Science and Arts in Mogadishu. This was a new dawn for research in medical sciences and other fields in Somalia. This initiative and the others mentioned earlier mainly contributed to health manpower production and development, (WHO 2009).

However, these gains were reversed by the economic downturn and political turmoil of the 1980s and civil war of the 1990s. All in all, the health status indicators in Somalia remained at the bottom among the developing countries. Currently, in the absence of a central government, health care services have become a local initiative, and with mixed success. Therefore, to avoid misguided national health development plans and policy, it is essential to examine the deficiencies and gaps in the operation of the past health care systems, and to provide a basic framework to ensure a functional and sustainable health care system in the future, (WHO 2009).

Although 84 percent of the world's poor shoulder 93 percent of the global burden of disease, only 11 percent of the US$2.8 trillion spent on health care reaches the low- and middle-income countries. Vaccination strategies of modern health care systems have reached millions of poor. However, when ill, low-income households in rural areas continue to use home remedies, traditional healers, and local providers who are often outside the formal health system. The share of the population covered by risk sharing arrangements is lower at low-income levels. As a result, the rich and urban middle classes often have better access to the modern health care advances of the twenty-first century.

The flow of funds through the health care system, and the public/private mix, is complex. It can be differentiated into three discrete functions: (a) collection of revenues (source of funds); (b) pooling of funds and spreading of risks across larger population groups; and (c) purchase of services from public and private providers of health services (allocation or use of funds) (WHO 2009). A combination of general taxation, social insurance, private health insurance, and limited out-of-pocket user charges has become the preferred health financing instruments for middle- and higher income countries, where income is readily identifiable and taxes or premiums can be collected at the source.

1.1.2 Theoretical Perspective

This study was guided by the resource mobilization theory of social movements adapted from Jenkins (1983) and extended by Kendall (2006) which holds that a social movement arises from long-term changes in a group's organization, available resources, and opportunities for group action. Resource mobilization theory has five main principles (Jenkins, 1983): The actions of social movement's members and participants are rational; a social movement's actions are strongly influenced by institutionalized power imbalances and conflicts of interest; these power imbalances and conflicts of interest are sufficient to generate grievances that lead to the mobilization of social movement's intent on changing the distribution of resources and organization; Centralized and formally structured social movements more effectively mobilize resources and achieve goals of change than decentralized and informal social movements; The success of social movements is heavily influenced by group strategy and the political climate.

The resource mobilization theory of social movements examines structural factors, including a group's available resources and the position of group members in socio-political networks, to analyze the character and success of social movements. According to resource mobilization theory, participation in social movements is a rational behavior, based on an individual's conclusions about the costs and benefits of participation, rather than one born of a psychological predisposition to marginality and discontent (Klandermans, 2011).

1.1.3 Conceptual Perspective

Resource mobilization is the process by which resources are solicited by the program and provided by donors and partners (McCarthy and Zald, 2011). According to Buechler (2012), resource mobilization stresses the ability of a movement's members to 1) acquire resources and to 2) mobilize people towards accomplishing the movement's goals. According to Latifa (2013), resource mobilisation is about an organisation getting the resources that are needed to be able to do the work it has planned. Batti (2014) defined resource mobilization as a process whereby resources both financial and non-financial resources are mobilized either externally or internally to support organization activities. Canada's International Development Research Centre (2010) defined resource mobilization as a management process that involves identifying people who share the same values as your organization, and taking steps to manage that relationship. The operational definition of resource mobilization adopted for this study shall be health financing strategies to generate resources to support or pay for the goods and services used in the production and delivery of health care. This study will be limited to the following resource mobilization strategies: resource allocations from general government revenue; public revenue-raising efforts; and social health insurance.

The Department of Health Framework defines 'health care' project as: 'project concerned with the protection and promotion of public health, research undertaken in or by the Department of Health, its non-Departmental Public Bodies and the NHS, and research undertaken by or within social care agencies. It includes clinical and non-clinical projects; research undertaken by NHS or social care staff using the resources of health and social care organizations; and any research undertaken by industry, charities, research councils and universities within the health and social care systems that might have an impact on the quality of those services, (WHO 2009).'

An individual should take a rational decision as to whether you think your proposed project would fall under the Department of Health's definition of 'health care project'. If in doubt you may want to obtain a second opinion (for example, from your Head of Department), (ILO, 2012).

A health care project aims to undertake pre-protocol work (for example, preparatory work that will be used to subsequently develop a second project, namely a clinical trial of an intervention to improve the ability of patients with non-cancer diagnoses to participate in advance care planning). Depending on the success of the first project, the second project will aim to improve communication between patients with heart failure and other non-cancer diagnoses and their health care professionals. The first project (the pre-protocol work) will involve undertaking an appraisal of the literature to underpin the trial's design and facilitating the involvement of key stakeholders in the trial's design (for example, service users, professionals). This information will then be used to design an appropriate intervention), (ILO, 2012).

1. The first project would not be classed as health care research (for the same reason that is given in the first example above).
2. The second project would be classed as health care research ((for the same reason that is given in the first example above), (ILO, 2012).

In this study, the improvement in health care projects will be examined in terms of stakeholder involvement in these projects, proper project planning, and having sustainability measures in place.

1.1.4 Contextual Perspective

Somaliland is a post-conflict state whose systems remain fragile and susceptible to a multitude of external factors. Without a strong central government or international recognition, Somaliland has lacked the resources necessary to invest in the health of her own people. Its healthcare indicators demonstrate the vulnerability of an entire population and the glaring lack of proper health services coordinated nationally. The rudimentary health care system in Somaliland comprises of a central Ministry of Health, regional health offices (although few district health management structures exist); volunteer Regional Health Boards (primarily concerned with the financing and management of larger referral hospitals); 1 National referral hospital, 1 National Mental Hospital, 5 Regional Referral Hospitals, 3 District

Hospitals, 7 Tuberculosis treatment Centers, 73 Maternal and Child Health Clinics, and about 200 health posts. There also exist medical and nurse/midwifery associations, medical personnel training institutes, a vibrant market of private health care service provision and pharmacies.

However, the extent of skilled health care personnel shortage in the system is unsettling. The healthcare services are largely provided by under-trained, under-supervised, and under-paid staff who, in addition, lack a regulated and organized working environment. The system functions largely on donations from international agencies (such as the UN, NGOs, and Islamic Charity Funds). This under-investment in health services has translated to a large percentage (more than 85%) of the rural population remaining unreached with any service from the public health system with resultant huge health inequalities within the populations. There is therefore an urgent need to build the capacity of the health care system to provide a range of accessible, affordable and better quality services that people need and demand through resource mobilization.

1.2 Problem Statement

Ideally, nations need to emphasize proper mobilization of resources for success of their projects such as health care projects, water projects, education projects among others which can improve the standard of living of the community members in the society, (UNICEF, 2014). Several NGOs such as CARE international, UNICEF, Action Aid international, Action Africa International, Medicines Du Monde France, Nowegian Church Aid among others have substantially supported the health sector in Hargeisa Somaliland, (WHO, 2014). Despite the support from the various NGOs in Hargeisa Somaliland, still the performance of health care projects in Hargeisa Somaliland is poor, this is seen with the high rise in numbers of health cases sighting negligence and inadequate staff in health centers, (Chairperson CBOs report, Dec, 2014). The health care projects in Hargeisa Somaliland are found of not being able to provide the beneficiaries with the necessary requirements to enable them have improved standard of living. Some health Centers have been seen to provide only pain relievers due to insufficient drugs. In order to help solve the problem, the factors related to poor performance of health care projects need to be investigated upon, hence the need for the study which intends to investigate the impact of resource mobilization on health care projects in Hargeisa Somaliland. The researcher has selected

resource mobilization because she would like to find out whether performance of health care projects can be improved through resource mobilization.

1.3 Purpose of the Study

To investigate the relationship between resource mobilization and healthcare projects in Hargeisa.

1.4 Objectives of the study

i. To determine the resource allocations from government revenue for the health care projects in Hargeisa Somaliland.
ii. To establish the public revenue-raising efforts to improve health service delivery in Hargeisa Somaliland.
iii. To examine the usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland.

1.5 Research Questions

i. What is the resource allocations from government revenue for the health care projects in Hargeisa Somaliland?
ii. What is the public revenue-raising efforts to improve health service delivery in Hargeisa Somaliland?
iii. What is the usage of health insurance as a mode of resource mobilization for the health sector in Hargeisa Somaliland?

1.6 Scope of the Study

1.6.1 Geographical Scope

This study was carried out in Hargeisa which is the largest city in Somaliland, located in the Woqooyi Galbeed region. Hargeisa is the capital of Somaliland, a self-declared republic that is internationally recognized as an autonomous region of Somalia. It was the colonial capital of the British Somaliland protectorate from 1941 to 1960, when it gained independence as the State of Somaliland and united with Italian Somaliland to form the Somali Republic.

