Averting a famine in Somalia

Address read by Dr K M Bile on behalf of the WHO Representative for Somalia Dr Ghulam Rabani Popal at a media roundtable briefing

24 May 2017 – The international community and the Somali federal government have both raised a red flag over the drought and pre-famine situation that has affected half of the country’s population. The drought has resulted in food insecurity, which has led to large scale malnutrition that has directly affected the health of the population. During the past 43 years Somalia has experienced three famines of comparable intensity. In 1974 a devastating drought affected the central and northern regions of the country, during which the strongest response was mobilized with a historical mitigation of fatality with the loss of 18,000 lives. The 1992 and 2011 famine events were flawed by civil conflicts, insecurities, inaccessibility and delayed responses. As a result close to half a million lives were lost during the two disasters.

In this drought, which is geographically the most stretched, relative to previous droughts, the health sector is confronted by multiple challenges. Malnutrition and pre-famine situations are two killers in their own right and two major underlying causes of ill-health and disease. The cluster approach has been the best instrument enabling humanitarian response to be addressed collectively offering a unique opportunity for effective coordination and synchronization of health response efforts. In the emergency health response processes, WHO and the health cluster partners have responded to multifaceted health challenges encountered during this complex emergency. The salient emergency health response interventions targeted the following public health threats through robust and well-coordinated response:

1. The acute watery diarrhoea/cholera outbreak: In this disaster the country was confronted with an AWD/Cholera outbreak, a global threat to public health. Cholera can give its first symptoms in only few hours and cause explosive outbreaks that affect children and adults alike. The disease is transmitted by contaminated water and food and by person-to-person transmission. The scarcity of safe drinking water, malnutrition, poor sanitation and hygiene has contributed to the gravity of the outbreak. During this year the outbreak was reported from 53 districts in 14 of the 18 regions of the country with over 40,000 reported cases, about 700 deaths, with a
cumulative Case fatality Rate (CFR) of 1.7%. The number and trend of reported cases exceed the historical average of the upper limit of Cholera outbreaks in Somalia/Somaliland, hence the intensity of this pathogenic hazard. The AWD/Cholera response required the implementation of the following critical interventions:

• Early Warning and Surveillance: WHO has in collaboration with the health cluster partners and national health authorities across the health services delivery network established an early warning system and surveillance to detect, confirm and respond to disease outbreaks at community level and among the IDPs. A total of 275 disease surveillance sentinel sites are operational and regularly reporting, this being one of the most critical emergency health response activities for the prevention and control of AWD/Cholera and measles outbreaks in the country.

• Cholera treatment centres and units: To confront this outbreak, WHO has provided technical leadership to the health partners by setting operational standards in the establishment of 83 special cholera treatment centres (CTCs) and cholera treatment units (CTUs) that have significantly improved the survival outcomes of the cases reaching these health facilities. We must acknowledge the tremendous collective effort of the national health authorities and the engaged roster of health partners. The coordination through the health cluster under the leadership of WHO has progressively enhanced the effectiveness and quality of care in these CTCs and CTUs that serve the cholera outbreak affected areas in the country. The good news is that if cholera cases reach the health facilities in time, the lives of 99% of the cases could be confidently saved, meaning that generally 1% or less of the managed cases, fail to benefit from the care delivered. In the early weeks of the outbreak, public awareness to seek care was low, resulting in higher fatality rates, but in the recent weeks the average CFR was always less than 1%. This was very good news to the national and international health partners, and to the affected communities in particular.

• The Oral Cholera Vaccine (OCV): WHO and UNICEF have partnered with the national health authorities to introduce for the first time the OCV, of about two million doses and its successful implementation. We gracefully acknowledge the Global Task Force on Cholera Control, GAVI-the Vaccine Alliance, and the government of Sweden for enabling this preventative initiative in the country with focus on the most hit regions.

• Remote Monitoring of AWD/Cholera Treatment Facilities: To ensure regular feedback about the performance of the CTCs/CTUs and Nutrition Stabilization centers, WHO has introduced an electronic monitoring system, where staffing, operational gaps and performance outcomes are closely monitored. This approach has allowed actors to immediately undertake the necessary
corrective measures contributing to the quality of care and treatment outcomes.

- The health supply chain: To sustain a high performance capacity of the health services a fleet of supplies was procured and delivered by WHO to all the affected regions to ensure that the required levels of care and quality are sustained. A similar effort is pursued by other health partners, providing the needed support to emergency health operations.

- The Integrated Rapid Response Teams: WHO has in partnership with UNICEF, national health authorities and other health partners established an integrated response intervention, where health, WASH and nutrition combined interventions are carried out by emergency rapid response teams. These teams provide a package of integrated response activities at community level and assist in the prevention and control of the AWD/Cholera outbreak. This intervention was focused on outbreak hot spots in the southern part of the country.

