

Somalia Health Cluster Overview March 2010

prepared by WHO Somalia

SOMALIA HEALTH CLUSTER IN BRIEF

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 **30 active partners** (5 UN agencies, 25 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 in 2010. For instance, over 20 local agencies have expressed their interest in health cluster partnership for this year, and their profiles are currently being reviewed by the health cluster.

WHO as the lead agency of the health cluster at both 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. At regional level within South Central Somalia, different partners have been appointed as **Health Cluster focal agencies**. 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.

COORDINATION ACTIVITIES & TOOLS

Health cluster partners meet on a monthly basis in Nairobi 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 bulletin
- website & generic email
- 3W matrix
- regional/zonal focal agencies
- Tri-Cluster coordination (health/ WASH/ nutrition)
- AWD preparedness matrix

Information is shared on a wider basis through the **monthly health cluster bulletin** which aims to provide an overview of the health activities conducted in Somalia. Partners contribute updates, reports, pictures and any other health-related information relevant to the **generic health cluster email** at 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. Based on the information provided by partners, regularly updated and verified, the Health Cluster has also developed 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.

FUNDING & OTHER HEALTH CLUSTER TASKS

The Health Cluster facilitates joint strategic planning (e.g. Consolidated Appeal Process) and supports partner agencies in emergency resource mobilization (e.g. HRF).

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 **Humanitarian Response Fund (HRF)**.

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.

HUMANITARIAN RESPONSE FUND (HRF)

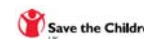
- In 2009, eight projects amounting to US\$1.52 million were funded by HRF. 3 of the projects include nutrition and/or WASH components.
- A total of 650,165 people in Lower and Middle Shabelle, Lower and Middle Jubba, Bay, Hiraan, Banadir, Galgaduud, and Togdheer regions benefitted from the projects.
- In 2010, health cluster partners have submitted 7 project proposals to the HRF. One of them has already received a grant of US\$ 150,000, another 4 are currently under revision.

HEALTH CLUSTER FOCAL AGENCIES IN SOMALIA

Region/ Zone	Agency
Somaliland	Save the Children
Puntland	Merlin
Galgaduud	CISP/ Merlin
Hiraan	WHO (as last resort)
Middle Shabelle	Intersos
Banadir	WHO
Lower Shabelle	COSV
Bay	GTZ
Bakool	GTZ
Middle Jubba	World Vision
Lower Jubba	Muslim Aid UK
Gedo	WHO (as last resort)



ICRC



CONSOLIDATED APPEALS PROCESS (CAP) 2009

- As of 1 December, 38% (including CERF grants) of revised financial requirements for health under the CAP 2009 have been funded (in May it was just 3%; in September 24%) according to FTS.
- In the mid-year review in June 2009, the health cluster had revised the financial needs for the remaining months from US \$43.8 to 39.2 million.

CONSOLIDATED APPEALS PROCESS (CAP) 2010

- The Health Cluster Response Plan in preparation of the CAP 2010 was developed in September and partners submitted over 40 project sheets based on the Health Cluster objectives. 36 projects with a total budget of US \$46,444,971 were accepted.
- The Health Cluster steering committee for CAP 2010 prioritized all projects against an established list of criteria. The 8 projects rated as high priority require US \$29,822,075.
- In early 2010, 2 health cluster partners were granted a total of US\$ 3.9 million under CERF for child health interventions. This equals to 8% funding of the CAP 2010 for health as of March.

ACHIEVEMENTS & CHALLENGES

In 2009, despite the worsening humanitarian situation, health cluster coordination and partnership have proven successful through the following health interventions:

- **Emergency health response for internally displaced people (IDPs)** in Greater Mogadishu and the Afgooye Corridor. Through joint efforts, partners are providing basic health services with utilization rates of up to 3 visits per person per year.
- The health cluster developed a **flood contingency plan** which has been incorporated within overall preparedness activities for communicable diseases. Partners contributed to the development of an **AWD preparedness matrix** which includes information about available stocks of AWD supplies and levels of preparedness of health partners in several locations.
- Health cluster partners have been able to ensure **early detection, timely response to** and **control** of more than 60 outbreaks throughout Somalia within 96 hours of reporting of rumors by timely information-sharing and coordination of response activities. 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 43 out of 135 tested samples collected in Lower Jubba, Lower Shabelle (including from the Afgooye corridor), Bay, and Mudug regions and from Mogadishu. Due to improved quality and timeliness of case management, good coordination of different partners and beyond different clusters and training of health care providers as well as the provision of standardized emergency medical supplies, the overall case fatality rate (CFR) of acute watery diarrhoea was steadily reduced since 2007. The Early Warning and Alert Response System (EWARS) has been reporting from 36 health facilities in Lower Shabelle covering key populations of humanitarian concern.
- Health cluster partners **trained over 280 health workers** throughout Somalia addressing AWD/cholera prevention, preparedness, response and control; case definitions, data collection and reporting for early detection, alert and response to communicable diseases including diarrhoeal diseases; malaria prevention and treatment; tuberculosis treatment standards; cold chain management; and emergency services such as first aid, trauma, and obstetric care.
- In order to be able to provide basic primary and secondary health care, health partners **rehabilitated 8 health facilities** including 2 hospitals, in Bay and Bakool, Lower Jubba, Middle Shabelle, and Galgaduud since the beginning of 2009.

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

- The performance of the health cluster relies upon the continuity of available and dedicated staff in the cluster lead agency. Currently, WHO is providing three staff members one of which is fully dedicated to tasks related to the health cluster; Merlin is supporting the necessary efforts with one staff member; and OCHA has assigned a cluster support officer. The demanding workload related to the effective functioning of the health cluster requires a dedicated health cluster coordinator and support staff.
- 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.
- Remote control monitoring and supervision were proposed in preparation of the CAP 2009 as a temporary solution to limited access and presence of the humanitarian community in Somalia.
- The lack of a 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 Somalia.
- Low capacity of local agencies and workforce implementing 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.
- Limited access due to gaps in the infrastructure, in addition with localized security constraints, lead to increased operational costs such as logistics and security measures.