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Country Cooperation Strategy for WHO and Somalia 2010–2014

Somalia



World Health
Organization

Regional Office for the Eastern Mediterranean

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Somalia



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Regional Office for the Eastern Mediterranean

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Abbreviations

AFP	Acute flaccid paralysis
AIDS	Acquired immunodeficiency syndrome
CAP	Consolidated appeals process
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention (Atlanta)
CFR	Case fatality rate
CISS	Coordination of International Support to Somalis
COOPI	Cooperazione Internazionale
DAC	Development Assistance Committee (of the OECD)
DPT	Diphtheria, pertussis, tetanus
EmOC	Emergency obstetric care
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization of the United Nations
FGM	Female genital mutilation
FSNAU	Food Security and Nutrition Analysis Unit (of FAO)
GDP	Gross domestic product
HDI	Human development index
HIV	Human immunodeficiency virus
HMIS	Health management information system
HSC	Health Sector Committee
IASC	Interagency Standing Committee
IBRD	International Bank for Reconstruction and Development
ICD	International Cooperation for Development
ICDP	International Child Development Programme
ICRC	International Committee of the Red Cross
IDP	Internally displaced person
IFRC	International Federation of Red Cross/Red Crescent Societies
ILO	International Labour Organisation
IOM	International Organization for Migration
ITN	Insecticide-treated nets

KEMRI	Kenya Medical Research Institute
MDGs	Millennium Development Goals
MOHL	Ministry of Health and Labour (northwest Somalia)
MSF	Médicins sans frontières
NES	Northeast Somalia
NWS	Northwest Somalia
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OECD	Organisation for Economic Co-operation and Development
PHC	Primary health care
SACB	Somali Aid Coordination Body
SCS	South/central Somalia
SRCS	Somali Red Crescent Society
STI	Sexually transmitted infections
TFG	Transitional Federal Government (for Somalia)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDCP	United Nations Drugs Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner on Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
UNTP	United Nations Transition Plan
USAID	United States Agency for International Development
WASH	Water, sanitation and hygiene
WB	World Bank
WFP	World Food Programme
WTO	World Trade Organization

Executive summary

WHO's Country Cooperation Strategy (CCS) defines the Organization's strategic framework and medium-term vision for working in and with a particular country. The CCS, developed in the context of global and regional health priorities, examines the overall health situation in the country, including the state of the health sector, the socioeconomic status of the population and the major health determinants. It goes on to identify the major health priorities and challenges and frame WHO's support over the next four to six years. The CCS does not preclude other ad hoc technical assistance in response to specific requests from the country.

The present CCS sets out WHO's strategic framework for Somalia, where 18 years of war, armed conflict and insecurity have had a devastating effect on the health sector. The current situation is at worst level since the beginning of the civil war in 1991, with unprecedented levels of child malnutrition, levels of displacement, and conflict and insecurity in some parts of the country. Continuing conflict has left most health facilities looted, damaged or destroyed. A large percentage of health professionals have left the country; the few who remain are often inexperienced and poorly trained. The health sector faces overwhelming challenges in bringing humanitarian relief to a country where nearly two decades of lawlessness have resulted in the collapse of central government, vast numbers of internally displaced people, poor security conditions and a scattered nomadic population that struggles to survive in the face of repeated

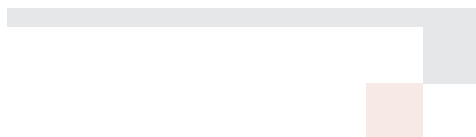
droughts and food insecurity. Although Somalia depends entirely on external assistance, there has been no sustained United Nations presence in Mogadishu since the mid 1990s, and external support tends to be fragmented and uncoordinated.

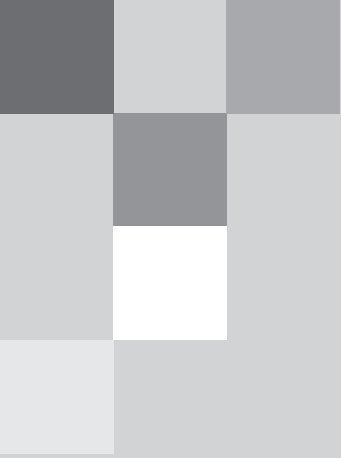
This CCS is the result of a preliminary health sector review and WHO missions since 2004. WHO has visited Nairobi and Hargeisa, consulted with health authorities in northwest Somalia, northeast Somalia and south/central Somalia, and conferred with key UN agencies, bilateral and multilateral donors and the international humanitarian community. While a national planning cycle is not yet established, the CCS as the interim health sector strategy was endorsed by health authorities of Somalia and coincides with the time-frames and cycles of the health system strengthening programmes of both the GAVI Alliance and Global Fund to fight AIDS, Tuberculosis and Malaria. This synchronization allows for better collaboration and coordination of programmes in line with the principles of the Paris Declaration on Aid Effectiveness, to which WHO is a signatory.

WHO's medium-term support to Somalia will be guided by a strategic approach that encompasses a comprehensive longer-term perspective. In the immediate future, WHO will support critical priorities including reducing child and maternal mortality; strengthening communicable disease programmes; improving water supply and sanitation; strengthening human resources development; advocating for health and mobilizing financial resources.

WHO's support for the country's long-term health sector development will be focused on supporting the development, implementation, monitoring and evaluation of a national health and development plan based on six priority areas of intervention: health system development; priority health programmes; social determinants of health and health equity; emergency preparedness and response; and coordination and partnerships.

The situation of health and health services in the three zones of Somalia are outlined in sections 2, 3 and 4. This information provides the basis for the formulation of critical priorities for support to the health sector and the articulation of the strategic agenda for WHO cooperation in section 5, in line with WHO's overall policy framework. Section 6 summarizes the implications for WHO in implementing the strategic agenda for Somalia in 2010–2014.





Section

1



Introduction



❖ Section 1. Introduction

The Country Cooperation Strategy (CCS) reflects a medium-term vision of WHO for technical cooperation with a given country and defines a strategic framework for working in and with the country. The CCS process, in consideration of global and regional health priorities, has the objective of bringing the strength of WHO support at country, Regional Office and headquarters levels together in a coherent manner to address the country's health priorities and challenges. The CCS, in the spirit of Health for All and primary health care, examines the health situation in the country within a holistic approach that encompasses the health sector, socioeconomic status, the determinants of health and upstream national policies and strategies that have a major bearing on health. The exercise aims to identify the health priorities in the country and place WHO support within a framework of 4–6 years in order to have stronger impact on health policy and health system development, strengthening the linkages between health and cross-cutting issues at the country level. This medium-term strategy does not preclude response to other specific technical and managerial areas in which the country may require WHO assistance.

The CCS takes into consideration the work of all other partners and stakeholders in health and health-related areas. The process is sensitive to evolutions in policy or strategic exercises that have been undertaken by the national health sector and other related partners. The overall purpose is to provide a foundation and strategic basis for planning as well as to improve WHO's contribution to Member States towards achieving the Millennium Development Goals (MDGs).

The CCS for Somalia is the result of analysis of the health and development situation and of WHO's current programme of activities. During its preparation key officials within the Ministry of Health as well as officials from various other government authorities, United Nations agencies, nongovernmental organizations and private institutions were consulted. The critical challenges for health development were identified. Based on the health priorities of the country, a strategic agenda for WHO collaboration was developed.



Section

2



Country Health and
Development Challenges



Section 2. Country Health and Development Challenges

2.1 Country brief

Somalia covers a surface area of 637 657 km² and borders Djibouti, Ethiopia and Kenya, with coastline on the Gulf of Aden and the Indian Ocean.¹ Its long coastline and multiple borders mean Somalia has long been an important trading zone, with cross-border trade and international import and exports through various ports. Due to prolonged conflict and lawlessness, regulation of the flow of goods is extremely difficult. Recently, sea piracy has made the Gulf of Aden the most dangerous shipping route in the world.

The Somali Republic was created on 1 July 1960. Somalia is populated by a resilient and highly independent people whose nomadic heritage plays a major role in determining their collective persona. Somali culture has evolved to survive in the harsh and arid environment of the Horn of Africa. Following the civil war of 1991, the country now consists of three zones: northwest Somalia (NWS), known as Somaliland; northeast Somalia (NES), known as Puntland; and south/central Somalia (SCS). Each has its own quasi administration.

The northern part of the country is mountainous, with a coastal strip running along the Gulf of Aden. Undulating plains characterize central and southern Somalia. Rising in Ethiopia, the Juba and Shabelle are Somalia's only perennial rivers. The Somali climate is generally dry and semi-arid. The

average daily temperature varies between 25 °C and 37 °C. In the central region it is warmer and in the south it is tropical. Average rainfall also varies: in the northwest and northeast it is around 400 mm, in the dry central region it is 100–150 mm and in the south it is 400–500 mm. There are four main seasons, dictated by shifting wind patterns, which determine pastoral and agricultural activities.

Somalia has a clan-based society, with clan membership playing an integral role within socioeconomic and political arenas. The clan is an important social unit, where collective responsibility and clan relationships form the basis for traditional agreements including dispute settlement. Major clans include Hawiye (25% of the population), Isaaq (22%), Darod (20%), Rahanweyn (17%), Dir (7%), Digil (3%), and other ethnic minorities (6%).²

Somali is the official language of Somalia and spoken by most people. It is also the language of instruction in schools, although Arabic, English and Italian also are used.

2.2 Socioeconomic profile

2.2.1 Overview

Since 1991, Somalia has been in a state of violence and civil strife. As a result, social and economic infrastructure has collapsed and hundreds of thousands of people have been displaced. Security continues to be a fundamental concern. Each zone has its own

¹ NWS covers a geographical area of 176 000 km², NES 212 510 km² and SCS 388 800 km²

² Central Intelligence Agency 2002

administration. The authorities in NWS have judiciary, legislative and executive systems. Similar ministries exist in NES. In SCS, which has experienced chronic conflicts since 1991, with recent escalation of hostilities, the security situation has severely hindered and restricted international humanitarian assistance.

Human development progress has been limited in Somalia. Sustained conflict has hampered progress towards achieving the MDGs. The prevailing conflict situation has led to a continuing lack of governance institutions and institutions of economic management and destroyed infrastructure of economic and social sectors. Continuing and widespread population displacement and stunted socioeconomic opportunities have all contributed to the limited progress documented on MDG achievement. The latest human development index for Somalia was only 0.299.³

Population estimates for Somalia are contentious. The last population census was conducted in the 1970s. All population estimates since then have been derived through projections based on these figures as well as services and/or household surveys (for example national polio vaccination campaigns). Somalia's current population is estimated by UNDP to be roughly 8 million, although other estimates range from 6 to 11 million. Conflict has resulted in considerable displacement, and hence debate persists about both the size of the population and

its geographical distribution. According to UNDP estimates, 70% of the population lives in SCS.⁴ One third of the population is estimated to be urban, with the remaining two thirds living in rural areas. Currently 1.6 million people are displaced across the country.⁵ A 2002 UNDP survey found the average household consisted of 5.8 persons, with nearly 50% of the population under the age of 15. Over 80% of the population was estimated to be illiterate (65% urban and 89% rural).

Somalia is experiencing its worst humanitarian crisis since 1993. Conflict, combined with the economic shocks of increased global food and fuel prices and the collapse of the Somali currency, has created unprecedented levels of poverty. Around 43% of the population lives in extreme poverty (less than US\$ 1 a day) and 73% live on less than US\$ 2 a day, with ever-increasing destitution rates.⁶

According to the most recent food security and nutrition assessment,⁷ 3.64 million people—approximately half of the population—are in need of emergency livelihood and lifesaving assistance. This high proportion of the population that is in need confirms that Somalia is one of the worst humanitarian emergencies in the world. Developments over 2009 represent a serious deterioration in food security and nutrition situation even since the beginning of the year.

³ MDG report for Somalia. UNDP, 2007

⁴ Population estimates and projections for Somalia 2005–2009. Nairobi, UNDP Somalia, 2005

⁵ OCHA 2009

⁶ World Bank 2007

⁷ Post Gu Analysis. Technical series report no. VI.24, Nairobi, Food Security and Nutrition Analysis Unit, 2009

Food security and malnutrition are of most concern in SCS. This can be attributed to several factors including escalated conflict, severe drought, high food and non-food prices, widespread displacement and lack of humanitarian access.

2.2.2 Economy

Due to the complexity, dispersion and informal nature of the Somali economy, most figures are educated guesses. Somalia's GDP is estimated at US\$ 2.5 billion, with a growth rate of 2.6% (roughly US\$ 320 per capita).⁸ Remittances by the Somali diaspora, estimated at US\$ 1 billion per year, are regarded as one of the pillars of the economy, and essential to the survival of large portions of the population. Telecommunications are reliable; money transfer and exchange services fill the gap left by a nonexistent formal banking sector. Total reported exports have risen from an estimated US\$ 117 million in 2000 to US\$ 380 million in 2007,⁹ demonstrating how entrepreneurs are able to thrive in a compromised security context.

Somalia's average per capita income ranges from US\$ 226 to US\$ 320 per annum.¹⁰ Among the economically active population, total employment is at 52.6% (38.5% for urban and 59.3% for rural and nomadic areas).¹¹ The country has a sizeable diaspora, with over a million Somalis residing in Canada, the Netherlands, Scandinavian countries, United Kingdom and the United

States of America as well as neighbouring Djibouti, Ethiopia and Kenya.¹²

The economy is mainly based on agriculture, livestock and fishery, which account for 65% of export earnings. Somalia has to import 60% of basic food needs, a situation which has major implications for the country's ability to buffer itself from international food security and economic crises.

Governance remains weak even in relatively peaceful areas. NWS and NES have formal budgets, but most expenditure is on security and salaries. The budget in NWS was estimated at between US\$ 22 million and US\$ 26 million in 2007, of which 80% of revenue came from the port of Berbera. In SCS, there is a no approved public budget, and severe lack of central public revenues and financial management and accountability mechanisms.

