

WHO Somalia

Biennial Report 2010-2011



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Table of contents

Foreword	1.	2.	3.	4.	5.
	Introduction	Primary health care	Emergency preparedness and humanitarian action	Malaria	Tuberculosis
2	7	8	14	20	22
6.	7.	8.	9.	10.	11.
Essential medicines	Routine immunization	Polio eradication: polio free somalia	HIV / AIDS and sexual transmitted infections (STI)	Laboratory services and blood safety	Partnerships in health development
24	26	28	32	34	36

Foreword

Looking back at the biennium 2010-2011, Somalia experienced one of the worst humanitarian crises since many decades. In 2011, Southern regions of Somalia endured famine. Thousands of Somalis fled by foot and became displaced at the Kenyan and Ethiopian borders or in Mogadishu. These Somalis, especially women, children and the elderly, suffered immensely and many were too weak to reach the places where humanitarian assistance was provided. In collaboration with over 60 health cluster partners, WHO established and expanded emergency primary health care services in Central and Southern regions. Mobile clinics and field hospitals were established to meet the huge humanitarian health demand. The international response was overwhelming and WHO was able to respond effectively after receiving substantial donor support.

On 7 September 2011, the Regional Director of WHO Eastern Mediterranean Region, Dr A. Gezairy, visited the capital Mogadishu to meet with the Transitional Federal Government President and Minister of Health. During this occasion, medical supplies were handed over to Benadir Hospital to symbolize the generous support of the Saudi Government to the Somali population in need.

WHO strengthened its disease surveillance and response activities by receiving weekly reports from over 400 sentinel sites, especially on diarrhea and malaria. In addition, WHO continued and increased the provision of medical supplies and equipment to health authorities and cluster partners for adequate emergency response.

The year 2010 was dynamic with announcements of newly approved programmes especially in health system strengthening granted by the Global Fund and later by GAVI. In June 2010, a WHO Health System Strengthening mission with participation of UNICEF and UNFPA concluded that a mind shift has to be made by moving away from emergency response towards health sector development approaches. In 2011, a joint health programme was formulated with a long term vision.

Somalia remained polio-free during 2010 and 2011. This is due to the unconditional dedication and commitment of the zonal health authorities, polio staff, thousands of local volunteers, Somali parents and communities in the whole country. By late 2011, GAVI awarded the approval of the Pentavalent vaccine application, which includes immunization against diphtheria, tetanus, pertussis, hepatitis B and Haemophilus influenza (Hib). With this introduction, more lives can be saved.

During 2010 and 2011, other disease control programmes such as HIV/AIDS, Tuberculosis and Malaria, made good progress in activities related to case detection, lab confirmation, and the provision of adequate patient treatment and care. WHO advocated for integrated laboratory services and started to establish blood safety services in all zones of the country. Health staff benefited from regular in-service training, technical support and supportive supervision.

Community-based initiatives were revived to allow communities to take better charge of their health problems. An integrated case management programme was initiated by WHO-UNICEF to address the killer diseases such as diarrhoea, malaria and pneumonia by training village health workers in case detection and early treatment.

More attention and advocacy was provided to mental health. The mental health situation analysis revealed that 1 in 3 Somalis suffered from a mental health disorder.

With these successes and ongoing programme achievements WHO faced like other humanitarian agencies a challenging working environment due to the ban to operate in various areas controlled by an anti-government entity mainly in South Central Somalia. Despite this difficulty WHO maintained its presence in every district of Somalia with over 300 national staff working in health or disease control programmes and still managed to reach communities in biggest needs through local partners.

On behalf of all staff of WHO Somalia, I express my gratitude to the Zonal Health Authorities, generous donors and implementing partners for their sustained dedication and continuous support in responding to the health needs of the Somali population.

Dr Marthe M. Everard WHO Representative for Somalia



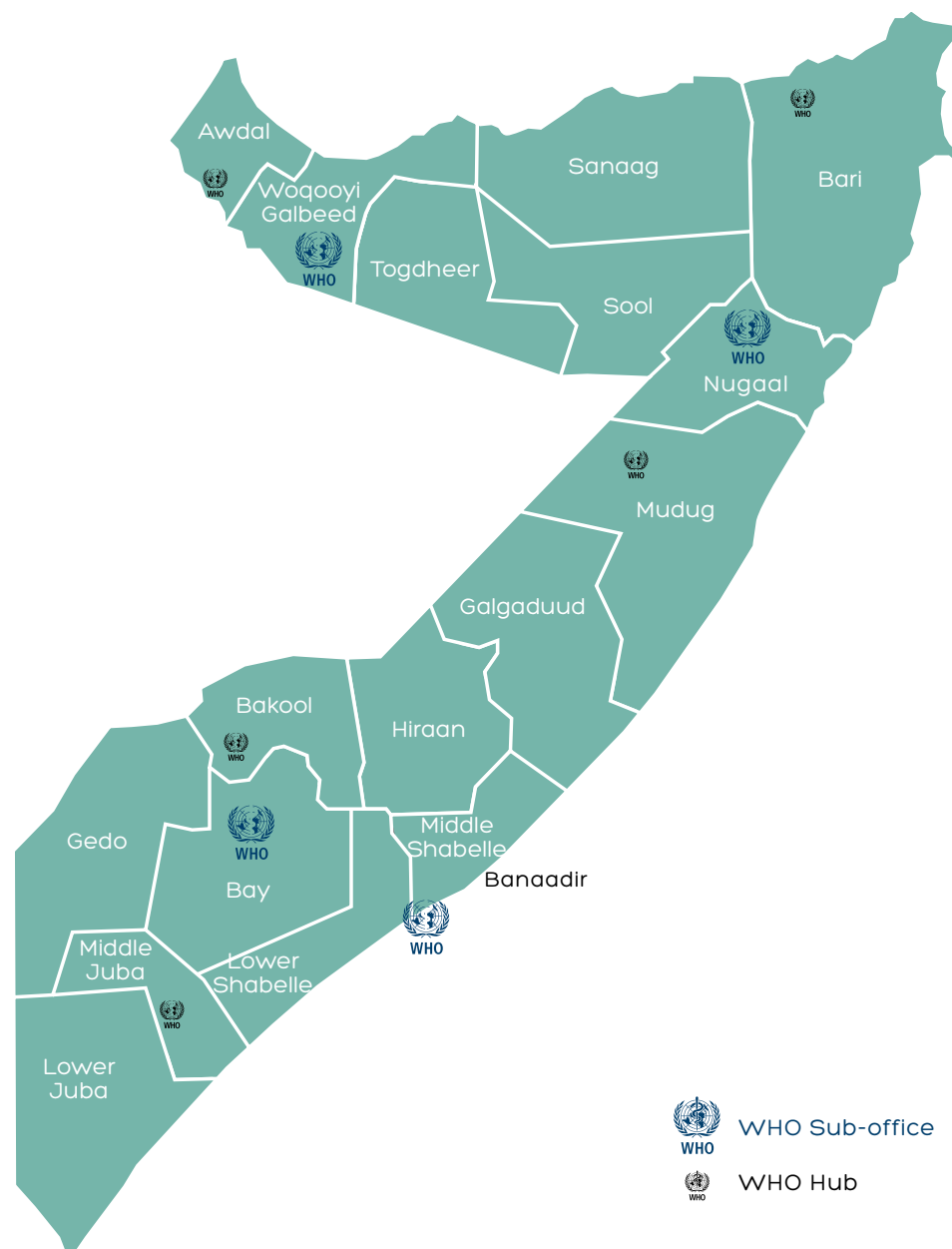
A handwritten signature in blue ink, appearing to read 'M. Everard', with a horizontal line underneath.

1. Introduction

This biennial report highlights the operations undertaken by the WHO Country Office for Somalia during the biennium 2010-2011. In this report the WHO contributions to the health programmes in Somalia are summarized. They are in line with the WHO Medium Term Strategic Plan 2008-2013, and reflecting the 11 technical strategic objectives of WHO. The report also highlights aim and objectives, main achievements, and lessons learnt in 2010-2011, and the strategic directions for each of the health programmes for the biennium 2012-2013.

The progress made in the health programmes in Somalia was with the support of a dedicated country team of 350 staff working at the WHO Liaison Office in Nairobi and at WHO sub-offices in Baidoa, Garowe, Hargeisa, and Mogadishu, and at various WHO hubs in the country. The country team received technical back-stopping from colleagues at the Eastern Mediterranean Regional Office in Cairo and at WHO headquarters in Geneva.

The report should not be seen as an exhaustive account of WHO's inputs in Somalia, but highlights in the 11 sections the emergency health response and development.



2. Primary Health Care

Main achievements in 2010-2011

• Social determinants of health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, and influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. An orientation and sensitization seminar was held in Entebbe, Uganda, in September 2010 in which Somali health authorities and WHO field staff participated. During the workshop, the participants identified priority social determinants of health and the effect of conflict on those determinants. The outcome of the seminar was presented to various stakeholders including UN agencies, donors, international and local NGOs.