1.6.2 Content Scope

This study was limited to resource allocations from government revenue for the health sector in Hargeisa; the level of public revenue-raising efforts to improve health service delivery in

Hargeisa; and the usage of health insurance as a mode of resource mobilization for the health sector in Hargeisa.

1.6.3 Time Scope

This study looked at data of 5 years, that is, from 2010-2015. This was because this period is wide enough to provide the researcher with credible information regarding how resource mobilization has managed to promote healthcare projects.

1.7 Significance of the Study

It is hoped that the results of this study will help the Ministry of Health to work with the international community to create stronger international accounting frameworks to manage funds. This will help track funds and will improve accountability for domestic finances raised and spent. It will also provide a stronger assessment of domestic health spending and a disaggregation of where funds are allocated. A stronger accounting framework will allow countries to see where resources are being poorly or properly allocated. This would improve the quality and efficiency of spending by governments.

It is hoped that the findings this study will help Health ministers to work with their national governments and development partners to encourage political leadership on issues of health, and craft advocacy messages that are tailored to the country's needs. This will help the government to support healthcare projects and also improvise strategies for mobilizing domestic resources, and take responsibility for their own needs.

The findings from this study will help future researchers who are carrying out a similar study on resource mobilization and healthcare projects to use it as a point of reference.

CHAPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter reviewed literature from different authors regarding resource mobilization in accordance to the objectives of the study. The chapter was further sub divided into theoretical review, conceptual framework and review of related study.

2.1 Theoretical Review

This study was guided by the resource mobilization theory of social movements adapted from Jenkins (1983) and extended by Kendall (2006) which holds that a social movement arises from long-term changes in a group's organization, available resources, and opportunities for group action. Resource mobilization theory has five main principles (Jenkins, 1983): The actions of social movement's members and participants are rational; a social movement's actions are strongly influenced by institutionalized power imbalances and conflicts of interest; these power imbalances and conflicts of interest are sufficient to generate grievances that lead to the mobilization of social movement's intent on changing the distribution of resources and organization; Centralized and formally structured social movements more effectively mobilize resources and achieve goals of change than decentralized and informal social movements; The success of social movements is heavily influenced by group strategy and the political climate.

The resource mobilization theory of social movements examines structural factors, including a group's available resources and the position of group members in socio-political networks, to analyze the character and success of social movements. According to resource mobilization theory, participation in social movements is a rational behavior, based on an individual's conclusions about the costs and benefits of participation, rather than one born of a psychological predisposition to marginality and discontent (Klandermans, 2011).

The resource mobilization theory of social movements is used to explain how social movements since the 1950s have evolved from classical social movements, which are characterized by local leadership, volunteer staff, collective actions, large membership, and resources donated from direct beneficiaries; to professional social movements, which is characterized by professional leadership, paid staff, informal membership, resources donated from outside the movement, and actions that represent the movement but do not require member participation. Resource

mobilization theory of social movements explains how social movements mobilize resources, from inside and outside their movement, to reach goals (Jenkins, 1983).

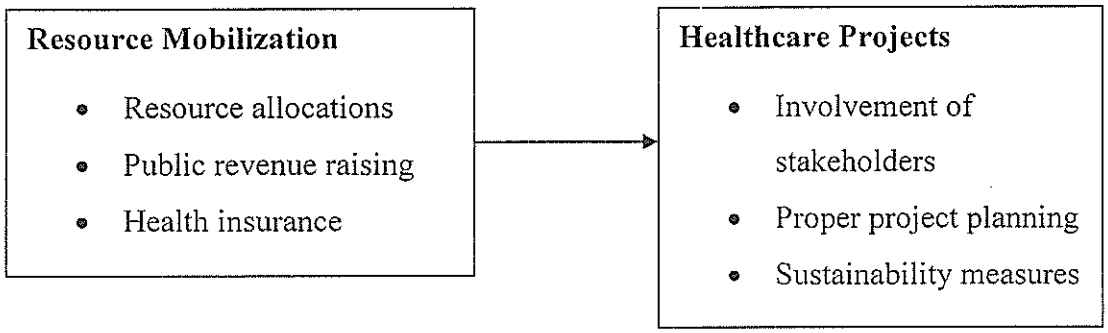
Resource mobilization theory argues that social movements succeed through the effective mobilization of resources and the development of political opportunities for members. Social movements can mobilize both material and non-material resources. Material resources include money, organizations, manpower, technology, means of communication, and mass media, while non-material resources include legitimacy, loyalty, social relationships, networks, personal connections, public attention, authority, moral commitment, and solidarity (Fuchs, 2012).

Resource mobilization theory holds that social movement organizations with powerless or resource-poor beneficiaries require outside support and funding. There are two types of members belonging to social movement organizations: conscience constituents and beneficiary constituents. Social movements often seek out and receive resources from conscience constituents. Conscience constituents refer to individuals or groups outside of the social movement who have a moral alliance with the social movement's cause, goal, or mission. The social movement and the mass media are responsible for framing the social movement's message and character.

Resource mobilization theorists have found that conscience constituents tend to contribute more when beneficiaries are framed, by the social movement itself or mass media, to emphasize commonalities with conscience constituents (Paulsen and Glumm, 2013). Ultimately, the resource mobilization theory of social movements helps to explain the formation of social movements, the process of social mobilization, and the politics of social movements.

2.2 Conceptual Framework

Figure 1 Showing the Relationship between Resource Mobilization and Healthcare Projects in Hargeisa, Somaliland.



Source: adapted from Batti (2014), modified by the researcher, (2016).

Figure 1: Conceptual Framework of the Study

The figure 1 above shows a diagrammatic representation of the relationship between resource mobilization and healthcare projects. Resource mobilization have been measured using resource allocations, public revenue raising, and health insurance. This means that if resources are mobilized through resource allocation from the government revenue for health care projects, there will better delivery of healthcare services. For example if a big percentage of government budget is allocated to the health sector, several projects will be accomplished hence improving healthcare service delivery. Secondly, the resources can also be mobilized from the public through charging user fees for those who come to seek for health services. The user fee once accumulated can help in promoting healthcare projects. Thirdly, resources meant for healthcare projects can be mobilized through health insurance. This can be achieved by contributing funds to a common pool with the assistance of insurance companies. However these healthcare projects can also succeed or fail if the stakeholders are involved, if the projects are properly planned, and if there are sustainability measures in place.

2.3 Review of Related Literature

2.3.1 The Resource Allocations from Government Revenue for the Health Sector

The 2000, UNDP's Human Development Report ranked Somalia lowest in all health indicators except life expectancy. In 2005, HDR the country is not even ranked, due to the lack of reliable data. As a result, it was noted that "most Somalis spend most of their time trying to stay alive and keep their families alive" (UN, 2015). Extreme poverty in Somalia is estimated to be 43% with large disparities noted between the urban population at 23% and the rural and nomadic populations at 53% (UNICEF, 2041). The MDG health-related indicators in Somalia are among the very worst of the world. The infant mortality rate was estimated at 132 per 1,000 live births in 1999, with the rate of under-five mortality at 224. Maternal mortality was estimated as high as 1,600 per 100,000 live births in 1999 (WB, 2015).

Achieving the MDG 5 target -i.e. reducing the 1990 rate by three quarters- would imply to lower the rate to 400/100,000 by 2015, which seems very unlikely when one takes into account the available human resources, the emergency obstetric care (EOC) infrastructure and the services and the range of interventions that would be required to obtain such a dramatic improvement. The most recent survey (UNDP 2014) confirms that 80% of deliveries occur at home in all regions of Somalia. According to a survey of nine regions conducted by UNDP, only 28% of deliveries were attended by qualified personnel. Lifetime risk for maternal death has been estimated in 1 in 10 women (WHO, 2015). Other estimates, however, returned lower figures. The proportion of under-five children who are underweight is 26%. The immunization coverage (1 year-old children fully immunized) was only 36% in 2000. Measles is reckoned to be responsible for most deaths resulting from vaccine-preventable diseases in children under-5 years (WHO, 2015).

Researchers have found that, in many countries, for administrative reasons, resource allocation often is based on existing ministry structures and bureaucratic demand rather than on need (Diderichsen, 2014). Yet, in the interests of both horizontal and vertical equity, it is necessary that resource allocation be based more on need. The preponderance of the "inverse care law" in which the under-privileged with greater burdens of disease receive comparatively fewer resources across countries, regions, or socioeconomic groups perpetuates and often deepens the inequality of health outcomes. Such inequalities cannot be reversed unless resource allocation frameworks include needs-based resource allocation criteria (USAID, 2010).

Developing countries are increasingly using needs-based formulas to guide their allocation of health resources. The indicators of need most frequently used are: The size of the population in each area; The demographic composition of the population (given that young children, the elderly, and reproductive-age women tend to have a greater need for health services); Levels of ill-health; and Socioeconomic status (given the strong correlation between ill-health and low socioeconomic status and that the poor are most reliant on publicly funded services) (Semali and Minja, 2015).

