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The Silence That Costs Lives: How Clannism and Hushed Acquiescence Undermine the Health Care System: Dollo Addo Hospital

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ABSTRACT

This is an investigative piece of narratives that presents a firsthand field-based assessment of the Dollo Addo primary hospital, a vital health facility for the cross-border and refugee population in the area. The hospital accommodates a vast number of specialized medical personnel despite its remote setting and devastating health facilities. The hospital suffers from operational dysfunction, severe infrastructural decay, and systematic mismanagement. Employing a qualitative approach, including staff interviews, facility walkthroughs, and patient case reviews, critical service failures and operational troubles were observed, such as issues with water hygiene and sanitary systems, emergency services, procurement governance, discretionary financial expenditure, power supply irregularities, poor chain of command, and communication channels. Specialist staff remain idle due to a lack of surgical and basic diagnostic tools. Moreover, two-thirds of the hospital's budget is disbursed for informal salary top-ups and an under-the-table pay procedure, thereby sustaining the dysfunctional system. Documented informal payments during the field assessment, along with an inconsistent supply chain, further undermine patient trust and equitable access. Additionally, the internal governance system is marred by weak transparency, fragmented accountability, and a lack of prioritization. Thus, the report urges an immediate realignment of resources towards equipment provision, infrastructural rehabilitation, and a transparent governance system. It also calls for actionable strategies in line with Ethiopia's Health Sector Transformation Plan II (HSTP-II), including service readiness, need-based and comparable hiring procedures, and an optimistic referral network. In a nutshell, the report advocates for substantive investment in lifesaving system installation rather than symbolic staffing for political visibility and financial informalities, thereby restoring system functionality and dignity in frontline healthcare.

INTRODUCTION

This report presents an independent, professional assessment of Dollo Ado Primary Hospital, a vital healthcare provider for border and refugee populations in the Somali Region. It aims to identify the facility's operational strengths and systemic weaknesses through staff interviews, patient case reviews, and a structural evaluation. The findings are presented in the spirit of constructive engagement and institutional improvement. They aim to foster constructive collaboration and evidence-based solutions, not for partisan judgment or fault-finding, and will support informed decision-making through data-driven, solution-focused reflection. The hospital operates within the region's health system and has an expanded service mandate due to its proximity to major refugee camps and cross-border populations. However, a notable concentration of well-qualified specialists in such a remote rural setting seems unusual.

1. General Surgeon
2. Internist
3. Pediatrician
4. Gynecologist
5. Psychiatrist
6. Radiologist
7. Orthopedic
8. Dentist

Despite its peripheral and remote rural setting, the hospital accommodates atypical profiles. While it may seem puzzling, these experts earn the highest unofficial wages of any other professional

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undertaking in the country. Despite the service and a physically vulnerable situation of the hospital, the specialist staff receive an average monthly salary ranging from 150,000 to 170,000 ETB. This workforce is a vital human resource for regional healthcare, yet it currently offers largely irrelevant services due to a lack of essential diagnostic and treatment instruments.

Objective

The primary objective of the assessment is to evaluate the operational functionality, service delivery capacity, resource governance, and infrastructural adequacy of Dollo Ado Primary Hospital, providing actionable insights for strengthening the health services system.

Methods

The assessment employed a qualitative observational approach, featuring on-site facility walkthroughs, case-based documentation, and structured staff interviews. Information was triangulated across departments and the overall hospital units. Additionally, available hospital records and budget expenditures were reviewed when accessible.

Figure 1: The Main Entry Gate Of The Hospital

Key Findings

Physical Infrastructure and Structural Vulnerability

PATIENTS CARD SERVICES AND GUARD ROOMS

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Dollo Ado Primary Hospital provides clear evidence of significant physical deterioration, far exceeding the expectations for a referral hospital. The system requires in-depth improvement and upgrades as it is disintegrating and jeopardizing the ongoing provision of healthcare. There is no established water system to maintain proper sanitation. Most departments rely on makeshift buckets for cleaning and patient use.

