

**UTILISATION OF FISCAL RESOURCES IN HEALTH SECTOR IN SOMALIA**

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Master of Public Administration and management**

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**November, 2016**

## DECLARATION

This research dissertation is my original work and has never been presented for a degree or any other academic award in any university or institution of learning".

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**APPROVAL**

I affirm that the work presented in this research dissertation was carried out by the candidate under my supervision".

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Name and Signature of Supervisor

9/11/2016

Date

## **DEDICATION**

This dissertation is dedicated to my father Abdi Osman and my Waris Ali Haji for their great contribution and efforts that they have put in for me to reach this level of education. Thank you very much.

## ACKNOWLEDGEMENTS

I want to thank the almighty Allah, for providing me with his grace and opportunity to finish this academic study. I would also like to extend my sincere gratitude to all those who have contributed towards the successful completion of this dissertation.

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### **ABSTRACT**

The study focused on utilization of fiscal resources in health sector in Somalia as the case study. The study objectively thought to; identify the forms fiscal resource utilization on health sector in Somalia, to establish whether normal procedures are used in fiscal resources utilization in the health sector in Somalia and to identify the challenges of fiscal resource utilization in the health sector in Somalia. The study adopted a descriptive research design. Descriptive was used because of its ability to describe results from questionnaires and interviews and employs both quantitative and qualitative methods which were used because of its flexibility for instance. A sample of 167 respondents was selected. Using, purposive sampling and simple random data was analyzed using the computer package called SPSS to generate tables and graphs. The findings of the study were that there was Coordination, collaborate, and do no harm were as (mean=2.54, agreed) implying that there was a good relationship between the workers and team work was exercised. In addition, Respondents appeared reserved surprisingly on support improvements in the ability of developing country governments to develop sound budgets and report on their execution (mean=1.20, strongly disagreed) there should be planning purposes loosely linking planned performance to funding; were as follows; (mean=1.22, strongly disagreed) The study concluded that the Ministry of Health has to make efforts to ensure equitable access, through the regional allocations for public health services, for which user fees have been abolished. Performance budgeting should be more than the development of performance information: it is concerned with the use of this information in budget processes and resource allocation. PI can be used by the MOF for planning purposes and/or accountability purposes. The study recommends that government should stimulate the formation of a social health insurance scheme by pooling the large out-of-pocket expenditure that goes to private care and extending the revenue collected to low income groups. The ministry of Health should use resources more optimally by being more specific as to the drugs offered under the new Government. The low wage packages and lack of incentives has compromised the delivery of health services. Its recommended creating a link between public health workers' remuneration packages and performance, For example, provide nonmonetary rewards such as opportunities for learning and career progression, subsidized housing and education for dependents.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.0 Introduction**

This chapter entails the introduction to the study, background to the study, problem statement, purpose of the study and the research objectives. It also gives the research questions, hypothesis, and study of scope and significance of the study

#### **1.1 Background to the Study**

The background of the study was classified into perspectives namely; Historical, theoretical, conceptual, contextual perspective

##### **1.1.1 Historical Perspective**

Health is one of the most important services provided by the government in every country of the world. In both the developed and developing nations, a significant proportion of the nation's wealth is devoted to health. For example, the (World Health Reports, 2006) gave Nigerian government's expenditure on health as a percentage of the nation's Gross Domestic Product (GDP) for year 2001, 2002, and 2003 as 5.3 percent, 5 percent, and 4.7 percent respectively. This is to show the fact that Nigerian government health care expenditures are not only significant in absolute terms but also relative to the Gross Domestic Product.

Health outcomes across the EU are strikingly different according to where people live, their ethnicity, sex and socioeconomic status. The Europe Union (EU) promotes the coordination of national healthcare policies through an open method of coordination which places particular emphasis on the access to, and the quality and sustainability of healthcare. Some of the main objectives include: shorter waiting times; universal insurance coverage; affordable care; more patient-centred care and a higher use of outpatients; greater use of evidence-based medicine, effective prevention programmes, generic medicines, and simplified administrative procedures; and strengthening health promotion and disease prevention (NORAD, 2009).

Access to healthcare, the introduction of technological progress and greater patient choice is increasingly being considered against a background of financial sustainability. Many of the challenges facing governments across the EU were outlined in the European Commission's

White paper titled (COM (2007) 630 final). In February 2013, the European Commission adopted a Communication titled (COM (2013) 83 final), which was accompanied by a staff working document titled 'Investing in health' (SWD (2013) 43 final). The main axes of the Communication and working document include: ensuring that social protection systems respond to people's needs at critical moments throughout their lives; simplified and better targeted social policies, to provide adequate and sustainable social protection systems; and upgrading active inclusion strategies in the Member States. Concerning health, the Communication notes the differences in the accessibility to and quality of healthcare between EU Member States as well as underlining the need for reforms of healthcare systems with the twin aim to ensure access to high quality healthcare and to use public resources more efficiently. In the context of social investment throughout an individual's lifetime, the Communication notes that investing in health, starting from an early age, allows people to remain active longer and in better health, raises the productivity of the workforce and lowers the financial pressures on healthcare systems (Longo, 2008).

The western health care system dates back to the time when missionaries started coming to Central Africa. Through their efforts churches, healthcare institutions and education facilities were established (Stock and Anyinam, 1992; Falola and Ityavyar, 1992). These early missionaries preferred to settle in very remote areas to serve needy populations. It is therefore suggested that missionaries were the first to introduce modern health care services to such areas. Many changes have taken place in the health sector since then (Falola and Ityavyar, 1992). After Zambia's independence in 1964, the Ministry of Health (MoH) assumed the role of main financier and provider of health care services, but worked in collaboration with the existing mission health care providers and health clinics operated by statutory corporations (NSO, 2004). Most of the health services were oriented towards curative, rather than preventive health care services and involved interventions that were largely supported by various donors (Ngalande et al, 1995).

Consequently, spending on health is not only consumption expenditure, but a productive investment both at individual and national levels. On the enterprise scale, for example, a healthy workforce reduce the cost of building slacks into the production schedules; enhance investment

in staff training and exploitation of the benefits of specialization. At the national level, a healthy population is potentially a more productive population. This reasoning justifies national resource deployment to health and the increased campaign to use organized healthcare. It is assumed that increased access and use of health services will improve the health status of the population (Helleiner, 2000).

In terms of institution, the primary health care level is made up of public health care centres and clinics, dispensaries, private clinics and maternity centers. The secondary care level consists of general, cottage and mission hospitals, while teaching and specialist hospitals exist at the tertiary level. These tiers, by design, are closely related to one another with the higher tier designed to assist the lower care levels by handling referral cases from the lower facilities. Responsibilities for health at the primary level reside with the local government while the Federal government has responsibility for policy formulation, monitoring and evaluation of the nation's health system. The states manage secondary facilities and provide logistic support for the local government in form of personnel training, financial assistance, planning and operations (Federal Ministry of Health, 2000).

In the absence of a functioning health surveillance system, accurate data on mortality and morbidity is difficult to obtain in Somalia. There is a consensus, however, that Somalia has some of the worst health indicators in the world, with life expectancy of 47 years, infant mortality of 132 per 1,000 live births, under-five mortality of 224 per 1,000 live births and maternal mortality of 1,600 per 100,000 live births. Vaccination rates are dismally low, with only 10.6% of all children less than one year and 27% of children less than five years fully immunized against all the childhood diseases, with considerable variations between urban, rural settled and nomadic populations<sup>71</sup>. There has been no Yellow Fever vaccination for a decade. Despite the investments made in health services by international agencies and the private sector over the past decade, there appears to be little improvement in these indicators (ECOSOC, 2009b):.

Infant, child and maternal mortality rates in Somalia are among the highest in the world. Diarrhoeal disease-related dehydration, respiratory infections and malaria are the main killers of infants and young children, together accounting for more than half of all child deaths. Cholera is

endemic in Somalia, with outbreaks occurring annually from December to June. The major underlying causes of diarrhea are the lack of access to safe water and poor food and domestic hygiene. In the 2000 multiple indicator cluster survey, it was found that almost 24 per cent of children under five years of age had diarrhea in the two weeks preceding the survey.

### **1.1.2 Theoretical Perspective**

The study was guided by theory of fiscal policy advanced by British economist John Maynard Keynes, (1936) Also known as Keynesian economics, this theory basically states that governments can influence macroeconomic productivity levels by increasing or decreasing tax levels and public spending. This influence, in turn, curbs inflation (generally considered to be healthy when between 2-3%), increases employment and maintains a healthy value of money. Fiscal policy is very important to the economy. For example, in 2012 many worried that the fiscal cliff, a simultaneous increase in tax rates and cuts in government spending set to occur in January 2013, would send the U.S. economy back to recession. The U.S. Congress avoided this problem by passing the American Taxpayer Relief Act of 2012 on Jan. 1, 2013. Quantitative Easing is also a type of fiscal policy, implemented in Europe in several iterations in response to the eurozone debt crisis.

Fiscal policy uses government purchases, transfer payments, taxes, and borrowing to affect macroeconomic variables such as employment, the price level, and the level of GDP. Tools of fiscal policy: Automatic Stabilizers – Structural features of government spending and taxation that smooth fluctuations in disposable income, and hence consumption, over the business cycle. Federal Income Tax. Discretionary Fiscal Policy – The deliberate manipulation of government purchases, taxation, and transfers in order to promote macroeconomic goals such as full employment, price stability, and economic growth.

### **1.1.3 Conceptual Perspective**

According to GFATM, (2007) fiscal resources are the means for purchasing and/or obtaining the supplies, materials, equipment, services, and personnel required to provide programs for children and students with disabilities. The district, in providing for the education of children and students with disabilities within its jurisdiction, must have in effect policies, procedures, and



programs that are consistent with the State's policies and procedures. In the following text, application refers to the district's submission of an approved local budget and the annual application for state and federal special education aids. Reporting refers to the reports that must be submitted to state and federal agencies, including all supporting documentation as required for an audit.

According to Carrin (2004) effective utilization of public resources is critical to meeting development goals. Key programs in education and health are overwhelmingly conducted within the public sector. And although private provision of infrastructure has expanded in areas like telecommunications and energy, private investors remain wary of socially-oriented sectors such as water and sanitation, and also show little willingness to invest in the poorest countries. At present, though, research indicates that increases in public spending are only weakly correlated with the achievement of development outcomes in most developing countries. Government ineffectiveness in the form of waste, inefficiency and corruption is largely responsible. Poor resource usage is due in part to the fact that public spending is a complex, multifaceted process, which is not naturally transparent to the general public. Budgets typically pass through a sequence of stages, including formulation by ministries, scrutiny by legislative committees, approval by the legislature, distribution of funds to ministries, further distribution to state and local authorities, and end-point delivery. Accountability is hampered by deficiencies that include closed-door discussions, limited documentation, and poor data reliability.