Several African countries including Uganda, Kenya, Tanzania etc have created resource allocation formulas to address equity concerns during the allocation process. Each country's formula addressed population factors and poverty variables, and weights were assigned to each factor in the formulas. Several countries, such as South Africa and Zambia, based their revised allocation formulas on a "material deprivation index," along with population factors. Many of these countries rely on a combination of National Health Accounts (NHAs) and district-wide reviews to monitor data and expenditures (USAID, 2010).

Virtually every country in the world uses general tax revenues to finance various components in the health sector. This tax support ranges from total public financing of all health services to financing of only specific services for specific segments of the population. In most countries with a tax-based health care system, the allocation of funds to the health sector depends on the explicit decisions of the finance ministry, and on the availability of funds. The health ministry competes for funds along with other ministries, and the allocation of funds to the health sector directly affects some other ministry's allocation. Allocation of funds to the health sector is therefore likely to grow and shrink as total tax revenue grows and shrinks (Akin, Nancy and DeFerranti, 2011).

In most developing countries of the world, government revenue (income tax, capital gains tax, social security, sales taxes, custom duties, and non-tax revenues) has tended to be around 15-20% of total GNP (few exceptions include Egypt, Lesotho and Zimbabwe). In many countries in Africa, notably Kenya, Madagascar and Zambia, government revenue as a percentage of GNP has actually declined over the eleven year period 1980-1991. In some countries, like Cameroon, Côte d'Ivoire, Lesotho, Malawi and Zimbabwe, government revenue as a percentage of total GNP has risen. Overall, the general trends in developing countries seem to indicate that the

governments in African countries cannot really expect to raise much more revenue from taxes than they are doing already (Attah, 2012).

At the same time, government expenditure on health as a percentage of total expenditure of the government has tended to remain low in many countries in sub-Saharan Africa. In some countries government health expenditures have actually fallen (Cameroon, Kenya). In fact, over the ten year period 1975-1985, many countries experienced significant falls in the growth rate of central government expenditure on health, adjusted for purchasing power parity, in terms of US$ in 1980 (Barnum and Kutzin 2013).

2.3.2 The Public Revenue-Raising Efforts to Improve Health Service Delivery

The World Health Organization (WHO) has attempted to reduce the impact of AWD by developing local capacity, and this course seems to be working. Reported cases of AWD fell from 118,187 in 2007 to 78,378 in 2009 and the cause specific mortality rate associated with AWD fell 80 per cent, from 1,076 deaths in 2007 to 324 in 2009. The WHO is focusing their efforts on strengthening coordination between local health actors, early disease detection and training health care workers. This is allowing for a timely response to outbreaks. Nonetheless, the lack of sanitation and safe-water infrastructure will continue to compromise the health of Somalis and promote conditions where cholera and AWD outbreaks are possible, even likely.

Female Genital Cutting (FGC), a practice that threatens the short and long-term health of women, is performed throughout Somalia and by all regional ethnic groups. Surveys by UNICEF, CARE and the now defunct Somalia National Ministry of Health suggest that between 90-99 per cent of all Somali women have experienced FGC. Type III cutting, where part or all of the genitalia is removed and the vaginal opening is sewn nearly shut, has been performed on approximately 91 per cent of all women surveyed. Type III cutting is considered the most extreme form of FGC, but is practiced regularly due primarily to the belief that it is required by the Koran. It is also thought to preserve a woman's virginity and thus her family's honor—the two being significantly linked. The scar tissue left by the cutting is also considered to be aesthetically appealing.

User fees are direct payment by patients. As is the standard practice all over the world, user fees (prices) are charged for resource mobilization and for generating private revenues used for financing health care services (Gertler and Van Der Gaag, 2011). The extents to which revenue can be raised through user fees depend to the extent people are willing to pay a price for health care services. Usually patients are not willing to pay any price for curative services. Economic theory suggests that when user fees rise, utilization of health care services falls, but the question is how much? This depends on the price elasticity of demand.

If the demand is less sensitive to price increases, more revenue can be mobilized through increase in user fees. Such price increase will have two effects on revenue: as user fees rise, more revenue is generated through increasing the number of visits, and conversely low revenue is generated by reducing the number of visits. Reduction in visits is enough to offset price increase: overall revenue will decline. However, there can be some problems in raising revenue through user fees. If demand is inelastic, it will be less sensitive to price changes. Providers inducing health care demand can offset effects of user fees, and user fees may result in adverse effects for the poor.

Consumers of health care are accustomed to user fees in most countries round the world where the private sector participates in health care provision. However, the prevalence of user charges in public facilities is not so widespread. In fact, in several countries in sub-Saharan Africa there is no user fee system in place at all, while in many others it has only a minimal impact (Shaw and Griffin, 2010).

Many countries, notably Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Zambia and Zimbabwe in sub-Saharan Africa, have implemented user fees with the primary objective of revenue mobilization. Other countries that have implemented user fees have done so primarily for different reasons, like improving drug availability. However, user fees have not contributed significantly to government revenues in most countries, though recent evidence suggests that there have been improvements over time (Litvack and Bodart, 2013).

In fact, in most countries in sub-Saharan Africa user charges have contributed very little to recurrent government expenditure. With the exception of Ethiopia, Mauritania, and Lesotho, user

charges have contributed less than 7% of recurrent government expenditure in the health sector (LaForgia, Charles, and Randall, 2012).

User fees have the potential of improving sustainability of the health system. Sustainability refers to the financial and institutional characteristics of a country to sustain a project over time. In the context of user fees, sustainability depends on the contribution of user fees to revenue and costs associated with its implementation, as well as on the institutional capability it develops and sustains (Kutzin, 2009).

Implementation of user fees may bring about a positive change in quality of health care, more so if the revenue so generated is reinvested in the facilities. Several recent studies suggest that such reinvestment can significantly counterbalance any negative effects of fee increases, such as reduced utilization (Litvack and Bodart, 2013).

Maxwell (2012) suggests six different dimensions along which quality of care may be judged: effectiveness, acceptability, efficiency, access, equity, and relevance. Donabedian (2010) looks at quality in terms of structure, process, and outcome. Combining the two approaches gives one way of defining quality. This way of defining and assessing quality highlights many important elements which are seen differently by the various agents involved: patients, providers, governments, etc. and include physical facilities, organization and management, patient complaints, patient satisfaction, diagnostic activity, health outcome indicators, etc.

2.3.3 The Usage of Health Insurance as a Mode of Resource Mobilization for the Health Sector

Health Insurance is a method of health care financing whereby the insured people do not bear the full cost of health care treatment. Health insurers act as payers of health services and the type of health insurance (public or private) determines the degree of control government has over health spending. The degree to which government is able to exert control over health care financing has important policy implications. In an effort to extend health care coverage for all, the government of Pakistan is exploring health insurance as a means of extending coverage. However, there are several hurdles involved in the process of transition from low to high, and eventually universal health coverage for all at affordable prices. Health care financing through general tax revenue is by far the main source in Somaliland. However, for exploring alternative strategies, it is

important to know that in the presence of a large informal sector in Somaliland, how practical it is to register and collect health care contributions from people who do not have a regular income or their incomes are classified as middle and low categories? A closely related issue is cost escalations associated with universal coverage as a result of moral hazard and resulting increase in health expenditures.

In social health insurance, services are paid through contributions to a health fund. The common basis is payroll with contributions both from the employer and the employee based on the ability to pay and access to health care, which is based on the needs of people (Griffin and Shaw, 2013). However, critical questions remain about resource efficiency, technical efficiency (mix of inputs) and impact of social health insurance (SHI). In Somaliland, a referral system that requires that medical services should initially access the lowest and least inexpensive system of primary health care is not very common. There are various reasons for this, including drug shortage in public health centers, lack of adequate equipment, and technical staff. Many patients rely on centralized hospitals for illnesses that can be treated at primary levels. A closely related issue is lack of a formal insurance market in Somaliland. However, prospects for expanding health insurance need to be explored bearing in mind that health care financing can only be established when its viability has been assessed both on demand and supply side.

Illness and injuries befall people quite randomly. This creates a health risk that in turn creates a financial risk as people seek medical care to alleviate the effects of illness. Health insurance protects people from this financial risk when they fall ill. Health insurance collects financial contributions from many people that are made whether the person is ill or not. These contributions are pooled together and used to cover expenses of those who experience catastrophic events. Health insurance is therefore a mechanism of spreading risk over time as well across many people (Brunnet-Jailly, 2011).

Health insurance is of increasing interest as a means to generate resources for health care, as well as for its potential to improve the supply and provision of health services. However, experience to date in developing countries is limited, especially in the lower income developing countries (China was a striking exception to this, although rates of coverage have declined substantially in the 1980s). Available evidence indicates that only a small percentage of the population in sub-Saharan Africa has any kind of health insurance. Health insurance in the lower income countries

has been mainly government or employer provided, with limited coverage. Private insurance is not very common (International Labor Organization 2012).