During the biennium, important exercises towards understanding the situation of the identified key priorities were implemented, including the mental health situation analysis and the environmental health situation analysis. However, the identified issues related to the findings of these situation analyses are yet to be fully addressed.

• Mental health

Prolonged conflict and instability have largely impacted on the mental and psychological well-being of the Somali people. It is estimated that one in three Somali's are affected by some kind of mental illness, a prevalence which is higher than in other low-income and war-torn countries. Many Somali's have experienced beating, torture, rape or have been injured for life. Others witnessed horrific violence against family or friends. Many Somalis with mental illness are socially isolated when becoming violent. The pain of this isolation is felt intensely because Somali culture is traditionally communal and family oriented. These are generally chained or imprisoned. The country has only five health centres (Hargeisa, Berbera,

Bosaso, Garowe and Mogadishu) that provide essential mental health care services. To address this issue, WHO Somalia in collaboration with the local health authorities provided medicines to mental health care services and expanded the Chain Free Initiative. This initiative that addresses the rights of the mentally ill by advocating for chain-free hospitals, chain free homes and chain-free environment is well established in Mogadishu and Hargeisa and will start in Bossaso in 2011. To have a better understanding of the mental health services within the country, WHO Somalia produced a mental health situation analysis. The document groups all crucial information on mental health in Somalia. In 2011, in collaboration with Gruppo per le Relazioni Transculturali (GRT), an on-the-job refresher training was organized in Hargeisa and Garowe for 48 mental health workers.

Focus: 'Condemned' – mental illness in Somalia (world mental health day 2011)

- On 10 October 2011, "CONDEMNED" was opened at Alliance Francaise in Nairobi, Kenya. This photo exhibition is a project undertaken by photojournalist Robin Hammond and set out the challenges faced in Somalia in dealing with the problem of mental health and Somali living with mental disorders. It is estimated that in war-torn Somalia, with a population of 8 million people, one person out of three has been affected by some kind of mental illness. Yet in the entire country there are only three psychiatrists working in mental health facilities. By contrast, the United Kingdom has one psychiatrist for every 10 000 people.



Mr. Al-Shamrani, Deputy Ambassador of the Kingdom of Saudi Arabia in Kenya opens the photo exhibition "CONDEMNED"



A traditional birth attendant examines a pregnant woman in the outskirts of Mogadishu
© WHO Somalia

Children playing at a dumpsite
just outside the city of Hargeisa,
Northwest Somalia
© WHO Somalia



• Environmental health

Somalia's long-lasting civil strife, unrest and lack of a functioning government for the last 20 years have all contributed to the current worsening of the environmental conditions and the implications for public health. The absence of proper governance and a regulatory and legislative framework and its enforcement and control over access to and use of natural and environmental resources has consequences for the Somali population at large. Concerns expressed by the Government and health authorities about the implications of environmental neglect and degradation on public health have led to an environmental health assessment in Somalia, which was undertaken by WHO Somalia in 2010. The situation analysis brought to light the current efforts invested in environmental health activities by various stakeholders in both public and private sectors, and the local communities. Based upon this situation analysis, an environmental health strategy will be developed in 2012.

• Reproductive, maternal and Newborn child health (RMNCH)

With 1040-1400 deaths per 100 000 live births, Somalia has one of the highest maternal and newborn mortality rates in the world. Poor access to quality skilled care at the health facilities, a limited number of skilled health care workers as well as limited access to emergency obstetric care are among the major contributors to high maternal mortality in rural Somali communities. In 2011, the Accelerated Young Child Survival and Maternal Health project was initiated to help the Ministry of Health to address part of these issues by developing a strategic plan to expand access to skilled birth attendance. To improve and standardize quality care, the IMPAC guidelines will be adapted to the Somali context and will be made available in the Somali language. A list of reproductive health indicators will be set up to monitor and evaluate the reproductive health services.

• Blindness prevention

Avoidable blindness is a major health problem in Somalia. The estimated blindness prevalence rate is 1.2%, and more than 100 000 people are blind. Cataract remains the major cause of blindness. Other major causes of blindness are corneal opacity, refractive errors and glaucoma. WHO supports the human resource development for eye care by facilitating training Somali doctors, provision of cataract kits, diagnostic and surgical equipments. In 2010, more than 10 000 patients have benefited from various eye camps conducted all over Somalia.

• Community-based initiatives

During 2010, the plan to revitalize community-based initiatives in Somalia was initiated. Three model villages/demonstration sites were identified in Somalia. A training manual for community representatives (CR's) and village development committees (VDC's) was adopted and translated into Somali language, followed by training of 165 CR's and VDC's. The training covered family health, emergencies, environmental health and food safety, communicable and non-communicable diseases and emergency preparedness, response and recovery.

Malaria, pneumonia, diarrhea and malnutrition remain a major public health challenge in Somalia especially among children. The majority of cases of severe disease and death are due to delays in seeking prompt, appropriate and effective treatment. So far, no single intervention has proved effective in reducing the levels and deaths in Somalia. The leading causes of death among children under five years of age are well understood yet efforts to protect the children most at risk have not kept pace with global goals. A growing body of evidence supports a new approach that may make a difference in childhood deaths from the biggest killers: pneumonia, diarrhea, malaria and malnutrition. Known as integrated Community Case Management of sick children (iCCM), this approach sends community-based health workers out to find, diagnose, and successfully treat sick children. The approach includes promoting timely care-seeking, encouraging appropriate home care, as well as referrals to and continuous supervision.

In collaboration with selected health partners a number of areas will be selected in 2012 to implement this project. A trickle-down training will be used to train a total of 600 village health workers. These village health care workers will be selected from the community and will receive a village health workers kit (medical and non medical materials). This project will be linked to GAVI (HSS), which focuses on the building of the capacity of female health workers, and the health and nutrition strategy for Somalia.



Examining child with eye disease at
Al-Nur Eye Hospital, Mogadishu
© Al-Nur Eye Foundation

• Health systems strengthening

Somalia is in the process of rebuilding its destroyed health care system. The Country Cooperation Strategy (CCS) for 2010-2014 was published in 2010 and is used as an interim Somali Health Sector Strategy. The basic health care delivery system in Somalia is tiered, comprising of zonal, regional and district hospitals, MCH centres and health posts. The laboratory and blood bank services are barely working, health wards have not been rehabilitated, and the harsh working conditions severely limit the ability of staff to put the newly developed skills into practice.

There is a shortage of essential equipment and supplies, universal screening has not been achieved and quality control mechanisms are yet to be established. The hospital medicines stock management is also neglected with no mechanism for regular supply of reagents. To control the spread of HIV/AIDS and other transmissible infections, there is a need to improve the scope and performance of existing services.

With financial support from the Global Fund, the following components of health system strengthening are being strengthened:

- Laboratory and Blood Safety Component
- Management Capacity Building of health authorities
- Essential Medicines and Quality Control Component

With financial support from the Global Alliance for Vaccine and Immunization (GAVI), the following components of health care are being strengthened:

- Strengthen 40 out of total approximately 250 MCH/HC, meeting core essential package of health services (EPHS) standards in the three zones by 2013.

- Deploy 200 community based Female Health Workers by end 2013 in the catchment areas of these MCH/HC.
- Expand health services by 2015 into areas that are more disadvantaged and covered by the programme, including improved immunization coverage, decreased infant and child mortality, improved antenatal, natal and post natal care and referral of complicated cases, and promoting deliveries by skilled birth attendants.

Lesson learnt

- Most NGOs who do implement primary health care activities have the capacity to do but need to get more resources in order to increase their coverage.

Strategic directions for 2012-2013

- Development of mental health strategy
- Development of environmental health strategy
- In the area of reproductive health: to work with the health authorities and their partners to develop a strategic plan to expand access to skilled birth attendances; adapt the IMPAC guidelines to improve and standardize maternal and newborn health; and to finalize the reproductive health indicators to standardize reporting system in whole of Somalia.



3. Emergency preparedness and humanitarian action

Main achievements in 2010-2011

While the numbers of people in need for humanitarian assistance in Somalia decreased during early 2010, escalating conflict, shrinking humanitarian access and the limited capacity of service providers contributed to the lack of access to the urgently needed health services. The deleterious drought effects of late 2010 spilled over into 2011, resulting in a 40% increase of people in need of humanitarian assistance. In mid-2010, 2 million people were in need of humanitarian assistance, while this number rose to 2.4 million people in January 2011, reaching its highest peak of 2.85 million people by mid-2011. Of particular concern was the South, which hosted 75% (241,000) of all malnourished children and 61% of the people in need across the country. Other affected regions included Gedo, Lower and Middle Jubba, the agro pastoral areas of Shabelle and Bakool regions, Hiraan, Mudug, Galgaduud, Sool, Sanaag, Bari, Nugaal and the coastal areas of central Somalia.