Reproductive health is a major problem in Somalia, with a maternal mortality rate of 1,600 per 100,000 placing Somali women among the most high-risk groups in the world. The high maternal mortality dismally reflects how years of conflict have resulted in virtually all basic facilities such as referral hospitals, maternal and child health (MCH) facilities and services – being damaged or totally destroyed. Hemorrhage, prolonged and obstructed labour, infections and eclampsia (toxemia that may occur in late pregnancy) are the major causes of death at childbirth. Anemia and female genital mutilation (infibulations) have a direct impact on, and aggravate these conditions. Poor antenatal, delivery and postnatal care, with an almost complete lack of emergency obstetric referral care for birth complications, further contribute to these high rates of mortality and disability (Longo, 2008).

The impact of poor environmental sanitation is particularly felt in the cities, towns and large villages, or other places where people live in close proximity to each other. Defecation is generally close to dwellings and water resources and lack of garbage collection and the proliferation of plastic bags affect the urban environment and water sources. Poor hygiene and environmental sanitation are major causes of diseases such as cholera among children and women. Cholera is endemic and claims hundreds of lives annually, particularly in densely populated areas. Access to clean water is essential for prevention of diarrhea diseases and cholera.

According to Barrett & Lalta (2004) the healthcare industry (also called the medical industry or health economy) is an aggregation and integration of sectors within the economic system that provides goods and services to treat patients with curative, preventive, rehabilitative, and palliative care. It includes the generation and commercialization of goods and services lending themselves to maintaining and re-establishing health. The modern healthcare industry is divided into many sectors and depends on interdisciplinary teams of trained professionals and paraprofessionals to meet health needs of individuals and populations. The healthcare industry is one of the world's largest and fastest-growing industries. Consuming over 10 percent of gross domestic product (GDP) of most developed nations, health care can form an enormous part of a country's economy. For purpose of finance and management, the healthcare industry is typically divided into several areas. As a basic framework for defining the sector, the United Nations International Standard Industrial Classification (ISIC) categorizes the healthcare industry as generally consisting of: Hospital activities, Medical and dental practice activities, Other human health activities, Healthcare equipment and services; and Pharmaceuticals, biotechnology and related life sciences

The healthcare equipment and services group consists of companies and entities that provide medical equipment, medical supplies, and healthcare services, such as hospitals, home healthcare providers, and nursing homes. The latter listed industry group includes companies that produce biotechnology, pharmaceuticals, and miscellaneous scientific services. Other approaches to defining the scope of the healthcare industry tend to adopt a broader definition, also including other key actions related to health, such as education and training of health professionals,

regulation and management of health services delivery, provision of traditional and complementary medicines, and administration of health insurance.

#### **1.1.4 Contextual Perspective**

The Ministry of Health (MOH) in Somalia had six departments: planning and training, personnel, prevention services, curative services, finance and administration, and procurement and medical supplies. In the mid-1980s a new structure was introduced but was later abandoned. The MOH practiced a centralized system for decision-making and had links to the 18 administrative regions through regional medical officers (RMO) that reported to the curative services department. However, the regional primary health care project coordinators had semi-independent management from the RMO and worked under the directives and authority of the national PHC coordinator, who reported to the prevention services department. The MOH was responsible for the health care services of the civilian portion of the nine million Somalis who were mostly rural inhabitants (Banati, 2008).

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. 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 (GFATM, 2007).

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 (ECOSOC, 2009b). 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. However, these gains were reversed by the economic downturn and political turmoil of the 1980s and civil war of the 1990s (Government of Bangladesh, 2009).

### **Study conceptualization**

Universal access to health care is an ideal goal for all nations. Nations often base their health care development plans on this principle. 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. 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.

In addition, 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.

### **1.2 Statement of the Problem**

Provision of health care services is also driven by principles and delivery of services is publicly funded like other social services, such as education (Banati, 2008). However, that goal has never achieved and the health status indicators for Somalia, even before the collapse of the central been

government, showed grim statistics (Carrin, 2004). Development plans were driven by institutional history, political interest, and personal desires, instead of need and resource capacities based on empirical evidence (ECOSOC, 2009b). 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. Health care facilities in many districts collapsed and were unable to provide even the minimum required clinical and preventive services, 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 (NORAD, 2009). There has been wastage of resources and mismanagement health funds have been practiced (Reeves, 2008). 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; there has been lack of a strong regulatory body on drug importation and utilization, the needs of the health care system and its effective operation were mis-conceptualized (Longo, 2008). However the government of Somalia has tries to apply strategies which included budgeting strategic planning, improved investment in health, improved allocation strategies among other still the situation has not improved where poor leadership, disappointing outcomes of treatable diseases such as tuberculosis, malaria, typhoid, and dysentery were mainly attributed to the poor quality of imported drugs (OECD, 2011), As a result, many patients succumbed to serious illness, in addition to those who fell victim to provider negligence and ignorance. It is against such a background, the study sought to examine the utilization of fiscal resources in health sector in Somalia

### **1.3 Objectives of the study**

#### **1.3.1 General Objective**

The purpose of the study was to establish how fiscal resources are utilized in health sector in Somalia

#### **1.4 Specific objectives**

The objectives of this study were:

- i. To identify the forms fiscal resource utilization by the hospital managers in health sector in Somalia

- ii. To establish whether normal procedures are used by the hospital managers in fiscal resources utilization in the health sector in Somalia
- iii. To identify the challenges of fiscal resource utilization by the hospital managers in the health sector in Somalia

### **1.5 Research Questions**

- i. What are the forms of fiscal resource utilization by the hospital managers in health sector in Somalia?
- ii. What are the normal procedures are used by the hospital managers in fiscal resources utilization in the health sector in Somalia?
- iii. What are the challenges of fiscal resource utilization by the hospital managers in the health sector in Somalia?

### **1.6 Scope of the study**

#### **1.6.1 Geographical scope**

The study was carried out in Mogadishu-Somalia located in the coastal Benadir region on the Indian Ocean. This area was chosen because it there has been poor Hospitals and health centers management where it required such a study to come up with interventions and policies which are crucial to the attainment of the nation's health goals.

#### **1.6.2 Content scope**

This study mainly focused on the utilization of fiscal resources in health sector in Somalia. It focused on the forms fiscal resource utilization on health sector, establishment of whether normal procedures are used in fiscal resources utilization in the health sector and identified the challenges of fiscal resource utilization in the health sector.

#### **1.6.3 Time scope**

The study considered a time period of utilization of fiscal resources and health sector cases in Mogadishu-Somalia from 2010-2015. it was it this period that there was poor utilization of fiscal resources in the Health sector where drugs were lacking in the Hospital, Nurses and Doctors were not paid well, there was poor infrastructure.

## **1.7 Significance of the Study**

The study is intended to benefit the following categories of people;

Hospitals and health centers are at the Centre of implementing interventions and policies which are crucial to the attainment of the nation's health goals. In particular, these facilities provide the largest share of services in health delivery through a wide range of diagnostic and therapeutic services. In this view, hospitals are responsible for the treatment of ill persons and restoring their abilities for role performances. It is therefore, not out of place that in developing countries, hospitals consume an average of 50 -80 percent of recurrent health sector expenditures. This represents a significant financial burden on any developing nation.

This study has set out to fill this gap and provide supportive evidences from Somalia in the body of literatures and thereby enhance Somalia hospital performances. Monitoring of efficiency in care delivery of these health institutions is part of the broader stewardship role of the state through the health ministry, especially, ensuring that health sector investments are optimized.

Health care managers, especially public health facilities managers, are entrusted with a portion of society resources for the production of health services. As noted earlier, hospital (health institutions services) can reduce poverty level by promotion of economic development through minimizing mortality and morbidity.

## **1.8 Operational definition**

**Input management** refers to the agent's action to acquire and use inputs in order to achieve the contractual requirements as specified in the contract. Relevant inputs in the case of health care services include skilled health workers, medical supplies, medical equipment, essential drugs and infrastructure.

**Output Management** refers to the actions of the agent to maximize health services output for achieving the contractual target e.g. utilization, coverage and access with the available resources.

**Outcome management** refers to the use of services to produce health and client satisfaction (i.e. selection of an efficient mix of health services from the perspective of health and client satisfaction outcomes.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.0 Introduction

This chapter presents the related literature review that have been explored and studied both theoretically and empirically on the existing literature on the negotiation and implementation process of the comprehensive peace agreement in developing countries and elsewhere in the world and this was done in line with the specific objectives of the study in order to identify the knowledgeable gaps. It was important to note that the greatest part of the existing literature on the works of other scholars, opinions, suggestions who have written about the topic of the study or those who have addressed similar issues as those of the variable that were available in the study.

#### 2.1 Theoretical review

Fiscal policy is based on the theories of British economist John Maynard Keynes. Also known as Keynesian economics, this theory basically states that governments can influence macroeconomic productivity levels by increasing or decreasing tax levels and public spending. This influence, in turn, curbs inflation (generally considered to be healthy when between 2-3%), increases employment and maintains a healthy value of money. Fiscal policy is very important to the economy. For example, in 2012 many worried that the fiscal cliff, a simultaneous increase in tax rates and cuts in government spending set to occur in January 2013, would send the U.S. economy back to recession. The U.S. Congress avoided this problem by passing the American Taxpayer Relief Act of 2012 on Jan. 1, 2013. Quantitative Easing is also a type of fiscal policy, implemented in Europe in several iterations in response to the eurozone debt crisis.

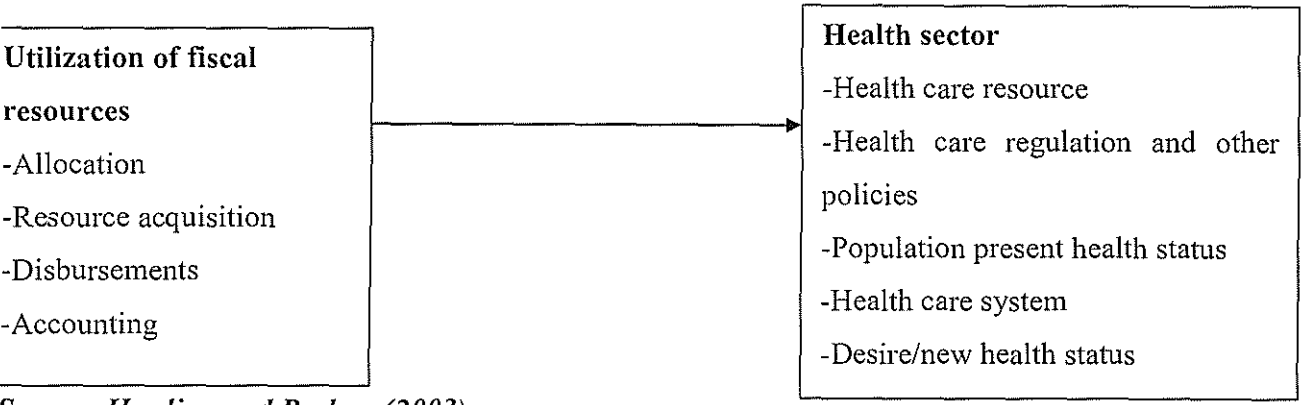
The idea, however, is to find a balance between changing tax rates and public spending. For example, stimulating a stagnant economy by increasing spending or lowering taxes runs the risk of causing inflation to rise. This is because an increase in the amount of money in the economy, followed by an increase in consumer demand, can result in a decrease in the value of money - meaning that it would take more money to buy something that has not changed in value. Let's say that an economy has slowed down. Unemployment levels are up, consumer spending is down and businesses are not making substantial profits. A government thus decides to fuel the



economy's engine by decreasing taxation, which gives consumers more spending money, while increasing government spending in the form of buying services from the market (such as building roads or schools). By paying for such services, the government creates jobs and wages that are in turn pumped into the economy. Pumping money into the economy by decreasing taxation and increasing government spending is also known as "pump priming." In the meantime, overall unemployment levels will fall. With more money in the economy and fewer taxes to pay, consumer demand for goods and services increases. This, in turn, rekindles businesses and turns the cycle around from stagnant to active. If, however, there are no reins on this process, the increase in economic productivity can cross over a very fine line and lead to too much money in the market. This excess in supply decreases the value of money while pushing up prices (because of the increase in demand for consumer products). Hence, inflation exceeds the reasonable level. For this reason, fine tuning the economy through fiscal policy alone can be a difficult, if not improbable, means to reach economic goals. If not closely monitored, the line between a productive economy and one that is infected by inflation can be easily blurred.

