

Emergency Preparedness

Background

Somalia witnesses its fair share of emergency situations. The country, for instance, experiences yearly cyclic outbreaks of cholera, which is endemic in Mogadishu. Apart from this, measles, malaria and meningitis outbreaks have claimed the lives of many Somalis. As a result, there is a great need to strengthen WHO's surveillance system and response to emergencies/outbreaks.

This can be done by strengthening the technical capabilities of nationals; strengthening reporting, supervision and monitoring mechanisms; recruiting a short-term consultant to assess the trend of outbreaks and map out epidemic-prone areas so that epidemics can be prevented.

Training of national health professionals on disease management and epidemiological surveillance is also crucial in a country of complex emergency like Somalia.

Adequate drugs and supplies (such as emergency kits containing essential medical supplies and laboratory reagents) need to be pre-positioned and delivered in time to respond to identified outbreaks.

In addition, the project management and administrative support needs to be improved so as to ensure a smooth flow of operations, monitoring and communication in general.

Achievements

Mass Vaccination against Meningitis

In January 2002, WHO, in collaboration with health authorities and other partners, held a mass campaign against meningitis. The campaign, held in Hargeisa, north-west Somalia, saw approximately 190,000 people vaccinated with meningitis vaccines A and C, out of a targeted 200,000. This brought the coverage to an impressive 86%.

Although Somalia is not within the Meningitis Belt, this was the first outbreak of meningitis the country experienced. The outbreak began in October 2001 in Hargeisa, with about three cases being reported.

Cross-Border Vaccination

As part of WHO's plan to curb further spread of the disease, in May 2002, trained teams from Hargeisa were sent by WHO and UNHCR to

vaccinate 5,200 returnees from Camp Abokor in Ethiopia.

In order to keep up its emergency preparedness plan, the need for pre-positioning meningitis vaccines and other supplies (needles, etc.) is strongly felt.

Cholera

WHO provides cholera kits to health facilities in Somalia during cholera outbreaks.

By the end of 2002, a total of 1304 cases and 10 deaths were reported as a result of the spread of the water-borne disease.

Current Situation

WHO has 54 sentinel sites all over the country—all of which report on a weekly basis to the surveillance office based in Hargeisa, north-west Somalia.

Future Objectives

- ✦ To sustain and expand outbreak surveillance/response/control system
- ✦ To preposition emergency medical supplies and rapid response
- ✦ To enhance capacity building for nationals in epidemic preparedness and response with the aim to improve on case management of cholera and other epidemic diseases



Dr. Ibrahim Bet Elmal, WHO Representative for Somalia, meets Somali health representatives at a cocktail party held in honor of their visit to the WHO liaison office in Nairobi, March 2003.

(Left to right: Dr. Hassan Ismail Yusuf from Hargeisa, Dr. Bet Elmal, Dr. Professor Osman M. Mohamed (Dufle) from Mogadishu, and Dr. Abdi Awad Ibrahim from Garowe.

EPI/ Polio

Polio

Background

The Regional Committee of the World Health Organization (WHO), Eastern Mediterranean Regional Office (EMRO) adopted a resolution to eliminate poliomyelitis in 1988. This report summarizes polio eradication activity in Somalia, one of the remaining endemic countries in EMRO, during 2002. Despite tremendous achievement, Somalia must overcome many challenges to interrupt poliovirus transmission by the end of 2003.

Strategies

To accelerate the polio eradication program, and to overcome the constant constraints of insecurity and inaccessibility, the polio eradication program adopted a number of unique strategies:

- ✎ WHO and UNICEF jointly coordinate, implement, and promote polio eradication activities, utilizing the strengths of each partner. WHO assumes leadership in technical guidance, while UNICEF coordinates logistical issues and supports social mobilization activities. The division of responsibilities between the agencies is periodically updated based on field conditions and agency resources.
- ✎ Organizationally, there is a single polio unit. National and international staff hired by WHO or UNICEF work as a single team and implement a common programme. Direct administrative and logistical support for field operations is provided through



decentralized hubs in each zone.