In the following months, the crisis was aggravated by the ongoing conflict, which led to further displacement, limited health and water and sanitation services. On 20 July 2011, famine was declared in two regions and spread further to four, raising the caseload of people in need to 3.7 million in August 2011 and to 4 million in October 2011. In November 2011, an unforeseen ban of 16 humanitarian agencies in South and Central Somalia was imposed, slowing down the implementation of several activities that were earlier planned and scheduled. Various health and nutrition programmes were affected, which experienced delays in the delivery of supplies and outreach activities, such as the expansion of mobile clinics and vaccination activities. As response, additional health partners were identified in the areas affected by the ban to ensure the continuity in service provision. Alternatively, some activities shifted to other locations that were equally in need.

1. Early detection and timely response to outbreaks of communicable diseases within vulnerable populations

While in 2010 a total of 89 outbreak investigation missions for rumor verification were conducted, over 184 outbreak rumors were reported in 2011 of which 86% (235) were investigated within 96 hours. However, only 74% (136) had response activities launched within the targeted 96 hours. This was due to insecurity and restricted movement where security situation permitted access. Other challenges included looting of supplies while being transported to the affected areas; staff and supplies retention; late reporting and local authorities refuting the existence of an outbreak while health staff was threatened if an outbreak was declared. More than 500 samples were collected and tested, including for dengue fever (confirmed in Somaliland and Mogadishu), cholera, measles (outbreaks were confirmed in Puntland, Somaliland and Mogadishu) and diphtheria.

Over 60 000 cases of acute watery diarrhea (AWD)/cholera, including 73% children under the age of five, and 1099 related deaths, including 65% children under the age of five, were reported from the sentinel sites. The case fatality rate for AWD was recorded at 1.6% (within the target of below 2%). Banadir region, which was the epicenter of the humanitarian crisis in 2011, accounted for 41% of all AWD cases, Lower Shabelle region for 12% and Bay region for 10%. During 2011, Medina district alone (Banadir region) accounted for 19% of all reported AWD cases. Confirmed cholera outbreaks occurred in Mogadishu, Banadir region (affecting all 16 districts), Baidoa, Qansadheere, Dinsoor and Burhakaba districts (Bay region); Awdhegle, Wanlaweyne and Afgooye districts (Lower Shabelle region); Kismayo and Afmadow (Lower Jubba region); and Haradheere and Hobyo (Mudug region). Of the 279 stool samples collected from AWD cases and referred for culture, 31% tested positive for *Vibrio cholera* serotype 'inaba'. In the reporting period, more than 1500 health staff was trained in surveillance, AWD/cholera management, outbreak detection and response operations, 200 staff trained in environmental hygiene and prevention of vector-borne disease, and 140 staff trained in the prevention and treatment of malaria and AWD.



Diarrhea patients at a cholera
treatment centre
© WHO Somalia

Focus: Increase of confirmed cholera cases in Mogadishu

In 2011, more than 60 000 acute watery diarrhea cases were reported in Somalia, with confirmed cholera in Banadir, Bay, Mudug and Lower Shabelle regions. Banadir Hospital, a major hospital in Mogadishu, received the biggest caseload of patients. The combination of poor sanitation conditions, a shortage of safe water, overcrowding and high malnutrition rates, creates the perfect combination for infectious diseases, such as cholera and pneumonia, to spread and increase the number of deaths. About sixty-five percent of all cases of acute watery diarrhea are children under the age of five. Emergency diarrheal disease kits made up of medical supplies such as syringes, infusions, and oral rehydration fluids, were prepositioned by WHO and sent to 13 hospitals in Somalia.

Watch the full video clip: <http://youtu.be/Zjgm4ERfAbk>

2. Emergency health care services (including emergency obstetric care and emergency surgery)

Since mid-2011, and once famine was declared in Somalia in July 2011, the emergency response focused on the famine response. Additional mobile clinics were deployed for hard-to-reach populations and those displaced due to the natural disaster and/or conflict. More than 20 mobile clinics in Mogadishu, Galkayo, Awdheegle, Wanlaweyne, Beletweyne, Jalalaqsi, Gerile and Hargeisa received support from WHO, serving a population of more than 30 000 direct beneficiaries.

Focus: Access to essential health services through mobile clinics in Somalia

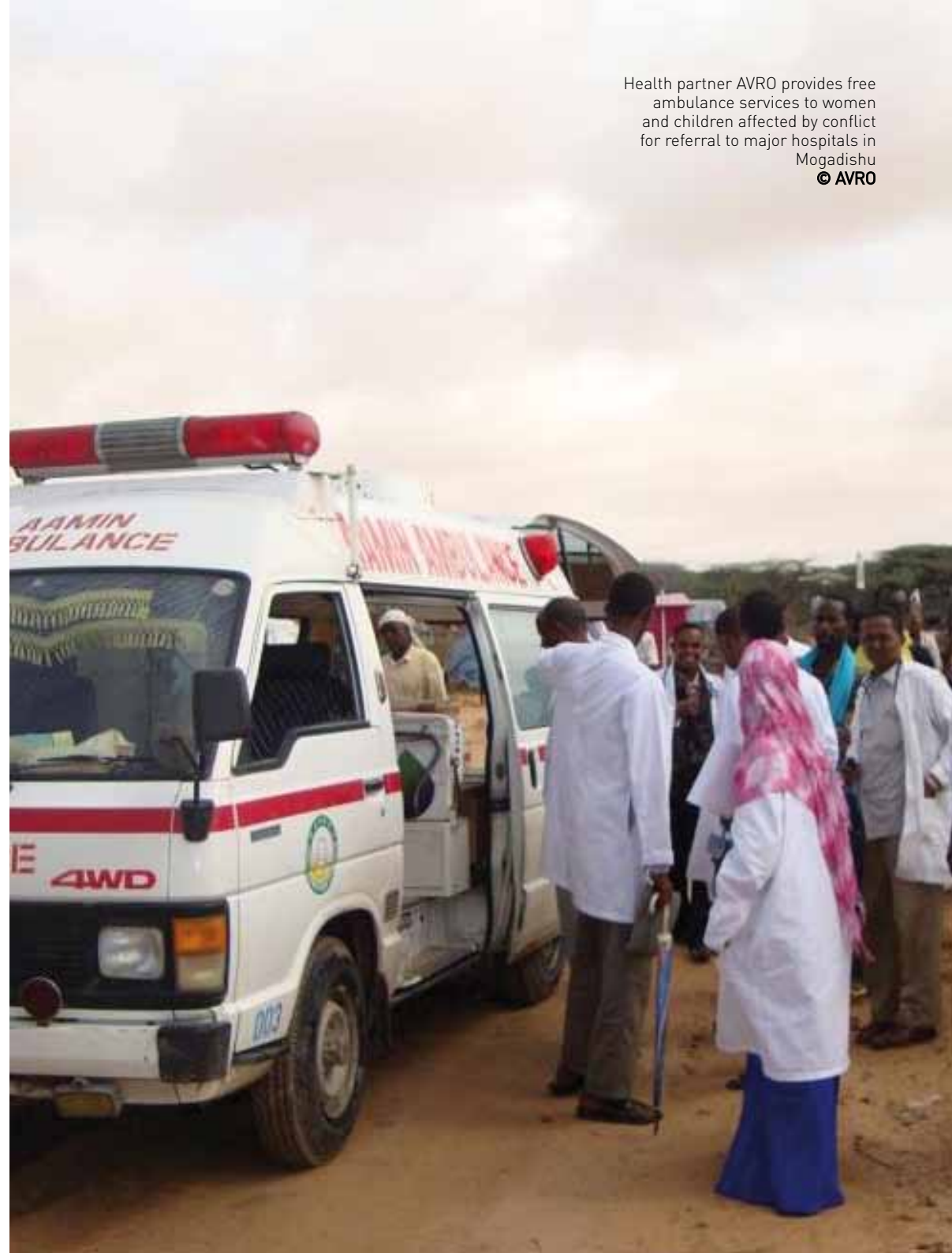
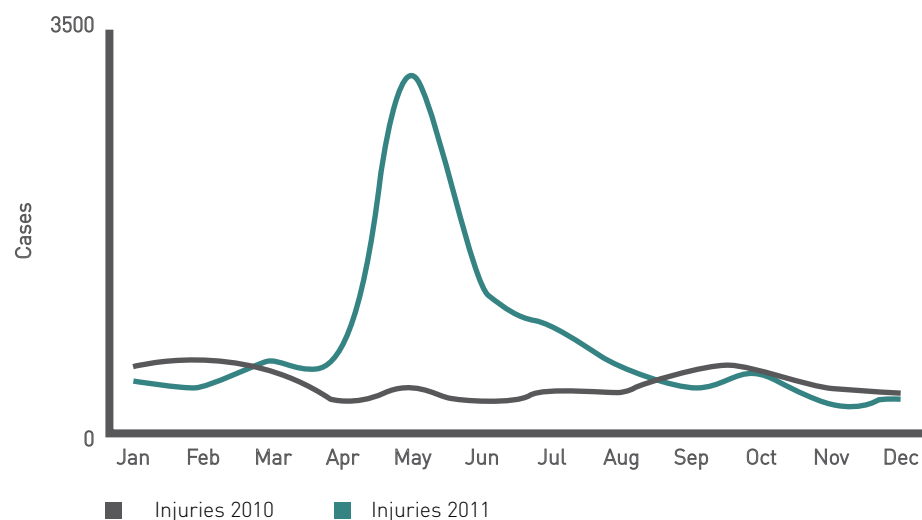
Mobile clinics are used as a last resort with the aim of providing health services to population groups, which have no access to a health-care facility. They have been considered as a short-term intervention strategy, pending the reopening of fixed health facilities or access to such facilities. About two thirds of all patients seen by a mobile clinic team are children under the age of five. One of them is Mustafa.

