

Photo: SOYDA



# OVERVIEW AND ACHIEVEMENTS OF THE HEALTH CLUSTER IN SOMALIA 2010



# SOMALIA HEALTH CLUSTER IN BRIEF

prepared by WHO Somalia

## PARTNERS

The health cluster approach was launched in Somalia in April 2006 to address identified gaps in **response** (e.g. predictability, timeliness and effectiveness); facilitate joint strategic **planning, resource mobilization, monitoring and reporting**; and enhance the quality of humanitarian action by strengthening **leadership, accountability, and local capacity**.

Currently the health cluster consists of a group of more than **35 active partners** (5 UN agencies, 30 international and local NGOs, and in addition the International Red Cross and Red Crescent Movement and MSF as observers) **and other stakeholders** working together in humanitarian health response. The expansion of partnership and networks linked with local capacity building is an integral part of the health cluster strategy for response to the deteriorating humanitarian situation. For instance, over 20 local agencies have expressed their interest in health cluster partnership in 2010, and profiles of new appealing organizations are regularly being reviewed by the health cluster.

**WHO as the lead agency of the health cluster** at global and country level, facilitates the coordination of health interventions in the different regions of Somalia. The international NGO **Merlin co-chairs the health cluster in Somalia** and, together with WHO, is in charge of cluster coordination and emergency preparedness in Puntland. **Save the Children UK** partners with WHO in the coordination of humanitarian health interventions and emergency preparedness in Somaliland.

Within South Central Somalia, different partners have been appointed as regional **health cluster focal agencies**. Focal agencies are appointed for one year and are currently being confirmed for 2011. The linkage of field-level and Nairobi-based coordination (e.g. tele-conferencing; field visits; joint trainings) aims to enhance the efficiency of emergency response by avoiding duplication of activities, emphasizing the potential of local capacities, and facilitating inter-agency support and partnerships.

PROPOSED HEALTH CLUSTER FOCAL AGENCIES FOR 2011 IN SOMALIA	
Region/ Zone	Agency
Somaliland	Save the Children (to be confirmed)
Puntland	Merlin
Galmudug	WHO
Galgaduud	CISP/ Merlin (division of tasks to be confirmed)
Hiraan	WHO (as last resort)
Gedo	WHO (as last resort)
Banadir	WHO/ WARDI
Middle Shabelle	Intersos
Lower Shabelle	COSV
Bay	GTZ (to be confirmed)
Bakool	GTZ (to be confirmed)
Middle Jubba	AFREC/ Zamzam (to be confirmed)
Lower Jubba	Muslim Aid UK/ AFREC (to be confirmed)

## COORDINATION ACTIVITIES & TOOLS

Health cluster partners meet on a monthly basis at national level to share information and updates concerning current situation (e.g. conflict, population movement and displacement, natural disasters) in different regions of the country; completed, ongoing and planned health interventions; disease outbreaks; and other issues relevant to the health situation and coordination in Somalia.

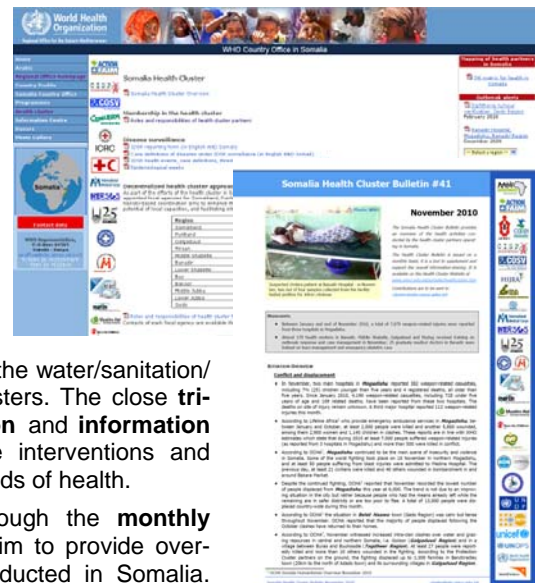
**Health cluster meetings** are also attended by representatives of the water/sanitation/hygiene (WASH) and nutrition clusters. The close **tri-cluster coordination, cooperation and information sharing** facilitates more effective interventions and response to meet humanitarian needs of health.