**2.2 Conceptual review**

2.2.1 Conceptual frame work showing the relationship between utilization of fiscal resources and health sector



Source: Harding and Preker, (2003)

According to the conceptual framework above the relationship between utilization of fiscal resources and health sector where Utilization of fiscal resources was measured in form of Allocation, Resource acquisition, Disbursements, Accounting, whereas Health sector was measured in terms of Health care resource, Health care regulation and other policies, Population present health status, Health care system, Desire/new health status, Health care resource, Health care regulation and other policies, Population present health status, Health care system and Desire/new health status. Proper management of human resources is critical in providing a high quality of health care. A refocus on human resources management in health care and more research are needed to develop new policies. Effective human resources management strategies are greatly needed to achieve better outcomes from and access to health care around the world. Within many health care systems worldwide, increased attention is being focused on human resources management (HRM). Specifically, human resources are one of three principle health system inputs, with the other two major inputs being physical capital and consumables

## 2.3 Review of the Related Literature

The related literature was reviewed according to the objectives

### 2.3.1 Forms of fiscal resource utilization in health sector

**Performance budgeting:** Since at least the early 1990s, the majority of governments in OECD countries have been developing PI. However, performance budgeting is about more than the development of performance information: it is concerned with the use of this information in budget processes and resource allocation. Despite the fact that the idea of relating performance to resources has been debated since the early 20th century, there is no single agreed Standard definition of performance budgeting. The OECD has defined performance budgeting (PB) as a form of budgeting that relates funds allocated to measurable results. Different models and approaches to performance budgeting can be incorporated under this definition (Allen, 2009).

Taking this definition as a starting point, the OECD has sought to distinguish different categories of PB based on the proposed uses of PI in the budget process, where PI is taken to refer to both performance measures (outputs and/or outcomes) and evaluations. Proposed the establishment and institutionalization of a sustainable district or local health system with an aim of making them self-sufficient and responsible for a given population. In Myanmar, a national law was enacted to develop private health care services to effectively utilize the private resources in providing health care, to provide choice to the people and to ensure responsibility and quality at fair price. Tajikistan's approach was to provide per capita financing for primary health care and to finance hospitals using treatment-based clinical cost groups.<sup>26</sup> financial resources were to be distributed according to the number of people enrolled and specific regional and local conditions (Itoh, 1991).

In addition to the pool fund and resource targeting, some other measures such as financial and administrative delegation/decentralization/autonomy, social audit and community management were either mentioned in the policy or tried out to improve the efficiency of government spending. Another strategy employed by some countries to address the issue of inefficiency was rationing. Usefulness of measures such as community financing, user fee and demand side financing is still in doubt (Hutton, 2004). Demand side financing is a key financing strategy

receiving increasing attention, particularly in Bangladesh and India. It aims to break the demand side barriers in service utilization by vulnerable groups such as unaffordable cost of care, household preferences, education and socio-cultural norms. A Demand Side Financing (DSF) pilot using health vouchers for poor pregnant women has already been launched in 21 in Bangladesh.

**Integrating PI into the annual budget process:** An important factor in promoting the use of PI in budgetary decision makings the method used to integrate it into the budget process. PI can be used at different stages and levels of the budget process. Countries have taken a variety of approaches to include PI in budget negotiations. These can be split broadly into formal and non-formal approaches. Some countries have followed a formal approach, in which the MOF requires spending ministries to present performance plans and/or performance results along with their spending proposals, while other countries have no formal requirements. PI can be used by the MOF for planning purposes and/or accountability purposes. In both these cases there is an ongoing discussion of how PI should be linked to funding. There are different classifications of PB: presentational, performance-informed budgeting, and director formula PB. Depending on the approach adopted, countries can seek to link PI to decisions on resource allocation not at all, loosely, or tightly (Bennett et al., 1996).

**Presentational performance budgeting:** In this approach PI is presented in budgeting documents or other government documents. It does not play a role in decision making on allocations nor is it intended to do so. Some countries have taken a non-formal approach to the development and use of PI in negotiations between the MOF and spending ministries. For example, Denmark and Sweden have an informal and discretionary approach on a government-wide scale which allows individual ministries to decide whether to produce and present PI in budget negotiations (Mills et al., 1997). There is no formal mechanism for the systematic integration and use of the information at this stage of the budget formulation process. In the case of Canada, PI is utilized throughout the planning, monitoring and reporting phases of expenditure management. This largely takes place outside the annual budget process.

**Performance-informed budgeting:** In OECD countries when PI is part of the budget process, it is most commonly used to inform budget allocations along with other information on Linkage between PI and funding Planned or actual performance Main purpose in the budget process Presentational No link Performance targets and/or performance results Accountability Performance-informed budgeting Loose/indirect link Performance targets and/or performance results Planning and/or accountability Direct/formula PB Tight/direct link Performance results Resource allocation and accountability political and fiscal priorities. Thus, it is only one factor in the decision-making process. There is no direct or mechanical link between performance (planned or actual) and funding. When performance information is used, it can be for planning and/or accountability purposes. Most budget negotiations have traditionally included some output information, as budgetary estimates generally state what a spending ministry aims to achieve with its funding, e.g. the number of roads or hospitals. The introduction of PB has formalized this process and placed a greater emphasis on setting targets and measuring performance.

**Planning purposes: loosely linking planned performance to funding:** In countries where the MOF is involved in setting performance targets, these can be discussed and/or agreed during budget negotiations. Except for New Zealand, OECD countries do not have a systematic government-wide approach to linking expenditures to targets. Over 46% of countries do not link expenditures to outputs or outcome targets; the countries that do so only link them to a few targets. In some cases, even where there is a link, it can merely be a reflection of presentational changes in the budget structure rather than any real change in the decision-making process. Both Australia and the United Kingdom have requirements that link increases in spending or new spending to performance targets or performance evaluations. For example, the United Kingdom has a more systematic approach in which each department develops three-year spending plans and public service agreements, which include performance targets negotiated with the Treasury. In some countries planning is completely separated from budgeting and strategic and performance plans are primarily presented and approved by the office of the prime minister or president, the ministry of planning or the legislature.

**Performance results for accountability purposes: loosely linking performance results to funding.** The MOF can use performance results to hold other ministries and agencies accountable for performance. There is an ongoing debate about how tightly performance results should be linked to funding. In OECD countries, the MOF rarely uses performance results to determine budget allocations. At best, performance results can be used to inform budget allocations along with other information. Even this use of performance-informed budgeting can be sporadic. The use of PI in budget negotiations and the weight given to it varies among countries and also within countries depending on the information available, the policy area, and the wider economic and political context.

### **2.3.3 Challenges of fiscal resource utilization in the health sector**

Contracting out of health care services is widely used as an option in many settings, including in both high and low income countries. There is available evidence on the experiences in both middle and low income countries about contracting out of health care services, (Palmer et al. 2006). However, the evidence suggests that making a decision about contracting out the provision of health care services is not a straight forward undertaking and there is no recipe to follow (Mailly, 2009). Generally, contracting out of services responds to a country's particular need at a particular period. Contracting decisions may then arise due to reasons including: The inability of public sector organizations to perform certain functions in house (due to lack of capacity)

Cost-efficiency motives, for instance to free up resources such as cash, skilled personnel, time and facilities for activities where the organization holds a competitive advantage. Similarly, it has been stated that contracting out is not a solution to weak public sector management; rather it places new demands upon public health care managers, which, although distinct from direct health care provision, require management and supervisory skills (Abramson, 2001). In addition to this, a report by the African Development Bank has pointed out that the progression and sequence of EHR, particularly in developing countries' health facilities has never been an easy undertaking as there are many peculiar factors impeding the progression and diffusion of such technologies (Sood et al., 2008). But the point ought to be made fiercely that challenges of EHR

implementation in developed countries, somewhat differ from the challenges of EHR implementation in developing countries. The works of is a clearer manifestation of the differing challenges of EHR implementation in developed and developing countries. This section of the work thus, would be much more interested in the challenges of EHR implementation in developing countries owing to the research objectives.

Countries continue to face challenges with issues of measurement, especially with outcomes. Even with outputs it can be difficult to find accurate measures for specific activities. Governments carry out a wide variety of functions, from building roads to providing advice on foreign travel. Performance measures are more easily applied to certain types of functional and programme area than others. Problems especially arise with regard to intangible activities such as policy advice. The functional areas with the most developed performance measures are education and health.

Khalifehsoltani and Gerami (2010), in their study obtained a model, which considers the challenges facing E-Health in Developing Countries. This model included challenges relating to six areas of Technology and Operational; Social and Cultural; Native Environment; Legal; Policymaking; and Financial. However, their model had a general outlook of e-Health, which EHR is just a fraction. Therefore upon a further review of other works regarding the challenges of EHR implementation in developing countries, some peculiar issues that affront EHR implementation in developing countries were discovered. Inadequate Electric Power Supply; Lack of ICT Infrastructure; lack of basic ICT knowledge/skills; Poor Internet connectivity; financial issues; and Resistance to New Technology were identified broadly (albeit others) as the major challenges that hinder the successful implementation of EHR in developing countries like Ghana.

Output and outcome measures each present a different set of challenges. Systems which only concentrate on outputs can result in goal displacement. Outcomes are technically more difficult to measure; they are complex and involve the interaction of many factors, planned and unplanned. It can also be problematic to relate what an agency or programmed actually

contributes towards achieving specific outcomes. There are also problems with time-lag issues, and in some cases the results are not within the control of the government. Outcomes, however, have a strong appeal for the public and politicians.

**Inadequate electric power supply:** Most developing countries, particularly in sub-Saharan Africa, find it difficult to provide Uninterrupted Power Supply (UPS) to their citizens. This invariably affects any good ICT service provision like EHR (Achampong, 2012). The Ghanaian experience is even worse with the current ongoing load shedding exercise. Thus a health facility operating an EHR cannot safely depend on the flow of electricity supplied by the Electricity Company of Ghana (ECG) since at any time without prior notice power can go off (Ibid). In touring some health facilities in Accra (the capital city of Ghana) in order to ascertain how these facilities have been dealing with the electricity shortages, Beatrice Adu, a Joy News (a leading private news TV station in Ghana) reporter, described the erratic power supply as “worrying” to the general healthcare delivery system (Adu, 2013).