The absence of piped and potable in inpatient water at emergency areas and its surrounding significantly undermines infection prevention and control, maternal healthcare, and surgical readiness. Medical waste disposal is compounded by the region's unreliable plumbing system, worsening the biohazard threat. Additionally, the facility suffers from disorganized departmental units instead of a well-equipped functional setup.

Spaces are shared by units such as psychiatry, pediatrics, surgery, and more, without physical separation. This arrangement is not conducive to infection control, restricts clinical privacy, and causes operational confusion, especially when the clinic becomes crowded or faces urgent cases. Essential actions like intra-hospital triage, wound management, and laboratory deliveries occur in shared or non-dedicated areas, negatively impacting care quality and increasing health risks. Dirty roads lead to the facility from all directions, unpaved and challenging for ambulances; patients must navigate through dust clouds as if there were no police station. The buildings show surface poor sanitary and wornness, inadequate roofing, and a lack of rainwater drainage, which affects internal cleanliness.

Central clinical departments, including maternity, pediatrics, and surgery, face seasonal flooding and soggy indoor conditions. Ventilation is either nonexistent or severely lacking. There is virtually no temperature control in the high-volume maternity area; if anything, it’s terrible. Countless patients and providers endure extraordinarily harsh conditions with no alternative options. The power infrastructure is equally inadequate. Frequent blackouts occur, and the hospital lacks the automatic backup power needed for conducting operations, neonatal care, and emergency stabilization.

Staff commentary, “We frequently clean using buckets since we have no stable piped water. We even have to use torches during delivery when the power fails.” It's not just a hassle; it's a safety risk.

The area surrounding the facility is insecure. Due to the lack of a controlled entry system, overcrowding, sardine-like packing of patients and families, and occasional disruptions to the safe flow of clinical care have become the norm. Overall, the hospital presents a scene of operational disrepair, not from human inadequacy but from significant infrastructural decay. The hospital's condition is not merely a background issue but a central aspect of service disruption. Addressing structural weaknesses and establishing environmental health must be integral to any service investment, as staffing levels or budgets will not change health outcomes, no matter how high. Electricity is unreliable, with frequent outages and no emergency power backup systems for surgeries. The plumbing is outdated and more prone to leaks, compromising essential facilities like delivery rooms and operating areas. “We clean using buckets in the maternity ward because there is no steady water flow through the pipes.

Midwife commentary: At deliveries, power failure often forces us to use torches. This is not just an inconvenience; it’s dangerous.”

Compounding these vulnerabilities is the hospital’s failure to secure its perimeters, which leads to safety and crowd-control issues, particularly in busy departments like emergency and outpatient care. The physical structure of the hospital is profoundly fundamental. Without a functioning facility, it doesn’t matter how talented your staff are; satisfactory health outcomes cannot be achieved. The facilities' complete physical rehabilitation and systemic retooling cannot and must not be delayed for life saving purpose.

Severely Compromised Emergency and Theatre Capacity

Although the hospital is the primary referral center, its emergency and surgical operations are nearly immobilized. The emergency room lacks essential life-saving equipment, including functional defibrillators, working oxygen cylinders, suction machines, and sterile trauma kits. In several

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observed cases, the “sickest” OFCs (i.e., those who required immediate intervention) were rehydrated with IV fluids and discharged for referrals.

Case Report: Bladder Mass and Catheter-Associated Hematuria

A 73-year-old man was hospitalized due to urinary retention and catheter-borne hemorrhage. Initial assessment using ultrasound showed a suspicious bladder mass, accompanied by kidney function tests indicating complications. Surgical treatment was first planned according to the imaging findings. Nonetheless, on the day of surgery, visible hematuria through the catheter prompted new concerns, which necessitated further evaluation. The surgeon on duty said a decision could not be taken until the source of the bleeding was known. Regrettably, vital follow-up diagnostics were unavailable, including urinalysis, coagulation, and cystoscopy. The patient was, therefore, referred to Hawassa “almost 700 km.