Watch the full story of Mustafa: <http://youtu.be/s1jB6pWGSao>


Health workers in South and Central Somalia faced increased challenges to provide the much needed care to the people. The challenges ranged from hazardous working environments, lack of proper qualifications and insufficient number of health workers. The emergency programme deployed 11 national and international doctors in South Central Somalia to provide direct service delivery and on-the-job training to build the capacity of the local health workforce (nurses, doctors, technicians). As a response to the lack of access to health services, WHO supported hospitals in South and Central Somalia by providing technical assistance, medical supplies and equipment, medical personnel and referral equipments. A total of three field hospitals were established in Dolow, Dhobley and Galkayo South. These emergency facilities are being expanded to fixed structures hosting fully functional hospitals.

Fighting in Mogadishu and military interventions further aggravated the limited access and humanitarian space in South Somalia. During 2010-2011, WHO reported more than 14 700 war-wounded civilians who were admitted to three main hospitals in Mogadishu (see graph 1). During May 2011, at the height of the fighting, more than 3047 weapon-related injuries were admitted to three major hospitals in Mogadishu. As a response, in 2010 more than 850 health workers and in 2011, more than 500 health workers were trained on mass casualty management, emergency surgical care, burn management, emergency obstetric care, management of trauma in children and neonates, basic surgical handcraft and damage control surgery. In all trainings, participants were provided with standard treatment guidelines, which are also distributed to health facilities and partners throughout Somalia.

Graph 1: Weapon related injuries reported in 2010 and 2011, from 3 main hospitals in Mogadishu



Health partner AVRO provides free ambulance services to women and children affected by conflict for referral to major hospitals in Mogadishu
© AVRO

A woman wearing a purple and blue patterned headscarf and a matching long-sleeved dress is leaning over a young child lying on a patterned cloth. The child is wearing a red and white striped garment and has a white bandage on their right arm. The woman is looking down at the child with a concerned expression. In the background, another person in a dark headscarf is partially visible.

An injured child receives trauma care
at the Banadir Hospital in Mogadishu
following conflict in the region
© WHO Somalia

Focus: Somalia surge in children casualties

Twenty years of civil war has devastated Somalia, hampering its health services. Accessibility issues, poor infrastructure and an insufficient number of health facilities, hamper the service delivery. Wherever health facilities are operating, they often lack very basic and essential medicines, supplies and equipment, operational and logistical support. The number of patients treated for weapon-related injuries at Mogadishu's three main hospitals reached a peak in May 2011.

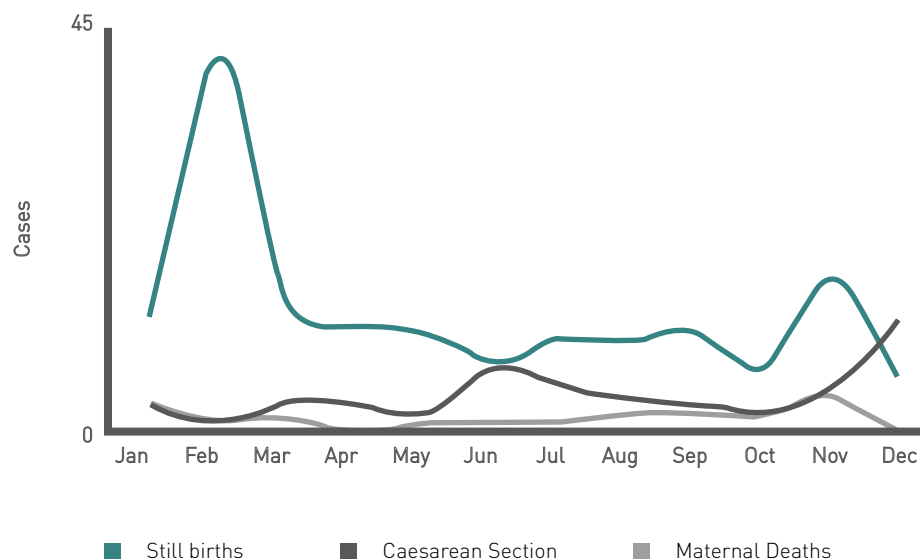
Almost half of the injured people reported were children under the age of five. Many of these children suffered from very severe wounds, burns and other injuries from bullets, blast injuries and shrapnel. The civilian population is especially vulnerable in the ongoing conflict because the fighting in Somalia's capital often occurs in the streets of the city. Health workers are stretched thin to treat the high number of war-wounded patients. In many cases, they lack proper equipment and means to cover all cases. To help national staff to cope with the sudden increase in the numbers of wounded children, WHO trains doctors and nurses on how to provide the children the needed treatment for their burns and chest injuries.

Watch the full video clip: <http://youtu.be/hjHFWWhYrdKA>

Skilled care during pregnancy and at birth is scarce. Only 33% of all births in Somalia are attended by skilled health personnel. One in four pregnant women attend antenatal care, but only 7% complete the four recommended antenatal visits. Access to basic emergency obstetric care (EmOC) is poor, as shown by a caesarean rate of 0.5% (minimum recommended level is 5%) and only 11% coverage of major obstetric emergencies (minimum recommended level

is 100%). International standards demand five functioning health facilities providing BEmOC services and one CEmOC (comprehensive emergency obstetric care) services per population of 500 000 people. The level for Somalia is only 0.8 BEmOCs (basic emergency obstetric care) per 500 000. In 2011, 6100 live births and 162 stillbirths were registered in 18 health facilities providing basic emergency obstetric care services in South and Central Somalia (see graph 2). The peak of number of still births in February 2011 is situated in Baidoa Hospital due to the increased number of pastoralists fleeing towards Baidoa town as the first signs of the drought started.

Graph 2: Still births, caesarian section and maternal deaths in 18 health facilities in south and central Somalia, January - December 2011



Lessons Learnt:

Close cooperation was maintained among health partners, from the initial stage of planning and developing interlinked project proposals. Throughout the implementation of planned activities, this has proven to be effective when it comes to provide emergency health services in the challenging environment of conflict and complex emergencies. The access restrictions due to insecurity and administrative impediments forced the various health actors to find alternative arrangements to minimize delays in the transportations of supplies (e.g. partners to collect supplies from major hub if WHO could not negotiate prompt and safe passage). Additional health partners were identified in areas affected by the November 2011 ban to ensure continuity in service provision. Alternatively, some health activities were shifted to other locations that were equally in need. With bad road conditions in place due to flooding and security, anticipation and proper planning has been done to send medical supplies in smaller amounts as well as preposition them in strategic locations.

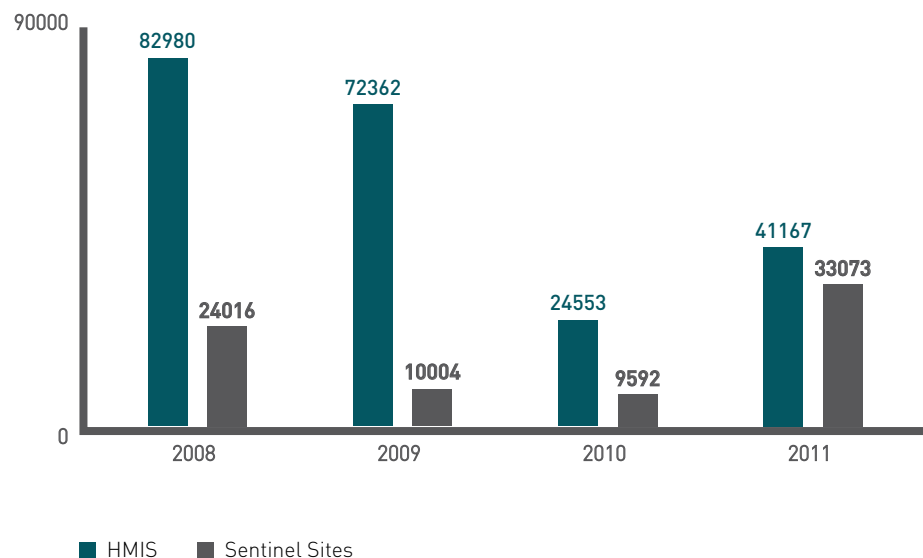
Strategic directions for 2012-2013

In 2012-13, the Emergency Preparedness and Humanitarian Response Programme will continue to support the regional preparedness and response to humanitarian crises and strengthen the emergency health coordination. In order to increase access to health services, the programme will continue to support and rehabilitate health facilities in strategic locations in South Central Somalia. The early detection of and timely response to communicable disease outbreaks remains a major focus of the programme's plans and activities. Lastly, the emergency programme aims at decreasing the morbidity and mortality among vulnerable population groups by strengthening emergency health care services and provision of medical supplies and equipments.