2.2.3 Social determinants of health

Education

Somalia's education system has been severely crippled by internal conflict, resulting in an increasingly unstable and insecure environment. School enrolment reached its lowest point in 1994, with most if not all schools destroyed, materials unavailable, and teachers and students abandoning the educational process. Somalia's primary education gross enrollment ratio of around 20% is arguably the lowest in Africa, easily

⁸ Economist Intelligence Unit, 2008

⁹ International Monetary Fund, Direction of Trade Statistics <http://www.imf.org/external/pubs/cat/longres.cfm?sk=20721.0>

¹⁰ World Bank 2002

¹¹ Population Reference Bureau 2008

¹² UNICEF Multiple Indicator Cluster Survey 2006

one half the levels of Ethiopia and Sudan, and one quarter the level of Kenya. In recent years, as stability and security have increased, local communities have taken impressive steps to re-build education, drawing on the limited resources available. The international community has also begun to provide limited support for these local initiatives. Thus over the past four years, enrollment rates have increased at an annual rate of around 20% (starting at less than 10% in 1998). The major gains are in urban areas, with a sharp drop-off in educational opportunities in rural areas, especially for the children of nomadic pastoralists. There is a “lost” generation of adolescents who were unable to attend school as children, yet now seek academic and vocational training in order to improve their prospects for employment. Table 1 shows the most recent education indicators, indicating the low level of enrollment, attendance and completion rates as well as highlighting the gender inequity in education. For example, the most recent gender parity indices show that for every 10 boys who attend primary and secondary school, there are 8 girls and 5 girls, respectively.

Water supply

Somalia is an arid country, with severe water scarcity and a sparsely scattered population. The mean annual rainfall is 282 mm, with one of the highest inter-annual variations of rainfall of any mainland African state. The total per capita availability of water is classed as “stressed” and very little of this water is actually accessed. Most water accessed is used for agriculture and livestock, and very small quantities are for personal use (drinking and hygiene). Water quality is poor, with access to potable water limited due to high levels of turbidity, high mineral content, chemical and biological contamination.

Most of the population (pastoralists, semi-settled agro-pastoralists and some permanent village dwellers) lives in rural areas. Water demands are met by rivers (seasonal in NES and NWS), springs, rainwater harvesting facilities, shallow wells and deep boreholes. Water shortages usually occur during the long dry season (*jilaa*) when the population can only rely on the two permanent rivers and groundwater supplies. A 2006 survey found that only 29% of the population used an improved source

Table 1. Education indicators for Somalia (2006)

Indicator	Value
Net intake rate in primary education (%)	9
Net primary school attendance rate (%)	23
Net secondary school attendance rate (%)	7
Primary completion rate (%)	4
Gender parity index: Primary school	0.8
Gender parity index: Secondary school	0.5
Adult literacy rate (%)	25

Source:¹²

of drinking water (58% in urban areas, 14% in rural areas, 4% in nomadic groups). Water collection is a significant burden and source of tension leading to outbreaks of violence and disputes.

Around 65% of the population does not have reliable access to safe water throughout the year. Most people with access to safe drinking-water and adequate sanitary disposal reside in urban areas. Access to potable water and sanitation is severely restricted in many rural areas, particularly for nomadic populations. Most people without access reside in SCS. However, the numbers of people without access in NWS and NES are significant in their own right. Drought and internal displacement severely constrain access to water, with supply needs often met through costly trucking of water to water storage facilities in permanent settlements or directly to grazing areas.

Sanitation and hygiene

Less than half the population live in households with the sanitary means of excreta disposal.¹³ The lack of clean water contributes significantly to high rates of illness and death. The impact of poor environmental sanitation is particularly felt in cities, towns, large villages or other places where people live in close proximity. Defecation is generally close to dwellings and water resources, and lack of refuse collection affects the urban environment and water sources. Poor hygiene and environmental sanitation are major causes of diseases such as cholera among children and women. Cholera is endemic and claims hundreds of lives annually, particularly in

densely populated areas. Access to clean water is essential to prevent diarrhoeal diseases and cholera.

Nutrition

Somalia's rates of malnutrition rank among some of the worst in the world and saw marked deterioration during 2009. Malnutrition is widespread due to a range of factors including food insecurity, low purchasing power, unhealthy feeding practices and lack of access to safe water and sanitation. The proportion of children who are acutely malnourished rose from one in six in January 2009 to one in five by end September 2009. One in 20 children is severely malnourished, placing several geographical areas firmly above internationally-recognized emergency nutrition levels. The Food Security and Nutrition Analysis Unit (FSNAU) estimates that 285 000 children under 5 years of age are acutely malnourished, out of which 70 000 are severely malnourished and are at risk of death without appropriate specialist care.

Environmental concerns

Insecticides are widely used in farming, including in the cultivation of *khat* leaves (in Kenya), fruit and vegetables. There are problems of rangeland degradation, deforestation, coastal desertification, sand dune encroachment and depletion of wildlife. Natural environments are degrading owing to the clearing of forests and bushland in rangelands to make charcoal for export. Suspected dumping of highly toxic waste along the Somali coastline by ships from

¹³ *Urban water and sanitation in Somalia*. UNICEF, 2009

outside the country represents a serious environmental health issue requiring urgent attention and action by the international community.

Gender and equality

Gender segregation is deeply rooted in traditional Somali socio-cultural structures, and remains a formidable barrier to women's participation in decision-making processes and access to – and control of – resources. Female marginalization is also a result of lack of education and self-reliance. Women's participation in governance and respect for human rights in Somalia fall short of those expressed in internationally-recognized instruments such as the Convention on the Elimination of all Forms of Discrimination Against Women and the Beijing Declaration and Platform for Action. Gender-related

disparities remain an area of major concern, especially in the field of education. More boys than girls are enrolled in primary, secondary and tertiary education. Moreover, there is a higher dropout rate for girls. Despite recent successes, the representation of women in parliament remains very low at 12%.³

2.3 Health profile

2.3.1 Overview

Years of war and institutional decline have resulted in very poor health status in Somalia. The population is largely destitute and totally dependent on remittances and international aid flows, and has limited access to the health system.

The population-based health survey information, provided in Table 2, indicates a major decline in mortality rates for women,

Table 2. Selected health indicators: estimates for 1997–1999 and 2006

Indicator	1997–1999	2006
Under-5 mortality rate (per 1000 live births)	224	145
Infant mortality rate (per 1000 live births)	132	86
Neonatal mortality rate (per 1000 live births)	NA	41
Maternal mortality rate (per 100 000 live births)	1600	1044–1400
Measles vaccination coverage before age 1 (%)	16	19
DPT1 coverage (indicator of access) (%)	57	20
DPT3 coverage (indicator of utilization) (%)	33	12
Children acutely malnourished (low weight for height) (%)	17	12
Antenatal care attendance (%)	32	26
Women vaccinated against tetanus (%)	24	NA
Access to safe drinking-water (%)	23	29

Source: UNICEF Multiple Indicator Cluster Surveys, 2001 and 2006
NA Information not available

infants and children in Somalia over the past decade, yet no clearly associated improvements in the overall situation or access to vital public services. The decline may be associated with small improvements in access to food and clean water, and awareness of their importance. However, other data sources tracking the nutritional situation have not indicated such declines and maintain that levels of acute malnutrition remain high across Somalia and are currently worsening due to the unstable political and worsening humanitarian situation.

Despite the lack of coherence in overall statistics (coverage versus mortality), they indicate there are major gains to be made through increasing and sustaining high levels of vaccination coverage and basic health, water and sanitation services, as well as improved food security with particular focus on improving feeding practices and the quality of food for young children.

In terms of progress toward achieving Millennium Development Goals, Somalia has seen a gradual improvement in maternal, under-five and infant mortality rates.³ However, the current humanitarian crisis and implications for maternal and child health may jeopardize the recent health gains.

According to UNDP, the maternal mortality rate per 100 000 live births declined from 1600 during 1987–1990 to 1044 in 2006. Achieving the target for 2015 will mean that the rate should be reduced to at least 400. The current chronic and complex emergencies, due to lack of quality health care services and record low levels of literacy among the population, particularly among females, may limit progress in achieving this target.

Communicable diseases

The prevalence of communicable diseases such as malaria, tuberculosis, vaccine-preventable diseases, acute respiratory infections and diarrhoeal diseases is high, causing high morbidity and mortality, while tropical and neglected diseases such as visceral leishmaniasis, schistosomiasis and leprosy are also prevalent.

During 2008, the leading reported causes of morbidity were: acute watery diarrhoea, 77 962 cases with 432 associated deaths; malaria, 27 567 cases including 18 deaths; bloody diarrhoea, 16 255 cases with no deaths; and measles, 560 cases with no deaths.

The main causes of mortality were meningitis, with 9.2% case fatality rate (CFR); neonatal tetanus, 7.9% CFR; whooping cough, 1% CFR; and acute watery diarrhoea, 0.6% CFR. Table 3 shows the morbidity trends of 2007 and 2008. In 2008, increased case detection and response was possible due to the establishment of an early warning and response system and timely health interventions, which resulted in reduced morbidity and case fatality rates compared to 2007.

Malaria is hyper-endemic in SCS and hypo-endemic in NES and NWS. Different prevention and control strategies are adopted in the different zones. Case management is standard and comprises artemisinin-combination therapy. In NES and NWS, biological measures are used combined with early diagnosis and prompt treatment of cases, and with insecticide-treated nets (ITNs) in endemic areas. In SCS, control measures include the use of long-lasting

Table 3. Communicable diseases in Somalia, 2007–2008

Health event	2007		2008	
	Cases	Deaths (CFR)	Cases	Deaths (CFR)
Acute water diarrhoea	11 818	1 348 (11.4)	77 962	432 (0.6)
Bloody diarrhoea	25 346	28 (0.11)	16 255	0 (0)
Meningitis	246	20 (8.13)	294	27 (9.2)
Measles	1 149	4 (0.35)	560	0 (0)
Malaria	43 423	35 (0.08)	27 567	18 (0.1)
Whooping cough	1 738	3 (0.17)	504	5 (1.0)
Neonatal tetanus	41	11 (26.82)	266	21 (7.9)

ITNs, intermittent presumptive treatment for pregnant women, early diagnosis and prompt treatment.

In 2007, an HIV/AIDS and sexually transmitted infections (STI) sero-surveillance survey was conducted by WHO in Somalia and showed an HIV prevalence rate of 0.9% among antenatal care attendants in the three zones (1.4% in NWS, 1.0% in NES and 0.6% in SCS). In addition, the same survey found a prevalence rate of HIV of 4.3% among those with STI. HIV and AIDS are considered as a low concentrated epidemic in NES and SCS. When examining the burden of treatable STI (gonorrhoea and chlamydia) among pregnant women in Mogadishu, Bosasso and Hargeisa, the figures showed an average rate of 2.5%. The prevalence of syphilis among pregnant women is still low at 1.1%. The 2007 WHO survey also confirmed a prevalence rate of HIV/tuberculosis co-infection of 4.5% among newly confirmed tuberculosis patients.

Currently, Somalia has 20 voluntary counselling and testing sites, 5 sites prescribing antiretroviral therapy and

providing supply chain management and voluntary counselling and testing services and 5 sites providing follow-up antiretroviral therapy, supply chain management and voluntary counselling and testing services. In 2007, WHO and UNAIDS projected that around 23 480 Somalis would be living with HIV by 2009 and around 25% (5977) of them would require access to antiretroviral therapy and care. Currently, 700 patients are on antiretroviral therapy, which reflects around 12% of the projected figure.

As reported by a tuberculin survey which was conducted in 2006, tuberculosis prevalence is high in Somalia. The latest estimates indicate that around 18 500 people develop tuberculosis every year (217 per 100 000 population), out of whom 8500 are smear-positive. The estimated current annual risk of tuberculosis infection is 1.96% (0.51%–2.8%). Assuming a Styblo ratio of 50, an annual positive sputum smear (SS+) incidence of 98 (26–141) per 100 000 population can be expected. The majority of tuberculosis patients are young: 71% of SS+ cases belong to age groups between 15 and 44 years.

In 2007, UNDP reported that Somalia's progress towards achieving Millennium Development Goal 6 was on track for the target related to tuberculosis, whereas progress towards targets related to HIV/AIDS and malaria were lagging.

Vaccine-preventable diseases are prevalent. Measles is estimated to be the major cause of deaths among children under five. The UNICEF multiple indicator cluster survey in 2006 indicated that only 5% of children had been fully immunized by their first birthday; only 12% of children received a DPT3 dose; and the coverage for measles vaccination by 12 months was only 19%.

Somalia achieved polio-free status in 2002 with the concerted efforts of partners. It remained polio-free until July 2005, when a wild poliovirus that originated from Nigeria was detected and left 230 young children paralysed. To interrupt wild poliovirus transmission, Somalia implemented more than 25 rounds of polio supplementary immunization activities, and became polio-free again by March 2007. This was supported by acute flaccid paralysis (AFP) surveillance indicators, which have remained above the international certification standard since then.

Leprosy is another disease that causes significant disability. Despite the gradual elimination of leprosy worldwide, elimination activities have yet to begin in Somalia. Leprosy is endemic in SCS. WHO in collaboration with World Concern International supports the control and management of leprosy. Schistosomiasis is highly prevalent along the riverine areas in SCS of Somalia.

Noncommunicable diseases

As detailed in Table 4, the situation of malnutrition has seen a considerable deterioration across Somalia over 2009. FSNAU and partners reported that in 2009, global acute malnutrition among children aged 5–9 months was 19%, an increase of 17% from the last round of comparable surveys within 2009. In many parts of the country, rates of severe acute malnutrition remained high, with a median rate of 4.6%. SCS is disproportionately affected by the high rates of malnutrition and accounts for 70% of all acutely malnourished children in Somalia, with a rate of 19.6% (excluding IDP communities).

The prevalence of blindness in Somalia is unknown, although it is reasonable to assume that most causes of blindness can

Table 4. Prevalence of malnutrition in different zones of Somalia (2009)

Zone	Global acute malnutrition (%)	Severe acute malnutrition (%)
All (including IDPs)	19.0	4.6
All (excluding IDPs)	18.0	4.5
IDPs	20.1	4.8
NWS (excluding IDPs)	15.0	3.3
NES (excluding IDPs)	17.3	3.3
SCS (excluding IDPs)	19.6	4.6

Source:⁷

be prevented and cured. In 2008, the main causes of severe visual impairment were cataract (37%) and glaucoma (6%). WHO, in collaboration with Manhal International and health authorities, has trained doctors and provided cataract kits, surgical equipment and materials for eye-care centres across Somalia. In 2008, at least 11 000 eye operations were carried out through eye-care camps organized by a local branch of Manhal International.