The hub offices are equipped with communication and cold chain equipment and are located in either WHO or UNICEF offices.

- ✎ The program employs 8 international staff and 175 national staff on a “permanent” basis. These staff work within an organizational structure that includes a coordination team in Nairobi, an international focal point in each zone, national focal points in each region, and district polio officers (DPOs) in each district. During immunization campaigns, district field assistants (DFAs) and vaccinators are selected from the community as temporary staff.
- ✎ WHO/UNICEF recruit staff and vaccinators from the community they are to serve. Selection is determined with the help of the community and WHO established criteria. A similar combination of community involvement and selection criteria guides the historically controversial process of car rental.
- ✎ An extensive logistics system was established and is constantly maintained. A national-level cold chain was set up in Nairobi. The cold chain in all hub offices is kept fully operational. To avoid stock rupture and delay of delivery, all SIA items (vaccine, cold boxes etc.) are purchased two rounds in advance.

These strategies allow the polio programme to implement activities year-round and ensure greater access and security. Joint programme management prevents the duplication of activity allowing for a more effective use of funds. National staff often have access to areas where international staff are not allowed. Transparency in all hiring/renting procedures and uniform policies across the country reduce tensions over financial issues.

Enhanced community participation generates a feeling of increased ownership over the programme. The logistics capability minimizes the problem of the cumbersome transport system between Nairobi and Somalia. In combination, these strategies allow the program to utilize windows of opportunity whereby supplemental immunization activities are conducted on short notice if there is a period of relative calm in an insecure area.

Expanded Programme on Immunization (EPI)

Health-care services to the estimated seven million persons residing in Somalia are delivered through national and international non-governmental organizations (NGOs),

	2000	2001	2002
Round 1	1,298,103	1,155,578	756,899
Round 2	1,370,928	1,092,377	1,364,831
Round 3	1,264,801	1,356,109	1,342,691
Round 4		1,387,365	656,812
Round 5		116,719	1,109,868
Round 6			1,080,818

Table 1: Results of Supplemental Immunization Activities, Somalia 2000-2002

supported by the United Nation's Children's Fund (UNICEF), WHO, and other UN agencies.

Routine immunization is weak throughout the country. According to UNICEF's 1999 Multiple Indicator Cluster Survey, immunization rates for children aged 12 to 23 months were: BCG 69%, DTP_3 35%, Pol_3 37%, and Measles 16%. In 2002, two rounds of EPI acceleration campaigns were implemented in major towns to prepare for more extensive coverage in 2003.

Somalia has received approval from the Global Alliance for Vaccine and Immunization (GAVI) for support to improve and expand their routine immunization services and improve immunization safety.

Supplemental Immunization Activities

Polio eradication activities were initiated in Somalia in 1997 when WHO and UNICEF



conducted the first sub-national immunization days (SNIDs) in the north-east and north-west zones. In 1998, the first round of national immunization days (NIDs) covering the entire country was planned. The first implementation of the door-to-door campaign strategy in Somalia was during the 1999 NIDs. All subsequent campaigns used this strategy.

By the end of 2002, every zone had undergone at least 16 rounds of immunization days. An average of 1.2 million children were vaccinated in each NID round. Vitamin A is given twice a year during the campaigns. The overall results of the 2000-2002 campaigns can be found in Table 1 and detailed results from 2002 in Annex 1.

AFP Surveillance

Acute flaccid paralysis (AFP) surveillance started in Somalia in 1998. Since 2000, Somalia has exceeded the WHO-established minimum AFP reporting rate of 1 non-polio AFP case per 100,000 children aged <15 years, which indicates a sensitive surveillance system (Annex 2). In 2002, the rate was 3.12.

The second key indicator of the quality of AFP surveillance is a minimum of 80% adequate stool specimens collected for all persons with AFP. Although there is steady progress towards the target, Somalia has not yet reached it: the adequate stool specimen collection rate was 59% in 2001 and 67% in 2002.