Health insurance is characterized by a group of persons who contribute funds to a common pool, usually held by a third party. These funds are then used to pay for the health care costs of the members of the pool. This third party can either be a governmental social security, a public insurance fund pool, employer sponsored pool, or a private insurance fund pool. Depending upon who owns the third party fund pool, insurance can be categorized as "government" or "private". The term "government" in describing insurance needs some qualification. Social insurance may be organized by government, but be implemented by a variety of quasi-public organizations. It is probably best in analysis to separate these funds from the direct government provision of health care (for example, through the MOH). Insurance plans may be further characterized by groups covered, type of management, size of the group (number of enrollees), services covered (inpatient care, outpatient care, preventive care, drugs, etc.), annual premium, copayments, deductibles, restrictions on use (like requirement of referrals), etc (Kutzin and Howard 2012).

Another significant type of government sponsored insurance arrangement is community, or cooperative, financing. Community sponsored plans and cooperative based programs are characterized by a group of individuals, like in a cooperative, who identify projects which have strong public goods characteristics, and establish a mode of mobilizing resources toward meeting the objectives of the program. Established by the common will of the people rather than the market forces, these programs permit a variety of resource mobilization methods, such as payment in cash or kind, payment in part or full, payment in the form of labor contribution, idle land, etc. This flexibility in the community sponsored plans has been useful in limiting the effects of seasonal income fluctuations on access to health care services in some countries in sub-Saharan Africa. In Zaire, for instance, the annual collections for a prepayment scheme for hospital services are made during a season where cash incomes are the highest (LaForgia, G. M., Charles, G., & Randall, B. (2011).

Another form of insurance coverage is employer-sponsored insurance coverage. Under this system the employer provides health care to the employees and their families through either employer owned or employer contracted providers. There are several examples of employer provided insurance coverage in sub-Saharan Africa. In Zambia, for instance, the state mining

company provides care to all employees and families in clinics run by the company. In Nigeria, five parastatals provide health coverage for their employees and families in their own clinics as well as by contracting outside facilities (Shaw and Griffin, 2010).

Health insurance coverage is also provided by private ownership of the third party pool. In private for-profit insurance schemes the individual premiums are determined actuarially, and administrative costs are recovered through an additional loading on the actuarially-determined premium. Private insurance is not very common in many developing countries. In sub-Saharan Africa private insurance is limited to Cote d'Ivoire, Ghana, Senegal, Zimbabwe, Rwanda, Nigeria, Kenya, and Swaziland. The share of private insurance in total insurance ranges from zero in most countries of Africa to 16.5 in Zimbabwe (Vogel, 2013).

Compared to tax based revenues and user fees, insurance mechanisms have a greater potential to contribute to revenue collection. First, insurance usually involves the mandatory contribution of new funds (especially employer's contribution) as well as some mandatory contribution of some funds that are probably just moved from private to public (especially worker's contributions). Second, in many developing countries tax avoidance is high; whereas since the insurance contributions are an "earmarked" contribution, kept separate and tied to specific benefits, compliance may be higher even where general tax compliance is not very good. Third, consumers of health care may often not have readily available funds to pay user charges. Fourth, since for most consumers of health care in developing countries the ability to pay is low in times of illness, people would find it easier to make small contributions at periodic intervals than large contributions at the time of illness. Fifth, members of an insurance pool may be able to choose to pay when they are more able to, like harvest time, than when they are less able to, like illness time. In Zaire, for instance, the annual collections for a prepayment scheme for hospital services are made during a season where cash incomes are the highest. Similarly, in Guinea Bissau annual collections are made just after harvest. In both of these countries insurance has been widely accepted (Vogel, 2013).

2.3.4 Related Studies

A study by Verhoeven and Tiongson (2012) revealed that while some countries set targets for public revenues for health, such as the Abuja target of allocating at least 15 percent of the annual government budget to health, there is no consensus on how much revenue governments should

allocate to health. The reasons for this diversity reflect different economic circumstances and the range of social contracts that governments have with their citizens for ideological or historical reasons. The economic rationale for devoting public revenues to health are (i) to correct for market failures (e.g., private markets do not work well when consumers and providers have different levels of information regarding the appropriate type and amount of care to purchase); (ii) to ensure that public goods are correctly funded (e.g., immunization may be undervalued if the benefits flow to society at large); and (iii) to ensure that the poor and other disadvantaged groups are not excluded (to meet equity objectives). The concern in many developing countries is that the very low amount that many governments now devote to health is too low to fund these necessary functions.

A study by Lagarde and Palmer (2011) that a government's revenue-raising capacity is affected by factors such as the country's economic development, institutional constraints, level of formalization of the labor market, and tax administration capacity. Where these are weak, countries rely more on revenues from private and external sources for health. Private revenue—mainly user payments on fees charged by providers—amounts to 62 percent of total health funds in low-income countries. User fees have raised concerns about the financial consequences for poor households and the negative effect on health service use. As countries grow economically, public revenue for health comes to predominate.

Recent syntheses of impact evaluations find that increasing public spending and lowering payments for patients positively affects health outcomes. Using a large panel dataset at the country level, with annual data for 14 years (1995–2008), Moreno-Serra and Smith (2011) applied a two-step instrumental variables approach that directly estimates the reverse causal effects of mortality on coverage indicators. They found that higher public spending on health leads to better population outcomes, measured either by under-five or adult mortality rates.

Furthermore, a synthesis report of 16 impact evaluations found that introducing user fees decreases utilization of care, whereas removing them sharply increases utilization of curative services. A systematic review of 20 impact evaluations of user fees for maternal health services found that the removal of such fees contributes to increased facility delivery but has no clear impact on health outcomes (Dzakpasu et al. 2013).

2.4 Gaps of the Study

The above study only look at government efforts to raise and allocate resources for healthcare projects however do not look at public revenue raising efforts and usage of health insurance. This study is intended to close such a gap.

CHAPTER THREE
METHODOLOGY

3.0 Introduction

This chapter covered research design, target population, sample size, sampling procedure, data source, research instruments, validity and reliability, data collection procedure, data analysis and ethical considerations.

3.1 Research Design

Leedy and Ormrod (2001) defined research design as the strategy to approach a central research problem. A research design helps a researcher to conceptualize an operational plan to undertake the various procedures and tasks required to complete the study and ensure that these procedures are adequate to obtain valid, objective and accurate answers to the research questions. This study adopted both qualitative and quantitative research approaches. The quantitative research approach consisted of descriptive research design, while the qualitative research approach consisted of survey design. The researcher prefered descriptive survey design because it is best suited for explaining or exploring the existence of two or more variables at a given point in time and will give the researcher an opportunity to collect relevant data to meet the objective(s) of the study.

3.2 Study Population

The target population of this study was 420 individuals who consisted of health workers and officials from the ministry of health.

According to the permanent secretary ministry of health Somaliland, (2014), the health sector especially in Hargeisa Somaliland consist of 420 workers distributed as follows: 360 health workers from the referral hospital and general hospital in Hargeisa, and 60 officials from the ministry of health, Hargeisa Somaliland. The researcher selected Somaliland due to proximity to the researcher's residence and access to the required information.

3.3 Sample Size

The sample size of this study was 205 respondents who were selected from the target population of 420 in Hargeisa Somaliland. This sample was arrived at using Sloven's formula of sample size determination which states that:

$$n = \frac{N}{1 + N(\alpha)^2}$$

Where: $n = sample\ size;\ N = target\ population,\ and\ \alpha = 0.05\ level\ of\ significance$

$$n = \frac{420}{1+420(0.05)^2}$$

$$n = \frac{420}{1 + 420(0.0025)}$$

$$n = \frac{420}{1 + 1.05}$$

$$n = \frac{420}{2.05}$$

$$n = 205$$

Table 3.1 gives the summary of the findings

Table 3.1: summary of the sample population and sample size

Category of respondents	**Sample population**	**Computation of sample size**	**Sample size**
Health Workers	360	$\frac{360 \times 205}{420}$	175
Ministry of Health representatives	60	$\frac{60 \times 205}{420}$	30
Total	**420**		**205**

3.4 Sampling Procedure

The researcher used simple random sampling to select the health workers and the officials from the ministry of health. In this technique, each and every individual in the target population had equal chance of being selected. This simple random sampling technique will be used because the researcher can easily get the list of the workers from the hospital administrator and list of officials from the permanent secretary ministry of health. In this simple random sampling technique, the researcher used a simple rotary method to select the sample. In this rotary method, the researcher got the names of these workers and officials and write them on pieces of papers

with answers yes or no, the papers were put in a box, mixed together and then picked one by one. The papers picked which have names and answers yes were considered while those whose names have answer no were left out.

3.5 Data Sources

3.5.1 Primary Data

The researcher collected primary data using questionnaires.