In 2008, many people were displaced, injured or killed due to fighting in Mogadishu and in SCS. At least one million people are estimated to be experiencing mental health and social problems. *Khat* consumption and other drug use contribute to the burden of mental disorders. There are four mental health centres in the country: two in NWS, one in Bosasso and another one in Mogadishu. In 2008, 2500 people with mental health disorders were treated in NWS and SCS. An initiative to improve the quality of mental health services—the Chain-Free Initiative—has been established in Mogadishu and will be expanded to include the mental health unit in Hargeisa.

No surveys have yet been conducted to estimate the prevalence of cardiovascular diseases, hypertension, diabetes mellitus and other chronic noncommunicable diseases, although smoking, sedentary lifestyles, diet and other harmful lifestyles are widespread.

Reproductive health

Somalia's maternal mortality rate is estimated to be 1044 per 100 000 live births, one of the highest in the Region.³ This corresponds to a lifetime risk of one maternal

death for every 10 women. Other corrected estimates arrive at even higher numbers. The high maternal mortality rate is to a large degree rooted in obstetric complications such as young age at first birth, high fertility, low skilled attendance at birth, suboptimal nutritional status and prevalence of female genital mutilation (FGM). The main causes of maternal deaths in Somalia are believed to be antepartum and postpartum haemorrhage, obstructed labour, pregnancy-induced hypertensive disorders and puerperal sepsis.

Obstetric fistula is the most serious cause of maternal morbidity. Other causes include chronic infections, urinary disorders, chronic anaemia and malnutrition, secondary infertility and post-traumatic psychiatric disorders. Normal delivery care in Somalia is characterized by a vast majority of home births conducted by unskilled women, with significant urban–rural and socioeconomic differences in access to safe delivery. Apart from a few hospitals, skilled birth attendance is rare.

Human resources

The health sector suffers severely from the lack of skilled and qualified staff, structural fragmentation, insufficient salaries and almost nonexistent supervision of health services and management structure of the health system. Over half of SCS health staff is unskilled and most professional staff receives no structured in-service training. A recent assessment of maternal and child health in NWS found that 70% of staff had no formal training or qualification. There is no budget to recruit newly trained staff from nursing and medical schools and consequently they join the private health sector or go overseas.

Since there are no proper structures and procedures, there is no human resource development policy or plan, no job descriptions, no formal in-service training or career development path, and no mechanism for performance assessment. Training results in substantial numbers of new nurses and even some doctors entering the workforce, but very few work for nongovernmental organizations or the public sector.

Health training institutions do not have accreditation systems and standardized curricula. The shortage of qualified and competent teachers, lecturers and tutors is a key concern. Furthermore, training institutions concentrate on turning out nurses and doctors (there is some training for midwives in Hargeisa) but do not produce the diverse range of other cadres needed to manage and implement health services (e.g. administrators, laboratory technicians, pharmacists, pharmacy and X-ray technicians and community health workers).

There is currently a unified nursing curriculum in place across the country, developed by WHO and training institutions. Efforts are ongoing to unify midwifery teaching.

The most recent estimates show that the average health workforce ratios are very low in Somalia: 3 physicians per 100 000 population (253 physicians) and 11 nurses per 100 000 population (861 nurses). There is an acute shortage of midwives reflected in a ratio of 2 midwives per 100 000 population, a total of 116 midwives (Table 5).

Health system/service delivery

Somalia's public health care system is tiered, comprising regional referral hospitals, district hospitals, maternal and child health centres and health posts. However, hospitals and health facilities are limited in number, inadequately distributed, operate using vastly different standards, and often cannot provide a minimum package of primary health care (PHC) services. There is limited standardization

Table 5. Number and categories of the health workforce in Somalia, 2007

Category of health workforce	SCS			NWS		NES			Grand total
	Total	Public sector	Private sector	Total	Public sector	Private sector	Total		
Physicians	94	43	42	85	32	42	74	253	
Pharmacists	4	NA	NA	NA	14	3	17	21	
Qualified nurses	189	240	96	336	128	208	336	861	
Qualified midwives	10	44	15	59	29	18	47	116	
Auxiliaries and technicians	333	462	242	704	160	215	375	1412	
Total	630	789	395	1184	363	486	849	2663	

NA Information not available

Source:¹⁴

¹⁴ UNDP population projections, 2007

in terms of infrastructure, staffing and service delivery. Most facilities operate at a level far below their intended capacity and are poorly organized, staffed and managed, with very low utilization rates as a result. Overall coverage of essential PHC services is low, especially for rural and nomadic populations. Health facilities in urban areas are easy to access and benefit more from facilities run by nongovernmental organizations and private health providers, resulting in fewer services for remote communities. Similarly, most health personnel are concentrated in major towns, leading to a shortage of qualified workers in rural areas. The public health care system operates in a fragmented manner, maintained largely by medical supplies provided by UNICEF and other agencies. In the absence of an efficient and adequate public health care system, the private sector has flourished but remains unregulated with poor quality of services and poor access to the rural population (Table 6).

Data are scant and incoherent. An analysis of 2007 HMIS data indicates that utilization rates are 0.13 per person per year: in other words, the average Somali visits a public health facility once every eight years. DPT1

and DPT3 coverage rates can serve as a proxy for access and utilization; they confirm that the use of public health services is very low. Various other surveys indicate that between 50%–75% of the population use private pharmacies and private health services if, and when, they do use modern health care services, and less than 20% of the population use public sector services.

Essential medicines

Somalia's essential medicines programme ceased with the collapse of central government. Access to essential medicines, particularly through public health services, is low and variable depending on the local presence of donor-supported programmes. Procurement and distribution of medicines and supplies must be urgently improved. Currently, maternal and child health centres and health posts largely depend on essential medicines and supplies, in the form of pre-packed kits, provided by UNICEF as the major supplier for the country. WHO provides tuberculosis medicines and supplies, blood safety supplies, laboratory equipment and supplies, but also medicines and supplies, in the form of pre-packed kits, for emergencies

Table 6. Number and types of health facility in all zones of Somalia, 2008

Zone	Health post	Maternal and child health centre	District hospital	Referral hospital
NWS	160	70	8	1
NES	120	44	4	1
SCS	264	134	15	5
Total	544	248	27	7

Source:¹⁵

¹⁵ UNICEF Somalia, 2008

and outbreak response and emergency hospital services. The role of the health authorities is mainly limited to coordination. Medicines are frequently in short supply at service delivery points.

Health workers prefer to prescribe branded medical products since they guarantee greater sales value and so increase potential incentives. Medicines available in private pharmacies are often costly and of poor quality. Attempts to develop a national essential medicines policy have been initiated in NWS through donor assistance, but need to be institutionalized.

Health management information system

Despite efforts to strengthen the health management information system (HMIS), data collection and analysis remain fragmented, with different United Nations agencies, vertical programmes and nongovernmental organizations using their own formats to collect data and their own systems to generate data. An epidemiological surveillance system for key diseases exists but requires improvement, especially for reporting and analysis. Health posts and maternal and child health centres provide monthly summaries of their PHC activities. Hospital data are incomplete and unreliable, and no data are collected from facilities of the private sector. HMIS software has been developed jointly by WHO and UNICEF, but is not widely used.

2.3.2 Health profile of northwest Somalia

Health system

The Ministry of Health and Labour (MOHL) is weak and under-resourced. Health departments lack the technical and logistic capacity to supervise and monitor activities. Public health services depend heavily on donor aid for most operations, including staff incentives. Donor support accounts for most of the operational and medicine supply costs, materials and salaries of health workers. Aid is provided through an ad hoc service delivery framework that depends on donor preference rather than the expressed need of the beneficiaries. Health care services have neither the capacity nor the resources to meet the health demands of the population. Moreover, weakly functioning structures and systems make it difficult for donors to efficiently coordinate their support on the ground efficiently. Health care legislation, regulatory policies and operational guidelines to ensure quality care are also lacking.

Health infrastructure

Conflict has left 90% of health infrastructure looted or severely damaged with most trained health personnel having left the country. Some services have been rehabilitated with the help of the donor community. Currently, Hargeisa Group Hospital, five regional hospitals, two tuberculosis hospitals, one specialized mental health hospital and a number of maternal and child health centres and health posts are providing health care services. However, they have limited outreach and scant delivery capabilities at the peripheral

level. They lack medicines and supplies, have no running water and sanitation systems, and are open for only a short period of time during the day. Therefore, most people choose to go to traditional healers, private health clinics, pharmacies and other agents, in spite of the poor quality and expensive services and medicines offered by these outlets. Religious leaders are also consulted.¹⁶

Human resources

Several donors and agencies including UNICEF, WHO, International Child Development Programme (ICDP), CARE International, Somali Red Crescent Society (SRCS) and Cooperazione Internazionale (COOPI) provide technical and operational support for on-the-job training activities. Establishment of the WHO supported health science institute in Hargeisa for formal training of nurses and allied health staff is a significant development, since training is among the most urgent priorities in health system strengthening. Training for medical staff is provided through the medical schools of two universities in Hargeisa and Boroma-Amood, which are funded by the diaspora, business communities and Islamic organizations. Therefore training institutions are run mainly on a non-profit basis. On-the-job training is not coordinated or standardized.

Health sector reform

NWS is in the process of reforming and restructuring its health sector in order to move from vertical programmes and projects to an integrated approach where health services

are delivered through an essential health package focused on the needs of the poor. With WHO's assistance and support, the MOHL has established a health sector reform unit. New management and organizational structures have been developed with the aim of involving communities through village committees and supporting greater local autonomy in decision-making and allocation of resources. The health sector reform is based on decentralization, with districts and communities playing a central role. The current political and administrative environment in NWS is conducive to a shift from donor-driven, emergency, and ad hoc health interventions to sector development that addresses issues of efficiency, quality, equity and sustainability. Health sector reform strategies include the following:

- ❖ Assessing the impact of decentralization on the existing health sector policy.
- ❖ Establishing a district health management system in which health management teams in selected districts will be the primary managers of direct service delivery.
- ❖ Strengthening the technical, managerial and operational capacity of community health boards.
- ❖ Developing detailed guidelines on the roles and linkages between the MOHL, the regional health authority and the district health management teams.
- ❖ Strengthening the operational capacity of regulatory bodies including the zonal health council and improving registration of all professionals and professional associations, in order to improve professional standards and ethics.

¹⁶ *The private sector and health: a survey of Somaliland private pharmacies.* UNICEF, 2008

Health management information system

The health systems strengthening component of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Round 8, includes activities to strengthen the HMIS and harmonize standardized reporting and monitoring tools being implemented in maternal and child health centres. Due to security problems in other parts of the country, HMIS activities are mainly concentrated in NWS, and operate with the support of UNICEF. The fragmentation of initiatives does not allow for the efficient use of overall resources available. Data generation of the various information systems in place must be better coordinated in order to establish an integrated system in the future which has been envisaged in Global Fund health system strengthening component.

Communicable diseases

Tuberculosis, malaria and HIV/AIDS are major health concerns. Malaria is hypodemic but still a public health problem, particularly among children and pregnant women, with an estimated annual incidence rate of 2.6%. Of slides examined in 2008, 2% were found to be positive. Treatment for malaria is provided at health facilities. Preventive and control measures include early diagnosis and prompt treatment, breeding of larvivorous fish and distribution of impregnated bed nets in the known high-incidence areas. It is very difficult to contain outbreaks of malaria due to *P. falciparum* in remote areas.

Tuberculosis, with an annual infection rate of 4%, accounts for the highest number of deaths among men and women

of economically active and reproductive ages. WHO-supported DOTS programmes have been adopted in all eight tuberculosis treatment centres. Co-infection with HIV/AIDS presents new problems for tuberculosis control.

The main mode of HIV transmission is heterosexual and is emerging as a major public health threat. A 2008 analysis of data from 1766 young women attending antenatal care in NWS showed an HIV prevalence rate of 1.7% among women aged 15–24 years. Data from the antenatal care site in Berbera, where there is high cross-border mobility, show a steady increase in HIV infection rates, from 0% in 1999 to 2.3% in 2004 to 2.7% in 2007. HIV prevalence among patients with STI from Hargeisa Group Hospital outpatient clinic was 6.3% and was higher among males (7.4%) compared to females (5.4%). STI are also high among the population of reproductive age. Early diagnosis and treatment of STI do not occur due to cultural sensitivities around this issue.

Noncommunicable diseases

Lifestyles and eating habits are rapidly changing, and tobacco consumption is among the highest in the world. A 2008 youth tobacco survey found that around one in five students used tobacco (5% smoked cigarettes and 18% used some other form of tobacco). Environmental tobacco exposure is high: over 30% of students live in homes where others smoke, and approximately 47% are exposed to smoke outside of the home. Only 31% of the students thought smoke from others was harmful to them.¹⁷

¹⁷ Somaliland Global Youth Tobacco Survey Factsheet. Hargeisa, Ministry of Health and Labour, 2007

Cardiovascular diseases, diabetes mellitus and hypertension are on the rise. Road traffic crashes, armed fighting and landmine explosions are very common.

Mental health is another major public health issue that contributes greatly to the burden of disability. Stress due to conflict, combined with the increasing use of *khat* and other psychoactive substances, have resulted in increasing prevalence of mental disorders. Although no survey has been conducted, many patients with mental disorders can be seen in cities and villages. The two mental health institutions (one in Berbera and the other in Hargeisa) are run by a local nongovernmental organization (General Assistance and Volunteer Organization) in collaboration with MOHL and WHO. However, there is a shortage of qualified mental health staff and, despite the availability of appropriate medicines in both facilities, patients are still chained in hospital and at home. WHO is planning to support implementation of the Chain-Free Initiative in Hargeisa Hospital.

Khat chewing is widespread and has significant adverse health implications. A household survey in the city of Hargeisa found rates of severe disability due to mental disorders of 8.4% among males over the age of 12. The rate differed according to war experiences. Clinical interviews conducted verified that in 83% of cases, psychotic symptoms were the most prominent manifestations of psychiatric disorders.¹⁸

Maternal health

A 2006 UNICEF/UNFPA assessment of 85 public and private emergency obstetric care (EmOC) facilities that there was little or no EmOC capacity in many health facilities, low levels of utilization in most areas and that physical access to EmOC is hampered by long distances for rural populations (Table 7).