At the beginning of 2002, Somalia changed from the clinical classification scheme to the virological classification scheme. This change was implemented retroactively for 2001. In March 2002, the Somalia Expert Review Group met for the first time and classified the 29 pending cases from 2001 (those that had

inadequate stool collection and no wild virus isolated and residual paralysis/patient died/patient lost to follow-up). The Expert Review Group classified 19 of the pending cases as non-polio AFP and ten cases as polio-compatible. The Expert Review Group met quarterly in 2002 and classified 23 cases; 19 as non-polio AFP and four as polio-compatible.

The laboratory first confirmed wild poliovirus transmission in Somalia in 1999. In 2000, a large P1 outbreak was identified with 46 cases confirmed in four regions. In 2001, the 2000 P1 outbreak was contained. Circulation of wild virus was restricted to the central regions of Benadir and Lower Shabelle where seven polio cases infected with wild P3 were identified. In 2002, low-level transmission of wild poliovirus continued with three P3 cases confirmed in Benadir, Lower Shabelle and Middle Shabelle regions.

Stool specimens from Somalia are initially tested in the Kenyan Medical Research Institute (KEMRI) laboratory in Nairobi, Kenya. Isolates requiring intra-typic differentiation (ITD) are sent to the WHO-AFR regional reference laboratory in South Africa. In 2002, 216 specimens (108 cases) were tested at KEMRI. Laboratory results from KEMRI were reported within 28 days of receipt for 70% of stool specimens tested in 2002.

Epidemiology of AFP Cases

One hundred and eight AFP cases were reported in 2002. The distribution of cases can be seen in Annex 2. Twenty-four (22%) were less than a year old, 58 (54%) were between one and three years old. The majority of AFP cases presented with asymmetric paralysis (95%), acute onset (91% in less than four days), and a fever at onset (97%). Fifty (46%) reported no history of vaccination, 25 (23%) reported one to two doses, and 33 (31%) three doses or more. More AFP cases from nomadic families had no history of vaccination (66%) than AFP cases from the city (41%) or rural areas (28%).

Non-polio enterovirus was isolated in 13 (12%) AFP cases. Vaccine virus was isolated in 13 (12%) cases. The polio programme was notified about AFP cases by sentinel sites (37%), polio staff (30%), and the community.

Three cases with wild P3 poliovirus were confirmed. One child was less than a year old and the others were aged two years. One child had no history of vaccination and came from a nomadic family. The other two cases, who were city dwellers, received one dose of OPV prior to onset. A sentinel site, a traditional healer, and a district field assistant reported the cases.

Security

Insecurity and inaccessibility increased in 2002 severely restricting the movements of national and international staff. The main operational hub for the central and southern zones was evacuated (nationals and internationals) and many areas were off limits to international staff. In the north-east, political strife prevented international staff from visiting the zone for most of the year. In the north-west, travel by international staff to the regions of Sool and Sanaq was also restricted. Four polio staff were killed; one was shot, one was attacked by a crocodile, and two died in a car accident. In addition, numerous staff members sustained serious injuries in firefights and car accidents.

On a positive note, international staff were allowed to visit Mogadishu for the first time since April 2001. The two visits lasted only three-four days each but international staff were able to lend technical and moral support to national staff members, and to assess polio eradication activities.



Essential Drugs

Background

The pharmaceutical sector has been the least investigated area in Somalia. Prior to the civil war, the government was unable to procure drugs. Drug supplies were largely dependent on foreign aid.

Today, drugs are brought to the country, mainly through two channels: through the international aid organizations or through the private sector.

One by-product of the collapsed Somali government is a blossoming private sector. Pharmaceuticals have become a big business and pharmacy shops have mushroomed in every corner of all towns and cities. Although private pharmacies supply remote areas with much-needed drugs, the quality of the drugs sold in those pharmacies has been questioned. In addition, most of the drugs used are suspected to be generic, thus putting the already vulnerable patients to great risk.