4. Malaria

Malaria is still a major health concern in Somalia, particularly affecting pregnant women and children under the age of five. However in recent years, and in collaboration with health partners, progress has been made to combat malaria through many activities that are in line with the national strategic plan.

Graph 3: Number of (confirmed and clinical) malaria cases reported by 222 sentinel sites and Health information management system (HMIS) in Somalia 2008-2011



Main achievements in 2010-2011

"A significant decrease in the number of malaria cases was reported thanks to prompt treatment and mass distribution of long-lasting insecticidal-treated nets to a total of 41 hospitals in South Central, Somaliland and Puntland and indoor residual spray campaigns covering more than 6500 households in 2010 and more than 7100 households in 2011. During 2010 and 2011, the positive trend continued to decrease further. A vector sensitivity study undertaken showed that current treatments are adequate to combat malaria. Around 110 Somali health workers got a malaria microscopy refreshing training course in 2010 and 2011. In addition, two quality control laboratories are functional in Somaliland and Puntland. A third one is currently being rehabilitated in South Central Somalia. Having these in place will increase the quality of malaria diagnosis and improve the accuracy of lab results.

Lessons Learnt:

- Challenges in terms of accessibility in most of the areas of South and Central Somalia
- Pooling more resources and engaging more partners in malaria fight
- High skilled and well trained nationals are an added value to the programme to manage well the malaria activities

- High cost of transportation and security issues makes Somalia one of the most costly countries
- Effective control measures can lead to remarkable reduction of malaria morbidity but sustainability is another challenge

Strategic directions for 2012-2013

WHO and health partners will further strengthen the capacity building activities for Somali health workers working in the area of malaria by conducting refresher trainings of malaria microscopy, management of severe malaria cases and malaria quality control, strengthening HMIS capacities, malaria management and planning. In terms of human resources, each zone will have a national programme officer, a malaria data manager, an entomologist, and three laboratory experts.

Spraying of households in Hargeisa
as part of malaria control activities
in Somalia
© WHO Somalia/Lucie Ngugi

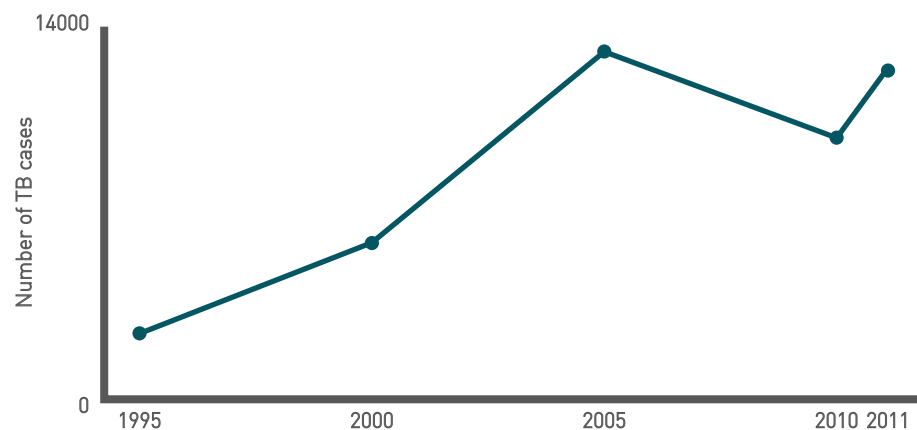


5. Tuberculosis

Main achievements in 2010-2011

During the biennium, more than 20 000 cases for TB were detected and about 5800 sputum smear positive cases registered in 2009 were evaluated for treatment outcome. A treatment success rate of 86% was maintained based on routine sputum smear investigation of over 11 000 positive cases.

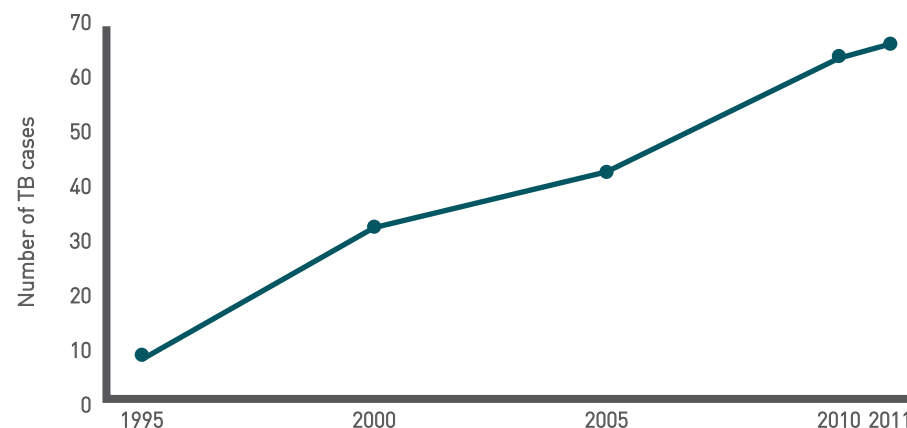
Graph 5: Number of notified TB cases as from 1995 to 2011



The Somali TB programme conducted a survey on multi-drug resistance TB (MDR-TB). Preliminary results showed that almost 11% of TB-patients have

MDR-TB, which is a worrisome outcome. The TB programme obtained approval to provide treatment to an initial 100 MDR-TB patients.

Graph 6: Number of TB centers as from 1995 to 2011



In 2010, an additional seven new TB centres were opened across the country, bringing the total number of centres to 63. Capacity building activities for staff resulted in a total number of 250 health workers trained on TB case detection and treatment. Three monitoring missions were carried out by Global Drug Facility to estimate needed quantities of TB medicines in the country.

Lessons learnt

- Slow progress in the implementation of TB/HIV collaborative activities
- Emerging drug-resistant TB, especially multidrug resistant TB (MDR-TB)
- Incomplete and uneven coverage of DOTS
- Booming private sector
- Uncontrolled over-the-counter anti TB medicines on sale
- Inadequate advocacy, communication and social mobilization implementation

Strategic directions for 2012-2013

The program expects to decrease the TB burden in Somalia in line with the Millennium Development Goals and the Global Stop TB Targets. In order to achieve this, the program will target the following:

- Capacity building for health workers both in the public and private institutions including community workers who will play a great role in community DOTS
- Support the expansion of the program as stipulated by the Global Fund objectives
- Ensure uninterrupted supply of anti-TB medicines
- Support the initiation of MDR surveillance and management including strengthening institutions that will be involved in MDR management
- Continue to support the development of relevant guidelines and protocols for TB management in Somalia
- Support operational research to strengthen the TB management in Somalia.



Patients waiting for tuberculosis treatment at a TB centre in Berbera, Northeast Somalia
© WHO Somalia

6. Essential medicines - promoting medicines quality consciousness

Essential medicines are the drugs that satisfy the health care needs of the majority of the population and should be available at all times in adequate amounts and in appropriate dosage forms, at a price the community can afford. The provision of pharmaceutical supplies to public health facilities in Somalia is heavily dependent on international aid channels through WHO, UNICEF, UNFPA and non-governmental organizations. However, as this does not adequately meet the needs of the population, the private sector became one of the main providers of medicines to the public. Overseeing the quality of these medicines is a challenge, considering the wide range of stakeholders involved. The quality of these imported medicines is not assured as they are hardly tested for their quality and due to the lack of drug quality control and assurance systems.

Main achievements in 2010-2011

In order to gradually meet this challenge of lack of drug quality control and assurance systems, the Somali Essential Medicines Programme (EMP) provided two Minilabs® (test kits), bringing it to a total of four in the country. EMP trained 12 health workers on the use of the Minilabs® for screening of medicine samples taken from the public as well as the private sector. A three-week training course taught health staff on how to screen antiretroviral, anti-malaria and anti-TB medicines. Following an initial screening of medicines, by using the Minilabs®, medicine samples were sent to the National Quality Control Laboratory in Nairobi, Kenya, for confirmatory quality analysis. All samples were found of assured quality.