Between 87% and 95% of all live births in five major NWS hospitals (Edna Adan Hospital, Hargeisa Group Hospital, Burao, Boroma, Gabiley) in 2006 were normal deliveries. However, these referral facilities are underutilized and subject to user fees. Very few of them provide maternity waiting shelters, there is no voucher system, and ambulance services are poor. On average pregnant women make less than two visits for antenatal care per pregnancy, indicating the poor quality of service provided by public health facilities or accessibility. Only 21% of deliveries are attended by trained traditional birth attendants.¹²

Child health

Although routine immunization coverage has increased, it remains as low as 39% in rural and nomadic areas. Cyclic epidemic outbreaks of measles are common. No cases of polio have been reported since March 2007. The drop-out rate for vaccinations is high. Management of vaccine supplies need to be improved, local health staff should be trained on cold chain maintenance and supervision and monitoring needs to be upgraded. More outreach activities and social mobilization are needed.

¹⁸ Odenwald M et al. *Khat* use as risk factor for psychotic disorders: a cross-sectional and case-control study in Somalia. *BMC Medicine* 2005, 3:5. Available at: <http://www.BioMedcentral.com/1741-7015/3/5>

Table 7. Summary of EmOC process indicators in NWS (2006)

Indicator	Value	Minimum level **	Remarks
Population	1 805 381		UNDP 2005 estimation
Coverage of basic EmOC facilities per 500 000 population %	1.1	4	Usage much lower than minimum standard, showing a major gap
Coverage of comprehensive EmOC facilities per 500 000 population %	1.7	1	Usage higher than minimum standard
% all births in EmOC facilities	9.5	15	Showing under utilization
% of expected direct obstetric complications treated	11.4	100	Showing drastic under utilization
% of all births by Caesarean section	0.4	5–15	Well below the minimum level
Case fatality rate (CFR) of direct obstetric complications (%)	21.3	< 1	CFR is very high

** Minimum recommended level according to UN process indicators

Source:²⁰

The average child in NWS experiences several episodes of diarrhoea each year. Diarrhoea is a leading cause of death among children under-five and accounts for 20% of all morbidity.¹⁹ During the twice-yearly child health days, all children under five receive a package of services including vaccinations (measles, DPT, oral poliovaccine), vitamin A supplements, oral rehydration salts, albendazole for de-worming, aqua tabs for water and measurements for nutritional status, while mothers receive tetanoid toxoid vaccination and soap for handwashing.

The FSNAU analysis in September 2009 found that 15% of children under 5 were acutely malnourished and 3% were severely

malnourished (excluding IDP communities). Anaemia is a major nutritional problem among women and children: more than 50% of pregnant women attending antenatal clinics have nutritional anaemia.

Laboratory and blood safety services

There are 11 laboratories in NWS with the laboratory of Hargeisa Group Hospital, with support from International Cooperation for Development (ICD) and WHO, acting as a reference laboratory. Blood banking is available across the zone, however as with other laboratory services is reliant solely on international support for provision of supplies.

¹⁹ Somaliland Annual Health Report 2006

²⁰ UNICEF/UNFPA 2006

Essential medicines

There are around 400 private pharmacies and about 80 private health clinics. There are no qualified pharmacists or pharmacy technicians. Due to the absence of medicine regulatory authorities or a food and drug administration pharmaceuticals are not registered or regulated in NWS, and therefore can be imported without quality control and safety assessment. All medicines are sold over the counter without any restrictions for use. Self-medication of medicines prevails, expired medicines are sold in the market at a very high price, and re-labelling of products is common practice. Private pharmacies sell medicines unregulated to the public. The Government Central Medical Stores maintains warehouses in Hargeisa and in some of the regional capital towns, but its management and operations need urgent improvement. UNICEF provides pre-packed medicine kits for maternal and child health centres and health posts. The MOHL's role is limited to ad hoc requests for medical supplies for communicable disease outbreak response, provided by WHO, UNICEF or international nongovernmental organizations. With WHO's support, an essential medicines list for PHC facilities has been formulated and endorsed. However, there is no agreed list of medicines for hospitals as part of a minimum package of PHC services. With UNICEF's support, a medicine policy, including proposals for a medicine regulatory mechanism and essential medicines lists for hospitals have been formulated. Quality of medicines is of a major concern to the MOHL and initial steps are taken with support of WHO to establish screening units by introducing quality screening kits of medicines, so-called Minilab®.

2.3.3 Health profile for northeast Somalia

Overview

Health status in NES is poor, with infant mortality rates of 86 per 1000 live births, maternal mortality rates of 1044 per 100 000 live births, and under-five mortality rates of 145 per 1000 live births. Fertility and life expectancy rates are 6.7 per woman and 47 years respectively. The main causes of morbidity and mortality are malaria, acute respiratory infections including pneumonia, and diarrhoea, which probably account for more than half of all mortality in children under five. Tetanus (especially neonatal) and tuberculosis are also major causes of mortality. Moreover, outbreaks of measles, cholera, dysentery and meningitis pose major threats to public health.

Health system

There is a functioning Ministry of Health with a policy and strategy framework. However, its primary role is to coordinate the activities of international and local nongovernmental organizations who have assumed health service responsibilities previously handled by the Ministry of Health before the civil war. The Ministry of Health is headed by the Minister, assisted by two vice ministers. The Director-General is responsible for technical aspects and supervises four directors, namely primary health care, training/personnel, administration/general services and planning/medical services. The Ministry of Health provides guidelines and regulations but lacks the capacity, funds and human resources to expand its role in the health sector.

Health infrastructure

Health services are provided by public referral hospitals, maternal and child health centres, health posts and private clinics, hospitals, laboratories, X-ray facilities and pharmacies. Most health facilities are in urban areas.

Primary health care services are provided by maternal and child health centres and health posts. In addition to working in the public sector, most health workers have established private practices which are highly developed but unregulated. Pharmacies operate on a private basis and are unregulated, with no quality control checks. Diagnostic services are also provided by privately owned laboratories and X-ray facilities, mainly on the basis of a doctor's prescription. In 2003, 19% of the population received health care. Almost 16% used modern health facilities, while only 3% resorted to traditional healers. Referral hospitals are ranked second in terms of frequency of usage. 2% of the urban population presented directly at pharmacies without consulting a medical doctor or other health staff.

Human resources

Over 60% of all health staff are community health workers. Doctors and nurses together account for 21% of the total workforce. There is one nursing and midwifery school in Bosasso, funded mainly by Islamic charities and institutions, and one private medical school in Galkayo. In 2006, Galkayo University launched a three-year basic training course to prepare assistant physicians for subsequent deployment to rural and remote areas.

Health sector reform

While policy guidelines and reforms have been formulated, they are not yet implemented due to the severe lack of capacity and financial and human resources, and rudimentary administrative systems. The goal of the *2008–2009 Programme plan and strategy/vision* of the Ministry of Health was to achieve sustainable technical, managerial and financial capacity at zonal and regional levels. Moreover, the plan aims to improve health care coverage and quality of care, to develop efficient health care systems, and to progressively reduce inequalities in access to basic health services. The vision is to increase human resources for health by setting modest goals. This will require building zonal institutions to support decentralization, as well as building small, lean, responsive management systems. The main areas of work for 2008–2009 are health financing, human resources for health and capacity building of health programmes. Progress so far has been slow.

Health management information system

The HMIS in NES is weak and fragmented in structure. Efforts are under way to strengthen the HMIS by harmonizing standardized reporting and monitoring tools, including developing guidelines for the use of HMIS. Furthermore, capacity-building is needed for all health workers involved. HMIS activities will be supported by UNICEF. Data generation of the various information systems in place must be better coordinated in order to establish an integrated system in the future which has been envisaged in the Global Fund component on health system strengthening.

Communicable diseases

Malaria is hypo-endemic in NES. In 2008, 4% of all slides showed to be positive for *P. falciparum*. One of the factors behind the increasing number of malaria cases is the presence of IDPs that have been displaced from SCS. Preventive measures such as distribution of ITNs, breeding of larvivorous fish in water catchment areas and early diagnosis and prompt treatment of malaria are generally lacking.

HIV/AIDS prevalence, estimated at 1%, represents a major threat. A survey of 1705 antenatal attendees in NES found an HIV

mean prevalence of 0.5%, with a mean prevalence of 0.9% among women aged 15–24 years. Patients with STI had an HIV mean prevalence of 2.2%. Prevalence was higher (1.3%) among women aged 15–19 years. Syphilis prevalence among antenatal care attendees was 1.9%.²¹

Tuberculosis is also a major public health problem. The DOTS strategy is being implemented in all eight tuberculosis treatment centres. Tuberculosis and HIV co-infection represents a significant threat to achievements so far. HIV prevalence is around 1%, but rates can easily increase if preventive measures are not adopted by the community.

Table 8. Summary of EmOC process indicators in NES, 2006

Indicator	Value	Minimum level*	Remarks
Population	912 696		UNDP 2002 estimates
Coverage of basic EmOC facilities per 500 000 population	0.5	4	Shows severe under utilization and major gaps in coverage
Coverage of comprehensive EmOC facilities per 500 000 population	2.2	1	Usage higher than minimum standard
% all births in EmOC facilities	0.7	15	Major under-utilization
% of expected direct obstetric complications treated	1.5	100	Underutilization and general low activity at EmOC level
% of all births by Caesarean section	0.6	5–15	Well below the minimum level
Case fatality rate (CFR) of direct obstetric complications (%)	33.1	< 1	The CFR is very high

* recommended according to UN process indicators
Source:²⁰

²¹ Report on sero-prevalence survey, Nairobi, WHO, 2007

Maternal health

Table 8 shows the findings of a UNICEF/ UNFPA assessment of 64 health facilities (15 hospitals, 38 health centres and 11 health posts, both public and private) in 2006.

Three main constraints within EmOC services in NES include a low level of utilization, weak or no EmOC capacity in many facilities and low access hampered by long distances for rural population. NES has no overall referral system between facilities, poor communication and transport networks and a shortage of ambulances. Most nongovernmental organizations are not fully familiar with obstetric care requirements, especially prepaid voucher schemes.

Child health

EPI coverage in NES is below 50% in all antigens. No cases of acute flaccid paralysis have been detected since March 2007. Acute respiratory infections and diarrhoeal diseases are a major cause of morbidity and mortality in NES. Malnutrition among children under 5 years was estimated by FSNAU in September 2009 to be 17.3% and 3.3% in terms of acute and severe malnutrition respectively (excluding IDP communities).

Laboratory and blood safety services

There are four functioning laboratories in NES, in the regional hospitals of Bossaso, Galcayo, Garowe and Gardo. The laboratory at Bosasso General Hospital acts a reference laboratory for NES. Some laboratories have limited availability and capacity of staff as well as availability of essential supplies and equipment. Blood banking services experience difficulties in the regular availability of supplies.

Essential medicines

As in NWS, private pharmacies and health clinics exist in NES. There are no officially qualified pharmacists or pharmacy technicians available. In the absence of medicine regulatory authorities and a food and drug administration, pharmaceuticals are not registered or regulated in NES and can be imported without quality control and safety assessment. All medicines are sold over the counter without any restrictions for use. Self-medication of medicines prevails, expired medicines are sold in the market at a very high price, and re-labelling of products is common practice. Private pharmacies sell medicines unregulated to the public. The Government Central Medical Stores maintain warehouses in Garowe and in some of the regional capital towns, but its management and operations need urgent improvement. UNICEF provides pre-packed medicine kits for maternal and child health centres and health posts. The Ministry of Health's role is limited to ad hoc requests of medical supplies for communicable disease outbreak response, provided by WHO, UNICEF or international nongovernmental organizations. As in NWS, quality of medicines is a major concern and initial steps are being taken with the support of WHO to establish screening units by introducing quality screening kits of medicines, so-called Minilab®.

2.3.4 Health profile for south/central Somalia

Health system

Health authorities are either weak or lacking at all levels in SCS. The Ministry of Health does not have a national policy

or health sector plan in place. The health system is fragmented and health services are offered by a myriad of nongovernmental organizations. There is an acute shortage of qualified health staff throughout the zone. Recently, a six-month minimum package of support to the Transitional Federal Government (TFG) was endorsed by UN to address the identified gaps in human and financial resources. The package includes human resources development (core staff for ministries); office equipment, transportation and running costs; rehabilitation or rental of premises; and community engagement. At this stage, improving operational capacity at state level is crucial. Overall implementation is slow and fragmented due to the unstable and insecure situation in Mogadishu.

The Ministry of Health is expected to redefine its mission, develop a policy framework, reorganize its management structure and draft short-term and medium-term strategic action plans. Job descriptions for key positions have been developed. The Ministry of Health and its donors plan to revive the Ministry at a scale commensurate with the available resources. The Ministry of Health will restrict its role to mainly stewardship: setting policies, standards and programmes; overseeing activities of nongovernmental organizations; managing health information; responding to emergencies; and coordinating donor efforts. The overall objective is to establish an enabling environment in which the Ministry can deliver its key functions through capacity development and institutional strengthening.

The Ministry of Health is grappling with a range of challenges including lack of resources and qualified staff, weak capacities

and political instability. It has produced a preliminary health policy document that will need to be discussed extensively and translated into initiatives to be implemented.

Health infrastructure

Health services are provided by public referral hospitals, maternal and child health centres and outpatient and health posts, and private clinics, hospitals, laboratories, X-ray facilities and pharmacies. Most health facilities are located in urban areas. Basic health services can be ensured at the district level through the sub-contracting of local and international nongovernmental organizations to deliver a defined package of basic health services with a strong outreach component to the communities.

Primary health care services are provided by maternal and child health care centres, health posts and public hospitals. In addition to working in the public sector, most health workers have established private practices which are highly developed but unregulated. Pharmacies operate on a private basis with no quality control checks. Diagnostic services are also provided by privately owned laboratories and X-ray facilities, mainly on the basis of a doctor's prescription.

Human resources

Over half of the health workforce is unskilled, and most professional staff receives no structured in-service training. Mogadishu has several private health institutions, such as the SOS Kinderdorf Missionary Hospital and Nursing School, and the ICRC-supported Keseney and Madina hospitals that specialize in trauma surgery. Chronic civil unrest and insecurity has

hampered the establishment of a properly functioning public health system. In addition to working in the public sector, most health workers have established private practices which are unregulated. Pharmacies operate on a private basis and are unregulated too, with no quality control checks.