### LIST OF INFORMATION SHARING & COORDINATION TOOLS

- monthly health cluster bulletin
- website & generic email
- 3W matrix
- regional/ zonal focal agencies
- Tri-Cluster coordination (health/ WASH/ nutrition)
- AWD preparedness matrix

Information is shared widely through the **monthly health cluster bulletins** which aim to provide overviews of the health activities conducted in Somalia. Partners contribute by sending updates, reports, pictures and any other health-related information to the **generic health cluster email** at [cluster@nbo.emro.who.int](mailto:cluster@nbo.emro.who.int). Reports, updates, reference documents and tools, as well as the bulletin and other information relevant for health cluster activities and coordination are available and archived on the **health cluster website** at [www.emro.who.int/somalia/healthcluster.htm](http://www.emro.who.int/somalia/healthcluster.htm). Based on the information provided by

partners, the health cluster established a **3W (Who/What/Where)-Matrix** in order to monitor which agency is providing which service in which location in Somalia, and to ensure gaps are identified and addressed. The document is updated with feedback from partners on a quarterly basis and available on the health cluster website.



## FUNDING & OTHER HEALTH CLUSTER TASKS

The Health Cluster facilitates joint strategic planning (e.g. Consolidated Appeal Process) and supports partners in emergency resource mobilization, e.g. through the **Common Humanitarian Fund (CHF)**.

With decreasing availability of funds for humanitarian aid in Somalia, more partners have sought support from the Health Cluster to submit short-term projects to the **Emergency Reserve of the CHF**.

The preparation for the **Consolidated Appeals Process (CAP)** was conducted in close inter-cluster coordination between health, WASH and nutrition clusters, and interactive consultation with health partners.

### COMMON HUMANITARIAN FUND (CHF)

- The Health Cluster has been a very active partner in the establishment of the CHF in Somalia.
- In early August, the first standard allocation of the CHF for Somalia was completed. The Humanitarian Coordinator allocated US\$20 million based on the recommendations from the Cluster Review Committees. \$5 million was allocated to 14 health projects, 11 of them submitted by NGOs and 3 by UN agencies.

### CONSOLIDATED APPEALS PROCESS (CAP) 2010

- As of 2 November 2010, the health cluster had received a total of **US \$23,693,102** against the CAP 2010. This amount equals to **48% of the requirements** as revised in the mid-year review in June 2010.

### CONSOLIDATED APPEALS PROCESS (CAP) 2011

- In October 2010, 45 health cluster partners submitted a total of 60 project sheets for the CAP 2011.
- After 3 review sessions by the cluster review committee (CRC) and the cluster gender focal point, 12 of the projects were rejected and 5 project sheets were merged into 2, leaving a total of 45 projects accepted to be included for health in the CAP.
- Of all approved project sheets, 9 were submitted by UN agencies, 21 by international and 15 by national NGOs.
- The funding requirement for the **45 health projects** that were included by the health cluster in the CAP 2011 totals to **US\$ 58.6 million**

## ACHIEVEMENTS & CHALLENGES

In 2010, despite the worsening humanitarian situation, health cluster coordination and partnership have proven to be successful. The Emergency Preparedness and Humanitarian Action (EHA) team of WHO has carried out the tasks of health cluster coordination until the dedicated cluster coordinator was recruited in December 2010. The health cluster successfully completed the following **achievements**:

### Planning, advocacy and fundraising:

- WHO as the health cluster lead agency, with support from the CRC and partners, reviewed all project sheets and response plan under the **CAP 2010 mid-year review**. Later in the year, WHO and CRC prepared the **cluster response plan**, reviewed and prioritized all projects, and finalized the health section for **CAP 2011**.
- The health cluster played a very active role in the **preparation and introduction of the Common Humanitarian Fund (CHF)** in Somalia, including WHO participation in advisory boards and other committees. The health cluster lead with support from the CRC coordinated the participation of health cluster partners in the **first standard allocation round of CHF** in August 2010. Later in the year, the CRC reviewed the proposals in **preparation of the second allocation round** for early 2011.
- Establishment of elected health **cluster review committee (CRC)** equally representing UN agencies, international and national NGOs. On behalf of the health cluster, the CRC reviewed HRF and CERF proposals, CAP project sheets, and CHF proposals.