**Lack of ICT Infrastructure:** In most developed countries like United State, United Kingdom, Norway, Denmark and Australia, there is a growing and robust healthcare infrastructure that receives ample financial support from its governments (Sood et al., 2008). This is however not the situation in most developing countries. In particular, professionals in various health facilities who implement healthcare information technology based solutions like EHR systems in developing countries are overwhelmed with the lack of ICT resources (such as unavailability of computers) and weak healthcare infrastructure.

**Resistance from public servants:** changing behavior and culture. Nearly all reforms encounter resistance, especially when they have to do with long-term budgeting practices that impact on the whole of government. Motivating key actors to move away from traditional and familiar budget practices proves to be difficult. Managers in spending ministries can resist change, particularly when its not clear whether or how PI will be used by the MOF and politicians. In many cases they fear the information will be misused to either publicly criticize programmes or to cut funding. They fear being held accountable for results that are not within their control. Alternatively, they can resist reform because of increased demands for the collection of data and



burdensome paper requirements. This is especially true if the information is not used at all by the MOF or politicians. The MOF can also reject change by favoring the familiar systems of input control over concentration on PI. The ministry may fear that change will give it less control over expenditure and spending. In some cases, the PI presented is in fact not relevant or of good enough quality to be used in decision making (OECD, 2011).

Again, infrastructure such as those that support the operation of EHRs remains a constraint (WHO, 2010). And this is consistent with the finding from a current empirical study conducted by Bedeley (2014), which rates *Lack of ICT Infrastructure* as the major challenge of e-Health. According to Bedeley (2014), for example health facilities that are equipped with computers or ICT infrastructures are often not in good conditions. Again other essential IT accessories that are basic elements for successful implementation of EHR systems are just not available in most health institutions in developing countries, particularly Ghana (Ibid). Thus limited access to computers and other ICT facilities remain a challenge to the successful implementation of EHR (Seoane, 2005).

**Lack of basic ICT knowledge/skills:** The majority of health professionals in developing countries lack the basic ICT knowledge or skills that are needed to effectively use the EHR systems. This hampers the full utilization of the system by health professionals. As confirmed by interview responses gathered from the healthcare professionals in Bedeley (2014), it was observed that the “majority of the current generation of Ghanaians grew up in the rural areas without computers or even common electricity. Such people therefore exhibit negative attitudes towards computers due to their ignorance as they rather prefer someone do their work for them with the computer than doing stuff by them.” They further opined that the “lack of enthusiasm... has slowed down implementation efforts as it raises the debate of whether the time is right or not.

As a result there are various training programs arranged by various health institutions themselves to boost the knowledge and skills of health professionals regarding basic computer skills. But, the period made available for these computer illiterate health professionals to acquire and master the rudimentary operations of the computer and to transfer the skills acquired to particular projects

might themselves also hinder the effectiveness of EHR (Sood, 2005). In some situations the period of time for the training is too short and this result is trainees acquiring limited computer skills or nothing at all. Again when the period of time is too long, it often create a vacuum for manpower needed to operate the system at critical moments.

**Poor Internet connectivity:** Another major problem that affronts the successful implementation of many EHR projects in developing countries is the lack of access to the Internet. An important function of the Internet is that it makes available enormous amounts of health related information that may be very useful for individuals as well as organizations such as hospitals. This functionality may also be accessible through or integrated in the EHR (Griffiths et al., 2006).

Although the access to the Internet is improving in many parts of Africa (Oyeyemi, Gabarron & Wynn, 2014), the problem of Internet connectivity and Internet services is still a major challenge in many developing countries like Ghana. Even if there is Internet connectivity available in a particular health institution, low speed, and high utility cost (Bedeley & Palvia, 2014) often makes the use of EHR unreliable and expensive (Swinfen & Swinfen, 2002). Computer viruses, spams together with limited bandwidth. Thus the issue of poor Internet connectivity and limited bandwidth often brings about Internet congestion that in turn affects image retrieval and image resolution (Durrani, & Khoja, 2009) as well as other non-image files. This largely can affect negatively, the effectiveness of diagnosis and treatment regimens.

**Developing the institutional capacity of the MOF and spending ministries:** Countries have experienced problems with developing the necessary institutional capacity at the level of the MOF and spending ministries to support these reforms. That capacity is influenced by the wider institutional structure and resources in terms of staff and expertise. PI is different from financial information. In order to make judgments and compare performance, the MOF needs the relevant expertise to be able to analyze and evaluate the information received from different spending ministries. Spending ministries depend on agencies for information. Therefore they, like the MOF, will need the capacity to understand and evaluate information they receive if they are to make judgments about how realistic the proposed targets are and the quality of the performance

measures and data. Even if the interest is there, ministries in some cases – dependent on the country – do not have the expertise or knowledge to develop performance measures or even effectively monitor performance. This can lead to the passive provision of data that has no real weight in the decision-making process (Makoka, and Kambewa, 2007),

**Changing the behavior of politicians:** Politicians have an important role to play in promoting the development and use of PI in the budget process. That role involves applying pressure on other actors to implement PB, playing an active role in setting objectives, and using PI in budgetary decision making. Their role in the legislature and the executive will vary depending on the nature of the legislative-executive relationship in the budget process, which in turn is influenced by the type of political system in place: presidential, semi presidential or parliamentary (NORAD, 2009).

**Financial issues:** another major challenge, which encumbers the implementing of health-related ICT projects like EHR in developing countries, is the issue relating to financial cost. The cost incurred in purchasing the necessary software and hardware together with the cost of transport and installation, the cost of maintenance, the cost of training of the hospital staff as well as other unanticipated costs might be too high to deter governmental and institutional commitment towards the implementation of EHR. Hence the implementation of EHR comes with huge financial responsibilities and commitments that often worsen already existing financial predicament of health institutions in developing countries (Bedeley, 2014).

**Resistance to new technologies:** Health care professionals (like their counterpart in other sectors) often harbour a fear that integration of new EHR systems into existing work practice might alter existing work practices, or interrupt workflow (WHO, 2010). Thus healthcare professionals turn to defy new technological developments like EHR that may threaten their job particularly in cases where the organisation introducing new EHR anticipates reducing staff strength and cost of operation (Achampong, 2012). This greatly affects the acceptability of such EHRs.

## 2.4 Related studies

There is an established literature on contracting out experiences in the UK particularly on reforms in the UK NHS and USA especially in the managed health care setting. These two sets of literature illustrate the potential benefits of contracting out, the remaining challenges in using health care contracts and the methodological difficulties in measuring performance, monitoring and evaluating the impact of contracts on health care in general. In England, for instance, where general practitioners are contracted as primary health care providers, they consider themselves as private contractors with the freedom to maintain contractual relationship with the public sector or to operate their private business. Regardless of changes that took place in the 1990s concerning the organization of group practices and the system of incentives and clinical performance, the fundamental idea of general practitioners as contractor and not a salaried employee remains. This difference provides the understanding of the contracting out model (Reeves, 2008).

Contracting out experiences in the UK NHS and USA managed health care are also illustrative in a number of ways. For example, contracts are being used for improvement in health care service quality and health care outcomes under managed health care in USA. In the UK NHS contracting out has been particularly driven by the central government strategy of improving quality and increasing efficiency in health care delivery in the period between 1990 and 1997. This was coupled with an increase of people employed in the NHS, and numbers went up through the 1990s and early 2000s, but have fallen since about 2006. The type of contracts varied from block contracts, cost per case contract to cost and volume contracts, but focused on performance targets and cost reduction (Mailly, 2009).

Empirical work on contracting targets on waiting – time and average cost reduction have been documented during the NHS reforms (Chalkley, 2006). The contracting targets were set as a mechanism for improving hospital efficiency and controlling the rate of budget growth. Hospitals with higher average costs were given higher targets as opposed to those with low average costs. The performance of the hospitals was assessed by indicators such as the number of patients seen and the costs per patient case. The strategies adopted by the hospitals to attain the

targets ranged from increasing outputs using the existing inputs and seeking higher discounts from suppliers, and cutting back on full time nursing staff.

These experiences indicate the potential impacts of contracting out health care services. The way providers responded was both positive and negative to the reform objectives. Evidence show that despite established institutional bases in both the UK and USA, measuring contracted services, establishing appropriate indicators and information systems remained a challenge (Saltman, 2002) and transaction costs for running the system were higher.

Experiences in Afghanistan, South Africa, Rwanda, Zambia, Uganda (Palmer et al, 2006;) are indicative of the potential and challenge of contracting out in low income country settings The experiences, especially in Rwanda and Zambia are relevant to Malawi's assessment given similar country settings (Palmer, 2000). Due to the differences in the measures used and the incentive designs in these studies, it is difficult to compare contracting out schemes. Among the key features shared by most of these experiences is that they have been driven by external funding from donor agencies and are heavily reliant on external technical assistance. Most were started as pilot projects in situations that have marked shortages of personnel, infrastructure and medical supplies required in the provision of health care. This probably explains why most of them have targeted non-profit private providers such as church run health facilities and NGOs. Despite the similarities, there are differences in how the contracts are structured, performance measured and in the magnitude of effectiveness.

Given the foregoing, contracts in Rwanda, South Africa and Zambia were designed differently. In Rwanda for instance, the country was just emerging from a conflict which had affected the capacity of the state to delivery health care. Contracts in Rwanda were therefore designed to address public sector capacity by delegating the provision of health care services to private providers under contracts. In 2001, the Rwandan government introduced Performance Based Financing (PBF) contracts with NGOs that were operating in the country, based on experiences from Cambodia (Mills, et al, 1997).

In contrast, South Africa had a stronger public service as well as institutional arrangements that would support contracting out already in place including already established private health care providers operating in the country. South Africa provides a distinct pattern, having a long history of contracting out to both for-profit and not-for-profit health care providers as well as a wide range of services encompassing both clinical and non-clinical services (Bennett, 1997).

In Zambia contracting out of services to the private sector involved both private for-profit and private not-for-profit providers. Contracts were for the management of public health care facilities (hospitals) by private firms (delegated management). On the other hand, the Ministry of Health signed a memorandum of understanding with the Church Medical Association of Zambia 1996 whereby hospitals and other health facilities under CHAZ would provide health care services (Perrot, 2006). The contractual relationship entailed that CHAZ hospitals would provide specified health services to a specific population and in turn the government would reimburse the health facility (Bennett, et al, 1996).

The experience of South African contracts demonstrates that competitive bidding based on both the quality of technical proposal and price is feasible. The approach resulted in low cost for health care provision that can be sustained by the government (Palmer and Mill, 2003 and 2005). The experience in South Africa also highlights that contract bidding procedures must be clear to all parties involved; tenders should be clearly delineated and outside experts should be involved in the process of bid evaluation (Palmer, 2003).

Performance indicators in most cases were linked to health systems indicators: access, equity, quality and efficiency, supplemented by some management processes indicators such as performance audit, attendance of coordination or management meetings and patient satisfaction surveys. Proxy variables that were used in South Africa, Zambia and Rwanda include increases in the number of new users, the number of institutional deliveries, the percentage of fully vaccinated children and the contraceptive prevalence rate. However these input and process measures have been criticized for providing limited information on the effectiveness of a contracting out program. Similarly, it has been argued that the use of cost as a performance

measure biases activity towards shorter and less intensive programs (Meessen et al, 2006; Perrot, 2006).