There is no functioning HMIS in place.

Communicable diseases

Malaria is hyper-endemic in the central and south regions especially in the riverine areas, where 59 800 slides showing 39% to be positive for *P. falciparum* and 200 clinical cases with 19 deaths were reported from sentinel sites in 2008. The increased number of malaria cases was due to the increased number of IDPs residing in endemic areas, with inadequate control and preventive measures, including early diagnosis and prompt treatment, breeding of larvivorous fish and distribution of impregnated bed nets in high-incidence areas. It is very difficult to contain outbreaks of falciparum malaria in remote areas due to insecurity and inaccessibility.

Tuberculosis is also a major public health problem, as in other zones of Somalia. DOTS is being implemented in all 36 tuberculosis treatment centres. A WHO survey in 2006 estimated a tuberculosis prevalence rate of 18.7% and a case detection rate of 74%.

HIV sero-prevalence was estimated in 2004 at 0.9% by WHO and UNAIDS. Tuberculosis and HIV co-infection is a major threat indicating an immediate need for antiretroviral treatment for these patients. The sero-prevalence survey conducted by WHO in 2007 in the other two zones could

not be undertaken in SCS because of armed conflict and insecurity, but efforts will be made to conduct a survey.

Since the 1930s there have been repeated outbreaks of Kala-azar (visceral leishmaniasis). Most recently in 2000, outbreaks have been reported in the Bakool, Gedo and Bay regions. Potential vector breeding sites are numerous and scattered throughout SCS. Outbreaks of Rift Valley fever usually occur after severe flooding events.

Bilharzia is endemic along the main rivers. More than half of the population (4 million) is believed to live along the two rivers where schistosomiasis is endemic. School-age children are the most affected group. There are no proper control measures in place, but ad hoc school-age mass treatment campaigns are voluntarily conducted by individuals of the community with praziquantel.

Leprosy is endemic in SCS. In 2007 and 2008, 539 cases were treated from seven sites in four regions.

Noncommunicable diseases

Renewed conflict in 2008, including in Mogadishu, caused major displacement, injuries death and destruction. At least a million people were exposed to severe stress, with subsequent extreme risks for mental health and social problems. The Chain-Free Initiative is well established in Mogadishu, and various awareness programmes are continuously aired in the media with the involvement of various community sectors. Mental health is not yet integrated within PHC services, and no surveys have been

conducted on the influence of the use of khat and other psychoactive substances on mental health disorders.

In 2008, the Habeb Public Mental Hospital admitted over 1800 people suffering from different mental health disorders under the broad categories of psychosis (49%), epilepsy (28%), neurosis (19%) and depression (4%).

Maternal health

Less than 10% of deliveries are assisted. Major causes of maternal mortality are eclampsia, haemorrhage and obstructed or prolonged labour. Common causes of newborn deaths include asphyxia and obstructed or prolonged labour.

No comprehensive needs assessment has been undertaken since 2006. Currently, an UNICEF/UNFPA assessment of EmOC in 2006 found that 1.7 facilities per 500 000 population offered EmOC, which is more than the minimum UN indicator, and around 16 facilities offered comprehensive EmOC. This number has decreased since 2008, when nongovernmental organizations evacuated expatriate surgeons and obstetricians from SCS. These facilities now provide only basic EmOC, with some level of blood transfusion services. The regions of Gedo, Bay, Bakool and Middle Juba do not have appropriate comprehensive EmOC facilities. There is at least one working comprehensive EmOC facility operating in the other regions. There are considerable unmet needs in terms of availability and quality of EmOC compared to WHO minimum standards.

District hospitals supported by nongovernmental organizations handle

100–200 births per year, with a higher rate of complicated deliveries than in NWS. This is a very low number considering that Caesarean section and specialized personnel must be maintained round the clock. There has been no systematic assessment of the quality of EmOC. Attracting qualified surgeons or obstetricians remains difficult. There is competition with the private sector; in some areas qualified midwives prefer to work in the better-paid private clinics.

Child health

Routine immunization coverage is low and needs to be improved for all antigens. No cases of acute flaccid paralysis have been detected since March 2007.

Acute respiratory infections (including pneumonia), diarrhoea and intestinal parasites are the leading causes of morbidity and mortality. FSNAU 2009 analysis found that 19.6% of children under 5 (excluding IDP communities) were acutely malnourished and 4.6% were severely malnourished.

Laboratory and blood safety services

There are 21 laboratories in SCS. The reference laboratories are located in Merka and Mogadishu, however the functions are limited in light of the ongoing conflict in the region. Specifically, laboratories cannot perform bacteriological culture, which has a detrimental effect on outbreak verification within SCS. All the functioning laboratories are able to undertake screening of blood and routine laboratory tests; however, they regularly lack routine supplies and equipment, and rely solely on international organizations for provision.

Essential medicines

As in NWS and NES, there are private pharmacies and health clinics in SCS. There are no officially qualified pharmacists or pharmacy technicians available. Due to the absence of medicine regulatory authorities or a food and drug administration, pharmaceuticals are not registered or regulated in SCS and therefore can be imported without quality control and safety assessment. All medicines are sold over the counter without restrictions for use. Self-medication of medicines prevails, expired medicines are sold in the market at a very high price, and re-labelling of products is common practice. Private pharmacies sell medicines unregulated to the public. The Government Central Medical Stores maintains warehouses in Mogadishu and in some of the regional capital towns, but its management and operations need urgent improvement. UNICEF provides pre-packed drug kits for maternal and child health centres and health posts. The Ministry of Health's role is limited to ad hoc requests of medical supplies for communicable disease outbreak response, provided by WHO, UNICEF or international nongovernmental organizations.

2.4 Country-wide priorities

2.4.1 Critical priorities, short-term (2–3 years)

The most critical priority is to develop a common framework or a Somalia health sector strategy, mobilize and coordinate the health activities of all partners (UN agencies, international and local nongovernmental organizations and bilateral donors) to ensure

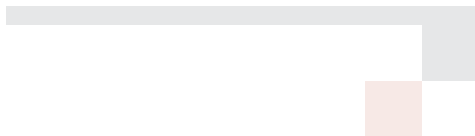
they focus their assistance on the following key actions.

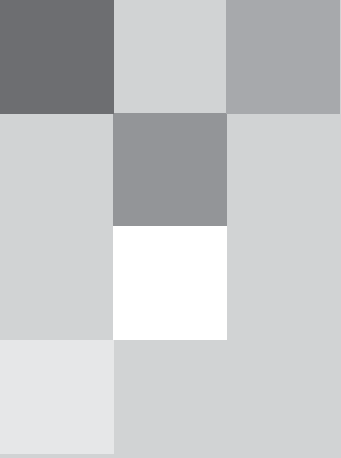
- ❖ Developing the district health system
- ❖ Capacity building and in-service training of national health workforce
- ❖ Rehabilitating and upgrading public health facilities and developing PHC packages for each level of health services
- ❖ Rehabilitating/building water supply and sanitation systems
- ❖ Providing medicines, vaccines, medical supplies and equipment and logistical support, and facilitating the delivery of food and nutritional supplements
- ❖ Providing experts, volunteers and financial resources to work towards reducing child and maternal mortality
- ❖ Advocating for and mobilizing resources for assessment and improving the water supply and sanitation systems and PHC services by using a community-based approach.
- ❖ Improving intersectoral collaboration and utilization of nongovernmental organizations; preventing the proliferation of unaccredited nongovernmental organizations

2.4.2 Secondary priorities, mid-term and long-term (4–6 years)

- ❖ Developing a decentralized health system including health and medicine policies and strategies, and legal framework and enforcement; improving governance, equitable access and outreach; strengthening delivery capacity, increasing health financing; regulating the private health and pharmaceutical sector; and improving availability of essential medicines and medical technologies

- ❖ Developing a human resource strategy and policy; restoring/ strengthening/ establishing health training and education institutions including medicine, dentistry and pharmacy, nursing and midwifery, nutrition, sanitary engineering, and laboratory, X-ray, pharmacy and medical assistants/technicians; and curriculum development of all health categories and disciplines
- ❖ Developing health awareness-raising campaigns
- ❖ Strengthening noncommunicable disease prevention and control
- ❖ Fostering links between the public, private and nongovernmental organization sectors





Section

3



**Development Cooperation
and Partnerships**



Section 3. Development Cooperation and Partnerships

Since 1994, UN agencies, nongovernmental organizations, donors and zonal health authorities have worked jointly under the umbrella of the Coordination of International Support to Somalis (CISS) – formerly the Somalia Aid Coordination Body (SACB) – in an effort to assist the people of Somalia through coordination of early recovery and developmental assistance.

CISS, which is based in Nairobi, oversees the sector system which includes sectors as health, WASH, nutrition, education, governance, food security and rural development. Regular meetings are organized with chair/co-chair representation of sectors, Somali donor group and civil society.

Since 2006, the IASC (Interagency Standing Committee) has been responsible for humanitarian coordination of the cluster system for Somalia. Clusters include health, water, sanitation and hygiene (WASH), nutrition, education, protection, logistics and livelihoods. IASC meetings are chaired by the Humanitarian Coordinator with OCHA as co-chair and represented by United Nations agencies, donors and civil society.

The aim of the cluster approach is to strengthen the effectiveness and predictability of humanitarian response by clarifying the roles and responsibilities of various humanitarian actors, designating an accountable cluster lead agency, and strengthening collaborative action so that the international humanitarian community can better support and complement the

humanitarian work of host governments, authorities and civil society while building on and developing national capacities.

WHO is the lead agency of the health cluster, which was launched in Somalia in April 2006. The health cluster is a group of United Nations agencies, international and local nongovernmental organizations, and other stakeholders working together in the humanitarian health response.

3.1 Aid environment in the country

3.1.1 Overview

Somalia received around US\$ 49 million in humanitarian and development assistance in 2007. These resources were allocated as follows: education 3%; health and nutrition 13%, water and sanitation 7%, governance 16%, food security and rural development 17%, emergency relief 2%, multisectoral projects 9%, and others 33%.

Aid flow to the health sector in Somalia is largely based on three groups of funders: 1) traditional (mostly bilateral and multilateral) donors; 2) the non-DAC donors or private donations; and 3) Somali diaspora remittances. Bilateral and multilateral donors normally fund health activities through the UN system and international and local nongovernmental organizations. Private donations support the health sector through international and local nongovernmental organizations or institutions, while the Somali diaspora remittances go directly to local nongovernmental organizations and

institutions and beneficiaries. The common UN system in turn funds UN agencies, health authorities, and international and local nongovernmental organizations or institutions. There are different layers of actors between donors and the ultimate beneficiaries, with varying operational and reporting modalities, resulting in huge transaction costs.

Since the onset of the humanitarian crisis, the health sector in Somalia has received substantial contributions from traditional donors, UN agencies and more recently from global health initiatives such as the Global Fund and the GAVI Alliance. A major inventory of external resources carried out in 2007 showed that the net official development assistance to Somalia increased from US\$ 174 million in 2003 to US\$ 200 million in 2004 and US\$ 236 million in 2005, while donor contributions for health increased almost threefold in seven years, from \$23 to \$62 million in 2006.

Health expenditure is estimated to account for 3%–3.5% of Gross National Income, which is put by the Economist Intelligence Unit (2008) at US\$ 320 million. Health received about 10% of the US\$ 390 million spent by the main donors in 2006. Per capita spending by OECD donors for health increased from an estimated US\$ 3.20 in 2000 to US\$ 7.30 in 2006. This does not capture the entire per capita health expenditure on health; for example, if MSF's spending in 2006 is included, external health spending rises to US\$ 10.20. Once non-OECD donors, remittances and out-of-pocket expenditures are taken into account, total per capita financing should be in

the range of US\$ 12 to US\$ 20, which is higher than many that of sub-Saharan African countries.

These surprisingly high health financing figures contrast strikingly with the poor performance of the health sector and its limited outputs. Contributing factors include the very high operational costs linked to transportation and security, a weak health management information system, high concentration of resources on a few vertical programmes, and unclear strategies and poor coordination, resulting in widespread inefficiencies and duplication of effort.

The Consolidated Appeal Process (CAP) yielded US\$ 463 million for Somalia in 2008 out of a total of US\$ 662 million requested. Of this amount, 70% (US\$ 319 million) was spent on food aid with the remainder shared among the other 10 sectors, resulting in a notable funding inequity. Funding requirements in the CAP for 2009 amounted to US\$ 918 million in total (revised mid year to \$849 million), of which \$516 million was received as of 2 December 2009. In 2009, health was heavily underfunded, receiving only 38% of the needed funding for the humanitarian response in health (as of December 2009).

As of December 2009, the Humanitarian Response Fund awarded nearly US\$ 1.8 million to 8 emergency health projects in 2009.

In 2009, the health cluster, through WHO received US\$ 2 million from the Central Emergency Response Fund in response to the worsening humanitarian situation in SCS.

3.1.2 Bilateral and multilateral partners

The main bilateral donors supporting health in Somalia are the European Commission, Norway, the United Kingdom and United States of America. Others include Canada, Finland, Italy, The Netherlands and Sweden. Other multilateral agencies are the Global Fund to fight AIDS, Tuberculosis and Malaria and the GAVI Alliance.

European Commission grants support the development and implementation of the essential package of health services, including capacity-building for medicine supply and management, an essential medicines list, public-private partnership and health workforce regulation through accreditation, standardization of salary scales and incentive packages. The GAVI Alliance's health system strengthening grant will support health legislation and regulation as well as strengthening of regional and district health management systems, including HMIS. Training institutions will be supported to ensure availability of basic emergency obstetric care and comprehensive emergency obstetric care and essential newborn care services at maternal and child health centres and health post levels. The Round 8 health system strengthening grant received from the Global Fund for the period 2010–2014 will support, among other health system developmental activities, the development of a common monitoring and evaluation system.

3.1.3 The United Nations system

The UN in Somalia comprises 16 UN agencies, funds and programmes covering a broad spectrum of humanitarian, recovery

and development work. The UN country team (UNCT) operates under the leadership of the Resident Coordinator (who is also the Humanitarian Coordinator). Somalia does not yet have a fully developed United Nations Development Assistance Framework but instead has a United Nations Transition Plan (UNTP) for 2008–2009. The UNTP, structured around 5 strategic outcomes including equitable access to quality education and health services, aims to support reconstruction and sustainable development.