### Coordination and information sharing:

- The health cluster lead prepared and distributed **monthly health cluster bulletins**, regularly updated the **health cluster website**, convened and chaired **monthly health cluster meetings**, and facilitated the quarterly updates and database management of the **health 3W matrix** (who is doing what where in health in Somalia)
- In close collaboration, health cluster focal agencies (see listed on previous page), local health authorities and OCHA, have established **health field cluster coordination meetings** in 2010 in Puntland, Galmudug, and Banadir.

### Capacity building and support to health facilities and partners:

- WHO and health cluster partners **trained over 850 health workers** throughout Somalia addressing communicable diseases surveillance, outbreak detection and control, emergency surgical procedures and trauma management, and reproductive health including emergency obstetric care (CEmOC).



Data available in 2010 indicated that over 15% of weapon-related casualties in Mogadishu were children under the age of 5 years



In June, HIJRA and Oxfam provided cholera beds and mattresses for Banadir Hospital to support the prevention of cross-infections and contamination by beddings which patients used to bring from their homes



In October, WHO trained 63 health workers in Galkayo (Mudug) on emergency medical care

### Emergency and outbreak response:

- WHO and health cluster partners have been able to ensure **early detection, timely response to** and **control** in 74% of the 89 outbreaks throughout Somalia within the recommended 96 hours of reporting. **Outbreak interventions** include social mobilization activities, case management training, and chlorination activities in coordination with the WASH cluster.
- As of the end of November, cholera has been laboratory confirmed in **15 out of 146** samples collected in Lower Jubba, Hiraan, and Lower Shabelle regions (including the Afgooye Corridor), and Mogadishu.
- 2010 was marked by renewed conflict, restricted movement of health care providers and medical supplies, and the withdrawal or suspension of aid agencies. However, the health cluster was able to counter these factors with improved quality and timeliness of case management, good coordination of different partners, inter-cluster collaboration, training of health care providers, and the provision of standardized emergency medical supplies.
- The **Integrated Disease Surveillance and Reporting network (IDSR)** has been established in Lower Shabelle Region. In total, 25 partners are reporting from health facilities in South Central Somalia covering key populations of humanitarian concern.
- Development and regular update of **contingency plan** for Greater Mogadishu and South Central Somalia to respond effectively to emergency health needs arising from increased conflict in the area.
- WHO (coordination and provision of medical supplies) together with 6 health cluster partners (implementation of health activities and provision of medical services) jointly planned and provided **emergency health response for internally displaced people (IDPs) in Greater Mogadishu**, also covering the Afgooye and Bal'ad corridors and parts of Lower and Middle Shabelle.
- Update of **AWD preparedness matrix** which includes information about available stocks of AWD supplies and levels of preparedness of health partners in several locations.

In order to improve the efficiency of the Health Cluster, the following **key challenges** need to be addressed:

- **Highly fluctuating operational presence** within Somalia results from the **fast-changing security environments**. This situation leads to **limited access for the humanitarian community** that jeopardizes the continuity and sustainability of health service provision.
- The **lack of a functional central government**, and the presence of 3 different health authorities with different levels of development in the zones of Somalia contribute to the complexity of coordination. Specifically, the lack of oversight mechanisms leads to unequal distribution of health service coverage throughout the country.
- **Low capacity of local agencies and lack of skilled health workers** to implement health activities can compromise the quality of services and requires more monitoring and quality control, which may be difficult due to limited access and security.
- The humanitarian community has faced gaps in **monitoring and supervision** of interventions due to **restricted access and movement** especially in South Central Somalia. The approach of "remote control" did not prove to be sufficient. The health cluster therefore aims to strengthen the capacity of local partners who will then be enabled to provide the cluster with information from the field and establish field-based coordination and information-sharing mechanisms.
- **Gaps in the infrastructure** and localized **security constraints** lead to increased operational costs such as logistics and security measures.



Photo: WHO

Over 100 patients received medical care during WHO on-the-job training for health workers in Banadir Hospital (Mogadishu) in March



Photo: SAMA

SAMA reported 1,351 consultations from Labatunjerow MCH (Bay) and the additional outreach programme in November



Photo: WHO

Of the 156 patients who received treatment for AWD in Banadir Hospital (Mogadishu) in October, 79% were children



Photo: SOYDA

Over 600 patients were seen by SOYDA's doctors in a 2-days health services campaign in Lafaole (Afgooye Corridor) in February



Photo: Islamic Relief

Islamic Relief provide medical services to IDPs in settlements along the Afgooye Corridor and one in North Galkayo (Mudug Region)