The capacity to successfully use and sustain a performance monitoring system was not adequate in Rwanda and Zambia, such that third party organisations were contracted to verify the performance of private providers. For instance the cost of monitoring performance through third party organisation was 11 percent of the contract cost in two remote districts. These performance measurement difficulties were prominent in Rwanda and Zambian contracts, and serve to demonstrate the problems of contracting out mechanisms especially in resource constrained settings (Meessen, 2006).

## **2.5 Research Gap**

The rationale to develop national health financing systems, particularly in low-income countries, is now well established. These countries are challenged by a huge health financing gap since a large number of them suffer from the twin disadvantages of high disease burden (hence, higher need for resources) and low financial capacity or income to address it. Government spending is crucial to ensure better access to essential healthservices and financial risk protection since it is a stable and sustainable source of financing. However, these countries face challenges in finding adequate fiscal resources or fiscal space for health (World Bank, 2006). A vast majority of the bottom billion people live in L-26 countries characterized by low national income, poverty, poor health outcomes, inadequate health spending, and higher proportion of household out-of-pocket spending (OOPs). Health financing gap figured prominently among the list of major health financing concerns in almost all L-26 countries. Evidence for resource inadequacy can be found in the literature too (WHO, 2007).

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

This chapter discussed the methodology that was used during data collection. It presented the research design, study population and sample size, research methods, data analysis, validity and reliability as well as the limitations to the study and ethical consideration.

#### **3.1 Research design**

The study used a descriptive research design. Descriptive was used because of its ability to describe results from questionnaires and interviews and employs both quantitative and qualitative methods which were used because of its flexibility for instance, it used survey for concerning literature experience and analysis of insight stimulating examples such as existing records (Bateman, 1999), it also allowed more insight into the studied phenomena for instance through the above the utilization of fiscal resources in health sector in Somalia. It also allowed flexibility in terms of methods in case of collecting data.

#### **3.2 Study population**

The research population was 280 as a target population representing Government officials, Ministry of Health officials, Auditors and other authorized persons with knowledge about the topic of study in Somalia (Annual report Ministry of Health, 2012).

#### **3.3 Sample size**

The respondents comprised of both sexes but of different marital statuses and age groups and the study used 162 respondents and were selected basing on a table for determining Sample size by Krejcie and Morgan, 1970, p.608).



**Table 3.1: Population and Sample Size**

Categories of respondents	Targeted Population	Sample size	Sampling Techniques
Government officials	10	10	Purposive sampling
NGO officials	25	15	Simple random sampling
Ministry of Health officials	35	27	Simple random sampling
Auditors	10	10	Purposive sampling
other authorized officials	200	100	Simple random sampling
<b>Total</b>	<b>280</b>	<b>162</b>	

### **3.4 Sampling Procedures**

The researcher used both purposive sampling and simple random sampling.

#### **3.4.1 Inclusion**

All respondents above 15 years were included in the study, they included; Government officials, NGO officials, Ministry of Health officials, Auditors and other authorized officials in Mogadishu Somalia.

#### **3.4.2 Exclusion criteria**

Persons below 15 years were not included in the study, community members who are critically ill; cannot talk or listen were not enlisted in the study.

The purposive sampling was used to select Government officials, Auditors. Simple random sampling was used to select other authorized officials and to give respondents equal opportunities to be among the selected ones and stratified random sampling was used to divide them in to groups. In addition we applied the assigning of number to the respondents where our sample was 162 and these respondents were given numbers so we could select the numbers from our list to be part of the sample. We kept doing this until we had all our 162 respondents that we wanted in our sample.

### **3.5 Research Instrument**

The research tools used in this study were the questionnaire and interview.

### 3.5.1 Questionnaires

The questionnaire was standardized and both primary and secondary data collection methods were used to collect data. The primary data was used to obtain and gather information from respondents of by the researcher using questionnaires. The questionnaires were self-administered and it was close ended questions to be simply answered by the respondents. Interviews were used to supplement the data collected through the questionnaire. The interviews were conducted on only in offices that are expected to be busy with daily schedules and might not find time to fill in the questionnaires. The researcher used the likert scale with four points to response mode.

### 3.6 Validity and reliability

#### 3.6.1 Validity

A research instrument is said to be valid if it actually measures what it is supposed to measure (Amin, 2005). Since validity is a measure of how the question asked makes sense to the respondent. A few selected respondents were advice whether the question makes sense by ranking it on a scale of very clear, not clear, and very unclear. Any question which was ranked as not clear were amended. The validity was measured by using "Content Validity", where all questions answered by the respondents made sure that they truly measured the variables being researched upon (Amin, 2005).

$$\text{Content Validity Index (CVI)} = \frac{\text{Agreed items by all judges as suitable}}{\text{Total number of items judged.}}$$

If the overall Content Validity Index (CVI) of the instrument was equal to the average acceptable Index of 0.7 or above, then the instrument were accepted as valid (Amin 2005)

$$\text{Content Validity Index (CVI)} = \frac{20}{22} = 0.90$$

From the above calculation, 20 was the Agreed items by all judges as suitable and 22 was the total number of items judged and 0.90 is the Content Validity Index (CVI) which had come out valid since it was above 0.7

### 3.6.2 Reliability

The reliability test involved a “test and retest” exercise. This means the instrument was subjected to the representative sample. Whether each time the question asked and the respondent answered a question similar or consistent, then the instrument was considered reliable. Reliability refers to the degree to which the instrument was consistent with whatever it was measuring (Amin, 2005).

The reliability on the other hand, was measured by using “test- retest and Cronbach’s Alpha” methods, where the researcher administered the questionnaire to a few people and then administers to the same people after two weeks. The two tests were analyzed using the Pearson’s linear Correlation Coefficient and the t- test. Alpha was used to measure instrument reliability and the minimum reliability according to Amin is 0.5.

The formula for Cronbach’s Alpha used was as follows-

**Table 3.2; Results of the Cronbach's Alpha Reliability Coefficient for Likert-type Scale test for Questionnaire**

Variable	Cronbach Alpha coefficient	No. of items
challenges of fiscal resource utilization	0.777	7
procedure are used in fiscal resources utilization	0.875	8
forms fiscal resource utilization	0.833	10

*primary data (2016)*

The Cronbach Alpha Reliability Coefficient test revealed that reliability results for the questionnaire as an instrument for challenges of fiscal resource utilization was 0.777; for procedure are used in fiscal resources utilization it was 0.875; and for the forms fiscal resource utilization it was 0.833.

**Table 3.3 Results of the Cronbach's Alpha Reliability Coefficient for Likert-type or the Interviews**

Variable	Cronbach Alpha coefficient	No. of items
challenges of fiscal resource utilization	0.879	6
forms fiscal resource utilization	0.705	6
procedure are used in fiscal resources utilization	0.820	6

Source: *Primary data (2016)*

The Cronbach Alpha Reliability Coefficient test revealed that reliability results for the interview instrument for challenges of fiscal resource utilization were 0.879; for forms fiscal resource utilization it was 0.705; and for procedure are used in fiscal resources utilization it was 0.820.

If a Cronbach's Alpha is above 0.7, it shows that the tool is reliable (Sekaran, 2003). The higher the reliability coefficient, the higher the reliability of the instrument being tested (Amin, 2005:295). Cronbach's Alpha produces values  $n=$ between 0 and 1.00 with the higher value indicating a higher degree of internal consistency and reliability (Gravetter and Forzano, 2012). Therefore, having a Cronbach's Alpha of 0.7 and higher for items proved that the data used for the study was reliable and consistent.

### 3.8 Data analysis

The quantitative data involved information from the questionnaires only. Data from the field was too raw for proper interpretation. It therefore was vital to put it into order and structure it, so as to drive meaning and information from it. The raw data obtained from questionnaires was cleaned, sorted and coded. The coded data was entered into the Computer, checked and statistically analyzed using the Statistical Package for Social Scientists (SPSS) software package to generate descriptive and inferential statistics descriptive analysis were applied to describe the primary variable and associated indicator items related to the study objectives.

The Pearson product correlation Co-efficient analysis was used to test the relationship among the variables and regression coefficient models to determine the extent to which the independent

variables impacts on the dependent variable. The results were presented in form of tables and charts then discussed in relation to existing literature. Conclusion and recommendations were drawn in relation to the set objectives of the study. Qualitative data was collected using focus group checklist during discussions with other authorized persons respondent category in meetings and documentary reviews using documentary checklist. Content analysis was used to edit the data and re-organize it into meaningful shorter sentences. The data was analyzed and organized based on patterns, repetitions and commonalities into themes based on the study variables. The data then was used to reinforce information got from questionnaires to draw conclusion and recommendations.

### **3.9 Ethical Considerations**

It was important during the process of research for the researcher to make respondents to understand that participation was voluntary and that participants are free to refuse to answer any question and to withdraw from participation any time they are chosen.

Another important consideration, involved getting the informed consent of those going to be met during the research process, which involved interviews and observations on issues that may be delicate to some respondents. The researcher undertakes to bear this seriously in mind.

Accuracy and honesty during the research process was very important for academic research to proceed. A researcher treated a research project with utmost care, in that there was no temptation to cheat since it jeopardizes the conception of the research.

Personal confidentiality and privacy was very important since the report was public. If individuals had been used to provide information, it was important for their privacy to be respected. If private information had been accessed then confidentiality had to be maintained (Stephen, 2002). All respondents were therefore, re-assured of this before being involved.

### **3.9 Limitations of the study**

In the process of carrying out this investigation, a number of limitations were met. These limitations obstructed the speed at which the study was carried out. These included;

- (i) Attrition; some respondents filled in the questionnaires without really reading or understanding the question but just to complete fast. The researcher however made an effort to avoid distributing questionnaires or holding interviews during rush hours and also try to capture the interest of the respondents.
- (ii) Sensitivity of information; some respondents felt that the information required was sensitive and could affect their working environment if revealed. The researcher however made an effort to convince respondents that the information exchanged was very confidential.
- (iii) Unwillingness to fill the questionnaires; some respondents were unwilling to share information. The researcher however endeavored to emphasize that was a purely academic research and confidentiality was upheld.
- (iv) Interpretation of the questions affected the meaning because some respondents got difficulty in interpreting the questions correctly because of the high levels of illiteracy. However the researcher tried to interpret the questions for them where necessary.