The major UN agencies active in the health and health-related sectors in Somalia are: FAO, ILO, OCHA, UNAIDS, UNDP, UNFPA, UNICEF, UNHCR, WFP and WHO. FAO supports the food security and rural development programme, with an emphasis on agricultural rehabilitation and diversification for nutritional improvement. ILO promotes employment, enterprise and livelihood projects for poverty alleviation while UNAIDS supports an expanded response to HIV/AIDS with emphasis on prevention, care and support. UNESCO provides strategic partnership for education recovery and development. UNDP provides continuous technical support for governance, rule of law, and the introduction of human rights, gender and equality into the work of local authorities. UNFPA provides support for sexual and rights-based reproductive health services and information, particularly for women and adolescents. UNICEF provides support for child health, emergency and early childhood education, nutrition, and water, sanitation and hygiene. In addition, UNICEF is the main provider of pre-packed medicine kits for maternal and child health centres and health posts. OCHA strengthens

coordination and enhances sustainable access to basic humanitarian services by vulnerable populations and IDPs. WFP supports distribution of relief food to population in need (half of the population in Somalia in 2009), including food stuff for improved nutritional status of malnourished pregnant and lactating women and children.

WHO provides technical and operational support to the entire health sector to reduce mortality and morbidity of the population. WHO's work focuses on setting norms and standards; providing guidelines; building capacity; strengthening medicine supply and management, quality control, and rational use of medicines; improving public health laboratory and blood bank services; eradicating polio; eliminating measles and other preventable childhood illnesses; controlling malaria, tuberculosis, HIV/AIDS and leprosy; preventing blindness; establishing disease surveillance and response systems; and promoting partnerships for health.

3.1.4 Nongovernmental organizations

Several local and international nongovernmental organizations have played a major role in maintaining and increasing coverage of health care services in Somalia over the prolonged period of humanitarian crisis. Around 21 local and international nongovernmental organizations are active in health services delivery throughout Somalia. The key international organizations are World Vision, Merlin, CARE International, International Federation of Red Cross/Red Crescent Societies (IFRC), SRCS, COOPI and Gedo Health Consortium (GHC); while

Daryeel Bulsho Guud (DBG) and Himilo Relief and Development Organization (HIRDA) comprise the national nongovernmental organizations. In 2006, health-related nongovernmental organizations mobilized almost US\$ 22 million from donors.

In most cases, the organizations operate through public health facilities and harmonize their work with partners of the health cluster and/or health sector. They are mainly involved in primary health care services. World Vision is the principal recipient for managing the Global Fund grants for tuberculosis, whereas UNICEF is the principal recipient for malaria and HIV/AIDS. Eligible nongovernmental organizations and WHO are sub-recipients for the Global Fund grants.

The prevailing insecurity, together with weak logistics, lack of accessibility and poor infrastructure, mean that nongovernmental organizations services are still largely restricted to urban areas, leaving a large proportion of rural areas without access to health care.

Although many nongovernmental organizations are registered with the Somalia NGO Consortium, coordination of activities in the field is poor, health regulation is lacking and there is no validation of service coverage claims. Other challenges experienced by the organizations include: weak capacity of health workers, rapid staff turnover, weak referral and linkages with district health systems, and lack of standard guidelines or protocols. The work of the organizations needs to be better coordinated, and they need to adhere more to agreed treatment guidelines and to adopt the remuneration of village health care workers as a strategy to increase health care coverage in rural or remote areas.

3.1.5 Diaspora remittances

The Somali diaspora community provides considerable finances to support directly health facilities, particularly hospitals and training institutions. The support includes funds for staff salaries and running costs of facilities run by local nongovernmental organizations, or institutions, and direct financial or in-kind support for emergency medical care, supplies and treatment.

3.2 Key challenges related to development aid and partnerships

The newly established Transitional Federal Government (TFG) is still working to strengthen its mandate since its inception in February 2009. Therefore, it has yet to put in place a national health and medicine policies, health and pharmaceutical sector strategies and initiating the necessary health reforms. The health authorities of NWS and NES have drafted health policies and designed health intervention packages which have remained largely on paper due to the weak capacity of health workers and limited political and financial support for effective implementation. Currently, the zonal health authorities' role is limited to ad hoc requesting of medical supplies for disease outbreak response provided by WHO, UNICEF or International nongovernmental organizations.

The fragile political situation has thus far not allowed the re-establishment of a national health authority to lead, drive, coordinate or oversee the implementation of and the financing of Somalia's health sector strategy.

Rather, responsibility for policy formulation, priority setting, supply management and health care delivery has been passed to UN agencies and donors who, in turn, are struggling with the challenges of enormous operational responsibilities amidst insufficient and hugely fragmented funding. In the absence of government leadership, inconclusive negotiations to agree on joint actions have been the norm, albeit with important exceptions such as responding to emergencies and implementing large-scale disease control programmes. Although several agencies are working to reorganize the Ministry of Health in SCS, zonal and regional health administrations in NWS and NES are currently being supported by the European Commission and several nongovernmental organizations. Well-coordinated institutional strengthening of the Ministry of Health to lead the setting and coordination of the health agenda for greater aid-effectiveness and mutual accountability is therefore a top priority.

3.3 Alignment of international cooperation with the national health agenda

In 2007, the Health Sector Committee established the Health Sector Working Group with the mandate of deepening the analysis of the health sector and fostering shared actions towards its development. There is a close relationship between population distribution and health expenditure²² by region in Somalia. There is, however, a huge imbalance between health sector aid and priority health needs. Donor emphasis has progressively shifted from horizontal

²² NWS accounts for 28% of the population and 20% of the health expenditure; NES has 20% of the population and 19% of the health expenditure, and SCS has 52% of the population and 61% of the health expenditure.

to vertical programmes, with 22% of the total health allocation going to malaria, HIV/AIDS and tuberculosis, and 20% to the polio eradication programme alone.

Even within the vertical programmes, EPI, reproductive health, noncommunicable diseases, nutrition and mental health, which account for the highest proportion of the disease burden of Somalia, are unacceptably neglected. The average yearly expenditure on reproductive health per woman of childbearing age was US\$ 0.55 between 2000 and 2006, a staggeringly low figure for a country with some of the highest malnutrition and child and maternal mortality rates in the world. This great imbalance should be redressed, and health financing and priority health needs should be better aligned.

3.4 Harmonization of international cooperation

A large number of agencies finance and/or support the implementation of health activities in Somalia. The 2009 CAP for Somalia appealed for about US\$ 919 million for 213 projects of 14 UN agencies, 32 international and 39 national nongovernmental organizations. As stated above, it has been difficult to agree on joint actions in the absence of national ownership. Success stories like the joint Child Health Days should be promoted.

The UNTP provides a platform for joint programming and harmonization of partners' activities. The UN and the World Bank are establishing a common humanitarian fund to channel external resources across sectors. While waiting for the establishment of a multi-donor trust fund, this interim, flexible

pooling mechanism will help to harmonize funding decisions and the flow of funds.

Donor agencies have invested heavily in creating aid management tools for Somalia. The Scanteam report in 2007 provides an overview of the existing tools as well as those under development. The overall conclusions of the report – few successes and many failures – serve to demonstrate the difficulty of harmonizing external assistance in the Somali context, and the risks and costs attached to such efforts.

3.5 Coordination of aid and technical assistance

As mentioned above, the IASC and CISS provide both a forum for all partners to discuss humanitarian, and rehabilitation, recovery and development issues respectively, including security trends, governance, and peace and reconciliation efforts. They also provide an opportunity to promote better understanding of the complex situation in Somalia which is moving towards a recovery and development phase for NWS and NES, whereas humanitarian assistance only is provided in SCS.

The CISS includes bilateral donors, UN agencies, intergovernmental organizations and international and national nongovernmental organizations. CISS partners share information and develop strategies for different sectors including education, food security and rural development, governance, health and nutrition, and WASH.

International support to the health sector development is coordinated by the Health Sector Committee (HSC) within the overall

CISS framework. The HSC has long been regarded as one of the most dynamic and effective aid coordination schemes for Somalia. However, needs assessments, priority setting, quality assurance for nongovernmental organizations activities, and support to national ownership, are not included in HSC's current remit. The HSC's mandate needs to be widened to encompass these functions. Coordinating the activities of nongovernmental organizations in the field is particularly important in order to ensure synergy and quality of services. National stakeholders should be encouraged to drive this coordination agenda to reduce transaction costs.

3.6 Development assistance and partnerships: key opportunities and challenges

3.6.1 Opportunities

Notable factors that have helped to prevent excess mortality and encourage continuous partnership in Somalia include the following.

- ❖ The resilience of the Somali population and the existence of skilled, experienced and motivated members of the Somali diaspora that actively support health development financially and through contributions in kind
- ❖ The extensive relief network delivering life-saving aid and assistance
- ❖ Improved security and access in the northern zones, allowing work on sustainable development within health

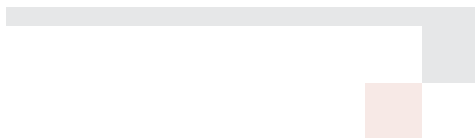
3.6.2 Challenges

Despite a period of increased funding for health within a short period of the past 7 years,

a sharp decline in bilateral funding was seen in 2009. Key challenges include the following.

- ❖ Health authorities must adopt a unified health sector strategy with a set of realistic priorities which all partners can identify with and support.
- ❖ Mechanisms are needed to facilitate priority-setting and allow health authorities and partners to focus on priority issues in a more coordinated manner, based on their respective comparative advantages.
- ❖ Donor coordination mechanisms must be strengthened in order to promote national ownership, align health financing with national health priorities, reduce transaction costs, enhance synergies and ensure quality services of nongovernmental organizations in the field.
- ❖ The intractable crisis means that many areas of the country are increasingly inaccessible, and many development partners are withdrawing their presence.
- ❖ There has been a steady increase in the number of people in need of humanitarian assistance, as well as a rise in commodity and delivery costs of the same.
- ❖ The need to have in place an agreed pre-qualification standard for engagement of nongovernmental organizations, standard operating guidelines and plans for building the capacity of nongovernmental organizations for improved services. This is in view of the extensive presence and use of nongovernmental organizations particularly in health service delivery within the country.

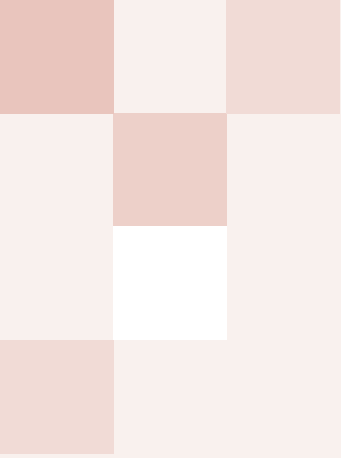
- ❖ Human resources must be developed in order to ensure adequate numbers of effective managers and highly performing health care staff at all levels.
- ❖ Efforts are required for generating new investment, capacities and partnerships in and outside the health sector, to reduce transaction costs, increase synergies and facilitate health outcomes not easily achieved through limited facility-based service delivery projects.
- ❖ Standards and norms to ensure equity and quality in health service delivery must be developed, agreed and disseminated.
- ❖ Interest and willingness and flagging among donors (“donor fatigue”) to support development and among humanitarian agencies and civil society to operate in Somalia.
- ❖ The ongoing insecurity and inaccessibility in SCS hampers humanitarian and development work in the short and medium terms.
- ❖ There is a need to ensure greater transparency in decision-making and use of resources, and establish accountability mechanisms at all levels.



Section

4

Current WHO Cooperation



❖ Section 4. Current WHO Cooperation

4.1 WHO's programme in Somalia

WHO's collaboration with Somalia dates back to the 1960s. Since the civil war of 1991, WHO, together with other UN agencies and nongovernmental organizations, has provided substantial humanitarian assistance in health to Somalia. It supports vital public health functions usually carried out by health authorities. These include tuberculosis, malaria and HIV/AIDS control programmes, polio eradication and the strengthening of services (i.e. support and rehabilitation of laboratories). However, WHO's efforts have been hampered by the scarcity of resources to meet the overwhelming needs.

In the absence of a strong central government, CISS is coordinating humanitarian assistance from Nairobi. Some CISS members have called on WHO to take a leadership role and provide guidance for health sector reconstruction and development efforts.

4.2 Office of the WHO Representative

WHO has maintained an extensive presence in Somalia, with staff and offices in all zones of the country. WHO continues to collaborate with health authorities in the three zones, UN agencies and other partners to ensure health development remains on track as far as possible. Because of the security situation in Somalia, the office of the WHO Representative is currently located

in Nairobi, Kenya, together with the offices of other UN agencies and international nongovernmental organizations.

4.3 WHO field offices

WHO has 4 sub-offices in Hargeisa, Garowe, Baidoa, and Mogadishu, and field offices in Boroma, Bosasso, Merka, Wajid and Jamame. The sub-office in Hargeisa is the largest, with a library and information/documentation centre. In view of the relative calm in NWS, WHO's health programmes are more extensive in that area. All sub-offices collaborate with local health authorities and provide technical assistance, training and capacity-building, laboratory and medicine supplies, support for disease surveillance, outbreak investigation and response, and assistance with emergency response activities. The sub-offices also collaborate with other UN and international organizations.

4.4 Key areas of WHO collaboration

4.4.1 Development of health programmes and health infrastructure

Communicable disease control and surveillance

WHO focuses on the prevention, control and eradication/elimination of diseases such as HIV/AIDS, tuberculosis, malaria, cholera, parasitic and zoonotic diseases, meningitis, leprosy and vaccine-preventable diseases. WHO aims to integrate these programmes into the PHC system. WHO

activities range from supporting the Ministry of Health to training health staff in all three zones to strengthening disease surveillance. WHO also donates medicines, supplies and laboratory equipment and provides technical support for the development of Global Fund HIV Round 8 and tuberculosis Round 7 proposals.

Somalia has been polio-free since 25 March 2007. WHO has supported more than 28 supplementary immunization activities since July 2005, and has provided de-worming tablets and vitamin A supplementation to millions of children.

WHO also supports capacity-building, human resources development, surveillance, monitoring and supervision. It works closely with UNICEF on Child Health Days. WHO aims to double immunization coverage in children by the end of 2009 (from 40% to 80%).