2. The measles Outbreak: The prevailing pre-famine and undernutrition are aggravated by a measles outbreak, as a result of reduced immunity in malnourished children. Measles is one of the most contagious viral diseases, and a leading cause of death among young children, despite the availability of a safe and cost-effective vaccine. High fever and rash are its common signs and symptoms. Common complications of the disease among the under 5 children include blindness, brain swelling, and severe respiratory infections. The vulnerability of the children population is related to the low access to vaccination, where susceptible children are often infected when brought together in large numbers to the IDP camps. 8390 cases have been so far reported across the country.

Vaccination campaigns were the major interventions carried out to curb the outbreak. In this effect WHO and UNICEF have in partnership with health authorities launched measles vaccination campaigns in specific hotspot areas in Somaliland, Puntland and several of the South Central regions of the country, targeting half a million children between the age of 6 months and 5 years.

3. Combatting Malnutrition: The Crisis (IPC Phase 3) and Emergency (IPC Phase 4) levels of acute food insecurity are affecting more than 3.2 million people and the risk of famine (IPC Phase 5) still persists. More than 360 000 children are acutely malnourished. The Food Security and Nutrition Analysis Unit of FAO reported Critical levels of Global Acute Malnutrition (15-30%) and a noted increase in the Severe Acute Malnutrition (SAM) level. The latter substantiates the need for health, nutrition and WASH inter-cluster coordination, particularly in the establishment
of stabilization centres and nutrition interventions at community level. In this regard, WHO has ensured the provision of guidelines and nutrition standards; nutrition surveillance for prevention/early warning and response and the necessary technical support for improving the management of severe and moderate malnutrition. Information dissemination and training of health workers for capacity building are also important components of the WHO technical contribution in this emergency.

4. Support to Lifesaving Interventions through the Health Services’ Network: WHO and health partners support a network of health facilities in the drought affected areas to ensure a sustained and effective implementation of essential care interventions with focus on maternal and child health. This support constitutes a health care lifeline to millions of the vulnerable population.

5. Capacity and Resilience Building Imbedded in all Health Emergency Response Interventions: Capacity building has become an integral part of the WHO health emergency preparedness and response, through resilience building interventions within the health system. These capacitating efforts include the training of trainers on cholera case management; maternal and child health care; disease surveillance; strengthening the capacity of the AWD/Cholera and measles diagnostic laboratories in the country; training in the application of the provisioned water testing kits and training on remote monitoring of health facilities and cholera treatment centers/units.

6. Notable Progress: At this stage of the response, health partners have in collaboration with other clusters, under the leadership of the Humanitarian Country Team (HCT) and the highly appreciated coordination role of OCHA and the medical supplies airfreight support by WFP, accomplished the above range of response interventions and many other health complementary activities. The health response has resulted in a meaningful reduction in the intensity and trend of the AWD/Cholera outbreak; successfully reduced the Case Fatality Rate to internationally acceptable level; created a strong partnership with national health authorities and promoted a range of capacity and resilience building efforts that need to be sustained. These achievements would not have been possible without the generous and invaluable support offered by the humanitarian and donor community.

However, there is no room for complacency, as to successfully manage this crisis, partners have to prepare for, detect and respond to the outbreak of AWD/Cholera and other communicable disease outbreaks predicted during this rainy season. In this paradigm, the humanitarian and donor community must take note of the large population groups who have lost their livelihood assets and are at the verge of famine. Hence, the imperative need to scale up action. The health cluster is short of resources and many of the ongoing interventions could be
seriously underpinned by securing the lifesaving needed resources, hence the appeal for greater support for this vital humanitarian sector.

7. The Key Lessons Learned: several lessons were learned from this emergency health response experience, the most salient of these being:

i. The ability of the humanitarian cluster system to generate effective, coordinated and coherent engagement of its health partners with the application of best practices and standards, which has not only boosted their response capacity, but stimulated the active participation of the national health authorities at all levels of the drought affected regions and ignited a wider partnership with other humanitarian clusters

ii. The imperative to link the emergency response interventions with inputs of capacity and resilience building, which will not only improve the response potential but will also enable the health system capacity to absorb future inevitable natural and pathogenic hazards that the country may face. This can be attained by supporting the ministries of health and their public health institutions through the imbedding of a critical number of health professionals that would assume acutely required technical leadership roles on emergency preparedness, coordination, planning, and response and recovery functions.

iii. The need to devise contextually sensitive strategies to improve the access of hard to reach and security compromised districts of the country, where engaging the community in early warning and surveillance is a case in point

iv. The importance of risk communication, where the outbreak prevention and control related information is widely shared with the drought affected population by scaling up health advocacy. Effective risk communication has the power to averts or mitigate the impact of the encountered threats. This capacity also provides a rich platform for media engagement.

In conclusion we may affirm that the scale of public health emergencies is not often predictable, but through shared initiatives and coordinated action, their tragic impact could be significantly reduced.

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