## **CHAPTER FOUR**

### **DATA PRESENTATION, ANALYSIS AND INTERPRETATION**

#### **4.0 Introduction**

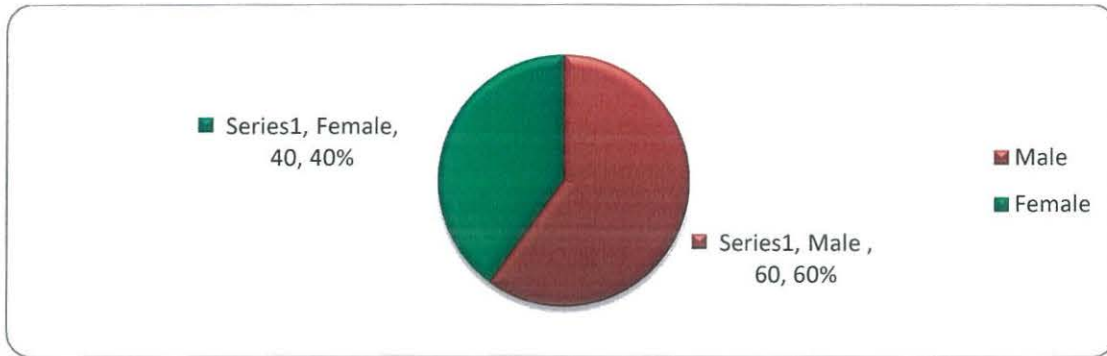
This chapter presents the facts, which the research discovered. The findings were presented in line with the objectives of the study whereby the raw data in form of questionnaires was edited and interpreted which ensured uniformity, legibility and consistency. The data-filled questionnaires were copied and analyzed by tallying and tabling in frequency polygons while identifying how often certain responses occurred and later evaluation was done. The information was then recorded in terms of percentages. Also, interview results were coded on frequency tables which were calculated in terms of percentages and presented in this study as illustrated below.

#### **4.1 Characteristics of the respondents**

The Background information of the respondents was important because they comprised of both sexes but of different marital statuses and age groups from various settings. This was intended in order to get a variety of views and unbiased responses which made the study a reality. The respondents were divided into Government officials, NGO officials, Ministry of Health officials, Auditors and other authorized officials. The findings are shown in the figures below;

### Classification of respondents by gender

In this section the respondents by gender was represented



*Source; Primary data*

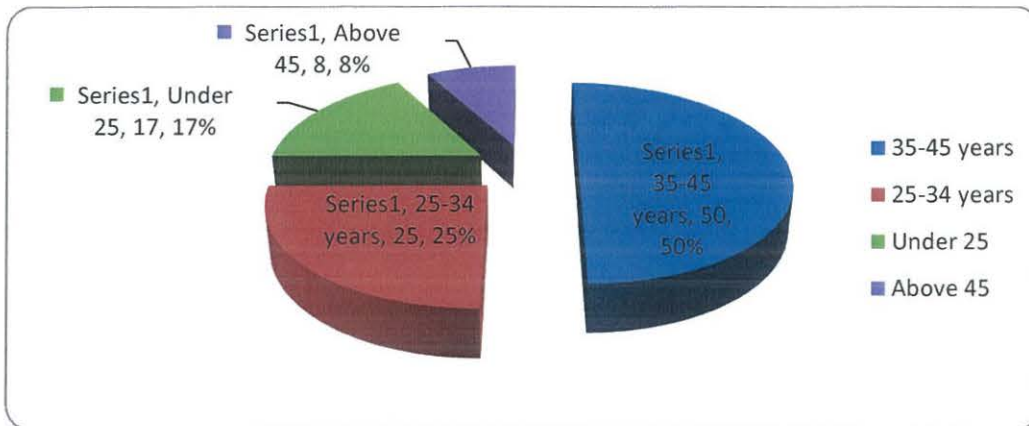
**Figure 4.1: Classification of respondents by gender**

During the field survey, it was found out that; males greatly participated in the study as represented by 60% whereas 40% of the respondents were females; implying that health sector in Somalia greatly employed males respondents compared to female as illustrated above in the figure.



### Classification of respondents by age

In this section the respondent's age was represented in the figure and included under 25 years, 25-34 years, 35-45 years, and above 45 years



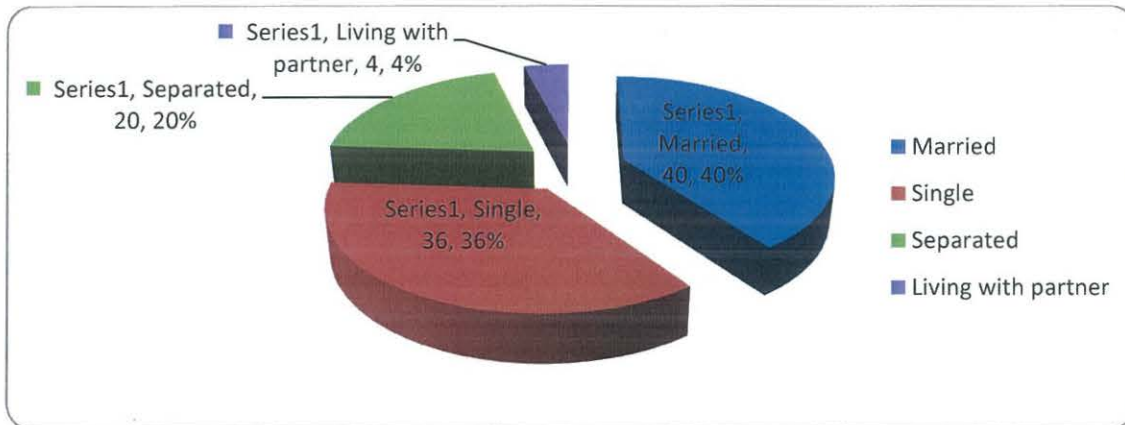
*Source; Primary data*

**Figure 4.2: Classification of respondents by age**

Figure 4.1 above show that; the biggest percentage (50%) of the respondents were in the age bracket of 35-45 years, followed by 25% of the respondents who were in the age bracket of 25-34 years, then 17 % of the respondents were under 25 years of age, implying that; the health sector in Somalia employed mature people who are energetic and understands better the challenges of fiscal resource utilization in the health sector in Somalia.

### Classification of respondents by marital Status

In this segment the respondent's marital Status was presented and included married, single, separated and living with the partner



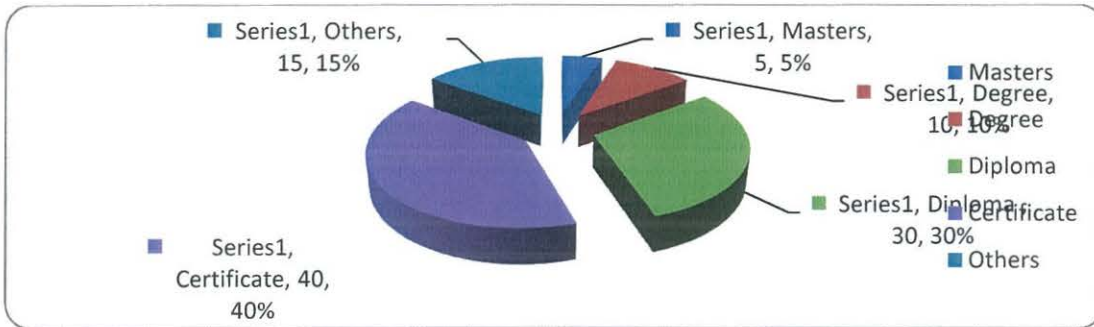
Source: Primary data

Figure 4.3: Classification of respondents by marital Status

An assessment of the respondents' marital status was as follows; the biggest percentage of the respondents were found to be married as shown by 40% where as 36% of the interviewees were single, 20% of the respondents were separated from their spouses lastly 4% of them were living with partners but were not officially married implying that they were still young with less responsibility but looking ahead for the bright future as illustrated in figure 4.3 above.

### Respondent's level of education

In this segment the respondent's the level of education was presented and included certificate, diploma, degree, masters and others.



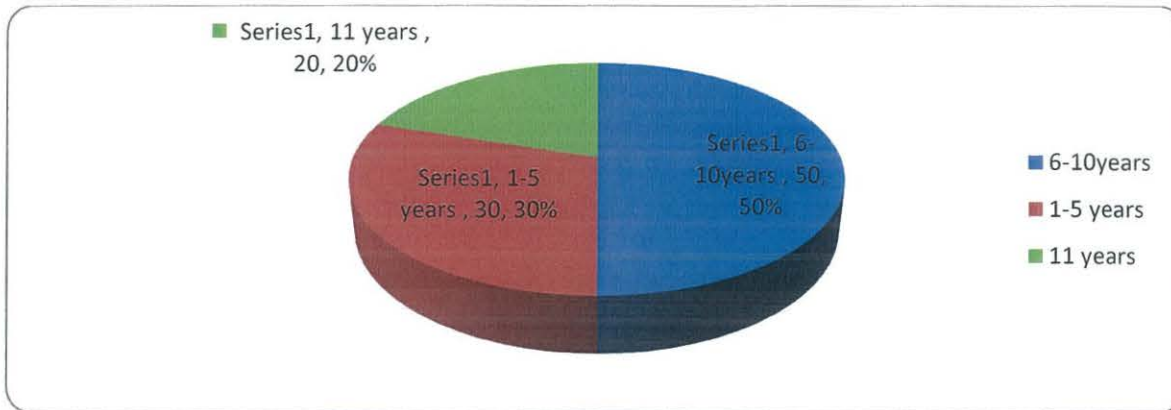
Source: Primary data

Figure 4.4: Respondents level of education

The biggest percentage of respondents were certificates holders as it was revealed by 40% of the respondents, then 30% represented respondents who had attained Diploma's in different fields, 15% of respondents were qualified in other fields whereas 10% of the interviewees were Degree holders, and lastly 5% of the respondents had attained their Masters majority of the respondents being with certificate implies that they understand well how resources in the health sector are supposed to be utilized in figure 4.4 above.

### Number of years of service of respondents

In this section the respondent's the number of years of service was presented and they included 1-5 years, 6-10 years and 11 and above years



Source: Primary Data

Figure 4.1.4: Number of years of service of respondents

From the figure above, it was found out that the biggest percentage of the respondents had worked with the health sector for a period between 6-10 years as represented by 50% whereas 30% represents respondents who had worked with health sector for the period of 1-5 years and 20% shows respondents who had worked with health sector for the period between 11+ years, implying that they have been employees for a long time thus possess enough experience.

#### 4.2 Forms of fiscal resources utilization in health sector Somalia.

The respondents were asked about the forms of resource mobilization used in health sector in Somalia. The responses are in table 4.1 below;

**Table 4.1; Forms fiscal resource utilization on health sector in Somalia**

Item	Mean	Std Dev	Interpretation
There is presentational performance budgeting	3.25	.615	Very high
There is performance-informed budgeting	2.54	1.18	High
There is planning purposes loosely linking planned performance to funding	3.33	1.35	Very high
There is a performance result for accountability purposes	3.85	.317	Very high
There is highest priority on responding to needs of in-country decision makers	3.76	0.97	Very high
There is Coordination, collaborate, and do no harm	1.20	.517	Very low
There is monitoring	3.1	.428	Very high
There is evaluation	3.3	1.23	Very high
There accountability	2.22	1.37	Low
<b>Average mean</b>	<b>3.28</b>		<b>Very high</b>

*Source: Primary data, 2016*

#### Table mean range interpretation

Mean range	Respondents mode	Interpretation
3.26-4.00	Strongly agree	Very high
2.51-3.25	Agree	High
1.75-2.50	Disagree	Low
1.00-1.75	Strongly disagree	Very low

Table 4.1: above shows that, respondents strongly agreed with the statement, that there was presentational performance budgeting (mean=4.25, strongly agree) implying that the

management was reluctant on as far as resource management was concerned. Whereas views on trainers whether there was performance-informed budgeting were as (mean=2.54, agreed) implying that there was a good relationship between the workers and team work was exercised. Responses on whether there was planning purposes loosely linking planned performance to funding was as follows; (mean =3.33 strongly agreed) implying that no information was available about the relationship between donors and the Health management team in the health sector in Somalia . Then, reactions whether there was a performance result for accountability purposes responses ranged from; (mean=3.85, strongly agree) implying that there was no information regarding whether health sector staff used information technology during resource utilisation. On whether there was highest priority on responding to needs of in-country decision makers was revealed by (mean = 3.76, strongly agree) implying that there was little knowledge about the role of Information systems. Respondents appeared reserved surprisingly on whether there was Coordination, collaborate, and do no harm (mean=1.20, strongly disagreed) implying that implying that both the management of the health sector in Somalia and citizen does support sound budgets and report but it never implemented. Responses on whether there was monitoring ranged from (mean = 3.1, strongly agreed) implying that the health sector accounting and budgetary support are not recognised and are not supported by the government of Somalia neither the ministry itself.