Health system development

WHO activities include working with zonal ministries of health on capacity building, assessing and developing human resource, planning, developing policy and regulatory systems, collecting information and establishing information management systems. WHO is establishing post-basic nurse-midwifery training programmes in Mogadishu, Hargeisa and Bosasso.

WHO is working to improve pharmaceutical services in both the public and private sectors. Local health authorities and WHO are planning to develop a national medicines policy. WHO provides training on a wide range of subjects including

quality assurance, essential medicines and laboratory services. It also helps local authorities purchase and distribute medicine and set up the required logistics infrastructure.

Reproductive health

WHO works with health authorities to strengthen the capacity of nurses, traditional birth attendants, midwives and major health facilities. WHO is also working to improve treatment coverage for emergency obstetric care, family planning services, sexually transmitted diseases and HIV/AIDS. Together with UNFPA and UNICEF, WHO has completed a comprehensive reproductive health situation analysis and is preparing an reproductive health strategy and action plan, in consultation with all partners.

Social determinants of health

WHO is working with health authorities to promote basic development needs to ensure sustainability and efficiency of health care, especially in poor communities. Basic development needs programmes are currently being implemented in 78 villages covering 183 000 beneficiaries.

In collaboration with the World Bank, FAO, UNICEF and other partners, WHO focuses on nutrition surveys, consolidating the results of other studies and strengthening nutritional programmes (supplementary feedings, iodized salt, iron and vitamin A-fortified flour). A nutrition education programme will be integrated into the basic health package as part of PHC health care delivery and community-based initiatives. Women and children will receive priority.

WHO also assists efforts to improve water quality at household level (solar disinfection or household water filters) and promote sanitation, solid waste and vector control and hygiene education through community-based initiatives. A critical issue is improving water supply and sanitation in health facilities.

Mental health

WHO has trained a large number of staff on the diagnosis and management of mental disorders and on community mental health. WHO has also donated medicine supplies. In collaboration with local health authorities, WHO has established the Chain-Free Initiative in Mogadishu. This initiative will soon be extended to NWS.

Blindness prevention and control

In line with Vision 2020, WHO is supporting the Manhal Group, which conducts eye-care camps throughout Somalia. WHO has also sponsored training courses abroad for Somali doctors, and supports institutional capacity-building through the provision of incentives to national focal points.

Information, communication and education

WHO plans to support the integration of information, communication and education components within existing health programmes into a more comprehensive information, communication and education programme using funds donated by the

GAVI Alliance. WHO will focus on conducting information, communication and education campaigns on health, the utilization of essential health services and the dangers of harmful practices such as FGM.

4.4.2 Collaboration within emergency and humanitarian assistance

WHO focuses on strengthening the coordination of the health cluster and emergency preparedness in all regions of Somalia. This includes ensuring access to essential health care services, supporting partners to reduce morbidity and mortality from outbreak-prone diseases, and establishing and maintaining an effective early warning alert and response system. In response to disease outbreaks, WHO supports the mobilizing of medical teams, the establishment of treatment centres, and coordinates activities among different partners. Media campaigns are periodically conducted to complement house-to-house case management.

WHO also assesses emergency-prone areas and regional health services as part of planning and preparedness efforts. WHO has begun rehabilitating several hospitals and has equipped laboratories in an effort to improve health care delivery at the secondary level.

4.4.3 Cooperation with partners

Table 9 shows WHO's primary partners and areas of work in Somalia.

Table 9. WHO partners and areas of work

Partner	Areas of work
UNICEF	Communicable disease control, EPI, reproductive health, water, environment, sanitation, health system strengthening in all zones
UNFPA	Reproductive health in all zones
UNOPS	Rehabilitation of health facilities in SCS
UNDP	HIV through its LICUS initiative
UNESCO	Primary and secondary education
WFP	Food for tuberculosis, HIV and hospital patients, logistics
IOM	IDPs, HIV research in NWS
Muslim Aid (UK)	PHC, emergency response activities, tuberculosis centres in SCS; PHC in Sanag, NWS
International Medical Corps	PHC, emergency preparedness and response in SCS
Manhal International	Blindness prevention and control in all zones; tuberculosis in SCS
Merlin	Outbreak response and health service delivery
Somali Red Crescent Society	PHC in all zones; basic development needs in NWS
African Muslim Agency	Ad hoc emergency response in SCS
Finland-Somalia Association	Tuberculosis in Mogadishu; tuberculosis culture in Mogadishu and Hargeisa
SAACID	Tuberculosis in SCS; voluntary counselling and testing
Mercy International (USA)	Tuberculosis in SCS and in NES; voluntary counselling and testing in SCS
ICD	HIV in NWS
ICRC/IFRC	War trauma in all zones; PHC in all zones
MSF	Trauma management in SCS; tuberculosis, communicable disease control, etc.
COOPI	PHC and tuberculosis in NWS
Cooperaziine Servizi Volontari	PHC and tuberculosis in SCS
Organizzazione Umanitaria per L'Emergenza	PHC, Jowhar Regional Hospital in SCS

Partner	Areas of work
Save the Children Fund (USA)	PHC in NWS
UNHCR	PHC in refugee camps across Somalia
Local authorities	Across Somalia
Local nongovernmental organizations in partnership with UN or other nongovernmental organizations	Different interventions in zones

4.5 Support received from different levels of WHO

Throughout the biennium, the country office has benefited from a range of technical and operational support from the Regional Office and WHO headquarters. Areas where the country office has received support from different levels of the organization have been within community-based initiatives, health systems strengthening, nutrition, reproductive health, vaccine preventable diseases, communicable diseases including outbreak response, emergency preparedness and humanitarian action, essential medicines, laboratory services, noncommunicable diseases including mental health and prevention of blindness and capacity-building including fellowships.

4.6 Logistics support and security

WHO maintains warehouses in Hargeisa, Mogadishu and Garowe to support various health programmes. The organization has trained its staff on security awareness and has worked to ensure its equipment and premises meet the UN's minimum operating security standards.

4.7 Funding

In the 2004–2005 and 2006–2007 more than 75% of funds were utilized to purchase supplies and conduct national training activities.

The WHO–Somalia joint programme review and planning mission for 2008–2009 has prioritized 25 programmes. Ten of the 25 programmes support health systems development including human resources for health. Communicable disease control accounts for 8 programmes. The remaining 7 programmes include support for community-based initiatives, water supply and sanitation, nutrition, emergency preparedness and humanitarian assistance, and mental health.

The overwhelming emphasis of WHO's work is within communicable disease control, emergency response and health system development. Despite the country's very high maternal mortality rate, the resources for reproductive health are negligible. Similarly, there are very few resources for environmental health, nutrition and health promotion, all of which constitute critical areas for health stakeholders.

4.8 Constraints

- ❖ Widespread conflict, lawlessness and political strife across large areas of the country that challenge WHO's involvement and other forms of external assistance at the field level and also leads to destruction of health infrastructure
- ❖ Limited capacity and fragmentation of health authorities in planning and management and lack of a functioning judicial system or law enforcement, allowing unregulated private health and pharmaceutical sector activities
- ❖ High level of displacement and humanitarian needs that hamper regular collaboration in health development
- ❖ Lack of qualified workforce, particularly within the management of PHC services
- ❖ Severely limited public funding of health services

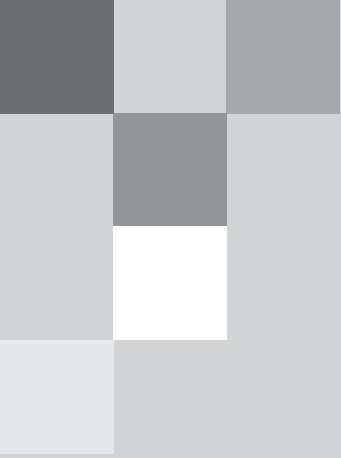
4.9 Challenges

WHO must bring stakeholders together to foster consensus among partners on the way forward, and in so doing will also need to strengthen its technical capacities at the country-office level. Main challenges include the following.

- ❖ Close collaboration must be fostered with other key partners in developing a joint health sector strategy to rehabilitate local level health facilities and services.
- ❖ In the absence of strong government, the CISS has assumed the coordination and the strategy-setting role. WHO,

as the lead agency in health, must be able to foster consensus among health authorities and key partners to develop coordinated medium-term policies and strategies, technical norms, procedures and guidelines for health development and health care delivery.

- ❖ In view of the severe shortage of skilled Somali health workforce, WHO must focus on training as many Somalis as possible. WHO must also explore ways of acting as a catalyst so that key partners can develop joint strategies, mobilize funds for human resource development and strengthen the health authorities in the three zones of Somalia.
- ❖ WHO will need to explore ways of collaborating with partners in developing a technical appraisal for the engagement of nongovernmental organizations that deliver health care services.
- ❖ WHO will need to mobilize resources and provide urgent expertise to strengthen reproductive health programmes in Somalia.
- ❖ WHO country office will need to strengthen its capacity in the areas of environmental health, health promotion, nutrition and health systems development.
- ❖ WHO will also need to assist in the development of a comprehensive information, education and communication strategy, using the local media to raise awareness of health and healthy behaviour.



Section

5



**Strategic Agenda
for WHO Cooperation**



Section 5. Strategic Agenda for WHO Cooperation

5.1 Introduction

The development of strategic directions for WHO collaboration with Somalia during 2010–2014 involved a comprehensive consultative process. The process included as many stakeholders as needed to ensure proper coordination and integration of programmes.

The guiding principle for the CCS and its implementation is the renewed primary health care approach, which broadly covers four areas of reform: universal coverage, service delivery, public policy and leadership. Within these areas, priority will be given to the reduction of maternal and child mortality, and prevention and control of communicable disease.

The balance between WHO adopting a development or humanitarian approach varies across the zones of Somalia. There are three health authorities at different levels of capacity, available resources and level of institutional development. NWS is the most developed, followed by NES which has a functional Ministry of Health with fledging capacity with some structure in place, limited capacity and resources. In SCS, ongoing conflict and political strife mean that health authorities are limited in the extent to which they are involved in health service planning, management and delivery. The precise nature that cooperation will take will be a further consideration within joint collaborative planning.

5.2 Strategic priorities

5.2.1 Priority health programmes

The strategic approaches below aim to complement the strategies to be implemented by other partners and agencies. The following main issues are considered.

Main focus 1: Integration of communicable disease control programmes

Strategic approaches

- Promote and establish an integrated disease surveillance system with an early warning and response component for epidemic-prone diseases in all the three zones of Somalia
- Strengthen and expand laboratory services that will support disease control programmes and assist in early confirmation of epidemic-prone diseases to ensure appropriate and prompt response

Main focus 2: HIV/AIDS and STI, tuberculosis, and malaria

Strategic approaches

- Assist in provision of medicines, testing kits, supplies and laboratory reagents, as well as logistical support for continued prevention and control of HIV/AIDS and STI, tuberculosis and malaria
- Within the integrated surveillance system, assist in strengthening national capacity for surveillance of HIV and STI

- ❖ Strengthen coordination and partnership with all stakeholders in health
- ❖ Strengthen the capacity of health authorities for health sector response to HIV/AIDS
- ❖ Support the integration of tuberculosis treatment and prevention with HIV/AIDS services
- ❖ Strengthen the capacity of zonal of AIDS commissions in monitoring and evaluation of HIV/AIDS activities
- ❖ Maintain and strengthen rapid diagnosis and prompt treatment of malaria especially for pregnant women and children
- ❖ Strengthen integrated vector control in all areas
- ❖ Strengthen capacity in epidemic preparedness and response

Main focus 3: Maternal, neonatal and child health

Strategic approaches

- ❖ Improve access, availability and quality of maternal, neonatal and child health services
- ❖ Improve access, availability and quality obstetric care in all zones
- ❖ Improve and increase access to quality and integrated child health services through the Child Health Days package
- ❖ Address harmful practices including FGM and early pregnancy
- ❖ Promote healthy families through birth spacing

Main focus 4: Neglected and other tropical diseases

Strategic approaches

- ❖ Continue to support, strengthen and expand the programmes for the control of neglected and other tropical diseases including leishmaniasis, leprosy, schistosomiasis, trypanosomiasis and trachoma in areas of Somalia where these diseases are endemic
- ❖ Integrate the control programme for neglected and other tropical diseases into community-based approaches

Main focus 5: EPI including measles elimination and polio eradication

Strategic approaches

- ❖ Support in increasing immunization coverage by strengthening and expanding routine and supplementary immunization activities
- ❖ Improve the vaccine management and distribution system
- ❖ Strengthen EPI management at all levels and build the required human resource capacity
- ❖ Work towards achieving the inclusion criteria for the GAVI health system strengthening approach
- ❖ Coordinate the efforts of polio eradication together with partners to maintain a polio-free Somalia through strengthening routine immunization, conducting supplementary immunization activities and maintaining certification standard for AFP surveillance
- ❖ Coordinate and enhance the measles elimination efforts together with other partners through measles follow

supplementary immunization activities, strengthening routine EPI and case-based measles surveillance

- ❖ Coordinate polio eradication and measles elimination through strengthening routine and supplementary immunization and AFP and case-based measles surveillance

Main focus 6: Improving nutritional status of targeted groups

Strategic approaches

- ❖ Engage with partners to develop a comprehensive integrated nutrition, food safety and security strategy for Somalia based on needs assessment and advocate for the re-positioning of nutrition as a central component of health development
- ❖ Integrate nutritional education into the curricula of primary and secondary education and all health training institutions
- ❖ Strengthen/build the capacity of health workers in the prevention and control of micronutrient deficiencies and management of severe malnutrition
- ❖ Promote appropriate infant and young child feeding, and adolescent and maternal nutrition based on a life-cycle approach
- ❖ Encourage food fortification for improved nutrition
- ❖ Incorporate nutritional surveillance into integrated disease surveillance and response for effective monitoring of nutritional status of vulnerable population groups

Main focus 7: Addressing mental health and noncommunicable diseases

Strategic approaches

- ❖ Support the development and provision of mental health care services for management of mental health disorders through the establishment of the Chain-Free Initiative in the three zones of Somalia
- ❖ Promote home management of people with mental health disorders through community-based initiatives
- ❖ Support the assessment and treatment of visual impairment to prevent blindness, in addition to related health education
- ❖ Support the prevention and control of major noncommunicable diseases including diabetes as part of programmes for healthy lifestyles