Surgeon Commentary: "We encountered a straightforward surgical indication complicated by unexpected bleeding. We could not move forward safely without basic lab or endoscopic tools. The only clinical course was to refer him, but that pathway might cost his life.”

Case Report: Patient with Septic Wound in a Dolo Town Clinic.

A prominent community elder from the Dollo Ado district, suffering from a septic shoulder wound that showed signs of tissue necrosis and systemic infection, came to the emergency room seeking care. The hospital lacked essential wound care supplies, such as sterile gauze, antiseptic solution, gloves, or fusidic acid. As a result, the wound could not be treated, and the patient was asked to purchase the necessary materials if he wished to continue receiving care.

Emergency staff commentary, “When he took his shirt off, we knew it was serious. But we didn’t have anything even to clean or cover the wound. It felt wrong to send him home, but we can’t do anything without tools.”

This was not a unique instance but a common obstacle for providers and patients. It serves as a poster child for a hospital that does not align with its operations. The unit's service was limited to oral advice and stabilization, without formal care guidance. These cases are not outliers; they reflect everyday challenges faced by the patients.

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Human Resources vs. Operational Readiness

Despite the Hospital hosting a wide range of highly skilled professionals, the gap between their expertise and the existing infrastructure has led to a significant underutilization of knowledge. Specialists often express frustration at their inability to perform essential clinical tasks due to a lack of equipment, malfunctioning support systems, or power outages. Most lack a functional operating theater, an initial diagnostic lab, or imaging backup; as a result, valuable medical knowledge remains untapped.

The current human resource complement results more from systemic momentum, political exposure, and inter-hospital rivalry than from the rationale of evidence-based need. According to staff and internal observers, the designation of specialist has become a symbol of prestige rather than a functional healthcare system. The existence of multiple leadership vacuums has led to a preference for human resources over investments that enable services.

"Staff Commentary: "The community doesn't need titles, it needs tools. We are here in full dress, and cannot use it. "We are there to show strength, and it is showing us to be quite feeble."

It is only 230 km from Filtu Zonal Hospital, a more suitable referral center for advanced tertiary care conditions. This proximity makes it unnecessary for Dollo Ado to duplicate the staffing structure of the tertiary level without complementary services. Under these circumstances, spending over two-thirds (2/3) of the hospital's working budget on salaries while patients lack oxygen, IV fluids, delivery beds, and diagnostics can be more accurately described as a strategic miscalculation, a failure of leadership, and a deficiency in a well-structured monitoring system. Instead, reallocating investments toward physical infrastructure, essential equipment, and service systems would be more effective.

Why is staffing at the tertiary level (specialist staff) are less important than investing in facilities and equipment now?

1. *Specialists Need Tools to Do the Job:* Highly specialized professionals cannot do their jobs without basic tools to perform procedures, diagnose, and manage care.

2. *Referral network,* only 230k from Dollo Ado is the Filtu Zonal Hospital, where more complicated specialist care can be readily referred, avoiding replicating advanced skills at Dollo Ado without commensurate infrastructure.

3. *Return on Investment Fit:* Specialists are too costly, but do not help to provide better service with a poor facility.

4. *Sustainability and continuum:* Investments in infrastructure, such as surgery theatres, labs, and diagnostic supplies, are still useful over time and between staff rotations. No system can compensate for skills alone.

5. *Utilization and Retention of Staff:* When the hospital provides staff with tools to enable meaningful practice, frustration and turnover are reduced, and workplace morale improves.

6. *Equity and Essential Access:* Infrastructure prevents you from needing advanced care until routine and emergency care are available to the general population.