Achievements

- ✍ In Hargeisa, a National Drug Policy was endorsed by the Ministry of Health with assistance from WHO
- ✍ A consultant was hired in an effort to carry out a situation analysis of essential drugs in the country. In collaborative efforts with local authorities and nationals, standard treatment guidelines were prepared



- ✍ WHO has been serving as co-chair- in conjunction with UNICEF- of the essential drugs working group
- ✍ In July 2002, the Health Institute for Sciences hosted a workshop where education materials were distributed
- ✍ National health representatives were sponsored to attend international courses

on Essential Drugs

- ✍ Quality control has been ensured for selected drugs rehabilitation of the central medical store in Hargeisa

Main Constraints

The availability of drugs from private practitioners or public pharmacies fuels drug resistance and misuse of drugs. In addition, some drugs may be of poor quality.

Insufficient funds also poses a problem for the programme.

Future Objectives

- ✍ Recruitment of a consultant to revise and update Somalia Treatment Guidelines (STG)
- ✍ Printing of STG in pocket format
- ✍ Translation of the STG into Somali
- ✍ Somali language Distribution of the STG
- ✍ Conduct quality control analysis of the available drugs in the market
- ✍ Technical support of the zonal health authorities in the development of a national drug policy
- ✍ Training of nationals

HIV/AIDS

Background/ Epidemiology

Due to the HIV/AIDS scourge already hitting the disease-ridden countries in Sub-Saharan Africa, UN agencies have decided to prioritize the HIV/AIDS programme in Somalia.

It is estimated that among ante-natal clinic attendants at least 30% had one or more Sexually Transmitted Infections (STI) symptoms; out of which, according to a study carried out in Bosasso (north-east) and Hargeisa (north-west), the HIV prevalence rates among the attendants were 1% and 3% respectively. However, the official estimate issued by SACB for the prevalence of HIV among the Somali population is around 1% with some regional variation.

The epidemiological survey conducted in 1999 revealed 0.9% HIV passivity among antenatal care attendants. Among TB patients in Boroma, a town in the border between Ethiopia and north-west Somalia, HIV passivity has reached alarmingly high levels, more than 10%.

Syphilis prevalence among antenatal care attendants and men in the general population is 1.8% and 1.9% respectively.

The KAPB study conducted in 1999 revealed interesting results. Despite the high proportion of people knowing about HIV/AIDS, the knowledge of the mode of transmission and standard identification of prevention means is surprisingly low.

Condoms are available only in some pharmacies and for health facilities while the Somali population has no culture of using condoms.

In 2002, during blood screening tests carried out, almost 1% of blood donors tested positive for HIV infection. In the same year, prevalence of the virus in TB patients was known to increase to more than 10%, from 6.7% in 1999. In one TB centre, in fact, 15% of all patients were reported to be full-blown AIDS patients.

Modes of Transmission

Despite the fact that there is scant data on the disease, HIV in adults in Somalia is believed to be spread mainly due to heterosexual transmission.

In children, infections are known to have been acquired from the mother during pregnancy,

delivery or at postnatal stage through breastfeeding. It can also be assumed that a small percentage of the Somali population has acquired HIV infection through blood transfusion or through injury with contaminated instruments.

Factors Fuelling the Spread of HIV/AIDS

Factors such as the civil strife, backed with poverty, low literacy levels and the extensive mobility of population - such as refugees/returnees from neighboring high-burden countries and internally displaced people - pose additional threats and risks to the increase in prevalence of the infection.

A behavioral survey carried out in 1999 in Somalia showed that although people are aware of the epidemic, there are a lot of misconceptions and specific preventive measures cannot be identified. Yet another survey carried out in 2000 supports this fact by stating that a mere two percent of women correctly knew of two ways of avoiding HIV infection.

Response towards the Epidemic

The Somalia Aid Coordination Body (SACB), through the defacto UN expanded country theme group for Somalia, has already embarked on the development of a strategic plan on HIV/AIDS; which is foreseen to be finalized later in 2003. WHO and UNICEF play a technical lead role in this process.