5.2.2 Health systems development

Main focus 1: Human resource development

Strategic approaches

- ❖ Develop of a strategic plan for human resource development based on a full assessment of health needs and priorities in the country
- ❖ Strengthen the capacity of medical, nursing and allied educational institutions through revision of curricula, training of trainers and provision of adequate training materials so as to improve the quality of education
- ❖ Develop of a cadre of skilled birth attendants and female community health workers so as to address the maternal, neonatal and child health problems and priorities

- ❖ Establish a programme of continuing medical education (i.e. distance learning) for all cadres of health workers employed in the public and private health sectors
- ❖ Improve management of human resources through development of post descriptions, career structure, supportive supervision, and measures to minimize staff absenteeism and improve staff retention
- ❖ Support short-term training of batches of health staff through WHO's fellowship programme as well as inviting members of the Somali diaspora to provide in-country training to health workers
- ❖ Support training in public health disciplines including health systems, health management, health financing, epidemiology, statistics and operational research

Main focus 2: Governance and leadership

Strategic approaches

- ❖ Foster institutional development of health authorities through capacity-building of staff and establishment and/or strengthening of health policy and planning, legislation and regulation, information and surveillance, monitoring and evaluation, disease prevention and control, and administration and finance departments within ministries
- ❖ Develop a health sector strategy in the short term and a national health policy and strategic plan in the medium term so as to guide the development of health sector in Somalia
- ❖ Build capacity of the health authorities to improve coordination amongst all health-related development partners

so as to increase aid effectiveness in line with the principles of the Paris Declaration on Aid Effectiveness (2005)

Main focus 3: Organization and management of the district health system

Strategic approaches

- ❖ Develop a blueprint for the establishment of a district health system in Somalia based on an in-depth review and needs assessment
- ❖ Strengthen and/or establish a cadre of mid-level health and hospital manager with appropriate authority and responsibility for effective delivery of health services
- ❖ Implement a facility health survey to map all public (and private) health facilities to determine their structure, function, geographical distribution and the range of services provided
- ❖ Strengthen and/or expand community-based initiatives and the use of community health management tools as a basis for community participation in the planning, management and monitoring of district health services
- ❖ Support the implementation of the essential package of health services including its delivery by the appropriate mix of public, nongovernmental organization and private providers, and by targeting poor and vulnerable populations
- ❖ Provide assistance in piloting of a female community-based health work programme to improve access to basic health services in rural areas of the country and its subsequent scaling-up
- ❖ Promote greater quality and safety of health services at all levels of health

care in the public and private health sector by developing a comprehensive quality assurance programme

- ❖ Support the functional integration of vertical programmes at the point of service delivery as a means to sustain these programmes

Main focus 4: Medicines, vaccines and technology

Strategic approaches

- ❖ Ensure access to essential medicines and vaccines and develop mechanisms for quality assurance, well-functioning supply systems and the rational use of medicines
- ❖ Promote safe blood transfusion practices in all laboratories by ensuring the universal screening of blood and its products
- ❖ Support capacity development in the area of technology assessment, repair and maintenance of medical equipment and in the rational use of technology

Main focus 5: Health information

Strategic approaches

- ❖ Improve the availability, quality and use of health information that covers disease surveillance as well as the management information system, through the development of appropriate reporting tools at facility level, training of health providers in their use, integration of vertical information systems, better use of information technology and training of managers and policy-makers in use of information
- ❖ Organize surveys at the facility and community level to acquire independent information on the performance of the

health system and health status of the population

- ❖ Establish a sample vital registration system in selected districts and undertake verbal autopsy studies to identify the causes of maternal and child deaths in the communities

Main focus 6: Health care financing

Strategic approaches

- ❖ Undertake a health sector expenditure analysis to acquire a better understanding of the current status of health care financing in Somalia
- ❖ Advocate for increased allocation of resources for health by external partners and from state revenues, ensure their allocation to PHC services, and target strengthening of health services for marginalized and vulnerable populations
- ❖ Pilot community-based health insurance programmes in geographical areas where the basic development needs approach is being implemented and evaluate the feasibility for their scaling-up in various parts of the country

Main focus 7: Health system components of global health initiatives

Strategic approaches

- ❖ Provide technical support for the mobilization of additional resources for health and for the effective implementation and monitoring of the health system components of global health initiatives (Global Fund and GAVI Alliance)

5.2.3 Coordination and partnership

Main focus 1: Coordination with partners

Strategic approaches

- ❖ Within its health leadership role, forge a closer collaboration between partners and national health authorities
- ❖ Revitalize donor coordination for health
- ❖ Incorporate the CCS into existing frameworks such as the United Nations Transition Plan
- ❖ Establish coordination mechanism for the private for-profit and not-for-profit sectors

Main focus 2: Evidence for informed decision-making

Strategic approaches

- ❖ Support development of monitoring and evaluation of implementation progress, including data collection for the tracking of aid flow for health
- ❖ Undertake operational research to identify most effective strategies and align the outcome with policy decisions
- ❖ Provide evidence on utilization, impact and cost of services in order to generate appropriate and affordable health care delivery models for maximizing efficiency and equity of immunization and other essential services, through operational and health system research
- ❖ Facilitate information-sharing on a continuing basis

Main focus 3: Resource mobilization

Strategic approaches

- ❖ Support capacity-building of national authorities in resource mobilization in the area of health and development

- ❖ Advocate for greater investment in public health from donors and other partners including the diaspora

5.2.4 Determinants of health

Main focus 1: Environmental health

Strategic approaches

- ❖ Promote provision of water of adequate quality and quantity particularly in health facility settings
- ❖ Strengthen the capacity of health authorities in establishing legal framework for environmental health issues.
- ❖ Support the scaling-up of the healthy cities programme and establishment of the healthy villages programme
- ❖ In collaboration with other partners, assist in the assessment and monitoring of the situation of environmental health and develop evidence for advocacy for provision of improved water supply and basic sanitation facilities, particularly in health facilities and schools
- ❖ In close collaboration with other stakeholders and partners, assist in resource mobilization for water supply, sanitation, hygiene education and solid waste management
- ❖ Support the strengthening of the capacity of health authorities for ensuring safety of population from environmental hazards such as unsafe drinking water, inadequate sanitation and absence of solid waste management, breeding grounds for disease-carrying vectors and toxic chemicals
- ❖ Support improved provision of water supply and sanitation through community-based projects such as the

basic development needs approach and the healthy cities programme

- ❖ Assist in strengthening/establishing linkages between environmental health and communicable disease control, mother and child health and other health programmes to reduce and control related to water, sanitation and hygiene epidemics and infections, especially in hospitals and health facilities
- ❖ Promote effective hospital waste management

Main focus 2: Social determinants of health and health equity

Strategic approaches

- ❖ Strengthen the capacity of health authorities to work across sectors and establish institutional frameworks for intersectoral approaches to health in the three zones
- ❖ Tackle social determinants of health and health equity at the grassroots level through community-based initiatives such as the basic development needs approach
- ❖ Advocate through partnerships for primary and secondary education for girls, empowerment of women, and reduction of gender disparities in health by raising awareness among opinion leaders, policy-makers and communities

Main focus 3: Health promotion

Strategic approaches

- ❖ Advocate public health oriented policies in all sectors
- ❖ Integrate health promotion components into all health programmes

- ❖ Strengthen the capacity of individuals, families and communities to promote healthy lifestyles through targeted health promotion interventions addressing issue of tobacco and khat use
- ❖ Develop and implement a comprehensive strategy for behavioural change communication that addresses the determinants of maternal, child and adolescent health
- ❖ Support health authorities in the development and implementation of school health programmes with an emphasis on the integration of prevention and control of priority communicable diseases
- ❖ Support health authorities to utilize local media for health promotion at the community level

5.2.5 Emergency preparedness and response

Main focus 1: Access to essential health services

Strategic approaches

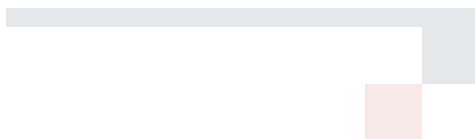
- ❖ Support the provision of health services to most in-need population through identification of gaps in health coverage, deployment of mobile health team and support for nongovernmental organizations and rehabilitation of key health facilities in SCS
- ❖ Coordinate with other partners, in re-settlement of returnees, IDPs and refugees through ensuring the availability of health, environmental services, food security and nutritional supplementation

Main focus 2: Emergency response

Strategic approaches

- ❖ Strengthen emergency preparedness and early warning systems through preparation of risk map assessment, continuous updating of regional health profiles and ensuring the availability of essential supplies and logistic support

- ❖ Strengthen the capacity of zonal and regional health authorities for emergency relief, response and recovery through training of staff and institutional development, upgrading the environmental health and nutrition components and coordination mechanisms





Section

6



Implementing the Strategic Agenda:
Implications for WHO



❖❖ Section 6. Implementing the Strategic Agenda: Implications for WHO

6.1 Overview

The strategic agenda calls for WHO to provide assistance to respond to the ongoing humanitarian health emergency and to a wide range of needs identified within health priorities. The following are the key priorities identified for 2010–2014.

- ❖❖ Priority programmes
- ❖❖ Health system development
- ❖❖ Coordination and partnership
- ❖❖ Determinants of health
- ❖❖ Emergency preparedness and response

Each one of these priorities entails a number of strategic objectives and related approaches. The tasks involved are substantial and will require a review and expansion of WHO's current operations in Nairobi and Somalia in terms of staff, management methods and administrative arrangements. The implications for the country programme, Regional Office and headquarters are indicated below.

6.2 Implications for the country programme

Unless there is a radical change in the security landscape in Somalia in the immediate future, management of WHO programmes will continue to be supported by physical presence in several locations inside and outside the country including from Nairobi. The most critical challenge for the WHO collaborative programme in Somalia is to strengthen the programme operational capacity to be able to respond to emergency health needs of people as well

as assist in health development in the areas that security allows.

Because of the fluid nature of events, there are sporadic lulls in conflict areas where it is possible to provide essential health care for most needy at the local level. Furthermore, as the lead UN agency for health, WHO should promote the rapid response system, when conditions allow, among UN and other key partners and assist in its realization. Therefore the operational capabilities and rapid response management is among the the key main challenges.

The existing staff, management and operation capacity of WHO country programme are substantial. In terms of operational procedures, logistics support and rapid technical assistance, the country programme should be supported by the Regional Office and headquarters. In view of enormous need for emergency and long-term health care, resource mobilization from donors and potential partners should also assume a very high priority. In this regard, country office capacity for lobbying, active fund-seeking, proposal development and presentation should be enhanced.

Furthermore, there is a need to ensure the continuity of services of key core technical staff, as the frequent turnover of staff seriously disrupts the programme. There will also be a need for additional specialist expertise, mostly on a short-term basis, to support the proposed new areas of collaboration and assistance.

In the areas where the security situation allows development activities, WHO programmes should be able to promote and assist in establishment of primary health care services at the local level.

In the longer term, the country office will focus on greater prioritization of health programmes using a more integrated approach to implementation in close collaboration with the health authorities of the three zones. Vertical disease programmes, such as those funded by the Global Fund, will be better coordinated with health systems strengthening component for greater coherence between disease-specific activities and building the health system. More emphasis will be placed on revitalization of the PHC approach with strong community involvement in planning, managing and delivering of health services. Considering the differences between the three zones in terms of security, access, level of development and institutional capacity, WHO will plan and implement activities to respond to the specific needs of each zone.

6.3 Implications for the Regional Office and headquarters

The strategic agenda in terms of technical content and scope calls for substantial

technical support from the Regional Office and headquarters. The current responses by both the Regional Office and headquarters are not fast enough due to procedural constraints. In view of insecurity and the restriction that it imposes on the programme, there is a need for long term planning in the Regional Office to support Somalia. This includes contingency plans for locating and alerting potential consultants, conducting missions as well as coping with the rapidly changing situation on the ground. The Regional Office needs to ensure a coordinated rapid response for Somalia operations.

Careful attention should be given to strengthening the coordinating and leadership role of WHO collaboration in relation to the large number of international bilateral and multilateral donors. Also, the advocacy role of the country office should receive adequate back-up by the Regional Office and headquarters. This includes technical, promotional and institutional support and inputs.

Table 10 outlines the required collaboration from external agencies for successful implementation of the CCS strategic agenda during 2010–2014.

Table 10. Implementation of the strategic agenda

CCS strategic agenda	External agencies
<i>Priority health programmes</i>	
Integration of communicable disease control programmes	CDC, KEMRI, nongovernmental organizations
HIV/AIDS and STI, tuberculosis and malaria	UNICEF, World Vision, UNFPA, UNAIDS, nongovernmental organizations

CCS strategic agenda	External agencies
Maternal, neonatal and child health	UNICEF, UNFPA, CDC, nongovernmental organizations
Neglected and other tropical diseases	World Concern, CDC
EPI including measles elimination and polio eradication	UNICEF, CDC, nongovernmental organizations
Improving nutritional status of targeted groups	UNICEF, WFP, FAO/FSNAU, nongovernmental organizations
Improving mental health and other noncommunicable diseases	Nongovernmental organizations
<i>Health systems development</i>	
Human resource development	UNICEF, UNDP, UNFPA, World Bank
Governance and leadership	UNDP, UNAIDS, World Bank
Organization and management of the district health system	UNICEF, nongovernmental organizations, World Bank
Medicines, vaccines and technology	UNICEF, UNFPA, nongovernmental organizations
Health information	UNICEF, nongovernmental organizations
Health care financing	World Bank
Health system components of global health initiatives	Global Fund, GAVI, World Bank
<i>Coordination and partnership</i>	
Coordination with partners	
Evidence for informed decision-making	
Resource mobilization	
<i>Determinants of health</i>	
Environmental health	UNICEF, UNEP
Social determinants of health and health equity	UNDP, UNICEF, ILO, nongovernmental organizations
Health promotion	UNICEF, nongovernmental organizations
<i>Emergency preparedness and response</i>	
Access to essential health services	UNICEF, UNFPA, health cluster, OCHA, WFP, nongovernmental organizations
Emergency response	UNICEF, UNFPA, health cluster, OCHA, WFP, nongovernmental organizations

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