7. *Strategic Health System Strengthening:* This phase establishes foundations, such as clean water, power, maternity wards, and diagnostics, that will serve as a base for all the other upgrades.

Thus, we need leadership to put its energy into costly, outcome-focused investment, not just symbolic top-up staffing. You don't have a staffing strategy if you don't have a sound infrastructure, service readiness, and vice versa.

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Critical Medical Supply Chain and Procurement Gaps

Additionally, a significant discrepancy in supply pricing and availability worsens concerns about supply governance at the hospital level and equity of service access. Anecdotal and ad hoc price monitoring suggests that the cost of critical products available through some transactions is priced substantially above typical purchasing benchmarks and at levels much higher than the price at a local pharmacy A significant discrepancy between donated supplies and those sourced or sold internally has resulted in a lack of transparency and trust regarding the origins of supplies.

"Some of the gloves and IV fluids we used were donated. Today, the same items are available only at significantly higher prices, if at all. There's no explanation. Patients feel they are paying twice for services they already deserve."

When combined with these discrepancies and the lack of system-wide internal price regulation or public inventory transparency, it is no wonder that there is a perception of systemic mismanagement or at least inefficiency. The absence of consistent pricing for medical items and the inability to differentiate between donated, publicly purchased, and privately sourced products have created a haphazard system that unduly punishes the most vulnerable populations. The response also highlights underlying issues regarding priorities in procurement, supply tracking, and accountability at the facility level. Concerning the procurement process, staff mentioned that the hospital's delivery, distribution, and allocation of supplies remain opaque and inconsistent.

Supplies may arrive unexpectedly, but not swiftly, at the points of care. There is growing concern that a disconnect exists between what is being procured and the service requirements, and that oversight of stock deployment is lacking. This cyclical problem of irregular supply flow, inefficient in-house distribution, and weak inventory control leads to service disruptions, even for basic procedures. It is not uncommon for providers to begin treatment only to have to stop midway due to a lack of gauze, IV fluids, catheters, syringes, or other necessary items.

Staff commentary, "We are in the middle of treating a wound, and in the middle of the procedure, the saline bottle is being shared between rooms, or there are no appropriate gloves. This is not a luxury; this is a continuation of care."

Such supply chain debacles jeopardize patient care, undermine trust, and deflate clinical staff. Reliable access to essential medical commodities should not be an admirable aspiration but the cornerstone of a functional healthcare system.

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Documented Informal Payment Practices

Multiple reported mavericks in some testimonies and shadow check-out audits have indicated a rising trend in cash under-the-table payments. Patients claimed they were asked to pay cash for medications, laboratory investigations, and even bed space in emergency units. These allegations were consistent between sources and were recorded and reported for confidential review by a high-ranking hospital official.

Internal Governance and Resource Management

The facility-based planning review showed sharp discrepancies between planned budgets and the resources of the actual clusters. According to staff, procurement and distribution are still not well synchronized with departmental needs, even though an operational budget is allocated annually, with a significant part based on internal revenue. Though the hospital has been positioned to compete with other urban and Semi-Urban health centers, this has skewed the focus from an appropriate service delivery model to visible staffing.

The Primary Hospital has an annual budget of approximately 64 million ETB allocated by the regional Health Bureau, along with an IGR generating a yearly income of 1.5 to 2 million ETB. If used correctly and strategically, these funds should be sufficient to provide primary healthcare to over 85% of the population. However, the hospital's budgeting process does not reflect operational priorities. Funds were not geared towards infrastructure, essential equipment, and core care delivery processes; instead, a significant portion of the operational budget was diverted to facade-related expenditures and nominal human resources to illustrate the facility's level in disguise.

Despite these funds and manpower inputs, the hospital has not been optimized. A vulnerable physical infrastructure, a misaligned operation, and a weak institutional governance mechanism drive the degradation of the institution's performance.

