

Somalia



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. Following the civil war of 1991, the country now consist of three zones: northwest Somalia (NWS), known as Somaliland, northeast Somalia (NES), known as Puntland and south/central Somalia (SC). Each has its own administration. Somalia has a clan-based society, with clan membership playing an integral role within socioeconomic and political arenas. Somali is the official language of Somalia.

HEALTH & DEVELOPMENT

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.

However, the population-based health survey information indicates a major decline in mortality rates for women, infants and children in Somalia over the past decade (Unicef Multiple Indicator Cluster Surveys). The decline may be associated with small improvements in access to food and clean water, and awareness of their importance. However, the overall health status and access to the essential health services remain poor.

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. However, the current humanitarian crisis may have implications for maternal and child health. In addition, the poor quality health services may jeopardize the recent health gains and limit the progress in achieving the MDG targets.

Total population (2005) ¹	8, 445, 000
% Under 15 (2006) ¹	44.4
Population distribution % rural (2005) ¹	67
Life expectancy at birth (2008) ²	50
Under-5 mortality rate per 1000 (2006) ³	145
Maternal mortality rate per 100 000 live births (2006) ³	1044-1400
Total expenditure on health as % of GNI (2008) ³	3-3,5
General government expenditure on health as % of general government expenditure	NA
Human Development Index Rank, out of 177 countries	NA
Gross National Income (GNI) per capita USD (2002) ⁴	226-320
Adult (15+) literacy rate (2000-2006) ³	25
Adult male (15+) literacy rate	NA
Adult female (15+) literacy rate	NA
% Population with access to improved drinking water source (2006) ⁵	29
% population with improved access to sanitation (2006) ⁵	37

Source

1. UNDP Somalia;
2. Unicef Multiple Indicator Cluster Survey;
3. Economist Intelligence Unit;
4. World Bank
5. Unicef.

OPPORTUNITIES	CHALLENGES
<p>Notable factors that have helped to prevent excess mortality and encourage continuous partnership in Somalia include the following:</p> <ul style="list-style-type: none"> ✚ 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 Somalia, allowing work on sustainable development of health. 	<p>Main challenges include the following:</p> <ul style="list-style-type: none"> ✚ Widespread conflict, lawlessness and political strife across large areas of 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 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 and skilled workforce, particularly within the management of PHC services; ✚ Severely limited public funding of health services.

PARTNERS

WHO Somalia primary partners include the following: UNICEF, UNFPA, UNOPS, UNDP, UNESCO, WFP, IOM, Muslim Aid (UK), International Medical Corps, African Muslim Agency, Merlin, SAACID, Manhal International, Finland-Somalia Association, ICRC/IFRC, Mercy International (USA), MSF, SRCS, ICD, COOPI, Cooperaziine Servizi Volontari and Organizzazione Umanitaria per L'Emergenza.

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> ✚ The Interagency Standing Committee (IASC) and Coordination of International Support to Somalis (CISS) provide both a forum for all partners to discuss humanitarian, 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 is merely provided in SC Somalia ✚ The Health Sector Committee and its working groups with the mandate of deepening the analysis of the health sector and fostering shared actions towards its development provide the opportunity for alignment of international cooperation with the national health agenda. 	<p>Despite a period of increased funding for health within a short period of past 7 years, a sharp decline in bilateral funding was seen in 2009. Key challenges include the following:</p> <ul style="list-style-type: none"> ✚ Health authorities must adopt a unified health sector strategy with a set of realistic priorities which all partners can identify and support; ✚ 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 incredible 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.

WHO STRATEGIC AGENDA (2010- 2014)

The strategic agenda calls for WHO to provide assistance to respond to the ongoing humanitarian health emergency and to a wide range of needs identifies within health priorities. The following are the key priorities identified for 2010-2014: Priority programmes(Integration of communicable disease control programmes, HIV/AIDS and STI, TB and malaria, Maternal, neonatal and child health, Neglected and other tropical diseases, EPI including measles and polio eradication, Improving nutritional status of target groups and Addressing mental health and non-communicable diseases); 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.



ADDITIONAL INFORMATION

WHO Country Page <http://www.who.int/countries/>
WHO Country Office Web Site

© World Health Organization 2010 - All rights reserved

The Country Cooperation Strategy briefs are not a formal publication of WHO and do not necessarily represent the decisions or the stated policy of the Organization. The presentation of maps contained herein does not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or areas or its authorities, or concerning the delineation of its frontiers or boundaries.