In its efforts to curb further spread of STIs, WHO has joined forces with other UN agencies (such as UNICEF, UNFPA, UNIFEM and UNDP), international non-governmental organizations (INGOs) and local authorities to embark on a project to introduce syndromic management of STIs, surveillance and trainings. WHO also proposes to initiate trainings on treatment and care to AIDS patients.

Thirteen STI pilot sites identified in all three zones thus far have been supplied with STD kits, drugs, manuals, diagnostic flow charts, reporting forms and tally sheets, etc. To date, at the sentinel sites, a total of 50 health and community social workers have participated in a training course on counseling skills. Another 15 health workers were supported in undertaking a Training of Trainers course. In addition, WHO is ensuring blood safety in 27 hospitals, by the provision of Human Immuno-Deficiency Virus (HIV) rapid testing kits.

In 2001, WHO carried out a number of trainings on syndromic management for health professionals in facilities in Garowe, Baidoa and Mogadishu, while UNICEF carried out trainings

in Hargeisa. An information package was developed and translated into Somali in order to complement the trainings. In addition, a workshop was held on the clinical management of HIV/AIDS in central and southern zones.

During meetings held in Nairobi with health authorities from Somalia in the first week of March 2003, it was unanimously agreed to develop one policy document on HIV/AIDS. Hopefully, this will act as a 'springboard' for unified health policies in the future in Somalia.

In an aim to lobby for donor support, WHO plans to submit a proposal to the Global Fund for the HIV/AIDS programme, in addition to the malaria and TB programmes.

Laboratory Support

Background

Laboratory support in Somalia is limited, except from the support provided by WHO Somalia to various health facilities. Almost all cases of diseases such as TB, meningitis, malaria and cholera are tested in all regions of the country. However, cases that need confirmation are referred to laboratories such as AMREF in Nairobi, Kenya.

WHO Somalia currently attempts to improve accurate diagnosis and management of diseases of public health importance. Laboratory support is currently provided to 27 general hospitals, 31 TB centres and 25 blood transfusion units in Somalia.

Achievements

New Centres

- ✍ Five new TB laboratories were established
- ✍ Eight existing health facilities began to offer malaria microscopy services in 2002

Supervision

- ✍ Laboratory focal points continued to supervise activities in laboratories in all regions, such as the Regional Hospital and TB laboratories in Bosasso

Trainings

- ✍ 16 technicians from eight health facilities in Bay and Gedo were trained in malaria microscopy for one month in May, with support from international and national non-governmental organizations
- ✍ Laboratory technicians working in Somalia, in the north-west, north-east and south/central Somalia were trained to provide practical laboratory support in Epidemic Preparedness, Response and Blood Safety
- ✍ Laboratory technicians in Boroma TB centre were trained for four weeks

Case Diagnosis

- ✍ Laboratory support was provided in Hargeisa, for the meningitis outbreak, since January last year. Support is still being provided for surveillance
- ✍ Cholera cultures were performed in regional hospitals in Mogadishu, Merca and Bosasso
- ✍ Stool samples from areas that do not have

access to reference laboratories were brought to the AMREF laboratory in Nairobi

- ✍ TB culture and drug sensitivity tests were processed in Nairobi laboratories



Support

Supplies

- ✍ Supplies continue to be distributed to blood banks, TB centres, malaria microscopy centres and general hospital clinical laboratories throughout the country on a regular basis
- ✍ Inventory of laboratory supplies in Nairobi, Merca and Bosasso were completed

Guidelines

- ✍ A manual for technicians, sputum microscopists in particular, was developed, printed and translated into Somali between January and June
- ✍ Malaria microscopy guidelines were translated into Somali

Human Resources

Three national laboratory focal points were hired for the north-west, north-east and south/central zones

Studies

- ✍ A feasibility study of blood banks in Somalia was undertaken, the findings and recommendations of which were sent to the regional office for approval
- ✍ Laboratory support was provided to the anti-malarial drug efficacy study carried out in Jowhar and Jamaame

Future Objectives

As part of its objectives to continue providing support to various laboratories all over the country, WHO Somalia's laboratory programme aims to use extra-budgetary funds to meet the cost of the supplies.