Responses on whether there was evaluation were as follows: (mean = 3.3, strongly agree) implying the government of Somalia through the ministry of health does not support private spending. Lastly, views on whether there accountability; (mean = 2.22, disagreed) implying there public always get feedback from the information resource in as far as resource utilization was concerned.

The average mean was 3.28 which can be interpreted very low implying that if the government of Somalia does not address the current forms of fiscal resources utilization in health sector the country's health situation might become worse.

#### **4.3.1 Procedure used in fiscal resources utilization in the health sector in Somalia**

The respondents were asked about the procedure used in fiscal resources utilization in the health sector in Somalia and their responses were as follows;

Using item means of resources utilization, an assessment of the procedure are used in fiscal resources utilization in the health sector in Somalia was carried out. The items were rated on the 5 point likert scale ranging between strongly disagree, disagree, not sure, agree and strongly agree. The findings are shown in table 4.2 below:

**Table 4:2: Frequencies of procedure are used in fiscal resources utilization in the health sector in Somalia**

<b>Item</b>	<b>Mean</b>	<b>Std. Dev</b>	<b>Interpretation</b>
Donor and other international agencies can advance the cause of better information systems in part simply by not making a bad situation worse	2.45	1.23	Low
Make the best use of modern information management technology	2.74	1.01	High
Information systems both in some donor agencies and in some middle income countries are structured to permit automated collection and reporting of policy-relevant information	2.65	1.10	High
There should be support improvements in the ability of developing country governments to develop sound budgets and report on their execution.	3.45	1.32	Very high
There should be support the integration and institutionalization of national health accounts into policymaking in developing countries.  There should be improved data on private spending	1.22	0.71	Very low
There should be support and refine global-level information systems	1.33	.719	Very low
There was application on information communication technology	3.90	1.20	Very high
<b>Average mean</b>	<b>2.53</b>		<b>High</b>

*Source: Primary data, 2016*



Mean range	Respondents mode	Interpretation
3.26-4.00	Strongly agree	Very high
2.51-3.25	Agree	High
1.75-2.50	Disagree	Low
1.00-1.75	Strongly disagree	Very low

The results shown in table 4.2 above reveal that, respondents agreed that Donor and other international agencies can advance the cause of better information systems in part simply by not making a bad situation worse (mean=2.45, agreed) implying that health sector of Somalia was not declaring their annual budgets regularly. Respondents agreed that; make the best use of modern information management technology as revealed by; (mean= 2.74, agreed) implying that some negative reports were always not declared to the public. Responses on whether Information systems both in some donor agencies and in some middle income countries are structured to permit automated collection and reporting of policy-relevant information was represented as follows (mean= 2.65, agreed) as some respondents emphasized that there should be support improvements in the ability of developing country governments to develop sound budgets and report on their execution. (mean= 3.45, strongly agreed). An analysis on whether there should be support the integration and institutionalization of national health accounts into policymaking in developing countries. There should be improved data on private spending; were as follows; (mean=1.22, strongly disagreed) implying that there was no be presentational performance budgeting during annual budgeting reports. Further respondents revealed that there should be support and refine global-level information systems (mean=1.33 strongly disagreed) implying that if these performance accountability budgets are declared then corruption and proper utilization of resources would be properly handled. Also respondents strongly agreed that there was application on information communication technology was represented with (mean=3.90 strongly agreed).

The average mean 2.53 which was interpreted as high portrayed a good practice that the procedure are used in fiscal resources utilization in the health sector in Somalia are somehow

followed and if there are maintained a lot can be achieved in as far in fiscal resources utilization in the health sector in Somalia was concerned.

#### 4.4.1 Challenges of fiscal resource utilization in the health sector in Somalia

The respondents were asked about the challenges of fiscal resource utilization in the health sector in Somalia and their responses were as follows;

Using item means of the fiscal resource utilization, an examination of the Challenges of fiscal resource utilization in the health sector in Somalia was carried out. The items were rated on the 5 point likert scale ranging between strongly disagree, disagree, not sure, agree and strongly agree. The findings are shown in table 4.3 below:

**Table 4.3: Frequencies the challenges of fiscal resource utilization in the health sector in Somalia**

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1	2	3	4	5

Item	Mean	Std. Dev	Interpretation
Changing the behavior of politicians	2.35	1.12	Low
Developing the institutional capacity of the MOF and spending ministries	2.45	.452	Low
Managers in spending ministries can resist change	3.2	1.11	Very high
Resistance from public servants	1.43	0.72	Very low
Output and outcome measures each present a different set of challenges	2.45	00.1	Low
Countries continue to face challenges with issues of measurement, especially with outcomes	3.25	00.1	Very high
<b>Average mean</b>	<b>2.52</b>		<b>High</b>

*Source: Primary data, 2016*

Mean range	Respondents mode	Interpretation
3.26-4.00	Strongly agree	Very high
2.51-3.25	Agree	High
1.75-2.50	Disagree	Low
1.00-1.75	Strongly disagree	Very low

Results in Table 4.3 indicate that; respondents disagreed (mean = 2.35, disagreed) that; changing the behavior of politicians. Implying that they help a lot in trying to expose the weaknesses in the fiscal resource utilization in the health sector. Similarly, respondents agreed (mean = 2.45, disagreed) that developing the institutional capacity of the MOF and spending ministries. Implying that was the only changes faced with the health sector in Somalia whereas it was established that promotion to higher positions (mean = 3.2, strongly agreed) respondents were not sure implying that they were not well vast information about. Whereas views whether the managers in spending ministries can resist change respondents (strongly disagreed=1.43 mean) and responses on resistance from public servants respondents (disagreed=2.45 mean) implying that this resist in change can promote corruption and encourage poor accountability. Output and outcome measures each present a different set of challenges (strongly agreed=4.35 mean) responses on Somalia health sector continuing to face challenges with issues of measurement, especially with outcomes. Implying that management was still facing a lot of challenges to address aimed at achieving the health sectors goals.

The average mean 2.53 which was interpreted as high Implying that they help a lot in trying to expose the weaknesses in the fiscal resource utilization in the health sector. In addition, their resistance to change can promote corruption and encourage poor accountability and management was still facing a lot of challenges to address aimed at achieving the health sectors goals.

## CHAPTER FIVE

### DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

#### **Introduction**

This chapter mainly dealt with discussion, conclusion and recommendation related to the utilization of fiscal resources in health sector in Somalia drawn from the findings. This was based on the themes of the forms fiscal resource utilization on health sector in Somalia, procedure used in fiscal resources utilization in the health sector in Somalia and the challenges of fiscal resource utilization in the health sector in Somalia

#### **5.1 Discussion of the findings**

Discussion of finding was in line with the objectives of the study

##### **5.1.1 The forms fiscal resource utilization on health sector in Somalia**

The findings revealed there was presentational performance budgeting there was performance-informed budgeting, there was planning purposes loosely linking planned performance to funding, there was a performance result for accountability purposes. The findings were supported with (Laffont, 2002) who in his study Firm as a Multi contract Organization pointed out that countries with low levels of fiscal deficits and debt levels, according to recent trends and projected levels, however, are more able to increase spending levels for any purpose, including for health should they choose to do so. In cases where the fiscal health of the country is weak, the roots of the fiscal stress should be highlighted and the implications for increasing spending for health discussed. If fiscal stress is high because of high rates of public subsidies, the implications for fiscal space for health are different than if it is due to increasing productive investment.

In addition, in addition the findings were in agreement with Hutton, (2004), who in his study *The sector- wide approach: blessing for public sector* pointed out that the support improvements in the ability of developing country governments to develop sound budgets and report on their execution. The essence of this recommendation is a recognition that the most important primary data upon which virtually all successful resource tracking relies are those generated within developing countries, and so efforts should be made to reinforce the initiatives currently

underway to bring budgeting and expenditure management and reporting systems up to an international standard. As a complement to these efforts, donors should identify and support in-country institutions to track the correspondence of public-sector budgets to national priorities, serving as an independent check or “watchdog” on public-sector agencies.

### **5.1.2 Procedure used in fiscal resources utilization in the health sector in Somalia**

Field findings revealed that there should be planning purposes loosely linking planned performance to funding: were as follows; (mean=1.22, strongly agreed) implying that there was no be presentational performance budgeting during annual budgeting reports. In this context, fiscal space for health can be defined as 'additional budgetary resources for health without prejudice to a country's financial sustainability'. The findings are supported by (Malcomson, 2000) who in his study pointed out that the pattern and prospects of general government health expenditure in a group of 26 resource-poor low-income (labeled here as L-26 countries). While almost all low-income countries are disadvantaged with inadequate total and government health spending, L-26 countries are more disadvantaged than others. About 2.1 billion people or 31.0% of the world's population, of whom about one-third are poor, live in these countries. Their average life expectancy in 2008 was 56 years (range 42-65 years). Their low income, restricted internal resource base for health, high disease burden, and persistent inequities make them most vulnerable with probably the highest health financing gap.

Further respondents revealed that there should be performance results for accountability purposes (mean=1.33 strongly agreed) implying that if these performance accountability budgets are declared then corruption and proper utilization of resources would be properly handled. The findings were in agreement with Harding and Preker, (2003) established that fiscal space can be defined as "the capacity of government to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position". Governments could create fiscal space in many difference ways - e.g. tax measures, external grants, efficiency gains, internal and external borrowing and reprioritization

Further finding were supported by Bennett et al., (1996) who in his study the positive contributions of Global Health Initiatives revealed that formal approach, in which the MOF requires spending ministries to present performance plans and/or performance results along with

their spending proposals, while other countries have no formal requirements. PI can be used by the MOF for planning purposes and/or accountability purposes. In both these cases there is an ongoing discussion of how PI should be linked to funding. There are different classifications of PB: presentational, performance-informed budgeting, and director formula PB. Depending on the approach adopted, countries can seek to link PI to decisions on resource allocation not at all, loosely, or tightly.