3.5.2 Secondary Data

The researcher collected secondary data from reports released by the Ministry of Health, WHO, dissertations, journals, books and internet materials.

3.6 Data Collection Instruments

The data collection instrument in this study was to mainly be questionnaires. Questionnaires by definition mean a set of printed questions addressed by the researcher to the respondent for him or her to answer and after answering return the questionnaires to the researcher. The questionnaires will be administered to the respondents by the research assistant and collected after time interval. The questionnaires were answered by the health workers and representatives from the ministry of health from Hargeisa Somaliland. The questionnaires comprised of closed ended questions that required the respondents to answer all the questions to the best of their knowledge. The questionnaires were used because they are cheap, quicker, they cover many respondents, and they are free from interview bias and give accurate information since respondents take their time to answer the questions. However, they have a disadvantage of non-despondence. The scoring system of this instrument is as follows: Strongly disagree, Disagree, Neutral, Agree, and Strongly agree with codes 1,2,3,4 and 5 respectively and the respondent were ticking the most appropriate answer.

3.7 Validity and Reliability

3.7.1 Validity of the instrument

Validity is the degree to which results obtained from the analysis of the data actually represents the phenomenon under study. The study tested three types of validity, face validity, content validity and construct validity. Face validity was achieved with the guidance of experts in the field of management. The researcher worked hand in hand with her research supervisors to adjust the instruments accordingly. It measured the content validity of the instruments. In order to test

this content validity of the instruments, the researcher availed the questionnaire to two experts to check each item for language, clarity, relevance, and comprehensiveness of the content. The items were rated as follows:

4 – Very relevant

3 – Quite relevant

2 – Somewhat relevant

1 – Not relevant

The researcher then put the items in 2 groups, with categories 1 and 2 in one group and the other 3 and 4 in the other group. The researcher then calculated the Content Validity Index (CVI) using the formula below:

$$\text{CVI} = \frac{\text{Items rated as very relevant and relevant (3 and 4)}}{\text{Total number of items}}$$

For the instrument to be valid, the CVI should be within the accepted statistical range of 0.5 to 1, specifically, the instrument which had the necessary content validity, it should have a CVI of 0.7 and above.

For construct validity, Construct Validity was achieved through Exploratory Factor Analysis (EFA). Using Principal component analysis and Varimax rotation methods. Communalities, Determinant, KMO and Bartlett's test for sampling adequacy will be used. SPSS software was used to perform the EFA.

Atleast 30 questionnaires were issued on the original nominal, ordinal , interval scales (eg likert scales). Convergent Validity is achieved when communality loadings of initial solution table (Communality Table) are 0.5 and above and determinant is greater than 0.000.

Discriminant validity was achieved when the items or questions in rotated component matrix are distinctively loaded (0.3 or more) to separate components (table component columns) and KMO is 0.7 OR more, Cummulative % variance of at least 50%. At this stage one is able to determine the constructs or indicators and Items or questions that should be retained on the questionnaire and conceptual framework.

3.7.2 Reliability of the instruments

Reliability is a measure of the degree to which research instruments yield consistent results or data after repeated trials.

The test-retest technique was used to assess the reliability (accuracy) of the instruments. The researcher devised the instruments to twenty one qualified respondents, ten from employees from production department, ten from casual laborers and only one from management. These respondents were not be included in the actual study. In this test- retest technique, the questionnaires were administered twice to the same subjects after the appropriate group of the subject were selected, then the initial conditions were kept constant, the scores were then be correlated from both testing periods to get the coefficient of reliability or stability. The tests and the trait measured if they are stable, will indicate consistent and essentially the same results in both times (Treece and Treece, 1973).

This was done in the following ways: the appropriate group of subject were selected (21 qualified respondents); then the test was administered to the subject; all initial conditions were kept constant; a time lag of one week was waited and then the same test was administered to the same subject; the scores were correlated from both testing periods. If the scores were the same or nearly the same, the conclusion was the instrument is valid.

3.8 Data Gathering Procedure

3.8.1.Before the administration of the questionnaires

1. An introduction letter obtained from the college on higher degrees and Research for the researcher to solicit approval to conduct the study from respective administration of Hargeisa Somaliland both the two hospitals and the ministry of health.
2. When approved, the researcher secured a list of the qualified respondents from the administration of Hargeisa Somaliland and then simple random sampling used to select respondents from this list to arrive at the minimum sample size.
3. The respondents were explained about the study and were requested to sign the Informed

Consent Form (Appendix 3).

4. Reproduce more than enough questionnaires for distribution.
5. Select research assistants who assisted in the data collection; brief and orient them in order to be consistent in administering the questionnaires.

3.8.2. During the administration of the questionnaires

1. The respondents were requested to answer completely and not to leave any part of the questionnaires unanswered.
2. The researcher and assistants emphasized retrieval of the questionnaires within five days from the date of distribution.
3. On retrieval, all returned questionnaires were checked if all questions are answered.

3.9 Data Analysis

Analysis of data is a process of inspecting, cleaning, transforming, and modeling data with the goal of discovering useful information, suggesting conclusions, and supporting decision-making (Tabachnick and Fidell, 2007). Manual coding was done on the transcripts to identify the significant statements across individual questionnaires. Mean and standard deviation was used to determine the resource allocations from government revenue for the health care projects in Hargeisa Somaliland, to establish the public revenue raising efforts to improve health service delivery in Hargeisa Somaliland and to examine the usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland.

All those were done with the help of software called Statistical Package for Social Scientist (SPSS).

3.10 Ethical Considerations

Informed consent

The researcher informed the key informants of her intention to involve them in her research.

Privacy and Anonymity

The researcher made sure she removes all identifying information from her and in any case seek permission from the participants if she wishes to make public information that might reveal who they are or who the

Confidentiality

The researcher treated the information got from the participants with confidentiality.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF THE FINDINGS

4.0 Introduction

This chapter presents empirical findings and references to the research questions in chapter one. The findings were obtained from both primary and secondary sources. They presented and analyzed using frequency tables, percentages (frequency counts).

4.1 Demographic characteristics of the respondents in Hargeisa, Somaliland

4.1.1 Gender of respondents in Hargeisa, Somaliland

It was necessary to find out the distribution of respondents in Hargeisa, Somaliland by gender. The findings were as shown on table 1 below.

Table 1: Showing gender of respondents in Hargeisa, Somaliland

Gender category	Frequency	Percent
Male	93	45.4
Female	112	54.6
Total	**205**	**100.0**

Source: Primary data, (2016).

Research findings from Table 1 above showed that 93 out of 205 respondents represented by 45.4 % of the total sample population were Males whereas all 112 respondents out of 205 represented by 54.6% of the total sample population were females. This implies that most of the individuals in Hargeisa, Somaliland females than males.

4.1.2 Age of the respondents in Hargeisa, Somaliland

It was necessary to determine the distribution of respondents in Hargeisa, Somaliland by age. The respondents were asked about their age and the results were tabulated in a table 2 below.

Table 2: Showing age of respondents in Hargeisa, Somaliland

Age group	Frequency	Percent
20-30	68	33.2
31-40	56	27.3
41-50	50	24.4
51-60	31	15.1
Total	**205**	**100.0**

Source: Primary data, (2016).

According to the research findings from Table 2 above, 68 respondents represented by 33.2 % of the total sample population were between the age group of 20-30 years, 56 (27.3%) of the total sample population were 31-40, 50(24.4%) of the total sample population fall under age group 41-50 while only 31(615.1%) of the total sample population were of age group 51-60 years. This implies that most of the individuals in Hargeisa, Somaliland fall under the age of 20-30 years.

4.1.3 Highest academic qualification attained by respondents in Hargeisa, Somaliland.

It was necessary to find out the distribution of respondents in Hargeisa, Somaliland by the occupation. The respondents were therefore, asked about their Occupation and the results were shown in table 3 below.

Table 3: showing highest academic education attained by the respondents in Hargeisa, Somaliland

Respondents highest academic education attained	Frequency	Percent
Diploma	50	24.4
Bachelor's degree	29	14.1
Master's degree	36	17.6
PhD	02	01
Others	88	42.9
Total	**205**	**100.0**

Source: Primary data, (2016).

Findings from table 3 above indicate that, 50 respondents out of 205 represented by 24.4% had attained diploma as their highest academic education, 29(14.1%) were Bachelor's degree holders, 36(17.6%) were Master's degree holders , only 02(1.0 %) were PhD holders and all 88(42.9%) had attained other academic qualifications such as secondary level, Vocational and primary level of education. This implies that most of individuals in Hargeisa, Somaliland attained education qualification such as secondary level, primary level and vocational qualification, followed by those with diploma qualification.

4.1.4 Marital status of respondents in Hargeisa, Somaliland

It was necessary to find out the distribution of respondents in Hargeisa, Somaliland by marital status. The findings on the respondents' distribution in Hargeisa, Somaliland by marital status was as shown on table 4 below.

Table 4: Showing the marital status of respondents in Hargeisa, Somaliland.