Malaria

Background

With malaria cases soaring to 8,171 cases in 2001 and a total of 15,772 in 2002, out of which 1,851 were confirmed, WHO's Roll Back Malaria initiative has gained a stronger momentum.

The initiative aims to reduce mortality and morbidity – both of which mostly affect pregnant women and children under-five. This is done by providing Insecticide Treated Nets (ITNs) as part of personal protective measures in the south and central zones and by increasing the use of larvivorous fish in various villages in the north-east and north-west zones as part of the biological method of controlling the disease. The latter is relatively cost-effective in the long run.



Achievements

Roll Back Malaria Programme

Being a high-burden country, WHO has successfully been implementing the Roll Back Malaria programme.

Since its inception in 1999, WHO has been supplying Insecticide Treated Nets (ITNs) to BDN villages in Merca in the south and the north-west in particular. Last year, WHO distributed 32,608 ITNs in collaboration with UNICEF.

In addition, WHO provided support to villages in regions such as Toghdeer (north-west) in form of provision of larvivorous fish in an effort to increase vector control. Fish ponds in various zones were also rehabilitated.

Anti-malarial drugs have been distributed to partners working in this field in Somalia. In addition, samples of widely-used drugs were sent to the laboratory in AMREF (Nairobi) for Assessment.

Malario-metric Study

In May 2002, WHO, in conjunction with Merlin UK, embarked on a malario-metric study in

Somalia. The main objective of the study was to determine baseline prevalence in each zone of Somalia.

Anti-Malarial Drug Efficacy Study

In November 2002, a study was commenced on anti-malarial drug efficacy. The drugs studied were Chloroquine and Fansidar. Six sentinel sites were selected; namely Jamaame, Burao, Galkaiyo, Jowhar, Merca/Janaale and Baidoa. The study has only been completed in Jamaame thus far, with 258 cases being studied for the efficacy of Chloroquine and 138 cases being studied for the efficacy of Fansidar. It was noted that resistance to Chloroquine was reported at a low level and it was still in use country-wide. Fansidar was seen to be effective although resistance was reported in the study carried out in Jamaame.

Current Situation

WHO is providing anti-malarial drugs and microscopic support to various health centres.

Future Objectives

- /// To institute prompt diagnosis and effective treatment of all malaria cases in all health facilities
- /// To promote the use of Insecticide Treated Nets (ITNs) to control spread of malaria
- /// To promote biological control of malaria by using larvivorous fish ponds
- /// To introduce Intermittent Preventive Treatment (IPT) in antenatal clinics by collaborating with various partners
- /// To strengthen malaria health information system and response to epidemics
- /// To strengthen surveillance system in order to make more appropriate decisions
- /// To collect baseline information for evaluation of specific activities
- /// To execute operational research to select the most appropriate control methods for specific areas
- /// To sustain large institutional, public and private sector partnerships for malaria control
- /// To increase capacity building (through acquisition of additional resources)
- /// To create awareness and inform community members about malaria as a disease



Tuberculosis

One of Somalia's greatest human killers comes in the form of Tuberculosis. With its efforts continuing to improve conditions in the field, WHO Somalia currently provides support to a network of 31 TB centres, from 26 in the beginning of 2002. However, challenges such as the lack of compliance with international/WHO standards still hinder progress of TB control.