### **5.1.3 The challenges of fiscal resource utilization in the health sector in Somalia**

Findings from the field also revealed that respondents on annual budget process published about challenges of fiscal resource utilization in the health sector in Somalia as revealed by; (mean=2.74, agreed) implying that some negative reports were always not declared to the public. The findings were in agreement with Sood et al., (2008) who in his study Vertical Restraints as Contract Enforcement Mechanisms' pointed out that there is a growing and robust healthcare infrastructure that receives ample financial support from its governments. This is however not the situation in most developing countries. In particular, professionals in various health facilities who implement healthcare information technology based solutions like EHR systems in developing countries are overwhelmed with the lack of ICT resources (such as unavailability of computers) and weak healthcare infrastructure.

More so, there should be planning purposes loosely linking planned performance to funding: were as follows; (mean=1.22, strongly agreed) implying that there was no be presentational performance budgeting during annual budgeting reports. In the same way, Reeves, (2008) said that changing the behavior of Politicians had an important role to play in promoting the development and use of PI in the budget process. That role involves applying pressure on other actors to implement PB, playing an active role in setting objectives, and using PI in budgetary decision making. Their role in the legislature and the executive will vary depending on the nature of the legislative-executive relationship in the budget process, which in turn is influenced by the type of political system in place: presidential, semi presidential or parliamentary.

In addition, the findings were supported by Adu, (2013) who pointed out that most developing countries, particularly in sub-Saharan Africa, find it difficult to provide Uninterrupted Power Supply (UPS) to their citizens. This invariably affects any good ICT service provision like EHR (Achampong, 2012). The Ghanaian experience is even worse with the current ongoing load shedding exercise. Thus a health facility operating an EHR cannot safely depend on the flow of electricity supplied by the Electricity Company of Ghana (ECG) since at any time without prior notice power can go off (Ibid). In touring some health facilities in Accra (the capital city of Ghana) in order to ascertain how these facilities have been dealing with the electricity shortages, Beatrice Adu, a Joy News (a leading private news TV station in Ghana) reporter, described the erratic power supply as “worrying” to the general healthcare delivery system

## **5.2 Conclusions**

### **5.2.1 Forms fiscal resource utilization on health sector in Somalia**

It can be concluded that priority setting relevant to the epidemiological burden, contributing to the improved health status of the population. By prioritizing, the sickest in the population are protected through various financing initiatives and arrangements such as the National Health Fund and the Global Fund. The Ministry of Health has to make efforts to ensure equitable access, through the regional allocations for public health services, for which user fees have been abolished. The Government has also created additional mechanisms that cover specific disease programmes; however, National Health Finance (NHF) copayments are required for the entitlements (mainly drug purchases) and co-payments are flat payments, thus regressive in nature. Increased access has also resulted on increased waiting times and longer staff working hours

### **5.2.2 Procedure used in fiscal resources utilization in the health sector in Somalia**

Performance budgeting should be more than the development of performance information: it is concerned with the use of this information in budget processes and resource allocation. PI can be used by the MOF for planning purposes and/or accountability purposes. In both these cases there is an ongoing discussion of how PI should be linked to funding. PI is utilized throughout the planning, monitoring and reporting phases of expenditure management. This largely takes place outside the annual budget process.



Additionally, accountability performance-informed budgeting Loose/indirect link Performance targets and/or performance results planning and/or accountability Direct/formula PB Tight/direct link Performance results Resource allocation and accountability political and fiscal priorities. Thus, it is only one factor in the decision-making process. MOF uses performance results to determine budget allocations. At best, performance results can be used to inform budget allocations along with other information. Even this use of performance-informed budgeting can be sporadic

### **5.2.3 Challenges of fiscal resource utilization in the health sector in Somalia**

The majority of health professionals in Somalia lack the basic ICT knowledge or skills that are needed to effectively use the EHR systems. This hampers the full utilization of the system by health professions. As confirmed by interview response gathered from the healthcare professionals

Somalia has experienced problems with developing the necessary institutional capacity at the level of the MOF and spending ministries to support these reforms. That capacity is influenced by the wider institutional structure and resources in terms of staff and expertise. PI is different from financial information. In order to make judgments and compare performance, the MOF needs the relevant expertise to be able to analyze and evaluate the information received from different spending ministries. Spending ministries depend on agencies for information.

Politicians have an important role to play in promoting the development and use of PI in the budget process. That role involves applying pressure on other actors to implement PB, playing an active role in setting objectives, and using PI in budgetary decision making. Their role in the legislature and the executive will vary depending on the nature of the legislative-executive relationship in the budget process, which in turn is influenced by the type of political system in place: presidential, semi presidential or parliamentary.

### **5.3 Recommendations**

#### **5.3.1 Forms fiscal resource utilization on health sector in Somalia**

- First and far most government should stimulate the formation of a social health insurance scheme by pooling the large out-of-pocket expenditure that goes to private care and extending the revenue collected to low income groups.

#### **5.3.2 Procedure used in fiscal resources utilization in the health sector in Somalia**

- The ministry of Health should use resources more optimally by being more specific as to the drugs offered under the new Government Health Card, in order to not replicate National Health Finance (NHF) individual benefits and cut back on costs associated with drug procurement and provision.

#### **5.3.4 Challenges of fiscal resource utilization in the health sector in Somalia**

- The low wage packages and lack of incentives has compromised the delivery of health services. Its recommended creating a link between public health workers' remuneration packages and performance, For example, provide nonmonetary rewards such as opportunities for learning and career progression, subsidized housing and education for dependents.

### **5.4 Areas for further study**

Further study should examine how Somalia has managed to achieve sustainable increases in health spending. The framework for expanding fiscal space (i e. The five pillars) should provide the basis with which to investigate this question. Also identify the key actors, processes, and policies that led to an expansion in fiscal space, as well as the political context in which they all operate. This study should also be amenable to Qualitative research methods, although a quantitative understanding of the financing picture was likely to be a prerequisite.

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Saltman (2002) has stated that "*As a result, the shift to a more entrepreneurial environment both within the public sector and beyond requires not only a similar level of state activity, but substantially more sophisticated types and levels of activity. This requires better trained and motivated personnel, better information, and greater financial and accounting expertise*"

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## APPENDIX I

### SELF-ADMINISTERED QUESTIONNAIRE FOR THE RESPONDENT IN SOMALIA

Dear Respondent

My name is **MEAD ABDI OSMAN** a student at Kampala International University pursuing a Master's Degree in Master of Public Administration and management this questionnaire is designed to collect information aimed at assessing how *utilization of fiscal resources in health sector in Mogadishu Somalia as a case study*. The information obtained will be strictly for academic purposes and it will be treated with utmost confidentiality. I kindly request you to fill this questionnaire. Thank you very much for your time and co-operation

#### SECTION A: Demographic data

(Tick in the appropriate box provided)

#### SECTION B:

1. Your age

Under 25

25-34

35-45

Above 45

2. Gender

Male

Female

3. Marital status

Single

Married

Divorced

Widowed

4. What is your highest level of education you have attained?



- PHD
- Masters
- Professional qualification
- Degree
- Diploma
- Certificate

5. For how long have you worked with the health sector?

- (a) Less than 1 year                      (b) 2-3 years
- (c) 4-6 years                                (d) More than 6 years

**SECTION B: FORMS FISCAL RESOURCE UTILIZATION ON HEALTH SECTOR IN SOMALIA**

Evaluate the following statements by ticking the appropriate alternative of your choice.

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1	2	3	4	5

	Items	1	2	3	4	5
1	There is highest priority on responding to needs of in-country decision makers					
2	There is Coordination, collaborate, and do no harm					
3	Donor and other international agencies can advance the cause of better information systems in part simply by not making a bad situation worse					
4	Make the best use of modern information management technology					
5	Information systems both in some donor agencies and in some middle income countries are structured to permit automated collection and reporting of policy-relevant information.					
6	Support improvements in the ability of developing country governments to develop sound budgets and report on their execution.					
7	Support the integration and institutionalization of national health					

	accounts into policymaking in developing countries.					
8	Improve data on private spending.					
9	Support and refine global-level information systems					

**SECTION C: PROCEDURE ARE USED IN FISCAL RESOURCES UTILIZATION IN THE HEALTH SECTOR IN SOMALIA**

Evaluate the following statements by ticking the appropriate alternative of your choice.

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1	2	3	4	5

	Items	1	2	3	4	5
1	There is performance budgeting					
2	There is integrating PI into the annual budget process					
3	There is presentational performance budgeting					
4	There is performance-informed budgeting					
5	There is planning purposes loosely linking planned performance to funding:					
6	There is performance results for accountability purposes:					
7	There is linking performance results to funding.					

**SECTION D: CHALLENGES OF FISCAL RESOURCE UTILIZATION IN THE HEALTH SECTOR IN SOMALIA**

Evaluate the following statements by circling/ticking the appropriate alternative of your choice.

Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1	2	3	4	5

	Items	1	2	3	4	5
1	There is a changing the behavior of politicians					
2	There is developing the institutional capacity of the MOF and spending ministries					
3	Managers in spending ministries can resist change					
4	There is resistance from public servants					
5	There is output and outcome measures each present a different set of challenges					
6	There is continue to face challenges with issues of measurement, especially with outcomes					

*Thank you very much for the cooperation*

## APPENDIX II

### AN INTERVIEW GUIDE FOR THE RESPONDENT IN SOMALIA

Dear Respondent

My name is **MEAD ABDI OSMAN** a student at Kampala International University pursuing a Master's Degree in Master of Public Administration and management this questionnaire is designed to collect information aimed at assessing how *utilization of fiscal resources in health sector in Mogadishu Somalia as a case study*. The information obtained will be strictly for academic purposes and it will be treated with utmost confidentiality. I kindly request you to answer the questions below. Thank you very much for your time and co-operation

1. What utilization processes are used in health sectors in Somalia?
2. How have Fiscal health and its disciplines affected the degree to which economic growth can be translated into increased resources for health?
3. How have the fiscal resources been utilized in the health sector in Somalia?
4. What are the forms fiscal resource utilization on health sector in Somalia?
5. What are the procedure are used in fiscal resources utilization in the health sector in Somalia?
6. What are challenges of fiscal resource utilization in the health sector in Somalia?

*Thank you very much for the cooperation*

**APPENDIX III:**

**SAMPLE SIZE(S) REQUIRED FOR THE GIVEN POPULATION SIZES (N)**

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	266	3000	341
20	19	120	92	300	169	900	269	3500	346
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	354
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	170	118	400	196	1300	297	7000	364
50	44	180	123	420	201	1400	302	8000	367
55	48	190	127	440	205	1500	306	9000	368
60	52	200	132	460	210	1600	310	10000	370
65	56	210	136	480	214	1700	313	15000	375
70	59	220	140	500	217	1800	317	20000	377
75	63	230	144	550	226	1900	320	30000	379
80	66	240	148	600	234	2000	322	40000	380
85	70	250	152	650	242	2200	327	50000	381
90	73	260	155	700	248	2400	331	75000	382
95	76	270	159	750	254	2600	335	10000	384

**SOURCE:** Krejeie and Morgan (1970), Determining sample size for research activities, Educational and psychological measurement, 30,608, sage publications.

## MAP OF MOGADISHU SOMALIA

Lafuole



Map data ©2016 Google