Respondents marital status	Frequency	Percent
Single	26	12.7
Married	108	52.7
Divorced	48	23.4
Widowed	23	11.2
Total	**205**	**100.0**

Source: Primary data, (2016).

According to the research findings on table 4, 26 respondents out of 205 respondents represented by 12.7% of the total respondents were single, all 108(52.7%) of the total sample population were married, 48(23.4%) had divorced while only 23(11.2%) of the total respondents were widows. This implies that most of the people in Hargeisa, Somaliland are married couples

4.1.5 Respondents' years of experience of work in the organization in Hargeisa, Somaliland

It was necessary to find out the distribution of respondents in Hargeisa, Somaliland by the years of experience of work in the organization. The respondents were therefore, asked about their years of experience of work in the organization and the results were shown in table 5 below.

Table 5: Respondents' years of experience of work in the organization in Hargeisa, Somaliland

Respondents' years of experience	Frequency	Percent
Less than 1 year	40	19.5
Between 1-3 years	71	34.6
Between 3-5 years	51	24.9
Over 5 years	43	21.0
Total	**205**	**100.0**

Source: Primary data, (2016)

According to the research findings on table 5, 40 respondents out of 205 respondents represented by 19.5% of the total respondents had worked in health sector for less than 1 year, 71(34.6%) of the total sample population had worked in health sector for between 1-3 years, 51(24.9%) had

worked for between 3-5 years while 43(21.0%) of the total respondents had worked for over 5 years in the health sector. This implies that most of the workers in the health sector in Hargeisa, Somaliland have working experience 1-3 years in that field. The above information can also be presented on figure form as shown on figure 5 below.

Source: Primary data, (2016).

4.2 The resource allocations from government revenue for the health care projects in Hargeisa, Somaliland

A question was derived from the first objective of the research study about what are the resource allocations from government revenue for the health care projects in Hargeisa, Somaliland? To achieve this objective, respondents were subjected to a number of questions to provide answers to the above research question. The questions delivered to the respondents were aimed at investigating their response towards the stated research objective. The response was as shown on table 6 below.

Table 6: The resource allocations from government revenue for the health care projects in Hargeisa, Somaliland

The resource allocations from government revenue	Mean	Rank	Interpretation
Somaliland uses general tax revenues to finance various components in the health sector	2.46	5	Satisfactory
The government expenditure on health as a percentage of total expenditure of government has tended to remain low	2.44	6.5	Satisfactory
Resource allocation in Hargeisa is based on existing ministry structures	2.44	6.5	Satisfactory
Resource allocation is also based on bureaucratic demand	2.48	4	Satisfactory
In Hargeisa, there is use of needs-based formula to guide the allocation of health resources	3.47	3	Very satisfactory
The needs-based formula for allocation of resources addresses equity concerns during allocation process	3.51	2	Very satisfactory
The resource allocation needs in the health sector in Hargeisa depends on the size of the population, demographic composition, levels of ill-health and socio-economic status of individuals	3.52	1	Very satisfactory
Overall mean	**2.9**		**Satisfactory**

Source: Primary data, (2016).

From Table 6: the findings show that the resource allocation needs in the health sector in Hargeisa depends on the size of the population, demographic composition, levels of ill-health and socio-economic status of individuals , (3.52), that the needs-based formula for allocation of resources addresses equity concerns during allocation process, (3.51), and that In Hargeisa, there is use of needs-based formula to guide the allocation of health resources, (3.47); all these were very high indicating a very satisfactory interpretation.

Also, from table 6, findings still indicated that Resource allocation is also based on bureaucratic demand, (2.48), Somaliland uses general tax revenues to finance various components in the health sector, (2.46), that the government expenditure on health as a percentage of total expenditure of government has tended to remain low, (2.44) and that resource allocation in Hargeisa is based on existing ministry structures, (2.44). All these responses were high indicating a satisfactory interpretation.

The overall mean on the resource allocations from government revenue for the health care projects in Hargeisa, Somaliland is 2.9 which is high, this implies that the resource allocations from government revenue for the health care projects in Hargeisa, Somaliland was satisfactory, meaning that the resources are properly allocated in the health sector for health care projects in Hargeisa, Somaliland.

4.3 The extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland.

A question was derived from the second research objective of the study about what is the extent to which public revenue-raising efforts is to improve health service delivery in Hargeisa, Somaliland? To achieve this objective, respondents were subjected to a number of questions t provide answers to the above research question. The questions delivered to the respondents were aimed at investigating their response towards the stated research objective. The response was as shown on table 7 below.

Table 7: The extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland

The extent of public revenue-raising efforts	Mean	Rank	Interpretation
There is much efforts in raising public revenue in Hargeisa	2.63	7.5	Satisfactory
There is public revenue raising through user fees as direct payment by patients	2.63	7.5	Satisfactory
User fees (prices) are charged for resource mobilization as a standard practice all over the world	2.64	6	Satisfactory
The extent to which revenue can be raised through user fees depend on the extent to which people are willing to pay a price for health care services	2.67	5	Satisfactory
Usually patients are not willing to pay any price for curative services	2.68	4	Satisfactory
When user fees rise, utilization of health care services falls	4.06	3	Very satisfactory
.Consumers of health care are accustomed to user fees where the private sector participates in health care provision	4.08	1.5	Very satisfactory
User charges have contributed very little to recurrent government expenditure	4.08	1.5	Very satisfactory
Overall mean	**3.18**		**Satisfactory**

Source: Primary data, (2016).

According to the research findings From Table 7 indicate that User charges have contributed very little to recurrent government expenditure, (4.08), that Consumers of health care are accustomed to user fees where the private sector participates in health care provision, (4.08), and that when user fees rise, utilization of health care services falls, (4.06); all these were very high indicating a very satisfactory interpretation.

Also, from table 7, findings still indicated that usually patients are not willing to pay any price for curative services, (2.68) that the extent to which revenue can be raised through user fees depend on the extent to which people are willing to pay a price for health care services, (2.67),

that User fees (prices) are charged for resource mobilization as a standard practice all over the world, (2.64), also that There is public revenue raising through user fees as direct payment by patients, (2.63) and that there is much efforts in raising public revenue in Hargeisa, (2.63). All these responses were high indicating a satisfactory interpretation.

The overall mean on the extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland is 3.18 which is high, this implies that the extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland was satisfactory, meaning that public revenue raising efforts improves health service delivery in Hargeisa, Somaliland.

4.4 The extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland

A question was derived from the third objective of the research study about what is the extent of the usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland? To achieve this objective, respondents were subjected to a number of questions to provide answers to the above research question. The questions delivered to the respondents were aimed at investigating their response towards the stated research objective. The response was as shown on table 8 below.

Table 8: The extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland

The extent of the usage of health insurance	Mean	Rank	Interpretation
Health insurance is a method of health care financing in Hargeisa, Somaliland	4.21	7	Very satisfactory
Health insurers act as payers of health services	4.22	6	Very satisfactory
There is either public or private health insurance mode of resource mobilization	4.20	8	Very satisfactory
The type of health insurance determines the degree of control government has over health spending	4.23	4.5	Very satisfactory
There is also a social health insurance where both employer and employee pay a contribution at the end of the month	4.25	2	Very satisfactory
In social insurance, services are paid through contributions to a health fund through payroll	4.24	3	Very satisfactory
There is lack of a formal insurance market in Hargeisa Somaliland	4.23	4.5	Very satisfactory
In Hargeisa Somaliland there is no very common practice of a referral system that requires that medical services should initially access the lowest and least inexpensive system of primary health care	4.26	1	Very satisfactory
Overall mean	**4.23**		**Very satisfactory**

Source: Primary data, (2016).

According to the research findings from table 8 above, the findings show that In Hargeisa Somaliland there is no very common practice of a referral system that requires that medical services should initially access the lowest and least inexpensive system of primary health care, (4.26), that there is also a social health insurance where both employer and employee pay a contribution at the end of the month, (4.25), that in social insurance, services are paid through contributions to a health fund through payroll, (4.24), that there is lack of a formal insurance market in Hargeisa Somaliland, (4.23), that the type of health insurance determines the degree of control government has over health spending, (4.23), that Health insurers act as payers of health services, (4.22), that Health insurance is a method of health care financing in Hargeisa, Somaliland, (4.21) and that there is either public or private health insurance mode of resource mobilization. All these responses were very high implying a very satisfactory interpretation.

The overall mean on the extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland is 4.23 which is very high, this implies that the extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland was very satisfactory, meaning that health insurance is a major mode of resource mobilization for health care projects in Hargeisa, Somaliland.

4.5 Significant relationship between resource mobilization and performance of health care projects in Hargeisa Somaliland

A question was derived from the third objective of the research study about whether there is significant relationship between resource mobilization and performance of health care projects in Hargeisa Somalia? To achieve this objective, the researcher stated a null hypothesis that there is no significant relationship between resource mobilization and performance of health care projects in Hargeisa Somaliland. Therefore to achieve this objective and to test this null hypothesis, the researcher correlated the means on resource mobilization and performance of health care projects by using the Pearson's Linear Correlation Coefficient as indicated in table 9 below.