Achievements

- ✍ Recording and reporting system is now streamlined. The treatment outcome in 2001 has increased from 83% to 88%. The number of cases, too, has increased to 7,200, which signifies that more patients are being attended to
- ✍ Five new TB centres were opened:
 - Wanle Wein (World Vision)
 - Kismayo (Muslim Aid)
 - Buu'ale (World Vision)
 - Mogadishu Pediatric Hospital (SOS)
 - Mogadishu Prisons (Mercy)
- ✍ Drugs supplies have been regular (no stock out at central/peripheral level) and laboratory services have been constantly upgraded
- ✍ Eleven Somali nationals have been sent to international conferences/ meetings on TB, such as the IUATLD conference in Khartoum (1); the Inter-country training on DOTS in Cairo (1); the IUATLD course in Arusha (3); the NTP managers' meeting (4) in Damascus; the Tropical Disease Research/TDR meeting in Cairo (2)
- ✍ Three high level meetings were successfully organized by WHO Somalia
 - the Third National Coordination Meeting on TB Control (May 2002)
 - HATCI meeting on TB/ HIV control in cross-border areas (August 2002)
 - first workshop on TB control for private practitioners (November 2002)
- ✍ A proposal including a TB component was submitted to the Global Fund Facility against HIV/AIDS, TB and malaria, in September 2002. However, unfortunately, the TB component was not selected
- ✍ The partnership with the World Food Programme has been strengthened, with an Memorandum of Understanding (MOU) between WHO and WFP, resulting in all TB centres being provided with food support from January 2003 onwards
- ✍ Somalia's TB programme has been accepted as a member of the multi-country study on delay analysis supported by the Tropical Disease Research (TDR) - a small grant scheme supported by the regional

office for WHO Somalia

- ✍ A ban on the sale of anti-TB drugs was obtained in the north-west (Somaliland), after WHO exerted a lot of pressure on the 'Ministry of Health', in an effort to prevent misuse of the drugs in the private sector and to prevent development of drug resistance
- ✍ WHO began collaboration with an internationally recognized TB institution (TB Hospital in Sondalo, Italy)
- ✍ WHO's role in the SACB was reinforced through the leadership in both the TB and the Global Fund Working Groups

Future Objectives

- ✍ To guarantee continuous provision of services in the already functioning TB centres/hospitals
- ✍ To expand DOTS activities by opening new TB centres in different areas (with a special focus on under-served areas)
- ✍ To develop new guidelines for Somalia
- ✍ To develop the strategic plan for TB control in Somalia for 2004–2007, based on the SACB strategic plan for 1999-2003
- ✍ To strengthen the quality control system for TB laboratories through the introduction of regular internal and external quality control in all TB centres/ hospitals
- ✍ To introduce—gradually— the new regimens based on 4 FDC (Fixed Drug Combination) through pilot projects
- ✍ To promote the participation of Somali doctors/ nurses in trainings and workshops, both at national and international level, in an effort to continue the capacity-building for health personnel
- ✍ To strengthen collaboration with the HIV/ AIDS control programme so as to promote integration of activities in response to the growing threat posed by the HIV epidemic in Somalia
- ✍ To enhance partnership with the private sector to limit the misuse of anti-TB drugs and the risk of insurgence of drug-resistant TB strains
- ✍ To facilitate the submission of a new application to the Global Fund and to other funding structures available

Mental Health

Background

Mental health services in Somalia are limited to psychiatric care provided in Berbera, Hargeisa and Mogadishu.

A mental health project is currently being implemented by GRT (an international non-governmental organization) in Berbera and Hargeisa.

Some of the constraints deterring the mental health situation in Somalia are the lack of mental health services at regional, districts and community level; the lack of qualified/trained national personnel; and the limitation of funds.

Achievements

Regular support has been provided to Berbera and Hargeisa mental facilities. Essential psychiatric drugs are currently being provided to various non-governmental organizations.

Future Objectives

- ✍ To provide continuous support to the mental health facilities in the north-west and the north-east
- ✍ To train nationals in the management of mental health disease
- ✍ To adapt the programme to the cultural and traditional behaviour of Somalis
- ✍ To introduce a mental health system based on community oriented approach with a link between community care, PHC and back up from the mental health hospital

Water and Sanitation

Background

The poor quality of water and the lack of sanitation throughout the country have accelerated the number of deaths caused by cholera and other diarrheal diseases.