A total number of 75 pharmacy and nursing assistants, who are in charge of hospital medicines stores, were trained on effective management of medicines. Another training on electronic data management of essential medicines was organised for 21 health workers working in the medicines stores of various regional hospitals in Somaliland. In addition, EMP produced a brochure for increasing awareness of good dispensing and storage practices of medicines in

Somali and English language and was distributed to medicine outlets across the country. A separate store for keeping inflammable materials and reagents was constructed in the premises of the central medical store/WHO warehouse in Hargeisa. The medicine stores in five hospitals in Somaliland and four hospitals in Puntland were rehabilitated. To computerize the medicines stock records, the rehabilitated medicine stores were provided with a laptop and printer.

Medicines steering committees were established in both, Somaliland and Puntland, to oversee the on-going quality control activities of the medicines. Training was provided to the health workers to familiarize them with the roles and functions of such a committee.

Lessons Learnt

- With the cooperation of health authorities, there would surely be steady continuous progress in the implementation of programme activities even in parts of the country that we have security challenges.
- More funding and capacity building for health workers is essential to maximise the impact of the programme.

Strategic directions for 2012-2013

WHO will continue to work to improve the policies of supply of medicines through human resource development and better interagency coordination. Health partners will promote quality consciousness and the rational prescribing and use of medicines. In terms of governance, WHO will strengthen health authorities in capacity building, rehabilitating of medicine stores, medicine policy, regulation and supply management.



7. Routine immunization

Main achievements in 2010-2011

Vaccine-preventable diseases remain one of the major causes of death and disability for Somali children. Routine immunization across the country remains low. Child Health Days, conducted twice a year in a campaign mode, provide an opportunity to improve the low childhood immunization coverage. Suspected measles cases were reported from across Somalia, with the greatest burden located in South and Central Somalia. In those areas, vaccination coverage rates have remained low for the past three years due to inaccessibility and security. In areas where Child Health Days were conducted, a high coverage for DPT and measles was reported (→80%). Months before the famine declaration of July 2011, thousands of people from Bay, Bakool and Jubba regions fled into Mogadishu, crossing areas that are highly endemic for measles and other communicable diseases. At the same time, the forced grouping of internally displaced people (IDPs) in camps and the forceful relocation of some IDPs to new areas without basic infrastructure fueled the spread of vaccine preventable diseases. In 2011 alone, a total of 13 854 suspected measles cases were reported (79% of them children under the age of five) and 292 deaths of which majority were above the age of five. There is no formal mortality data collection system in Somalia and the exact number of death remains unknown. Some blood samples were collected, testing positive for measles though were negative for rubella. In response to the humanitarian crisis, an emergency measles campaign was conducted in August and November 2011 in Banadir region.

Lessons learnt

- Strong partnership with the health ministries, UNICEF and other UN agencies and non-governmental organizations is vital in Somalia, where there is no functional government.
- Measles vaccination campaigns have served as the foundation for delivering other child health interventions in an integrated approach.

Strategic directions for 2012-2013

WHO will strengthen routine and supplementary immunization activities to increase immunization coverage. For the first time ever in Somalia, a pentavalent vaccine will be introduced from January 2013 onwards. The vaccine includes immunization against diphtheria, tetanus, pertussis, hepatitis B and Haemophilus influenza (Hib).

Focus: Measles control in Somalia

Worldwide the number of measles deaths fell by 78% between 2000 and 2008, from an estimated 733 000 in 2000 to 164 000 in 2008. Today, measles still kills globally nearly 450 people every day or 18 deaths every hour. In case of Somalia, the death rate has fallen drastically, but still thousands of children are dying each year. Samples of suspected measles cases from across Somalia

are collected and confirmed by the laboratory investigation units in Hargeisa, Garowe and Mogadishu. Since 2005, Somalia has known a reduction of more than 75% in the number of measles cases.

Watch here the full video clip: <http://youtu.be/GmQpOXvBoaw>



niiska caafinaadka
ka waa fursad kor loo
adka Hooyada Iyo Dhi

A child gets vaccinated against measles during the Child Health Day (CHDs) campaigns in Banadir region
© WHO Somalia

8. Polio eradication: Polio free Somalia

For the past four years, Somalia remained its polio-free status. The country is characterized by a low coverage rate of vaccinated children routinely and the inability to conduct adequate and timely vaccination activities especially in some regions of South Central Somalia due to inaccessibility and insecurity. The last wild poliovirus case from a four-year old female child was reported on 25 March 2007 from Hobyo district, Mudug region in Northeast zone of Somalia.

Main achievements in 2010-2011

- Polio free status maintained: no wild polio virus case reported since 25 March 2007
- Conduction of four rounds of polio vaccination in all accessible districts in 2010 and 2011.
- High oral polio vaccine coverage achieved during supplementary immunization days and Child Health Days (see table 1 and 2)
- Presence of the polio network in all districts, regions and zones of Somalia continued to act as the backbone of the AFP surveillance system. The 200 national staff conducted regular active AFP site visits and reported from over 400 AFP surveillance sites, which include hospitals, mother and child health centres, out-patient departments, private clinics, traditional healers and pharmacies to ensure that no AFP cases were missed. They conducted AFP case investigation soon after reporting, collected samples and sent them to the KEMRI laboratory in Nairobi for analysis. This has enabled Somalia to maintain a highly sensitive AFP surveillance system with all key indicators above the certification standards.

Table 1: Overview of National Immunization Days in Somalia (2010-2011)

National Immunization Days 2010 - 2011					
	Accessible areas/ regions	Target population (children younger than 5 years)	Date	Total number Reached	%
Round 1 - 2010	Somaliland, Puntland, Banadir, Galgadud, Lower Juba, Gedo	1,192,528	Aug- Sept	1,097,108	92%
Round 2 - 2010	Somaliland, Puntland, Banadir, Galgadud	1,050,338	Oct-Nov	981,244	93%
Round 1 - 2011	Somaliland, Puntland, Banadir, Galgadud	952,235	Mar-Apr	877,295	92%
Round 2 - 2011			May- June	899,803	94%
Round 3 - 2011			Nov-Dec	913,274	96%

Lessons Learnt

Security and accessibility are key elements for the successful implementation of polio eradication activities.



A child is given two polio drops as other children look during the national immunization campaigns in regions of Northeast Somalia
© WHO Somalia/Lucie Ngugi



Vaccinator Mohamed Abdi ensures that every single child of Liboi gets vaccinated during the cross-border (Kenya - Somalia) emergency vaccination campaign in 2011

© WHO Somalia/ Pieter Desloovere

Strategic directions for 2012-2013

The year 2012 will be important for the polio eradication efforts as it is expected that the WHO's Executive Board will declare polio as a 'programmatic emergency for global public health'. The Somalia programme will operate in this framework and implement the highest level of polio eradication activities in order to contribute to the eradication of polio.

Focus: Cross border emergency vaccination campaign – the story of vaccinator Mohamed Abdi

Liboi, a dusty Kenyan town located on the Kenyan-Somali border is an important border crossing point to Somalia. During the famine of 2011, communities in Liboi and around Dadaab, in north-eastern Kenya, suffered from a triple shock comprising drought, soaring food prices and a refugee influx from Somalia. In July 2011, an integrated vaccination campaign took place targeting 215 000 children under five in host communities in and around Dadaab, a large settlement for Somali refugees in north-eastern Kenya. Teams on the ground ensured that each and every child is vaccinated, by moving from house to house, in cities, towns, and villages, and in hard to reach areas.

Watch the full story of Mohamed Abdi: <http://youtu.be/OrBj82q04aw>

Focus: 'I have Polio' – the story of Mustafa and Saynab

"Waxaan qabaa cudurka dabaysha" or "I have polio" tells the story of two Somali children. Back in 2007, Mustafa and Saynab got affected by polio, a crippling disease that is caused by a virus. Despite the fact that one of Mustafa's legs is paralyzed, he enjoys playing soccer with his friends. Polio does not differentiate between rich, urban and rural people, everyone is at risk. Because there is no cure for polio, the best protection is prevention. For as little as half a US dollar, a child can be vaccinated and protected for life against this crippling disease. Since both children got polio back in 2007, no single Somali child got ever affected by this disease. The country has remained polio free since then,

although treats put the country in danger and therefore vaccinations are still needed. Every year during the National Immunization Days, about 1.8 million Somali children under the age of five get at least twice two polio drops. This campaign is spearheaded by health authorities at national and local levels, in collaboration with WHO, UNICEF, other polio eradication partners and the Somali communities.