Table 9: Correlations between resource mobilization and performance health care projects in Hargeisa, Somalia

Variables correlated	Resource mobilization	Performance of health care projects
Resource mobilization Vs	1	.349**
		.000
	205	205
Performance of health care projects	.349**	1
	.000	
	205	205
**. Correlation is significant at the 0.01 level (2-tailed).		

Source: *Primary data, (2016).*

Results in table 9 indicated a positive strong correlation between resource mobilization and performance of health care projects, since the value 0.349 was less than 0.5 and which the maximum level of significance is required to declare a significant relationship in social sciences. This implies that effective resource mobilization will fairly improve performance of health care projects, and ineffective resource mobilization will fairly reduce it, here the stated null hypothesis was rejected basing on these results and hence concluding that there is a significance relationship between resource mobilization and performance of health care projects in Hargeisa Somaliland

Table 10: Regression analysis between resource mobilization and performance health care projects in Hargeisa, Somalia

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.112	2.048		1.005	.028
	Resource mobilization	.316	.032	.479	11.793	.000
a. Dependent Variable: Performance of health care projects						

Source: Primary data, (2016).

The value of Beta (0.316) mean that 01 percentage increase in resource mobilization will lead to 31.6 percentage increase in performance of health care projects. The level of significance is 0.01 %, the null hypothesis was rejected while the alternative hypothesis was accepted and concluded that there is statistical significance relationship between resource mobilization and performance of health care projects at 0.01 % level of significance.

CHAPTER FIVE
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the findings, conclusions, recommendations and suggested areas that need further research following the study objectives and study hypothesis.

5.1Discussion of findings

5.1.1 The resource allocations from government revenue for the health care projects in Hargeisa, Somaliland.

Based on the analysis of chapter four, from Table 6: the findings showed that, the resource allocation needs in the health sector in Hargeisa depends on the size of the population, demographic composition, levels of ill-health and socio-economic status of individuals , that the needs-based formula for allocation of resources addresses equity concerns during allocation process, and that In Hargeisa, there is use of needs-based formula to guide the allocation of health resources, all these were very high indicating a satisfactory interpretation.

Also, from table 6, findings still indicated that Resource allocation is also based on bureaucratic demand, Somaliland uses general tax revenues to finance various components in the health sector, that the government expenditure on health as a percentage of total expenditure of government has tended to remain low, and that resource allocation in Hargeisa is based on existing ministry structures. All these responses were high indicating a satisfactory interpretation.

The overall mean on the resource allocations from government revenue for the health care projects in Hargeisa, Somaliland is 2.9 which is high, this implies that the resource allocations from government revenue for the health care projects in Hargeisa, Somaliland was satisfactory, meaning that the resources are properly allocated in the health sector for health care projects in Hargeisa, Somaliland.

The above findings are in line with Kerzner, (2001), proper allocation of resources is important factor for the success of most projects such health care projects, water projects among other.

5.1.3 The extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland.

To achieve this objective, respondents were subjected to a number of questions to provide answers to the research question derived from this objective. The questions administered to the respondents were aimed at investigating the respondent's response towards the stated research objective. Data analysis and interpretation revealed the following findings on this objective. Based on the analysis of chapter four, from Table 7: the findings showed that, User charges have contributed very little to recurrent government expenditure, that Consumers of health care are accustomed to user fees where the private sector participates in health care provision, and that when user fees rise, utilization of health care services falls, all these were very high indicating a very satisfactory interpretation.

Also, from table 7, findings still indicated that usually patients are not willing to pay any price for curative services, that the extent to which revenue can be raised through user fees depend on the extent to which people are willing to pay a price for health care services, that User fees (prices) are charged for resource mobilization as a standard practice all over the world, also that There is public revenue raising through user fees as direct payment by patients, and that there is much efforts in raising public revenue in Hargeisa. All these responses were neutral indicating a medium interpretation.

The overall mean on the extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland is 3.18 which is high, this implies that the extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland was satisfactory, and meaning that public revenue raising efforts improves health service delivery in Hargeisa, Somaliland.

The above findings are in line with Gupta, (2001), rising of more public revenue through taxation and other methods is a major way to improve service delivery to the community. This is due to the fact that revenue raised can be invested in public utilities as construction of health centers, schools, provision of water among others.

5.1.4 The extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland

To achieve this objective, respondents were subjected to a number of questions to provide answers to the research question derived from this objective. The questions administered to the respondents were aimed at investigating the respondent's response towards the stated research objective. Data analysis and interpretation revealed the following findings on this objective. Based on the analysis of chapter four, from Table 8: the findings show that In Hargeisa Somaliland there is no very common practice of a referral system that requires that medical services should initially access the lowest and least inexpensive system of primary health care, that there is also a social health insurance where both employer and employee pay a contribution at the end of the month, that in social insurance, services are paid through contributions to a health fund through payroll, that there is lack of a formal insurance market in Hargeisa Somaliland, that the type of health insurance determines the degree of control government has over health spending, that Health insurers act as payers of health services, that Health insurance is a method of health care financing in Hargeisa, Somaliland, and that there is either public or private health insurance mode of resource mobilization. All these responses were very high implying a very satisfactory interpretation.

The overall mean on the extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland is high, which implies that the extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland was satisfactory, meaning that health insurance is a major mode of resource mobilization for health care projects in Hargeisa, Somaliland.

The above findings are in line with The findings are in line with Wei and Tun, (2005), insurance is a form of resource mobilization through paying monthly premium to the insurance companies where money is paid to the company and is invested in other sectors.

5.1.5 Significance relationship between resource mobilization and performance of health care projects in Hargeisa Somalia.

Results in table 9 indicated a positive strong correlation between resource mobilization and performance of health care projects and results from chapter four indicated that effective resource mobilization will fairly improve performance of health care projects, and ineffective

resource mobilization will fairly reduce it, here the stated null hypothesis was rejected basing on these results and hence concluding that there is a significance relationship between resource mobilization and performance of health care projects in Hargeisa Somalia

Findings from table 10 indicate that, the value of Beta (0.316) mean that 01 percentage increase in resource mobilization will lead to 31.6 percentage increase in performance of health care projects. The level of significance is 0.01 %, the null hypothesis was rejected while the alternative hypothesis was accepted and concluded that there is statistical significance relationship between resource mobilization and performance of health care projects at 0.01 % level of significance

5.2 Conclusions

It can be concluded that the resource allocations from government revenue for the health care projects in Hargeisa, Somaliland was satisfactory, meaning that the resources are properly allocated in the health sector for health care projects in Hargeisa, Somaliland.

It can also be concluded that the extent to which public revenue-raising efforts are to improve health service delivery in Hargeisa, Somaliland was satisfactory, meaning that public revenue raising efforts improves health service delivery in Hargeisa, Somaliland.

And that the extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland was very satisfactory, meaning that health insurance is a major mode of resource mobilization for health care projects in Hargeisa, Somaliland.

And that there is a significance relationship between resource mobilization and performance of health care projects and that there is statistical significance relationship between resource mobilization and performance of health care projects at 0.01 % level of significance Hargeisa Somalia

5.3 Recommendation

5.3.1 To determine the resource allocations from government revenue for the health care projects in Hargeisa Somaliland.

The researcher recommends to the government that they should continue to properly allocate resources in the health care projects, this is because health is an important department in every government or state.

The Researcher appeals to the International Community including the World Bank, UNDP, Care International and other organizations to help further provide health services to the communities in Somalia through provision of funding.

5.3.2 To establish the public revenue-raising efforts to improve health service delivery in Hargeisa Somaliland.

The researcher recommends to the government to improve on public revenue-raising efforts for better service delivery in health care projects in Hargeisa Somalia.

The study further recommends to the various stakeholders including both private and public stakeholders in the health sector to further seek more ways of how to improve funding and solicit more income that can enable provision of medical services and products in Hargeisa.

5.3.3 To examine the usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland.

The researcher also recommends to the government to emphasize on the usage of health insurance for the success of health care projects in Hargeisa Somalia.

There is need for privatization of health facilities so that private companies could be able to invest and provide health services to the general public, shifting most of the burden from the government and international community.

5.4 Limitations of the study

Through this research, the researcher claimed an allowable 5% margin of error in view of the following anticipated threats to validity with relevance to this study. The study willed the following limitations:

Extraneous variables: This was beyond the researcher's control such as respondents' honesty, personal biases and uncontrolled setting of the study.

Testing: The use of research assistants can bring about inconsistency in the administration of the questionnaires in terms of time of administration, understanding of the items in the questionnaires and explanations given to the respondents. To minimize this threat, the research assistants were oriented and briefed on the procedures to be done in data collection.