In an effort to improve on these conditions, WHO needs to train chlorinators in the north-east and north-west zones on chlorination activities; as well as train health personnel on water-quality testing.

In addition, WHO aims to recruit a consultant to analyze the water situation in the country.



Achievements

In 2002, WHO ensured the use of hygienic water by using a chlorination plant in Hargeisa, north-west Somalia.

Current Situation

WHO has hired the services of a water and Sanitation engineer in Hargeisa, north-west Somalia, who also serves as the focal point for the entire of Somalia.

Future Objectives

WHO aims to work in conjunction with health authorities and other partners to promote water source protection and improve the quality of drinking water at household level.

Sub-office Report Hargeisa

Emergency Response and Control

- ✍ WHO provided support in conducting trainings on emergency preparedness at regional level for staff
- ✍ Provided laboratory support to emergency preparedness and response
- ✍ Supported the launch and introduction of the outbreak surveillance system in six sentinel sites in the north-west
- ✍ Propositioning of emergency response supplies, mainly related to epidemics such as cholera, malaria, diarrhoea and meningitis
- ✍ Provided support to epidemic preparedness by way of assisting all central hospitals as well as Edna Maternity Hospital
- ✍ Introduced support to rapid response teams by providing emergency response kits

Health Information System

- ✍ Provided support for trainings at regional level on the Health Information System (HIS) for regional staff/nationals in hospitals, Mother Child Health clinics (MCHs) and health posts
- ✍ Provided support on job-training and to short workshops in efforts to centralise the HIS unit

Basic Development Needs

- ✍ Provided support to income generation activities in Awdal and regions in the north-west
- ✍ Provided support to awareness campaigns on health risk and the hazards of pesticide use in agriculture
- ✍ Supported health education at the household level on the importance of nutrition and food hygiene
- ✍ Promotion and community organization on problem-solving and decision-making for eight villages
- ✍ Provided support for the promotion and training for BDN and the village development communities

Essential Drugs

- ✍ Provided support in terms of quality control
- ✍ Activities carried out in Hargeisa, Berbera, Las Anod, Erigavo and Burao

Reproductive Health

- ✍ Supported trainings to midwives and Traditional Birth Attendants (TBAs) on safe motherhood practices and reproductive health in Mother Child Health clinics (MCHs) and hospitals
- ✍ Supplied essential drugs

Water and Sanitation

- ✍ Installation and training of staff on the use of chlorination plant
- ✍ Supported monitoring and supervision of water quality

Polio Eradication

Provided support to:

- ✍ NIDs, SNIDs in all districts, regions and villages
- ✍ AFP surveillance and investigation
- ✍ All partners to eradicate polio in the near future

EPI

Collaborated with partners to strengthen and improve routine immunization

Tuberculosis

- ✍ Provided support to all TB centres in the north-west by providing drugs continuously
- ✍ Supported health professionals attending a workshop on DOTS
- ✍ Provided technical support, supervision and quality control

Malaria

- ✍ Provided quarterly reports, supervision, in-service training
- ✍ Distributed Insecticide Treated Nets and anti-malarial drugs
- ✍ Provided support to study carried out on chloroquine resistance
- ✍ Expanded biological control of spread of malaria

HIV/ AIDS

Provided support by:

- ✍ Assisting syndromic case management
- ✍ Trainings and assisting pilot sites

Health Education

A workshop on health education and awareness was held in Hargeisa in November 2002, during the holy month of Ramadan. The Sheikhs of Bosasso, Garowe and Galkaiyo further addressed gatherings at masjids (mosques) on issues such as TB and its transmission; immunization and prevention of diseases; HIV/AIDS; water and sanitation; child-spacing and breastfeeding; problems related to the use of tobacco and khat; personal hygiene and Female Genital Mutilation (FGM). WHO provided documents translated into Somali to facilitate the workshop.