Watch the full story of Mustafa and Saynab:
<http://youtu.be/dut--mDk1Co>

Table 2: Overview of Child Health Days in Somalia (2010-2011)

Child Health Days 2010 - 2011													
Date	Accessible areas/regions	OPV			Measles			Tetanus Toxoid			Vitamin A		
		Target	Reached	%	Target	Reached	%	Target	Reached	%	Target	Reached	%
May - July 2010	Somaliland, Puntland, Banadir, Galgadud, Gedo	1,162,815	1,016,478	87%	1,003,543	854,497	85%	1,339,343	836,534	62%	1,005,952	827,656	82%
Dec 2010 - Jan 2011	Somaliland, Puntland, Banadir, Galgadud, Bay Bakool	1,240,020	1,144,672	92%	1,061,057	937,785	88%	1,408,099	884,325	63%	1,117,747	969,101	87%
Jul - Aug 2011	Somaliland, Puntland, Galgadud	757,186	656,268	87%	643,610	559,360	87%	870,765	477,815	55%	684,543	585,641	86%
Aug-Sept 2011 (emergency campaign)	Banadir, Gedo	378,330	340,634	90%	851,153	747,782	88%	NA	NA	NA	787,543	690,747	88%
Nov 2011 (emergency campaign)	Banadir	331,042	273,448	83%	774,787	626,625	81%	NA	NA	NA	NA	NA	NA

9. HIV / AIDS and sexual transmitted infections (STI)

Limited information is available on risk and vulnerability factors that fuel the HIV epidemic in Somalia. Most of the country experiences a low level of HIV, with the exception of some areas in north-west Somalia.

Table 3: Sentinel survey data on HIV/AIDS for Somalia per zone

	North East Somalia (2009-2010)	North West Somalia (2009-2010)	South Central Somalia (2004)
HIV prevalence among antenatal care	0.4%	1.1%	0.6%
Syphilis prevalence	1.2%	1.4%	1.2%
HIV prevalence among patients with STD symptoms	4.6% (Bosaso hospital)	6.5% (Hargeisa hospital)	4.0% (Mogadishu only)

Main achievements in 2010-2011

The Somali HIV/AIDS programme opened an additional three HIV voluntary counseling and testing sites, bringing the total number to 30 sites. Compared to 2009, voluntary counseling and testing were increased by 60%. By December 2011, 1139 patients benefited from antiretroviral therapy. Retention on ART remained excellent with the proportions of those alive and on ART being 84.1% at 12 months, 81.4% at 24 months and 51.3% at 60 months after initiation of the treatment.

In 2010, a total of 175 health workers got trained in integrated prevention treatment components, meanwhile in 2011 an additional 247 health workers benefited from this training. This training course has improved the provision of quality services to patients resulting in an increase of service uptake and patient satisfaction.

In HIV/AIDS care and treatment, WHO continued to provide the backbone of technical assistance for antiretroviral therapy (ART) delivery. This support included the adaptation of the WHO Chronic Care IMAI guidelines to align with the 2010 WHO global recommendations. In addition, the ART patient monitoring tools were updated to better capture TB HIV activities and to align them to the new ART regimens entailed in the 2010 recommendations.

In the area of TB/HIV collaboration, HIV testing was introduced into TB treatment facilities and by the end of 2011, 24 out of 66 TB treatment facilities were also providing HIV testing and counseling. At these facilities 4,140 TB patients, representing 55.1% of those treated during the year, voluntarily underwent HIV testing and counseling, yielding a 5% HIV prevalence rate. Joint HIV/TB planning, activity implementation and supervision was undertaken, and guidelines for TB infection control in congregate settings and Isoniazid Prophylaxis Therapy (IPT) were developed and training of trainers undertaken.

Regarding *surveillance*, during 2010 the third round of sentinel surveillance was done in Somaliland and Puntland. The results indicated an ANC HIV prevalence rate of 0.33% for Puntland and 1.01% for Somaliland. Among the STI and TB sentinel sites, the HIV prevalence rate was 6.36% and 8.2% respectively. At the end of 2011, the second round of sentinel surveillance for South Central Somalia was also conducted (the first round took place back in 2004). These results will be available in 2012. In addition, in mid 2011 formative assessments for HIV surveillance among female sex workers were conducted in Bossaso and Berbera. The findings indicated that it was feasible to conduct bio-behavioral surveillance in these groups.

Lesson learnt

Good adherence to counseling has produced excellent adherence on ART leading to the high survival of patients on treatment. A weak area has been the procurement and management of medical supplies. The integration of STI treatment within the integrated prevention care and treatment centers (IPTCs) has facilitated the HIV testing for STI patients. Despite the security challenges faced in the country, it was possible to do external quality assurance at 14 health facilities in South Central Somalia. The lack of resources for the Ministry of Health in the three zones, in terms of personnel and other resources dedicated to the HIV/AIDS program, has limited the impact of skills transfer in the area of program management and leadership. Conservative groups, such as religious leaders, remain opposed to the collection of behavioral data among most at risk groups. However with careful advocacy, these difficulties can be overcome.

Strategic directions for 2012-2013

1. Continue the support to the Ministry of Health in terms of building capacity and assume the national responsibility for the HIV/AIDS response of the health sector.
2. Mobilize additional funding, instead of only funding from the Global Fund.
3. Expand surveillance to additional key risk groups and locations: female sex workers and their partners, truckers, etc.
4. Roll out of the updated ART patient monitoring tools, to better align with the generation of global indicators.
5. Strengthen the procurement and supplies management system for HIV/AIDS commodities.
6. Strengthen TB/HIV collaborative activities, including the roll out of Isoniazid Prophylaxis Therapy.

A health worker tests a patient for HIV in a VCT centre at the Hargeisa Group Hospital
© WHO Somalia/ Pieter Desloovere



10. Laboratory services and blood safety

The Somali laboratory programme has been at the forefront of providing timely and quality results. Laboratory services and blood transfusion are required for a wide range of health activities. The laboratory network in the country consists of 63 tuberculosis sputum centres, 107 malaria microscopy centers, 2 malaria quality control labs and 2 hospital blood banks. In partnership with health partners, WHO takes a leading role in supporting these services.

laboratory operations through capacity building, continuous provision of diagnostic and general medical laboratory supplies and equipment. More than 70 laboratory technicians were trained in different aspects of laboratory analysis for malaria, tuberculosis, HIV and measles. Monitoring progress and performance of laboratory technicians was done in more than 40 hospital laboratories throughout the country.

Main achievements in 2010-2011

In 2010, and in collaboration with other programmes, laboratory-automated instruments and equipment have been provided to more than 30 hospitals in Somalia. More than 100 laboratory technicians were trained in different aspects of laboratory analysis for malaria, tuberculosis, HIV and measles. Monitoring progress and performance of laboratory technicians was done in more than 30 hospital laboratories throughout the country, preparing a base for accreditation and scaling up external quality assessment. In 2011, a laboratory curriculum was developed to train the lab technicians how to carry out a reliable and accurate diagnosis as well as how to operate laboratory-automated instruments. The College of Health Services in Bossaso (Puntland) and the Institute of Health Science in Hargeisa (Somaliland) were selected as pioneer institutions for this new curriculum, which will start in 2012.

To further strengthen the capacity of the blood transfusion services, two new hospital-based bloodbanks were opened (Hargeisa, Somaliland and Bossaso, Puntland) while another six blood transfusion units got rehabilitated (Boroma, Berbera, Lascaanood, Burao, Gadho, and Galkayo). Over the biennium, a total of 23 447 units of blood were screened for transfusion. A total of 55 health workers were trained on blood safety methods using WHO modules.

In collaboration with other programmes, laboratory coverage was expanded to MCH level for the first time. Programmes have further strengthened

Lessons learnt

Collaboration with health authorities and disease programmes is highly recommended. The capacity of national laboratory officers needs to be strengthened to enhance better response to challenges faced during implementation of laboratory programme activities

Strategic directions for 2012-2013

WHO will further strengthen and expand quality laboratory services to support disease control programmes in all zones of Somalia. An additional two hospital-based blood banks will be opened in 2012, as well as two additional blood transfusion units. To increase the skills and knowledge of lab technicians, as well as to tackle the brain drain of lab personnel, the newly developed training curriculum will be rolled out in two pioneer sites. A laboratory data management system will be established with the aim of integrating laboratory data into disease surveillance systems and enable effective and efficient management of laboratory services countrywide.



Building the capacity of laboratory
technicians through training at the
malaria microscopy center in Hargeisa
© WHO Somalia

11. Partnerships in health development

Since April 2006, the Health Cluster approach has been used in Somalia. WHO as the cluster lead in health, the Somali Health Cluster continued to identify gaps in its response through facilitation of joint strategic plans, resource mobilization, monitoring and reporting and an enhanced quality of humanitarian action through strengthened local capacities, leadership and accountability at Nairobi and zonal levels. The international NGO Merlin co-chairs the health cluster coordination in Puntland while COOPI co-chairs the coordination in Somaliland. In South Central Somalia, WHO, as the agency of last resort, coordinates the health cluster activities at Mogadishu level with different partners acting as regional focal agencies (see Table 4).

Currently the health cluster consists of a group of more than 60 active partners (5 UN agencies, 30 international and local NGOs, and other stakeholders working together for the humanitarian health response. With the drought and famine response in 2011, the health cluster grew to more than 126 partners. In spite of the large number of active partners, more organizations continue to express interest and are regularly being reviewed by the Health Cluster Secretariat.