Attrition/Mortality: Not all questionnaires are returned neither completely answered nor even retrieved back due to circumstances on the part of the respondents such as travels, sickness, hospitalization and refusal/withdrawal to participate. In anticipation to this, the researcher reserved more respondents by exceeding the minimum sample size. The respondents were reminded not to leave any item in the questionnaires unanswered and were closely followed up as to the date of retrieval.

5.5 Areas for further research

Prospective researchers and even students are encouraged to research on the following areas;

1. Teenage pregnancies and the health of children in Hargeisa, Somalia
2. Maternity services and women rights in Hargeisa, Somalia
3. Women health education and socio growth in Hargeisa-Somalia

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APPENDICES

APPENDIX I A
TRANSMITTAL LETTER
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Dear Sir/Madam,

RE: INTRODUCTION LETTER TO CONDUCT RESEARCH IN YOUR INSTITUTION

Ms. ZEINAB ALI is a bonafide student of Kampala International University pursuing a Master's degree of Project Planning and Management.

She is currently conducting a field research for his dissertation entitled, Resource mobilization for health care projects in Hargeisa Somalia.
Your city has been identified as a valuable source of information pertaining to his research project. The purpose of this letter then is to request you to avail him with the pertinent information he may need.

Any data shared with him will be used for academic purposes only and shall be kept with utmost confidentiality.

Any assistance rendered to him will be highly appreciated.

Yours truly,

Deputy Vice Chancellor, College of Higher Degrees and Research

APPENDIX IB
TRANSMITTAL LETTER FOR THE RESPONDENTS

_____

Dear Sir/ Madam,

Greetings!

I am a student of Kampala International University pursuing a Master's degree of Project Planning and Management.

My study is entitled, "Resource mobilization for health care projects in Hargeisa Somalia.". Within this context, may I request you to participate in this study by answering the questionnaire. Kindly do not leave any option unanswered. Any data you will provide shall be for academic purposes only and no information of such kind shall be disclosed to others.

May I retrieve the questionnaire within five days (5)?

Thank you very much in advance.

Yours faithfully,

Ms. ZAINAB ABDIRISAK ALI

APPENDIX II

INFORMED CONSENT

I am giving my consent to be part of the research study of Ms. ZAINAB ABDIRISAK ALI that will focus on Resource mobilization for health care projects in Hargeisa Somalia. I shall be assured of privacy, anonymity and confidentiality and that I will be given the option to refuse participation and right to withdraw my participation anytime.

I have been informed that the research is voluntary and that the results will be given to me if I ask for it.

Initials:_____

Date_____

APPENDIX III
QUESTIONNAIRE

SECTION A

Demographic characteristics of the respondents

1. Gender

Male ☐ Female ☐

2. Age

20-30 ☐

31-40 ☐

41-50 ☐

51-60 ☐

3. Highest academic education attained

Diploma ☐

Bachelor's degree ☐

Master's degree ☐

PhD ☐

Others, specify.....

4. Marital status

Single ☐ Married ☐

Divorced ☐ Widowed ☐

5. For how long have you worked with your organisation?

Less than 1 year ☐ Between 1-3 yrs ☐

Between 3-5 yrs ☐ Over 5 yrs ☐

For sections, B, C and D, Use the following key to answer the following questions

1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

SECTION B

The resource allocations from government revenue for the health care projects in Hargeisa Somaliland

Questions	Response				
	1	2	3	4	5
1. Somaliland uses general tax revenues to finance various components in the health sector					
2.The government expenditure on health as a percentage of total expenditure of government has tended to remain low					
3.Resource allocation in Hargeisa is based on existing ministry structures					
4.Resource allocation is also based on bureaucratic demand					
5.In Hargeisa, there is use of needs-based formula to guide the allocation of					

health resources					
6.The needs-based formula for allocation of resources addresses equity concerns during allocation process					
7.The resource allocation needs in the health sector in Hargeisa depends on the size of the population, demographic composition, levels of ill-health and socio-economic status of individuals					

SECTION C

The extent of public revenue-raising efforts to improve health service delivery in Hargeisa Somaliland

Questions	**Response**				
	1	2	3	4	5
1. There is much efforts in raising public revenue in Hargeisa					
2.There is public revenue raising through user fees as direct payment by patients					
3.User fees (prices) are charged for resource mobilization as a standard practice all over the world					
4.The extent to which revenue can be raised through user fees depend on the extent to which people are willing to pay a price for health care services					
5.Usually patients are not willing to pay any price for curative services					
6.When user fees rise, utilization of health care services falls					
7.Consumers of health care are accustomed to user fees where the private sector participates in health care provision					
8.User charges have contributed very little to recurrent government expenditure					

SECTION D

The extent of usage of health insurance as a mode of resource mobilization for the health care projects in Hargeisa Somaliland

Questions	Response				
	1	2	3	4	5
1. Health insurance is a method of health care financing in Hargeisa, Somaliland					
2.Health insurers act as payers of health services					
3.There is either public or private health insurance mode of resource mobilization					
4.The type of health insurance determines the degree of control government has over health spending					
5.There is also a social health insurance where both employer and employee pay a contribution at the end of the month					
6.In social insurance, services are paid through contributions to a health fund through payroll					
7.There is lack of a formal insurance market in Hargeisa Somaliland					
8.In Hargeisa Somaliland there is no very common practice of a referral system that requires that medical services should initially access the lowest and least inexpensive system of primary health care					

APPENDIX IV

TIME FRAME

ACTIVITY	RESPONSBILITY	RESOURCES	TIME
Developing research Topic	Lecturers/ Researcher	Stationery	August 2015
Developing research proposal	Researcher/ Supervisor	Stationery, Computer	Dec 2015
Research proposal review and modification	Supervisor	Stationery	January 2016
Submission of research proposal	Researcher	Transport	April 2016
Approval of the research proposal	Supervisor	Transport	April 2016
Collection of data	Researcher	Transport	MAY-JUNE 2016
Data entry & transcribing	Researcher/ Assistants	Secretarial input	JUNE-JULY 2016
Report writing	Researcher	Stationery	JULY 2016
Final Report	Researcher	Transport	AUGUST 2016

APPENDICES V:

BUDGET

Stationery	Quantity/time	Unit Cost/Ug shs	Total/Ug shs
Stationery (Assorted)	-	-	800,000
Laptop Computer	1	1,200,000	1,200,000
Travel	30 days	8,000	240,000
Binding	6 copies	5,000	30,000
Printing and binding thesis	4	9500	38,000
Total			**2,308,000**

INTERNAL EXAMINATION REPORT

NAME OF STUDENT : [illegible] ABDIRAZAK ALI

REGISTRATION NUMBER : MPP/ 445588/143/DF

TITLE OF STUDY: Resource Mobilization for Health Care Projects in Hargeisa, Somaliland.

The structure of the study title is ok given that the independent variable (Resource Mobilization) and the dependent variable (Health Care Projects) are clearly brought out. However, there is no country in the Atlas called Somaliland rather Somalia. The cover page suggests the work is still at proposal stage.

1. Background

Generally this section of the chapter has been fairly addressed by the researcher though the language/ tense used suggest the work is still at proposal stage. Mark 3/5

2. Problem Statement

Problem statement should be presented in one paragraph. Besides, the problem that warranted the study is not tangible given that there is no evidence to the allegations. Mark 3/5

3. Objectives

The purpose of the study is well addressed. The research objectives too are well addressed. Mark 2/3

4. Hypothesis

Not presented yet Table 9 presents a test of relationship between the two variables of study. Mark 0/2

Final Ma

The student passes with MAJOR corrections

Name of Internal Examiner :

SIGN :

DATE : 17-Oct-2016

EXTERNAL EXAMINERS REPORT

FROM

COLLEGE OF HIGHER DEGREES AND RESAERCH KAMPALA INTERNATIONAL UNIVERSITY

CANDIDATE: Zainab Abdirazak Ali

REGISTRATION NUMBER: MPP /445588/121/DF

TITLE OF THE DISSERTATION: Resource Mobilization for Health Care projects in Hargeisa, Somaliland

DATE WHEN DISSERTATION RECEIVED: September, 2016

DATE OF SUBMISSION OF THE REPORT: October 2rd , 2016

NB: Create space between your subheadings and the text and consider deleting the budget from 57. On page 44, how many areas for further research did you intend to write ? You list and number 1..... see page 44

1. **TITLE OF THE THESIS**

The title is fairly written following the minimum requirements.

2. **BACKGROUND (7 Marks)**

The background to the study is fairly written. Provides a good context for the study and issues central to the study are properly introduced. The flow is good and central issues are highlighted and their linkage to the proposed study specified. The conceptualization of the Independent variable is well conceptualized from the background given.

3. **PROBLEM STATEMENT (3 Marks)**

Problem fairly articulated and an effort has been made to align it with the subject under investigation.

4. **OBJECTIVES (3 Marks)**