The buildings are in poor physical condition, and the walls, structure, and features are deteriorating and urgently need repairs. Additionally, the asbestos ceilings, high moisture levels, and other utilities are outdated and malfunctioning. Structural deficiencies can affect patient safety, infection control, and staff operations. Much of the operating budget has been redirected to cover inflated specialist fees instead of reinvesting in facility infrastructure and vital services. According to payroll records, specialist staff earn between 150,000 and 170,000 ETB per month, more than twelve times the official pay scale of similar academic rank in the health sector. These salaries are not processed through the HR system; they are drawn from the hospital's operating budget to retain staff, compromising service and basic functionality.

Admin officer: "We don't have a pay scale approved for what we pay." It's a fudge, what we call 'retention packages', yet they hoover up most of the money we should spend on equipment, maintenance, emergency readiness."

This informal setup highlights the underlying problem of governance: institutional vanity and competitive display rather than a sustained impact on services. Hiring high-profile specialists has increasingly become a symbolic gesture to signal regional visibility and competitiveness, both with other hospitals and in comparison, to competitors like Filtu Zonal Hospital. However, these experts are underutilized in practice due to a lack of diagnostic tools, operating theaters, and clinical systems to support patient care. Additionally, hospital governance lacks accountability and suffers from limited transparency in budgeting.

Internal review mechanisms are often rudimentary, concentrating on administrative accountability instead of strategic resource allocation. As a result, structural deficiencies persist, and frontline readiness declines.

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Senior staff commentary: *"We have personnel for whom we don't have equipment." We have budgets, but no transparency about priorities and where this budget goes. We say we need lab reagents and an oxygen system each year, which gets passed over for cosmetic things."*

Such a governance environment undermines returns on public and partner investments, threatens patient engagement, and harms provider morale. Revamping internal budgeting and ensuring transparent resource use are essential for transforming the hospital from a paper-based reality into a functioning health facility.

This informal structure reveals a fundamental governance letdown, prioritizing institutional prestige and competition while overshadowing sustainable service impact. Hiring well-known specialists is also symbolic and helps demonstrate regional relevance and competition with other regional hospitals of equal or greater stature. However, the potential of these experts is often not realized in practice, as they lack diagnostic tools, surgical facilities, and clinical support services.

CONCLUSION

Dollo Ado Primary Hospital presents an ideal opportunity as a regional anchor institution due to its human resources, geographical significance, and budgetary positioning. However, the persistent gap between its professional image and functional reality necessitates immediate strategic action. This paper serves as a collective and evidence-based call to action, informed by professional observations and the voices of the community.

RECOMMENDATIONS

1. *Prioritize Core Infrastructure Rehabilitation*. Invest in rehabilitating water supply systems, electricity, sewage, and the rearrangement of spaces. "No clinical investment will make any sense without functioning infrastructure.

2. *Rebalance Budget Toward Equipment and Essential Services*. Divert excessive specialist pay to essentials such as oxygen systems, advanced diagnostics facilities, surgical kits, and maternity kits that can save lives.

3. *Improve Internal Governance and Financial Monitoring*. Establish a transparent budget planning based on participatory needs assessments and ensure compliance with national salary scales and procurement procedures.

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4. *Optimize Human Resource Allocation:* Match the staff profile to the actual capacity of the facility. Specialist deployment should be demand-driven and infrastructure-readiness, not profile-driven.

5. *Adopt Minimum Service Readiness Standards.* Test readiness is assessed annually by applying the WHO SARA benchmarks for water, sanitation, emergency response, and maternal health care.

6. *Engage in Strategic Referral and Facility Network Planning:* Leverage proximity to zonal hospitals, Filtu, where advanced cases can be referred, to focus Dollo Ado facility development towards a well-staffed center for general care.

7. *Engage in Strategic Referral and Facility Network Planning:* All planning, budgeting, and infrastructure development should follow Ethiopia's HSTP II and other national health quality frameworks to promote systemwide consistency, equity, and quality healthcare.

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