Main achievements 2010-2011

Appointment of Health cluster coordinator in Nairobi

In 2010, the Emergency Preparedness and Humanitarian Action (EHA) team of WHO carried out the tasks of health cluster coordination until the dedicated Health Cluster Coordinator was recruited. Once the Health Cluster Coordinator was on board in 2011, it greatly streamlined coordination of health activities at Nairobi and the regional levels. Various Health Cluster activities including cluster meetings, joint assessments and trainings, were organized and undertaken in the whole of Somalia in cooperation with partners. Recruitment of project and other technical staff (surge capacity) in June and November 2011 provided the much needed support during the drought and famine emergency in the Horn of Africa, including Somalia.

Table 4: Health cluster focal agencies for Somalia

Somaliland	COOPI
Puntland	Merlin
Galmudug	Merlin
Galgadud	Relief International
Hiraan	WHO (last resort)
Gedo	WHO (last resort)
Banadir	WHO/WARDI
Middle Shabelle	Intersos
Lower Shabelle	COSV
Bay	GTZ
Bakool	GTZ
Middle Juba	AFREC/ZAMZAM
Lower Juba	Muslim AID UK /AFREC

Coordination activities and tools

On a monthly basis, the Health Cluster organizes coordination meetings in Nairobi and at the regional levels in Puntland, Mogadishu and Somaliland. These forums are used for sharing information on health updates, natural disasters, population movement and displacement with a view to assess completed, ongoing and planned health interventions, disease outbreaks and other issues relevant to the health situation and coordination in the different regions of Somalia.

Health cluster meetings are also attended by representatives of the Water, Sanitation and Hygiene (WASH) and Nutrition clusters. The close tri-cluster coordination, cooperation and information sharing facilitates effective interventions and response to meet the humanitarian needs of health.

Information is shared widely through the monthly health cluster bulletins aimed at providing overviews of the health activities conducted in Somalia. Partners contributed by sending updates, reports, pictures and other health-related information. The reports, updates, reference documents and tools as well as monthly bulletins are available on the newly created Health Cluster information portal: www.healthsomalia.org



Through mobile clinics, SOYDA health
teams treat internally displaced
persons (IDPs) in Mogadishu
© SOYDA

Based on the information provided by partners on a quarterly basis, the health cluster updates the 3Ws (Who is doing What, Where) and 4Ws (Who is doing What, Where and When) matrices to monitor organizations providing services in the different regions of Somalia to ensure that gaps are identified and addressed. The documents are also available on the health cluster portal.

Funding and other Health Cluster tasks

The Health Cluster facilitates joint strategic planning (e.g. Consolidated Appeal Process) and supports partners in emergency resource mobilization, e.g. through the Common Humanitarian Fund (CHF). Due to the huge need for emergency funding, especially for the drought and famine response in 2011, partners sought support from the Health Cluster to submit short-term projects to the Emergency Reserve of CHF. The preparation for the Consolidated Appeals Process (CAP) was conducted in close inter-cluster coordination between health, WASH and nutrition clusters, and interactive consultation with health partners.

Table 5: Overview of Consolidated Appeal Process for Health Cluster (Somalia)

Year	Original requirements (USD)	Revised requirements (USD)	Total resources available	% covered
2010	46,444,869	49,609,926	25,317,507	51
2011	58,790,106	81,062,702	71,597,285	88

Challenges and lessons learnt

The Health Cluster underwent various challenges, which were more pronounced during the drought emergency:

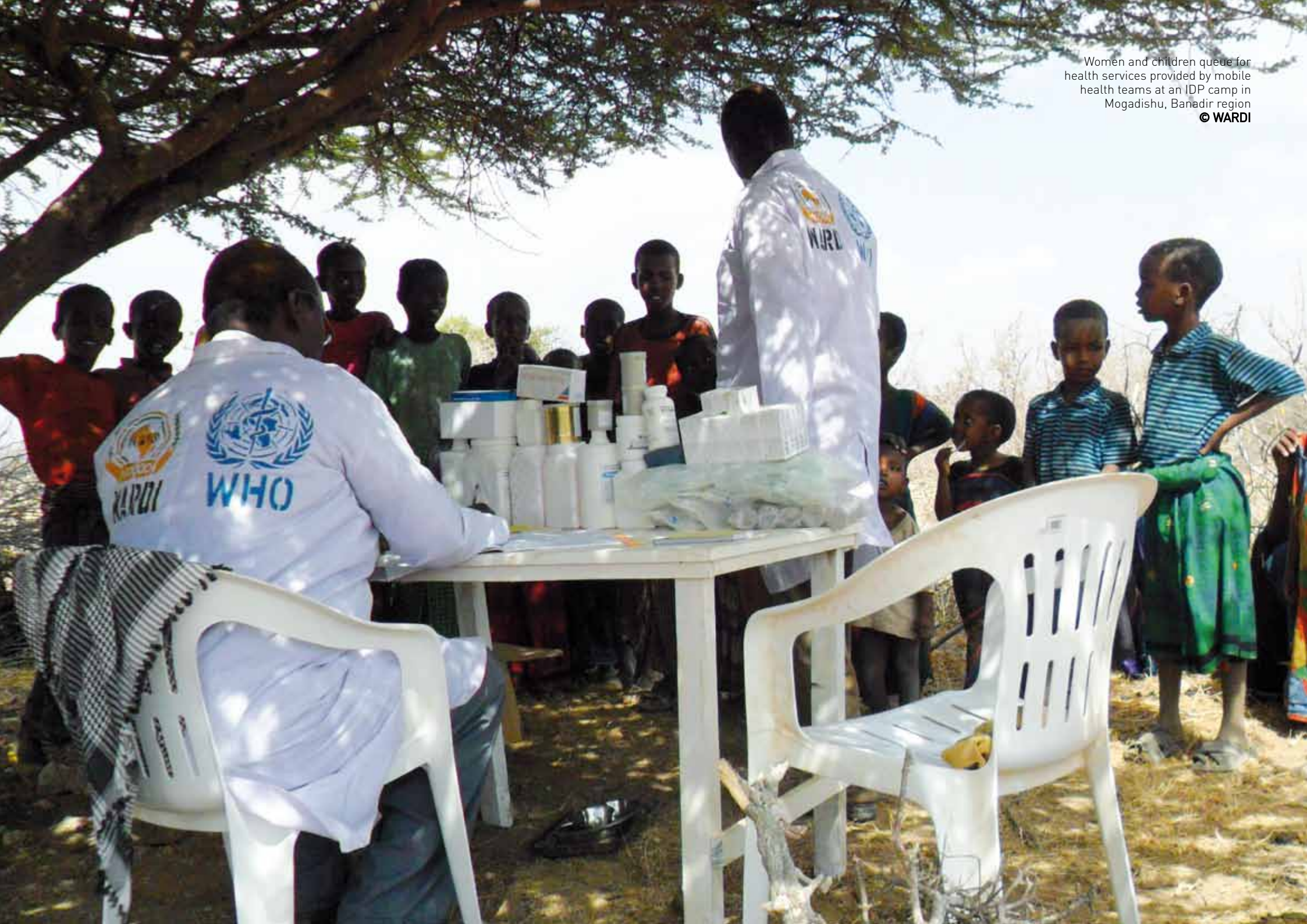
- The fluid operational presence in Somalia resulting from the fast-changing security environments, a situation which leads to limited access for the humanitarian community and jeopardizes the continuity and sustainability of health service provision.

- Lack of a functional central government, and presence of three different health authorities with different levels of development in the zones of Somalia. These contribute to the complexity of health cluster coordination. Specifically, this lack of oversight mechanisms leads to unequal distribution of health service coverage throughout the country.
- Low capacity of local agencies and lack of skilled health workers to implement health activities which compromise the quality of services and require more monitoring and quality control which is difficult due to limited access and security.
- The humanitarian community has faced gaps in monitoring and supervision of interventions due to the restricted access and movement especially in South Central Somalia. The approach of “remote control” does not prove to be sufficient.
- Gaps in the infrastructure and localized security constraints lead to increased operational costs such as logistics and security measures.

Strategic directions for 2012-2013

- The Health Cluster aims to strengthen the capacity of local partners who will be enabled to provide the cluster with information from the field and establish field-based coordination and information sharing mechanisms.
- In 2011, the multiple surveillance systems namely IDSR, CSR, measles, EPI, Malaria and AFP were revised after the partners and Centers for Disease Control (CDC) undertook an assessment. The new CSR system, starting from 2012 onwards, will use the outlined criteria for immediate alerts and weekly reporting for epidemic-potential diseases associated with high mortality in Somalia.
- The Health Cluster will organize more capacity and introduction trainings to raise awareness on what the Health Cluster does, encourage better reporting from partners and introduce the partners to the principles of partnership.

Women and children queue for health services provided by mobile health teams at an IDP camp in Mogadishu, Banadir region
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